Work Psychology Group
Thinking differently

What Supports Fairness in Managing Concerns and Employer Referrals of Doctors to the GMC?

Final Project Report

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Executive Summary

Background

The General Medical Council (GMC) has a 2026 target to ensure that employer Fitness to Practise (FtP) referrals are proportionate. Referrals are "disproportionate" when the composition by ethnicity or world region of primary medical qualification (PMQ) of doctors referred by an employer is out of line with respect to the composition of all doctors connected to that employer. Previous research has found that doctors who are white or UK-trained were less likely to be referred for an FtP concern than their ethnic minority or non-UK-trained colleagues, but this gap is reducing (GMC, 2019; GMC, 2024). Understanding the problem of disproportionality in referrals is complicated, which makes identifying specific solutions that directly reduce disproportionality complicated as well. There is a large variation across organisations that make referrals, known as Designated Bodies (DB). A DB is the name given to an organisation that doctors are connected to for the purpose of revalidation. They differ based on characteristics such as organisation size, type, and the region or UK country in which they operate. Most DBs have mechanisms and initiatives (referred to in this project as "interventions") in place to support doctors and ensure that investigations of any complaints or concerns are carried out fairly. This research project builds on previous work by investigating interventions in place to understand which have the greatest impact on reducing disproportionality in referrals.

Research Questions

Three specific research questions were defined, detailed below:

1. **Research Question 1:** What interventions are present in DBs, and how might these relate to proportionality in relation to PMQ region or ethnicity?
2. **Research Question 2:** What evidence is there that such interventions could support more proportionate referrals, and in which type of DB could they be effective?
3. **Research Question 3:** What else does an examination of interventions reveal about our pre-existing hypotheses[1]?

Methodology

A mixed-methods approach was used to generate greater depth of insight and provide well-supported findings across the full range of DBs. The methodology was split into five stages: (1) initial scoping and a rapid literature review, (2) interviews and (3) a survey, detailed below, before completing (4) analysis and (5) reporting.

[1] Pre-existing hypothesis: Disproportionality is not appreciably introduced by the referring person or group; disproportionality has its roots in disadvantages present in the workplace before an incident happens.

Initial Scoping and a Rapid Literature Review

Initial scoping provided a starting point to identify the data the research team wanted to collect for analysis. This included understanding existing GMC data available on DB characteristics and referrals, which was used to support the identification of a representative sample to target during data gathering and provided a starting point to document interventions in place across DBs. The rapid literature review aimed to build on the GMC's existing work on disproportionality in referrals by drawing on social psychological theory to explain its underlying causes, while also identifying and summarising current organisational interventions and initiatives designed to support fair referral processes.

Interviews

Interviews aimed to gather detailed insights on interventions in place across DBs. A representative sample was selected to invite to participate based on balanced representation of DB characteristics (type, size, region/country) and proportionality outcomes. Interviews were conducted with 21 Responsible Officers (ROs) from a range of organisations.

Interviews were recorded, transcribed, and analysed using template analysis. Interview data validated and expanded the series of interventions identified within the literature review, creating a final list of 52 interventions and allowing categorisation of them into five groupings (*Performance; Group-Specific Support; Diversity, Equity, Inclusion and Belonging; Management of Concerns; Culture of Learning*). Additional influencing factors (e.g., use of formal performance management frameworks, Employer Liaison Advisor (ELA) engagement, geography, referral type, RO experience) were also identified. The collated information from the literature review and interview analysis then informed the survey design.

Survey

The aim of the survey was to collect data from a broader range of DBs about what they were doing to support fair referrals. The survey was built in two sections: Section 1 captured data on the presence and status of the 52 interventions in the respondent's DB; Section 2 captured additional information on DB characteristics and other factors that might influence the proportionality of referrals.

The survey was distributed via email to 555 ROs, representing 1105 DBs out of the 1177 DBs with at least one doctor connected at the end of July 2025 (ROs can represent multiple DBs). It remained open for eight weeks, yielding complete responses from 53 DBs and partial responses from another 53 - representing 10% of all DBs (106 of 1,177 DBs). The number of responding DBs was smaller than originally planned and contained limited variation within the outcome of interest (proportionality). As such, the original intention of using supervised machine learning methods (specifically, classification trees) to generate results could only be partially completed. An alternative approach to generate results, using a combination of some modelling and inferential and descriptive statistics, paired with qualitative insights from the interviews and cross-referenced with findings from the literature review, was agreed between the GMC and the research team.

Results

Using the collated data, six interventions were identified as contributing to proportionate referrals. These six interventions were identified based on the following criteria: supporting evidence (in the literature, from DBs, or both) and in place >90% of DBs sampled, and/or an intervention that was statistically significantly or quantitatively associated with proportionate referrals regarding ethnicity and PMQ region. These are summarised below.

Intervention 1: Clear mechanisms for providing informal feedback

Clear mechanisms for providing informal feedback to doctors are a widely adopted and highly valued intervention to support good performance, with 92% of sampled DBs implementing this approach. The rapid literature review indicates that informal feedback supports early issue resolution, improves communication, and reduces reliance on formal processes. However, this depends on the presence of psychological safety and supportive environments, and such processes should not single out particular groups or individuals. Practical tips for implementation include creating regular feedback touchpoints, integrating feedback into existing frameworks, equipping supervisors with prompts, and ensuring private, comfortable settings for conversations.

Intervention 2: Required completion of GMC-provided "Welcome to UK Practice" training

The GMC's *Welcome to UK Practice* training is designed to help doctors new to the UK by offering practical guidance about ethical scenarios they may encounter. It is implemented both within DBs and centrally offered to doctors as they join the register, and is perceived to have a positive impact on supporting international medical graduates (IMGs). Quantitative analysis suggested a link between this intervention and proportionate referrals, though the findings should be interpreted with some caution given the small sample size. Research shows that the training improves practitioners' understanding of UK professional standards, ethical expectations, and cultural norms, reducing the risk of miscommunication and supporting safer practice (Kehoe et al., 2019). Practical steps include integrating the course into onboarding activities, providing protected time for completion, and recognising that this intervention should complement, rather than replace, ongoing support for IMGs.

Intervention 3: Informal, but documented, conversations with staff over lower-level concerns

Informal but documented conversations over lower-level concerns are among the most widely adopted interventions, in place at 96% of sampled DBs. This approach is perceived as critical for early resolution and preventing escalation to formal complaints. Research supports the effectiveness of this intervention when applied to all doctors regardless of demographic background. This includes the importance of completing adequate documentation for all doctors to provide accountability and promote consistency. Key success factors include clear guidance on how to have these conversations, trained managers, and a supportive underlying culture. Practical steps include using light-touch templates, integrating discussions into routine check-ins, ensuring secure record storage, and involving neutral third parties for sensitive cases.

Intervention 4: Rapid scoping exercise after an initial incident/concern to understand the extent of investigation required

Rapid scoping exercises following an initial concern are also widely implemented, with 92% of sampled DBs using this approach. This intervention is considered a critical first step in managing concerns, enabling an appropriate response and preventing unnecessary formal investigations. DBs emphasised their value, particularly when combined with informal documented conversations. Success depends on clear communication and transparent documentation to maintain trust and fairness. Practical steps include using a standardised scoping checklist (e.g. Patient Safety Incident Response Framework (PSIRF; NHS England, 2022) or the NHS Resolution Fair and Proportionate checklist (NHS Resolution, 2025), conducting fact-finding within 48 hours, recording decisions consistently and analysing patterns, and monitoring representation of different groups of doctors in the local disciplinary process to ensure accountability.

Intervention 5: Coordination with the GMC ELAs to get advice before referrals are made

Coordination with GMC Employer Liaison Advisers (ELAs) before making referrals is a highly embedded practice, in place across 93% of sampled DBs. As all DBs have regular contact with their ELA, this figure may simply reflect that some DBs did not need to make any referrals during the reporting period. This was cited as a very valuable first step in managing concerns. ELAs provide specialist advice to ensure that referral thresholds are applied accurately, reducing unnecessary or premature escalation. Evidence from the interviews highlights ELAs as an important resource for maintaining fair and appropriate referrals, though their advice should be understood as representing the GMC rather than being impartial. Practical steps include continuing to use ELAs as a source of advice while complementing their input with alternative perspectives, such as retrospective decision-making reviews or RO group discussions.

Intervention 6: Promotion of inclusive consulting in the lead-up to decisions, that welcomes challenge and incorporates feedback from those more at risk of being overrepresented in disciplinary processes

Promoting collective decision-making, including welcoming challenge and considering input from groups at greater risk of disciplinary overrepresentation, is in place in 71% of sampled DBs. ROs frequently mentioned relying on networks of RO peers or others involved in the disciplinary process for support, challenge, and sense-checking in the lead-up to referral decisions or disciplinary action. Promoting this inclusive collaboration encourages challenge, transparency, and the inclusion of diverse perspectives. Whilst the RO is ultimately the accountable decision-maker for referrals, incorporating a collaborative consultation reduces the influence of individual bias, strengthens fairness, and builds trust in how concerns are assessed.

Additional Interventions of Interest

In addition to the key interventions outlined above, 17 interventions of interest were identified as potentially valuable for supporting proportionate referrals. A summary of each intervention is provided in the main body of the report.

Influencing Factors

Wider considerations that emerged from the survey data and interviews were also identified, which were conceptualised as potential influences on the efficacy of any interventions in place, and on the proportionality of referrals more broadly;

- **Contextual Factors:** These factors are contextual conditions that shape the general working environment and risk of disproportionate referrals *(e.g. local disciplinary processes, RO proximity to connected doctors, type of potential referral, demographic composition of DB workforce).*

- **Moderators**: These factors can directly influence how well interventions aiming to support proportionate referrals work in terms of quality or consistency of impact (*e.g. RO as a pastoral role, experience with referrals/as an RO, underlying causes of (dis)proportionality, involvement of others in management of concerns*).

- **Capability Factors**: These are factors that affect the ongoing quality or sustainability of such interventions (*e.g. lack of evidence available, challenges in evaluation, limited funding*).

Additional analysis highlighted further points for reflection. Peer mentoring was significantly associated with greater disproportionality in referrals, potentially reflecting its tendency to reinforce shared perspectives and in-group thinking, despite also offering reassurance and support. Further, designated bodies (DBs) that were disproportionate by ethnicity or PMQ region were also likely to be disproportionate across other protected characteristics and areas of practice, suggesting that addressing one form of disproportionality via interventions may reduce disproportionality in other areas.

The concluding comments reflect the importance of DBs considering their own context when applying these findings. It may be that, due to the long timeframe for proportionality calculations, DBs already have some of these interventions in place, and results are not yet visible but will flow through the system in due course. Likewise, while identified interventions are applicable across all DBs, their implementation in practice will vary depending on the unique context and size of any DB. However, the underlying principles of these interventions should still be reviewed to understand how they might be adapted or implemented in a context-appropriate way which still meets the original intention of the intervention. Finally, analysing data at the individual DB level could provide insight into nuances within that context that may affect the proportionality of referrals. Maintaining a comprehensive, well-structured dataset capturing decisions made within local disciplinary processes would enable the DB to monitor internally whether certain groups are disproportionately represented at any stage. Such systematic monitoring would support early identification of potential inequities and enable timely, evidence-based local action to address them.

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Glossary

A number of key terms are used throughout this report; these are defined below in Table 1.

Table 1: Glossary Terms

Key Term	Definition
Designated Body (DB)	An organisation that doctors are connected to for the purpose of revalidation. In most cases, this is the doctor's employer.
Disproportionate	A DB is deemed disproportionate if the composition of doctors referred, grouped by ethnicity or PMQ region, is statistically very different to the composition of all doctors connected to the DB that were not referred.
Fitness to Practise (FtP)	An assessment of a doctor's ability to practise safely and effectively. It includes considering a doctor's overall ability to perform their individual role, their professional and personal behaviour, and the impact of any health condition on their ability to provide safe care (GMC, 2024).
Proportionate	A DB is deemed proportionate if the composition of doctors referred, grouped by ethnicity (white or Black, Asian and Minority Ethnic (BAME[2])) and Place of Medical Qualification (UK or overseas), is statistically similar to the composition of all doctors connected to the DB that were not referred
Responsible Officer (RO)	A senior, GMC approved doctor who oversees revalidation processes, as well as the conduct and performance of medical professionals within a DB.

[2] The term 'BAME' is used here to reflect the terminology adopted in the original research. Current Office for National Statistics (ONS) guidance recommends the use of 'ethnic minority' as the preferred term.

1. Project Scope

1.1. The General Medical Council (GMC) has a 2026 target to ensure that employer Fitness to Practise (FtP) referrals are proportionate (GMC, 2026; GMC, 2024; GMC, 2023). If referrals are "disproportionate", this indicates that an organisation refers certain groups of doctors more than expected when compared to the composition of its workforce. If referral numbers for each group align with the composition of the organisation's connected doctors, the organisation is deemed "proportionate" in its referrals.

1.2. The GMC's target and this research apply to referrals when analysed by the demographic characteristics of ethnicity and world region of primary medical qualification (PMQ). In the UK, doctors from ethnic minority backgrounds tend to be referred to the GMC by their employers for FtP concerns more often than white doctors. Referrals for doctors gaining their PMQ outside the UK are also higher than for UK-qualified doctors; however, this rate is reducing (Adhiyaman et al., 2023; GMC, 2024; GMC, 2019). It is important to note that ethnicity and PMQ region are highly related demographic characteristics. This research identified longer-standing organisational circumstances and processes as contributors to disproportionality in referrals, rather than differential treatment at the point of referral.

1.3. Understanding the problem of disproportionality in referrals is complicated, which makes the identification of specific solutions that directly reduce disproportionality complicated also. There is large variation across organisations that make referrals, including organisations that act as Designated Bodies (DB). A DB is the name given to an organisation that doctors are connected to for the purpose of revalidation. DBs vary based on characteristics such as size (number of connected doctors), type, and the region within which the organisation operates. Most DBs have interventions in place to support doctors and ensure that investigations of any complaints or concerns are carried out fairly. Interventions might refer to programmes, processes, or initiatives provided in advance of or during individuals' involvement in local disciplinary processes and FtP referrals.

1.4. Extensive work has been conducted by the GMC, and substantial progress has been made towards the 2026 target. This research project seeks to build on previous work by investigating interventions in place across DBs to understand which interventions have the greatest impact on reducing disproportionality in referrals. Three research questions were defined, detailed in Figure 1 below.

Figure 1: Research Questions[3]

Research Question 1: What interventions are present in DBs, and how might these relate to proportionality in relation to PMQ region or ethnicity?

Research Question 2: What evidence is there that such interventions could support more proportionate referrals, and in which type of DB could they be effective?

Research Question 3: What else does an examination of interventions reveal about our pre-existing hypotheses?

[3] Pre-existing hypothesis mentioned in Research Question 3: Disproportionality is not appreciably introduced by the referring person or group and disproportionality has its roots in disadvantages present in the workplace before an incident happens.

2. Methodology

Overview

2.1. The research project methodology was split into five stages as outlined in Figure 2 below.

Figure 2: Research Methodology

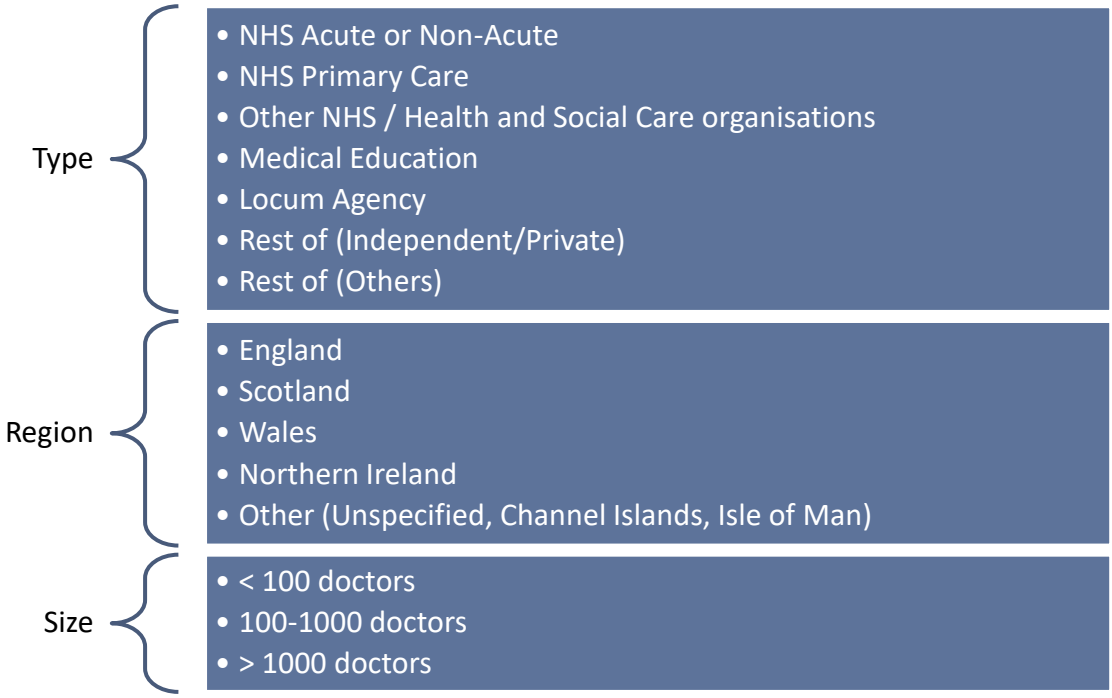
Sampling

2.2. The Responsible Officer (RO) for each DB is responsible for making referrals to the GMC on behalf of the DB, so has a key role to play in ensuring fairness. As a result, ROs were consulted throughout this project as the main source of information on what has been happening across DBs, and were also identified as the primary audience for this research. In some instances, ROs nominated someone else from the DB who had oversight of disciplinary processes to participate in the research.

2.3. Given the variation in DBs, it was crucial that a representative range of ROs was included in the research. The GMC collects and maintains data about DBs; 1,460 DBs had at least one doctor connected to them across the five years ending in July 2025, and 1,177 DBs had at least one doctor connected at the end of the same period. This dataset was reviewed to determine what would constitute a representative sample and which existing data could be used in the analysis. The DB characteristics in Figure 3 were used to identify a representative target research sample. The original 26 DB types were categorised into 7 broader DB types, as outlined within Appendix C.

Because of this, mitigating disproportionality involves understanding disadvantages present in the workplace before an incident happens.

Figure 3: Overview of DB Characteristics



2.4. The 26 DB types were also categorised into Centralised/Decentralised, informed by the DB type and signifying the level of oversight that the DB has (e.g. a centralised DB is usually single or close-proximity multi-sites, with doctors employed by the DB; a decentralised DB may be multiple sites with doctors employed by different employers). This DB characteristic did not inform sampling but was used in later analyses.

Literature Review

2.5. The literature review had two overarching aims. The first aim was to build on the extensive previous work conducted by the GMC on understanding disproportionality in referrals and to draw on social psychological theory to suggest underlying explanations for it. The second aim of the literature review was to provide detail on interventions and initiatives currently in place in organisations to ensure fair referral processes (or similar).

2.6. Sources reviewed included academic peer-reviewed sources (including papers within healthcare and medicine, and research from other relevant high-stakes professions such as law) and grey literature such as conference presentations, data from relevant organisations, government policy documents, and white papers. Figure 4 summarises the key findings.

2.7. The literature review resulted in a working list of interventions suggested to support fairer referrals and was also used to inform subsequent stages in the methodology, such as shaping questions in the interview schedule and survey.

Figure 4: Summary of Literature Review Findings

Why might we see differences in referrals across demographic groups?

Social psychology theories could provide a plausible hypothesis in explaining underlying reasons for variable referrals across demographic groups. The way that individuals categorise themselves, and others, has a significant impact on social interactions (Allport, 1954). Tajfel and Turner's (1979) social identity theory explores how membership of different groups guide who we are: the perception of 'us' (in-group) and 'them' (out-group) has been found to have a significant impact on individuals' social perceptions and judgements, resulting in individuals categorising themselves and others into specific groups, identifying with certain groups, and viewing their in-groups more favourably (Castano et al., 2002). These perceptions can also result in discrimination against those perceived to be from other groups, referred to as 'out-group discrimination' (Lyubovnikova, 2025).

What interventions are used by organisations to support fair and appropriate referrals?

Research exists that details examples of interventions in organisations to support proportionate FtP referrals (and general disciplinary processes at work). The Fair to Refer (GMC, 2019) report outlines the following six factors (with example interventions) related to proportionality: *Honest, immediate and direct feedback, comprehensive and ongoing socialisation, role and team integration to avoid isolated and segregated work, cohesive and accessible senior leadership team, a learning rather than a blame approach to mistakes, in-group/out-group dynamics and inclusion.*
A review of the literature expanded the list of example interventions. Evidence on the evaluation of interventions was collated; however, it was extremely limited as most of the literature focused on descriptions of the initiative or intervention in practice, with nothing reported on outcomes.

What contributes to an intervention's success or impact?

Other factors were identified that were not interventions but seen to influence intervention impact, such as: the involvement of leadership in intervention design and implementation (Kehoe et al., 2016; Greig et al., 2013); availability of resources (time and/or people) (Goldszmidt et al., 2007; Greig et al. 2013; Rosner et al., 1993); appropriate timing of intervention provision (GMC, 2019); involvement of a diverse group in design and implementation of interventions (Steinert & Walsh, 2006). These factors were largely aligned with the 'BEST model' - an internal GMC framework to help objectively analyse organisational interventions and inform discussions about best practice: Singhal and Yosef, 2024 (see Appendix A).

Interviews

Design and Sample

2.8. The aim of the interviews was to gain more detail on interventions in place across a range of DBs, building on the literature review to validate the working list of interventions and ensure the survey content was representative of real-world practice. The interview schedule was designed with GMC input.

2.9. A representative sample to approach for interviews was identified by review of the GMC dataset, ensuring that there were participants from all groups that were of interest. This involved the calculation of the proportions of DBs which represented each proportionality outcome (disproportionate, proportionate, and not enough referrals[4]) and further categorising them on key characteristics (type, size, region) to understand how many ROs from each group to invite to participate. This is outlined in Appendix D.

Interview Sample

2.10. Interviews were conducted with N=21 ROs (or someone in a similar role) representing DBs across the target sample. This was 9 interviews short of the target of N=30. This shortfall may reflect the RO group's demanding schedules, or it may indicate that the individual felt they were not the most suitable person to comment. Some ROs were likely to have been approached previously by the GMC to take part in similar or related studies, which can reduce their ability to participate due to research fatigue.

Outputs

2.11. The N=21 interviews were recorded and transcribed using MS Teams; transcripts were then analysed by researchers using a thematic analysis approach called template analysis (Braun & Clarke, 2006; Brooks et al., 2015). Each interview transcript was mapped against the existing list of interventions. Any additional interventions mentioned were added to the relevant section, resulting in an expanded and validated list of 52 interventions.

2.12. At this point, it became clear that organising interventions into the six categories outlined in the Fair to Refer (GMC, 2019) report meant that some interventions could be difficult to categorise. In addition, ROs often began their descriptions of how they promoted fair referrals by focusing on the general processes in place, allowing them to address concerns quickly and in a structured manner. This focus on local disciplinary processes underpinning the management of potential referrals was less of a focus in Fair to Refer, so there was a gap in the initial intervention framework that was expanded during the interviews. As such, the research team reorganised the list of interventions into five groups based on the type of intervention and when they were offered or implemented:

[4] Not enough referrals refer to DBs that have not made any referrals, or not enough data is held to determine if their referrals are proportionate or not.

- **Performance:** Preventative interventions to support good performance at work for all doctors.

- **Group-specific Support:** Preventative interventions or provision of support specifically targeted at different sub-groups of doctors based on need.

- **Diversity, Inclusion, Equity and Belonging (DEIB):** Preventative interventions to build an organisational culture underpinned by DEIB.

- **Management of Concerns:** Time-specific interventions to manage concerns as they arise.

- **Culture of Learning:** Ongoing interventions to support a culture of continuous learning.

2.13. The final list of 52 interventions identified from the literature review and interviews, split as above, was used to draft the survey. All 52 interventions presented in the survey are detailed in Appendix E.

2.14. Additional themes were identified during interview data analysis; these themes were broader than individual interventions and were perceived by ROs as potentially influencing proportionality in referrals. Of these, the factors that could be quantified were incorporated into the survey to support data collection on DB characteristics, in addition to type, size, and region. These are listed below. Survey respondents were also given the option to add free-text responses for some questions (response options or formats are indicated in brackets below).

- **Use of formal process or frameworks:** If a formal process or framework is used when deciding if a concern/complaint receives either a formal or informal resolution (Yes/No)

- **Local disciplinary processes:** An estimate of the number of doctors connected to the DB who have been involved in local disciplinary processes (including those that have not resulted in an FtP referral) (number range)

- **Engagement with the GMC Employer Liaison Adviser (ELA):** The frequency of communication between the RO and their ELA (four time bands)

- **DB Geography:** The physical proximity of ROs to the doctors they oversee influences contact time and familiarity (three options)

- **Conduct or capability referrals:** ROs reflected that they may be more likely to deal with certain types of concerns over others, influenced by the type of DB they held the RO role for (captured as three types of referrals, of which multiple could be selected)

- **Source of disciplinary concerns referral:** Identification of roles that were the source which referred disciplinary cases to the RO (captured as five groups of roles, of which multiple could be chosen)

- **Involvement of different individuals in management of concerns:** Two data points were captured here, one about involvement of others outside the RO in investigating concerns (three options) and one about involvement of an individual with a particular DEI/Diversity remit in management of concerns (three options)

- **Tenure as an RO:** Identification of the time survey respondent had been in the RO role (three time bands).

2.15. Other themes also emerged from the interview analysis, which were not possible to quantify in the same manner. These themes were not included in the survey as questions but were revisited during the survey analysis stage to determine whether they could aid the interpretation of referral behaviours (see *Results: Influencing Factors* section).

Survey

Design

2.16. The aim of the survey was to systematically collect data from a larger range of DBs than the interviews covered, about what they were doing to support fair referrals. The survey was split into two sections.

2.17. The first section was designed to capture data on the presence of each of the 52 interventions across DBs. Respondents were asked to indicate the status of each intervention in their own DB (Currently in place; planned but not yet implemented; previously in place but discontinued; never in place). For each intervention currently in place, respondents were then asked to rate it on two scales adapted from the BEST model (for full details, see Appendix A for the original model and Appendix B for the adapted version).

- **Evidence and Evaluation Scale:** The Evidence and Evaluation scale assesses the background evidence available for this intervention and the extent to which the organisation has been able to evaluate it within the DB.

- **Implementation Status Scale:** The Intervention Implementation Status scale assesses how established an intervention is and the level of stakeholder involvement.

2.18. The second half of the survey collected additional data about the DB, such as the factors seen as potential influences on the proportionality of referrals, which could be quantified (see 2.13).

Distribution

2.19. The survey link was distributed to DBs for completion by the RO (or someone with oversight of the local disciplinary process). After 4 weeks, the desired sample size had not been reached, so the survey close date was extended by a further four weeks, and ELAs contacted the DBs they work with to encourage participation.

2.20. The survey was distributed via email to 555 ROs who could be contacted, representing the 1105 DBs out of the 1177 DBs estimated to be active around July 2025 (ROs can represent multiple DBs). At the end of the extended window, 53 DBs had completed the survey in full, and 53 organisations had partially completed it. These 106 DBs were from across the UK and collectively represented up to 72,921 doctors connected to them at the time. Given the GMC's target to complete the research and support a reduction in disproportionate referrals by 2026, extensive discussions were held between the researchers and the GMC to review the data gathered. Leaving the survey open longer to try to

increase engagement was an option, but it was decided against to avoid putting too much pressure on ROs. The research team decided to proceed with the sample obtained, accepting that this might limit the analysis possible.

2.21. As the obtained sample was less than intended, the decision was made to use both complete and partially complete responses. This meant the total number of DBs sampled was N=106, albeit with varying levels of data (see Appendix D for a detailed breakdown).

Survey Analysis

2.22. The data was downloaded, cleaned, and merged with GMC-held DB data (DB type, location, number of doctors connected, demographics of connected doctors, etc.) and GMC time-specific DB data on referrals made over the last 5 years. The final DB sample represented 10% of all DBs (106 of 1,177 DBs with at least one doctor connected at the end of the five-year period; 1,460 DBs had at least one doctor connected to them across the full five-year period ending at July 2025). Of these 1,177 DBs in the full dataset, approximately 280 had a relevant outcome. The final DB sample obtained in this research provided between 33 and 75 responses with an outcome for each intervention.

2.23. The original methodology for this research proposed more complex statistical analysis using machine learning (specifically, regression or classification trees) to identify which interventions were better predictors of proportionality in referrals. However, results from such analyses were not able to serve as sole support for the conclusions drawn from the dataset obtained. This was partly due to limited representation within the sample of DBs which had a relevant outcome (‘proportionate’ or ‘disproportionate’ referrals, as opposed to a ‘not enough referrals’ outcome). This is partly explained by the relative infrequency with which DBs refer doctors. This limitation was compounded by achieving extremely limited representation of DBs with an outcome of ‘disproportionate’ in the DB sample obtained. Therefore, while the sample of 106 represented 10% of all DBs active as of the end of June 2025 and was in line with response rates for online surveys, the original methodology could not be used as the sole way of generating results.

2.24. The research team explored the data in multiple ways to ensure consideration of all possible analyses, with the input of two independent psychometricians. However, given the available data, it was not feasible to conduct an analysis based purely on quantitative modelling of interventions. The research team reviewed the available data from the quantitative modelling, plus the other survey data, interview data, and literature review, and agreed with the GMC on an alternative method of analysis.

2.25. The quantitative analysis was refocused to incorporate machine learning, inferential, and descriptive-level statistics to understand what was happening in practice. This allowed the research team to identify the most and least popular interventions and how these differed by DB characteristic. The team also explored any evidence that certain interventions were more or less related to proportionate referrals (combining statistical testing and quantitative metrics with qualitative insights from the interviews and cross-referencing with the evidence base). Despite the analytical approach changing in response to the sample obtained, the minimum 33 DBs that provided analysable responses for all interventions had approximately 39,367 doctors connected to them.

3. Results

Overview

3.1. Data was triangulated from the literature review, interviews, survey, and GMC data. The triangulation process enabled the identification and ranking of specific interventions based on the level of evidence regarding their relationship to the proportionality of referrals to the GMC.

3.2. A list of 52 interventions and initiatives was identified (from the literature and interviews) that were suggested to support proportionality in referrals. Of these 52**, six interventions** were identified **as contributing to proportionate referrals** across groups analysed by ethnicity or PMQ region, based on the available evidence after triangulation.

3.3. An additional 17 interventions were identified that were considered potentially valuable in contributing to proportionate referrals but had less triangulated evidence.

3.4. It is important to note that this research is focused on interventions that are directly related to fairer referrals and fairer local disciplinary processes by extension. If an intervention was not identified in the results below, it may still make a valuable contribution to improving another aspect of local workplace culture. It is important that DBs evaluate their current interventions to determine whether each is delivering the value they expect. It is also worth noting that most interventions are not specifically targeted at a single group based on a single protected characteristic. However, a few interventions are designed specifically for doctors who are International Medical Graduates (IMGs) or have an ethnic minority background, due to increased concern about these characteristics. It is also relevant that DBs who are disproportionate with regard to ethnicity/PMQ-region tend to be disproportionate regarding other protected characteristics at a statistically significant level; this is discussed in the Influencing Factors section.

The Six Key Interventions

3.5. The six key interventions were identified based on the following criteria:

- Robust evidence, drawn from both published research and/or DB/RO feedback during the research interviews, demonstrating the intervention's contribution to proportionate referrals. These interventions were also already widely embedded in practice, with adoption in over 90% of the DBs sampled[5].

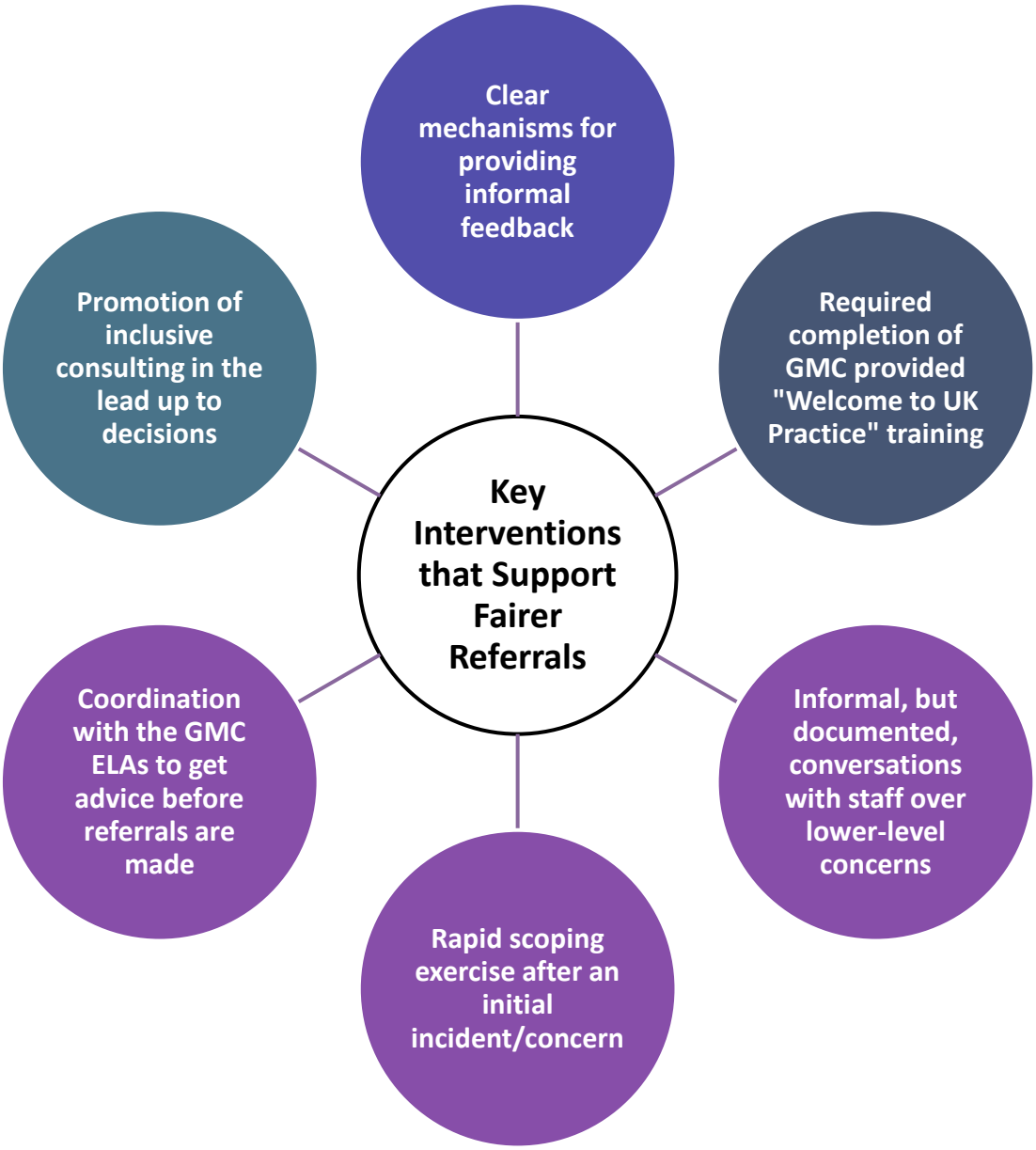
- An intervention which has been statistically associated with greater proportionality in referrals.

3.6. An outline of the **six key interventions**, what the research suggests about causal mechanisms for intervention impact, and suggested practical applications and underpinning psychological theory is presented below.

3.7. Three of the six interventions fell within the ***Management of Concerns*** group, illustrating that reactive interventions (as opposed to preventative ones) can be more directly linked to proportionality in referrals by DBs. Preventative interventions may be equally impactful, but it can be harder to trace the value of such interventions to longer-term outcomes. One of the interventions fell within the ***Performance*** group, one fell within the ***Group-specific support*** group, and one fell within the ***Culture of learning*** group. No interventions from the ***DEIB*** group were identified.

[5] While these interventions were already identified as having high adoption (>90% of DBs), widespread use does not necessarily equate to high-quality or consistent delivery. Re-emphasising them as key interventions helps reinforce the strength of the evidence base, legitimise their continued importance, and ensure that DBs who have not yet implemented them, or who are doing so inconsistently, receive the support they need. In addition, there is an opportunity for shared learning across DBs to better understand why these interventions are popular.

Figure 5: Six Key Interventions Identified to Support Fairer Referrals



Key	
1	Performance
2	Group-specific Support
3	DEIB
4	Management of Concerns
5	Culture of Learning

Clear Mechanisms for Providing Informal Feedback

Group: Performance - Preventative interventions to support good performance at work, for all doctors

Supporting Research

Clear mechanisms for providing informal feedback can be a valuable organisational intervention. They encourage early resolution of issues, strengthen communication and relationships, and support staff development, particularly for those new to the organisation or local system. They can also improve engagement and reduce reliance on formal processes. However, the effectiveness of informal feedback depends on the presence of important contextual factors such as psychological safety, supportive environments, trusting relationships and individuals' sensitivity to feedback cues (Rutter & Walton, 2021; O'Donovan & McAuliff, 2020; Sehlbach et al., 2020; Johnson et al., 2020). High-quality informal feedback tends to be specific, constructive, and improvement-oriented, prompting reflection and behavioural adjustment (Mulder, 2013; Winstone & Nash, 2023).

Practical Application Tips

- **Create simple, repeatable feedback touchpoints –** Where possible, encourage regular short check-ins so feedback becomes a natural, low-pressure habit rather than a formal event.
- **Review supporting frameworks -** Consider how existing frameworks support or restrict informal feedback - think about how opportunities for feedback are integrated in performance management or training frameworks (such as Maintaining High Professional Standards, Department of Health, 2005).
- **Provide prompts and guidance for supervisors** – Offer short scripts, example scenarios, or prompt questions to help managers initiate informal feedback conversations.
- **Consider the physical setting** – Ideally, such exchanges should take place in comfortable locations that offer privacy and are relatively free of distractions and the likelihood of disruptions.

What's Happening in Practice?

This intervention was among the most popular and was in place in 92% of DBs sampled. There is substantial evidence in the literature as to its value in supporting fair performance management processes.

- **DB Type analysis**: All NHS/HSC had this intervention in place (100%), followed by Rest of Other (92%), Rest of Independent/Private (89%), NHS Acute or Non-Acute (84%), compared to slightly lower implementation rates in Medical Education (75%), Locum Agencies (67%), and NHS Primary Care (50%).
- **Centralisation**: Centralised DBs were slightly more likely to have this intervention in place (87%) compared to decentralised DBs (80%).
- **Number of Doctors Connected**[6]: Small DBs (<100 connected doctors) were most likely to have this intervention in place (93%), followed by medium-sized DBs (100-1000) (84%), and large DBs (>1000) (81%).

[6] This refers to the number of doctors connected to the DB during the 5 years of data. It does not reflect differences in levels of rotations experienced within some DBs.

Required completion of GMC provided "Welcome to UK Practice" training

Group: Group-specific Support - Preventative interventions or provision of support specifically targeted at different sub-groups of doctors based on need.

Supporting Research

The GMC's Welcome to UK Practice training helps ensure that international graduates understand the professional standards, ethical expectations, and cultural norms of UK medical practice before beginning work. This structured introduction reduces the risk of misunderstandings about GMC guidance, supports safe and consistent patient care, and helps new doctors feel more confident navigating UK-specific legal, communication, and professional requirements (GMC, 2025). Previous evaluations have demonstrated that the workshop was highly valued by attendees, and it measurably improved their understanding of UK ethical and professional standards (Kehoe et al., 2016). A subsequent study by Kehoe et al (2019) found both short-term and long-term positive impacts of the training, reporting 62% of doctors had made changes in their practice based on their learning. The quantitative analysis found that the presence of this intervention was significantly related to proportionate referrals; this finding should be interpreted with some caution given the relatively small DB sample.

Practical Application Tips

- **Integrate the training into onboarding** – Promote attendance to the "Welcome to UK Practice" course, ensuring completion by doctors before they begin independent clinical duties.
- **Provide protected time and clear expectations** – Allocate a dedicated session within the first few weeks of employment to communicate why this training is relevant and allocate time to complete it; follow up after the session on any questions it may have raised. While there is a recognised wider challenge regarding the lack of protected time to complete desirable training, evidence suggests that allocating dedicated time where feasible offers tangible benefits for engagement and uptake.
- **'Welcome to UK Practice' may not meet all doctors' ongoing support needs** - Whilst the intervention is useful, it may not provide sufficient support in isolation to meet the needs of all, or most, IMGs transitioning to UK practice. Evidence suggests that brief introductory interventions should be seen primarily as a welcome rather than a substitute for longer-term support (Kehoe, 2019). It is also important to recognise that doctors trained outside the UK but within the European Economic Area (EEA) may have different support needs from those trained elsewhere (Al-Haddad, 2024).

What's Happening in Practice?

This intervention is implemented both within DBs and is also centrally offered to doctors as they join the UK medical register. This intervention was mentioned frequently by DB respondents and was anecdotally perceived to have a positive impact.

- **DB Type**: Medical Education was most likely to have this intervention in place (67%), followed by NHS Acute or Non-Acute (53%), Locum Agency (50%), Rest of Independent/Private (25%), NHS/HSC (22%), Rest of Other (15%) and Primary Care (0%).
- **Centralisation**: Centralised DBs were slightly more likely to have this intervention in place (39%) compared to Decentralised DBs (33%).
- **Number of Doctors Connected**: Larger DBs were most likely to have this intervention in place (47%), compared to medium-sized DBs (44%) and small DBs (22%).

Informal, but documented, conversations with staff over lower-level concerns

Group: Management of Concerns: Time-specific interventions to manage concerns as they arise.

Supporting Research

Evidence in the Human Resources (HR) literature demonstrates the effectiveness of this type of intervention in good performance management. However, it is important that it is implemented carefully and conversations must be handled sensitively; if they feel overly formal, poorly timed, or inconsistently applied, they can undermine trust and discourage openness (Employment Innovations, 2023; NHS Resolution Compassionate Conversations, 2024). Documenting the discussion ensures that both the employer and the individual are aware of what was agreed, providing accountability and fairness. Clear guidance, trained managers and a supportive organisational culture are key to making this intervention effective.

Practical Application Tips

- **Provide a light-touch template -** Provide supervisors with a very short, standard notes form (e.g., three prompts: *What's the concern?* / *What was discussed?* / *Next steps?*). This keeps documentation quick and consistent without adding admin burden. Afterwards, records should be agreed as accurate with all parties present.
- **Build conversations into routine checking -** Encourage supervisors to address small concerns during existing 1:1s or brief catchups, rather than creating new meetings. This normalises early intervention and keeps the tone supportive, not formal.
- **Store notes in a secure, accessible location -** The key is ease: supervisors should be able to document a conversation quickly in a secure manner.
- **Consider third parties attending** - Should more sensitive or contentious conversations be needed, then it is advisable to have a neutral third party present (for example, an administrative staff member who is there to take notes). Alternatively, video meetings can, with permission from attendees, be recorded, with the record retained for some time afterwards.

What's Happening in Practice?

This is one of the most popular interventions, currently in place across 96% of DBs sampled. It was frequently mentioned within the interviews and perceived as key in appropriately managing concerns or complaints. It is often combined with other interventions, such as offering additional pastoral support following these discussions.

- **DB Type:** All NHS Acute or Non-Acute, NHS Primary Care, NHS/HSC, Medical Education, and Rest of Other had this intervention in place (100%). This differed from Rest of Independent/Private (91%) and Locum Agencies (0%) sampled.
- **Centralisation:** 100% of Decentralised DBs had this intervention in place compared to 95% of Centralised DBs.
- **Number of Doctors Connected**: For the size of the organisation, all of the DBs within the small and large DB groups had this intervention in place (100%), compared to most medium-sized DBs (93%).

Rapid scoping exercise after an initial incident/concern to understand extent of investigation required

Group: Management of Concerns: Time-specific interventions to manage concerns as they arise.

Supporting Research

The majority of DBs mentioned this as a key intervention within the process of handling concerns or complaints. Rapid scoping exercises allow the organisation to determine the severity of the situation. Clear communication throughout is essential to promote trust in the process. ROs described how this often happens in tandem with another key intervention (Informal but documented conversations) to provide as much information as possible before potentially initiating a formal investigation.

Limited literature is available on how this process is handled specifically in relation to FtP referrals, but there could be the opportunity for ROs to collaborate and share examples of best practice, or what works/what doesn't, in RO groups and forums.

Practical Application Tips

- **Use of a standardised, scoping checklist -** Use of a template such as Patient Safety Incident Response Framework (PSIRF; NHS England, 2022) or the NHS Resolution Fair and Proportionate checklist (NHS Resolution, 2025), to capture descriptors of what level of incident/concern may require formal investigation. This will help supervisors quickly decide whether the issue needs informal resolution, a local review, or a full investigation.
- **Hold a brief fact-finding conversation within 48 hours -** Encourage supervisors to speak promptly with all individuals involved to clarify the basic facts. This keeps the process light-touch, avoids assumptions, and ensures early, proportionate action without unnecessarily launching a formal investigation.
- **Record the scoping decision transparently –** Decisions at any stage of the local disciplinary process should be documented in a central database and monitored for fairness. Such documents should include the outcome or next steps (e.g., "No further action", "Informal resolution", or "Formal investigation required"), the dates of decisions, and the characteristics of the practitioners involved, e.g. protected characteristics. This monitoring process provides accountability and consistent decision-making across cases, allowing identification of any themes and supporting DBs to identify potential issues of fairness at an early stage.

What's Happening in Practice?

This was another of the most popular interventions, in place across 92% of sampled DBs. It was frequently mentioned in interviews as an automatic, useful first step when handling concerns or complaints. However, how this occurred in practice varied by the type of DB.

- **DB Type**: All DBs across NHS Primary Care (100%), NHS/HSC (100%), and Medical Education (100%) had this intervention in place, closely followed by NHS Acute or Non-Acute (91%), Rest of Independent/Private (91%) and Rest of Other (80%), compared to Locum Agencies (0%).
- **Centralisation**: 91% of Centralised DBs had this intervention in place, compared to 82% of Decentralised DBs.
- **Number of Doctors Connected**: All large DBs had this intervention in place (100%), followed by small DBs (94%), and medium-sized DBs (81%).

Coordination with the GMC ELAs to get advice before referrals are made

Group: Management of Concerns: Time-specific interventions to manage concerns as they arise.

Supporting Research

This was a key intervention identified during data collection and is already embedded across most sampled DBs. ELAs are seen as a highly valuable resource because they provide specialist expertise, help ensure thresholds are applied accurately, and reduce unnecessary or premature escalation. Research in related professions suggests these roles are important in maintaining appropriate, fair referrals (not systematically under or over-referring practitioners; Wallace and Greenfield, 2025), indicating the value of this already embedded resource in medical decision-making.

Practical Application Tips

- **Continue to utilise ELAs –** ELAs are a source of advice and should continue to be used by all DBs when they are considering how to respond to concerns about a doctor.
- **Consider that ELAs are not impartial advisors** – It is crucial to remember that the ELAs represent the GMC and therefore cannot be assumed to be offering neutral or impartial advice. Alternative perspectives on managing concerns could come from retrospective decision-making reviews or RO groups and networks.

What's Happening in Practice?

This is a very popular intervention currently in place across 93% of DBs sampled; it is possible that those who didn't report this happening had not needed to discuss a referral within the specified timeframe. This was mentioned in the majority of interviews as the natural first step when faced with a concern or complaint to help determine whether a situation met the threshold for an FtP referral. ROs clearly valued their ELA's input and saw them as a valuable asset.

- **DB Type:** All types of DB had this in place currently or had had it at some point (100%), apart from Rest of Independent (73%).
- **Centralised**: 100% of Decentralised DBs had this intervention in place, compared to 93% of Centralised DBs.
- **Number of Doctors Connected**: All large DBs had this intervention in place (100%), followed by medium-sized DBs (96%), and small DBs (88%).

Promotion of inclusive consulting in the lead up to decisions, that welcomes challenge and incorporates feedback from those more at risk of being overrepresented in disciplinary processes

Group: Culture of Learning: Ongoing interventions to support a culture of continuous learning.

Supporting Research

DB respondents frequently mentioned relying on networks of RO peers or others involved in the disciplinary process for support, challenge and sense-checking in the lead-up to referral decisions or disciplinary action. Promoting this inclusive collaboration encourages challenge, transparency, and the inclusion of diverse perspectives. Whilst the RO is ultimately the accountable decision-maker for referrals, incorporating diverse perspectives reduces the influence of individual bias, strengthens fairness, and helps to build trust in how concerns are assessed. To support this, organisations need clear governance, appropriate training, and access to facilitation services if required (Mannion & Thompson, 2014). Statistical testing showed a significant relationship between this intervention and more proportionate referrals. Classification tree modelling showed a significant relationship between this intervention and more proportionate referrals for larger organisations (those with >1000 connected doctors). The results should be interpreted with some caution given the relatively small sample size.

Practical Application Tips

- **Inclusive consulting in the lead-up to decisions –** while the RO retains sole accountability for referral decisions, the use of collaborative consultation processes is encouraged. This may include seeking input from RO networks or colleagues involved in the local disciplinary process. These networks should, where possible, be diverse and reflective of the populations they serve to ensure a broad range of perspectives informs decision-making.
- **Actively invite input from staff networks or representatives** – when developing general disciplinary processes, ask for feedback from groups or representatives that reflect those who are more at risk of experiencing systemic bias.
- **Use simple "challenge prompts" in decision meetings -** to help teams slow down and check assumptions in a structured, accessible way.

What's Happening in Practice?

This intervention[7] is currently in place across 71% of DBs sampled. It was present at a larger percentage of Proportionate DBs (77%) than of Disproportionate DBs (33%).

DB Type: Rest of Independent/Private and NHS Primary Care DBs were most likely to have this intervention in place (100%), followed by Rest Of Other (80%), Medical Education (67%), NHS Acute or Non-Acute (64%), NHS/HSC (33%), and Locum Agency (0%).

Centralised: Decentralised DBs were slightly more likely to have this intervention in place (82%), than Centralised DBs (67%).

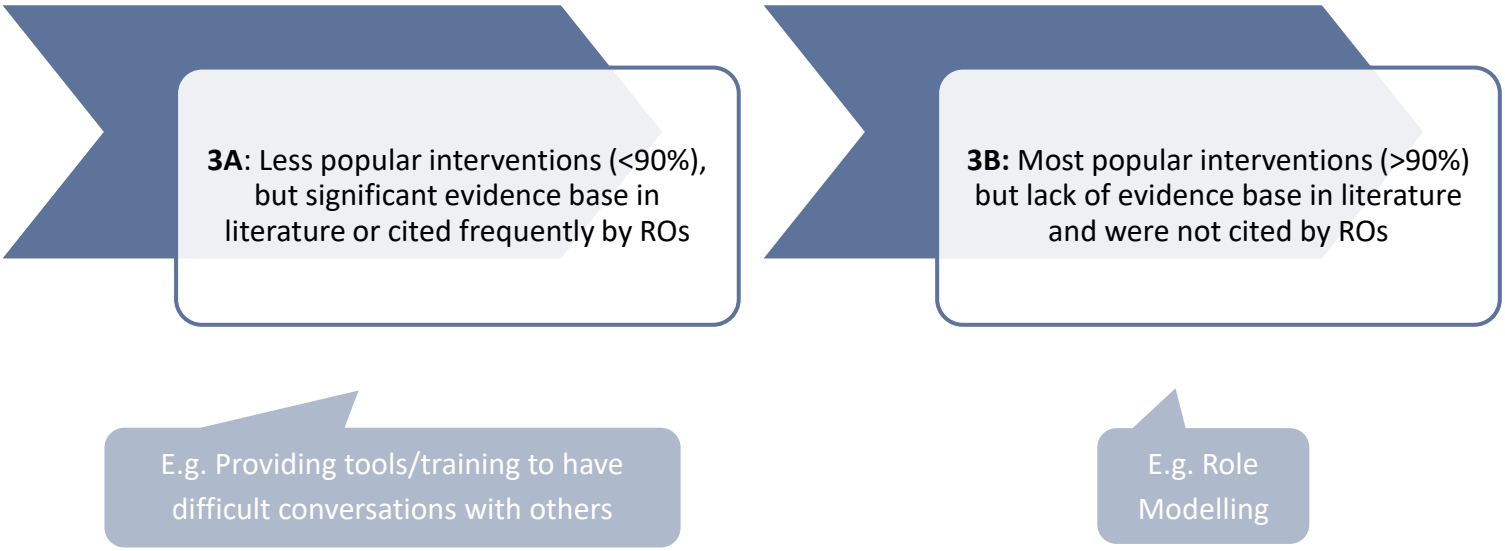
Number of Doctors Connected: Small DBs were the most likely to have this intervention in place (94%), compared to large DBs (70%). and medium DBs (54%).

[7] The name of this intervention was amended during the analysis, to ensure that it reflects that it accurately reflects the role of the RO as the accountable decision maker for referrals - the original title can be found within Appendix E.

Additional Interventions of Interest

3.8. In addition to the 6 key interventions, **a further 17 interventions were identified as potentially valuable in supporting proportionate referrals**. These were identified based on the following criteria shown in Figure 6 below:

Figure 6: Additional Interventions Criteria



3.9. The following section provides a summary of the **additional 17 interventions** identified as potentially valuable in supporting proportionate referrals. Information is provided about the current availability of these interventions across the DBs sampled, supplemented with details available from the relevant evidence source. Some practical tips to consider when implementing these interventions are provided in Appendix G.

3.10. Some further analysis regarding a number of the interventions not included in the Key Interventions or Additional Interventions lists is provided in Appendix H.

The 17 Additional Interventions of Interest in Supporting Fairer Referrals[8]

1. **Transparent performance management processes:** This intervention was currently in place across 84% of DBs. It was infrequently mentioned within the interviews. However, whilst not mentioned in relation specifically to proportionate outcomes, literature is clear on the value that transparent performance management processes can have on fairness and employee levels of acceptance.

[8] These interventions are not presented in order of importance, but are grouped based on the five groups; performance, group-specific support, DEIB, management of concerns, culture of learning.

2. **Providing tools and training to have difficult conversations with others:** This intervention is currently in place across 67% of DBs. It was mentioned frequently within the interviews, and was perceived to be an important intervention by DB respondents. They noted that, with appropriate training, these conversations can help guide the provision of targeted support for doctors and proactively prevent future FtP referrals.

3. **Clear mechanisms for individuals to anonymously raise concerns or whistle-blow:** This intervention was one of the most popular interventions and is currently in place across 95% of DBs. It was mentioned a few times during the interviews, mainly focusing on the importance of encouraging individuals to raise concerns and also feel comfortable in doing so.

4. **Provision of a corporate induction for all new starters:** This was one of the most popular interventions; it is currently in place across 92% of DBs. It was mentioned by a few ROs but not directly related to reducing unfair referrals. However, past GMC research looking at what might encourage doctors to return to practice in the UK found that a corporate induction was perceived as the least important element (GMC, 2020). While not specific to referrals, this suggests that the type of induction may be insufficient in isolation and may need to be supplemented with a more tailored induction intervention for specific groups.

5. **Inductions with a specific focus on Foundation programme trainees, or IMGs new to the DB:** This is currently in place across 66% of DBs. It was mentioned frequently by ROs as a useful strategy to prevent potential future issues and, as with other similar induction interventions, there is a wealth of literature on the value of tailored inductions across various high-stakes sectors.

6. **Networks for BAME staff:** This intervention is currently in place across 65% of DBs. BAME networks were frequently referenced during the interviews, with many ROs outlining formal networks that have been set up in their DB. Others highlighted the importance of more informal networks and peer support. Literature across many working sectors highlights the importance of BAME staff networks in creating a supportive space for colleagues to connect, share their experiences, and raise workplace issues, while promoting inclusion and amplifying under-represented voices.

7. **Networks for IMG staff:** 41% of DBs currently have this intervention in place; it was not mentioned frequently in the interviews conducted. However, literature highlights the role of IMG networks in providing specific support to ease transition, reduce isolation, and strengthen feelings of belonging. Diversity networks more broadly can act as employee-driven mechanisms for organisational culture change.

8. **Training sessions on topics such as race equality, bullying, micro-aggressions, anti-bias, and how not to be a bystander:** This intervention was in place in 74% of DBs. During the interviews, it was mentioned frequently during the interviews, with many reporting that their DB sees value in delivering Diversity and Equality-related training, including active bystander programmes and race equality sessions. There is some literature available on the importance of training and interventions like this (e.g. Carter et al., 2020), but offering this type of training can be resource-intensive. This intervention also links with the updated GMC 'Good medical practice' guidance on working in inclusive and supportive environments and professionals' responsibilities when witnessing potential incidents of bullying or harassment.

9. **Regular trend monitoring and analysis of any gaps in attainment/ pay/ benefits across groups:** 61% of DBs currently have this intervention in place. It was mentioned in some interviews that some organisations monitor the ethnicity distribution by role. A lot of more general HR literature is available on this intervention, highlighting the importance of monitoring pay, progression and treatment to create fairer, more inclusive work environments.

10. **Diverse hiring practices - intentionally seeking and including candidates from various backgrounds and demographics:** 48% of DBs currently have this intervention in place, but it was rarely mentioned by ROs. Literature suggests that diverse hiring practices support organisations to attract the strongest possible talent (Avery et al, 2013; Wallace et al., 2022). This leads to stronger decision-making and creativity, whilst creating a workforce that is more likely to reflect the communities they serve.

11. **Role modelling - individuals from diverse backgrounds represented in leadership roles or performance management processes:** 65% of DBs currently have this in place. A small number of interviewees mentioned the importance of role modelling by diverse leaders for fostering inclusion. The literature demonstrates that role modelling benefits both the individual acting as a role model, by supporting sustained behavioural change, and those observing it, by encouraging development and progression.

12. **Early warning systems where concerns about doctors are triaged or discussed before concerns escalate:** This is quite a common intervention, currently in place across 85% of DBs. Where ROs mentioned it, a structured process was described; ROs voiced that they valued being able to discuss potential concerns, especially if they are newer to the RO role. There was little literature on the efficacy of this type of intervention.

13. **Collaborations with other organisations (e.g. NHS Resolution):** This intervention is currently in place across 80% of DBs. Whilst not used by all DBs, it was mentioned within some interviews as a useful option for ROs when managing complaints or concerns.

14. **Provision of support for practitioners about how investigation of concerns / complaints works and what support they can access:** This is currently in place across 87% of DBs. However, it was regularly mentioned within the interviews as an important intervention to provide. ROs often felt this intervention would benefit from additional attention (e.g. drafting up new policies) or that they would be keen to see what others do in this area.

15. **Clear guidance or checklist for clinical leaders / managers for handling concerns or complaints, including how to support practitioners during the process:** This is currently in place across 65% of DBs. It was mentioned occasionally by ROs, who said they found that having a clear process aided discussions and helped them challenge their own or others' decisions regarding referrals.

16. **Training videos to facilitate understanding of the roles of other team members:** Only 21% of DBs currently have this intervention in place. However, 0% of Disproportionate DBs sampled had this intervention in place, compared to 23% of Proportionate DBs. This indicates that this intervention is more prevalent in DBs with proportionate referrals, although there was no statistically significant relationship between the presence of this intervention and the proportionality of referrals.

17. **Participation in an RO Advisory Group; peer learning opportunities with other ROs or discussion of anonymised past referrals:** This intervention is currently in place across 79% of DBs, and was mentioned

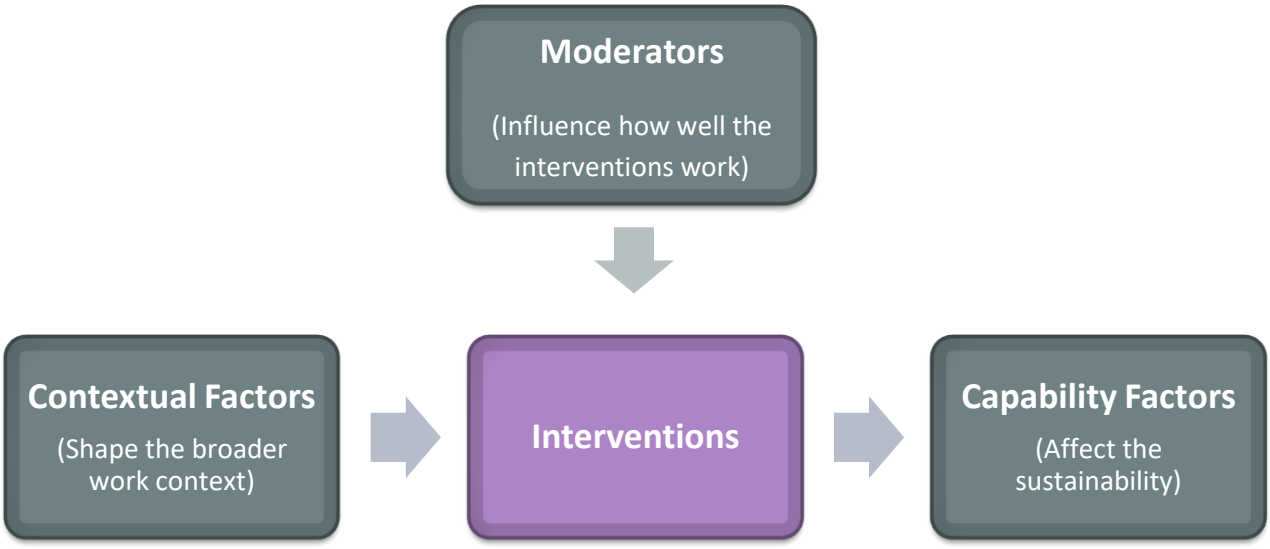
frequently within the RO interviews. ROs voiced how they valued others' perspectives and the opportunity to learn from others in how they approach referrals.

Influencing Factors

3.11. In addition to the specific interventions to support fair referral processes, the research identified a set of wider considerations on proportionality in the survey data and interviews. These were factors described as potential influencers on the efficacy of interventions in place. These factors can be grouped into three categories, shown in Figure 7.

- **Contextual Factors:** These factors are contextual conditions that shape the general working environment and broader risk of disproportionate referrals.
- **Moderators**: These factors can directly influence how well interventions aiming to support proportionate referrals work in terms of quality or consistency of impact.
- **Capability Factors**: These are factors that affect the ongoing quality or sustainability of such interventions.

Figure 7: Influencing Factors on Intervention Effectiveness



3.12. A summary of each of these factors is provided below, supported by statistics and anonymised quotes from both the interviews and survey to help bring them to life.

Contextual Factors

Local Disciplinary Processes

3.13. One key theme that influences how organisations manage performance (and therefore how they might mitigate the risk of disproportionate referrals) is the varied approaches used by different DBs. These

differences are due to several reasons. The main theme was how the context of their particular DB (in terms of size, type, centralisation, etc.) shaped their processes. A lot of ROs mentioned that they try to handle concerns or complaints rapidly and internally at first, putting additional support in place to try prevent early performance issues from resulting in a more serious problem, **"If I get a complaint sent to me or an incident involves a doctor that people think needs to be investigated, I'll try to push that back to the clinical groups... and ask them whether they've already attempted to deal with it locally".** However, this may be more difficult when ROs are working at arm's length from connected doctors or clinical groups, or when doctors are employed by, or working within, an organisation other than their DB. In these instances, the RO may not be able to take this proactive approach, or they may not be aware of what is happening in practice as early issues arise.

3.14. Local disciplinary processes were also more defined in some DBs: unsurprisingly, this was more prevalent in larger DBs, which have the resources and requirements for more complex internal processes, "**There's a structure for informal investigation of concerns. We try to resolve things informally when possible, but escalate if necessary, especially if the police are involved**". The implication from ROs was that the presence of these defined processes is likely to help with consistency and fairness in decision-making concerning performance issues.

3.15. The type of DB had a big impact on RO involvement in local disciplinary processes, particularly early investigation of issues at an informal stage. There were concerns that, if ROs have less visibility of what happens during early stages of concern management, or in management of doctors more generally, this makes it difficult to offer ongoing proactive performance management for individuals, "**At Locum Agencies there is very little scope for managing the performance of the doctors who connect. If concerns arise which are below the GMC threshold for referral, then the RO will encourage [the] doctor to use the appraisal process to reflect and learn from these... [but] doctors jump between DBs/agencies frequently, making it impossible to have continuity of RO oversight or performance management**". This suggests that whilst it is beneficial for DBs to use local disciplinary processes to manage the risk of inappropriate referrals, smaller or decentralised DBs (such as Locum Agencies or Primary Care DBs) may struggle to achieve the same benefits, and there may be more confusion about which organisation is responsible for what. In addition, it suggests that there is a benefit in ROs remaining aware of what is happening at the local level (even if not directly involved) to inform performance management.

Proximity to Connected Doctors

3.16. Another theme that may influence referrals more broadly is the geographical proximity of the RO to the doctors with whom they are connected. Geographical proximity refers to how much contact the doctor has with the RO. For some, they may be in the same building or department and therefore have more opportunities to interact or be aware of ongoing concerns. Other ROs may have very limited contact with their connected doctors. Some reported that geographical proximity meant the RO had a closer relationship with many of the doctors and a better sense of what was going on 'on the ground'.

3.17. Interviewees spoke about how geographical proximity could influence the likelihood of referral, based on how well ROs knew the individual, and being able to identify if the incident in question happened in isolation or was indicative of a broader pattern of behaviour, "**Proximity is less important now because you can do things like [MS] Teams, but… physical space, I think in many respects it is easier [being co-located]. I think you could be more assured that there's a consistency about how reports of poor behaviour [are made]**". The majority of DBs who responded to the survey (45%) reported some distance (working in a range of clinics/hospitals across the DB) between the person making the referrals (the RO) and the doctors themselves, whereas 15% reported very low distance (working in the same building across different departments), and 26% reported being distanced where they worked in separate organisations across different locations[9]. As such, no clear pattern was identified between geographical proximity and the proportionality of referrals. Additional modelling also showed no significant relationship between proportionality and the distance between ROs and their connected doctors. However, ROs regularly mentioned this as an important consideration.

Type of Referral

3.18. Another contextual factor that may have a broader influence on the proportionality of referral is the type of referral generally seen by the RO, broadly categorised as conduct, capability, or health-related. During interviews, the majority of ROs in this sample voiced how most of the concerns or complaints that they dealt with are about the doctors' conduct, as opposed to their capability or health: "**Most since I've been here has been around safeguarding-related issues. Rather than performance per se or clinical capability … issues**". Some ROs perceived this to be connected to demographic factors like age, "**Depending on what the problem is with regards to conduct, with the younger doctors generally, they're more conduct as opposed to [capability] concerns. You know it's drugs, it's alcohol, it's rape. It's all of those things**". The prevalence of conduct concerns was also reflected in the survey responses; 47% of respondents reported handling concerns about doctors' conduct, compared with 29% handling capability concerns and 29% handling concerns about doctors' health. While it is not possible to draw a clear link between the type of referral and its proportionality, some ROs implied that it was harder to avoid making referrals based on conduct because there are very clear thresholds for what is considered inappropriate behaviour.

Demographics of the DB

3.19. Finally, ROs reported that they felt the demographic composition of the DB is also an important consideration when exploring the proportionality of referrals. Proportionality is essentially calculated by comparing the proportions of different demographic groups who have had an FtP referral against the demographic composition of the entire organisation. So every DB is its own benchmark. However, feedback from the survey revealed a number of comments about the lack of diversity within their DB, "**Our workforce is not as diverse as many branches of medicine and overseas graduates are very rare**", this was especially common for smaller DBs "**Our small workforce is not diverse".** In more

[9] The remaining 14% selected that none of the options appropriately described the distance between the person referring the doctors from the doctors themselves.

homogeneous workplaces, underrepresented groups are more likely to be treated differently in processes such as performance management. In these settings, it may also be harder to implement some of the interventions listed above that facilitate more connection between individuals from underrepresented groups or encourage greater inclusion and representation.

Moderators

RO as a Pastoral role

3.20. A key theme that emerged was about the approach of the individual RO and the perceived impact this had on proportionate and fair referrals. A number of DB respondents described their understanding of the RO role as 'pastoral', with responsibility to support doctors through processes and investigations "**I don't think you can get past the approach that an individual RO brings to this. You know, fundamentally for me, it's principally a pastoral role. It sounds a little bit of an odd thing to say, but I think if you approach it only as a kind of 'head prefect' role, you're not going to be able to offer the support that you might want to."** Some contrasted a pastoral approach to other settings where they felt there was more of a focus on 'process', which did not always result in the right outcome, "…**in England we have a series of standard operating procedures… we have tried to put in some processes on revalidation and fitness to practice. Does it ensure that... every fitness to practice issue is dealt with in exactly the same way? Almost certainly not**". This view of the role of the RO as pastoral in focus aligns with the wider research base regarding the importance of an individualised, compassionate approach to achieving fairer outcomes.

Experience with Referrals/as an RO

3.21. On a related note, individual experience in the RO role was also cited as important in shaping an individual and organisational approach to managing performance issues. There was a large variation in the number of referrals made by different DBs, which was not surprising. However, ROs with experience of a high number of potential and actual referrals reflected that their tenure and exposure in the role significantly influenced how they approached subsequent referrals. Some offered support to other ROs based on their accumulated experience. The majority of ROs who responded to the survey (55%) had been in post for 1-5 years, and 34% had held the RO role for more than 5 years. "**One of the things I've noticed, particularly as I've been an RO for 12 years now, is the threshold at which you refer [evolves], so I think I've probably got quite a high threshold for referral…**". This suggests that ROs newer to the role, or those with a lower likelihood of making a referral due to DB size or services provided, may benefit from the opportunity to speak with ROs with a longer tenure or a higher rate of referrals to share reflections and learning.

Underlying Causes of (Dis)proportionality

3.22. Some DB interviewees also provided reflections on the analysis provided about FtP referrals more broadly, and how a focus on disproportionality as it relates to ethnicity and PMQ region might disregard other, equally important characteristics (for example, gender or neurodiversity were

commonly mentioned) "**I think the fixation on race from the GMC as opposed to, you know, sex/gender, and their failure to deal [with] or have a higher [tolerance] for sexism, misogyny in the NHS troubles me greatly".** While this research focused on interventions designed to reduce disproportionality in referrals regarding ethnicity and PMQ region, statistical testing suggested a high degree of relatedness between ethnicity/PMQ-region disproportionality and disproportionality regarding other protected characteristics. This implies that interventions identified through this work could help reduce disproportionality in referrals regarding other protected characteristics.

Involvement of Others in Management of Concerns

3.23. Another key theme that emerged during the interviews was ROs noting the value of multiple individuals being involved in the investigation of concerns, and how this influences decisions about which concerns progress in an FtP referral, **"[it's a] discussion between various people like me, medical director, non-executive director and between us, it's sort of a calibration of the concern and any risk and whether this can be remedied or not**". Some referenced the inclusion of a DEI/Diversity representative as providing a valuable alternative perspective, "**the diversity lead because that is one of the recommendations is having a senior doctor who would… attend meetings**". Only 15% of survey respondents had an individual who contributes to discussions/investigations of complaints or concerns with a primary focus on DEI, 23% had an individual who contributes with a DEI focus but also had other roles, and 62% had no specific individual with a DEI focus contributing to management of concerns.

3.24. Whilst the RO is ultimately the accountable decision-maker for referrals, use of collaborative consultation and the involvement of multiple stakeholders in investigations are likely to improve the efficacy of interventions focused on management of concerns.

Capability Factors

Lack of Evidence Available

3.25. A major theme that emerged, which was likely to influence ongoing practice and provision in this space, was the general lack of evidence available as to what meaningfully influences the proportionality of referrals. This was not surprising given the findings of the literature review, and addressing this gap was one of the overarching aims of this project. Some interviewees noted that providing certain interventions was seen as a statutory requirement or something they had no option but to do. In these instances, a lack of evidence as to an intervention's efficacy was unlikely to mean that the provision of that intervention stopped.

Challenges in Evaluation

3.26. When researchers and ROs discussed the value of evaluating interventions in place across DBs, interviewees provided some useful reflections. While there was a desire to understand more about what worked and why, individuals also felt cautious about the feasibility of evaluating their own

interventions "**No…we don't have any formal (evaluation) metrics. I've never thought about it**". Whilst there was limited appetite or resources available to perform such evaluations, low-resource ways to evaluate and monitor progress, such as short online surveys, may provide useful insights into the uptake and perceived value of DB interventions.

3.27. Engaging in discussions as part of this project may have had the added benefit of supporting reflections on fairer employer referrals. These conversations helped to raise awareness of the importance of fair referral practices and how interventions may support this, while also highlighting the need to evaluate interventions designed to address this issue.

3.28. When considering the BEST framework (Singhal and Yosef, 2024; see Appendix A) as a tool to evaluate interventions (the framework that was used as a basis for creating some survey questions), the majority of ROs perceived it as helpful, and clear but also felt it was unlikely ROs would be able to provide complete metrics against the full BEST framework for every intervention within their DB. Some were concerned that the scoring system may score certain interventions quite poorly, despite the fact they are anecdotally perceived as very helpful "**...it's extraordinarily difficult to evidence [effectiveness] across a large organisation. What happens is people pick and choose, don't they? Sometimes they use the [right] type of intervention, at the wrong time.**"

Limited Funding

3.29. There were regular comments made about the sustainability of interventions, "**It (mentorship programmes) would be really nice to have it funded properly, but there's no money".** Based on the available data, there were mixed reviews on how helpful the evaluation of interventions would be to increase regular funding. The limited evidence base (detailed above) is seen as unlikely to be the main reason an intervention is discontinued, but also makes it more challenging to justify implementation of new interventions.

Additional Findings

3.30. In addition to the findings showing the relationship between some interventions and proportionate referrals, some additional statistical analysis produced some further findings of note.

3.31. 'Peer mentoring' was statistically significantly related to disproportionality in referrals. It is important to note that peer mentoring differs from other types of mentoring, such as mentoring from an experienced clinician or reverse mentoring. A potential explanation for this could be drawn from prior research - while peer mentoring can help validate experiences and provide reassurance, there is also a risk of it promoting more insular or 'siloed' thinking. Diverse perspectives from other sources may not be used, potentially exacerbating the in-group/out-group effect (GMC, 2024; Roe et al., 2019). This result illustrates how some interventions may not have a positive impact on fairness of referrals but may positively impact some other aspects of local culture. It is not possible to establish causation here (i.e. does peer mentoring cause disproportionality, or vice versa) due to the design of the research, and it should also be borne in mind that this analysis involved a small sample (N=33).

As previously described in the Influencing Factors section, DBs who are disproportionate regarding ethnicity/PMQ-region also tend to be disproportionate regarding other protected characteristics (N=283, p<.01), and across various areas of practice (N=283, p<.01). This indicates that any efforts to tackle disproportionality in referrals regarding ethnicity or PMQ region may be likely to improve proportionality regarding other protected characteristics and regarding multiple areas of practice.

3.32. Finally, a relationship was identified between disproportionality and the number of doctors referred during the five-year period analysed: disproportionate DBs tended to refer more doctors than proportionate DBs did. It is unclear exactly why this relationship exists. However, it was also noted that bigger DBs tended to make more referrals, simply because they are connected to a larger population of doctors. Higher numbers of referrals then make it more likely that their proportionality can be statistically assessed. In contrast, smaller DBs with fewer doctors make fewer referrals, making it less likely that proportionality can be statistically assessed for these DBs. As a result, this could imply that some differences in (dis)proportionality between DBs may partly be influenced by the size of the DB, rather than other substantive differences in the referrals made by those DBs.

How to Apply the Results to Your DB

3.33. This research sought to create a practical output to aid the adoption and application of the findings; this aims to support organisations in considering how the findings align with what they are currently doing and apply them to their own context.

3.34. This research has clearly identified that the unique context of a DB will impact which interventions are feasible to implement within that DB and how interventions may look in practice. The information provided here offers practical guidance on key interventions for all types of DBs, regardless of their type, size, or location. However, adaptation is required for each DB's resources, structure, and setting to maintain the core intent of each intervention.

3.35. When considering the results in each context, it may be helpful to follow a cyclical review process similar to the example in **Figure 8** below. Iteratively adapting or evolving existing provisions can better identify which interventions are responsible for observed changes.

Figure 8: Cyclical Review Process

1. **Review:** What initiatives or interventions are already in place at the DB? Are they currently being utilised as intended? Which of the Influencing Factors reported above may be impacting their efficacy? What outcome criteria should be used to determine when an intervention is no longer delivering sufficient benefit to justify continued investment of time, staff effort, or funding?

2. **Develop:** Consider what is already in place at the DB that is similar to the six key interventions above. Is there an opportunity to adapt or build on interventions already in place?

3. **Design:** Has your review identified any gaps in provision? If so, is there an opportunity to design or implement a new intervention?

4. **Engage:** Work with other organisational stakeholders to design, share, or re-share available interventions across the relevant employee groups in the DB.

5. **Evaluate:** Monitor the uptake or impact of refreshed or new interventions. An evaluation framework, such as the BEST criteria (Singhal and Yosef, 2024) can help guide this. Refine key outcome criteria if relevant to input into the next Review stage.

4. Implications and Concluding Remarks

4.1. **Purpose of the Research**: This project sought to build on the findings of previous work to understand 'what supports fairer employer referrals to the GMC'; the goal was to identify which interventions and initiatives implemented within DBs contribute to a lower risk of certain groups being overrepresented within FtP referrals from that DB.

4.2. **Limitations in Data and Sampling:** The research methodology had to be adapted on completion of data gathering due to limitations identified within the available data, as a result of obtaining a smaller sample than ideal, with very limited representation of DBs with disproportionate referrals. ROs (or those in similar roles with oversight of the disciplinary process) are an oversampled group as regards to research, due to their ability to provide a wealth of information across various key organisational processes. This is particularly true for those from certain DB types in smaller regions or where there are fewer DBs of that type across the UK. In addition, the number of DBs in the full sample which had made enough referrals for their proportionality to be assessed statistically (N=283) further limited the size of the sample that could be used to answer the research questions. Data from some survey respondents was useful but came from a DB that lacked the outcome of interest. While DBs with the outcome of interest were purposively sampled at the interview stage, the survey was sent to all DBs to help obtain the largest, most representative sample available. As a result of these sampling constraints, the analytical approach was adapted to use descriptive and inferential quantitative analyses, along with some simple machine-learning modelling. More analysis was also done on qualitative data collected during previous stages of the project than originally planned, to supplement the findings.

4.3. In addition, it is important to acknowledge the potential for reporting bias. Interviews were conducted with ROs who volunteered to participate in the research and felt they had meaningful insights to share about their role. As a result, the views captured are likely to reflect a particular interpretation of the RO role and its relationship to disproportionality and may also reflect ROs who have implemented certain interventions in their context that are not consistently implemented across a wider range of DBs. Perspectives from individuals who did not engage, who may hold different or contrasting views, or who have a different perspective on the value of interventions were not represented in this research.

4.4. **Interpretation of Findings**: It is important to remember the timeframe in which the data was collected on interventions as compared to the timeframe of the outcome data. Referrals are analysed using data spanning a five-year period, whereas interventions were discussed as they currently exist. ROs were often aware of themes and patterns within their referrals, even without confirmatory outcomes about whether referrals in their DB were proportionate or disproportionate. As a result, these ROs have often put in place interventions to remove potential bias and support fair referrals. Therefore, an organisation that may be flagged with a 'disproportionate' outcome might also have best-practice interventions currently in place, but these may be at a less mature stage. It takes a relatively long time for the effects of different interventions and processes to flow through the system. Likewise, due to the very small number of referrals made by employers in general, it can often be a very small number of referrals that moves an organisation's outcome from proportionate to disproportionate, or vice versa.

4.5. **Key Outputs of the Research:** This project sought to explore interventions related to fairer referrals. The primary output of this research is an understanding of which interventions might promote the proportionality of local disciplinary processes and of employer referrals to the GMC. The results include details on 'influencing factors' that might impact both the efficacy of these interventions and the proportionality of referrals more broadly, which may provide useful insights to readers when considering their own intervention provision.

4.6. **Contextual Considerations for Implementation:** It is important to recognise that, while these interventions are applicable across all DBs, their implementation in practice will vary depending on the unique context of a DB. For example, many interventions are a more natural fit for employer or placement-provider DB contexts, which means they may be more challenging to implement in settings where doctors are not directly employed by the DB - such as in private practice, independent settings, or Locum Agency settings. The size of the DB (the number of connected doctors) will also influence the feasibility of particular interventions and the scale on which they can be implemented (smaller DBs will not have access to the same resources as larger ones with regard to time, funding, or people). Nonetheless, the underlying principles of these interventions should still be reviewed to understand which concepts might be adapted or implemented differently while still meeting the original intended purpose.

4.7. On a related note, it became clear that analysing data at an individual DB level could help provide insight into particular nuances of that context which may affect the proportionality of referrals. As such, DBs are encouraged to maintain a comprehensive, well-structured dataset capturing all decisions made within their local disciplinary processes. This would ideally include information on all doctors that enter the process, the outcomes of those cases, and whether any result in referral to the GMC. In addition, collecting data on the protected characteristics and PMQ region of the doctors involved would enable the organisation to monitor internally if certain groups are disproportionately represented at any stage. Such systematic monitoring would support early identification of potential inequities and enable timely, evidence-based local action to address them.

4.8. **Challenges in Evaluation and Evidence Availability:** This research project reinforced prior findings on the general lack of evaluation evidence available for such interventions. The literature review and interviews/survey all revealed very limited evaluation data. ROs and literature described a range of interventions designed to support fair referrals, describing how interventions were tailored to their settings and their general sense of their effectiveness, but there was very limited formal evaluation in place. The BEST criteria (Singhal and Yosef, 2024) for evaluation provide a starting point for guiding ROs in evaluating initiatives and interventions. While ROs found it helpful to consider it as a starting point to inform their own evaluation, they did not view all the BEST criteria as relevant to every intervention. The researchers were generally unable to capture reliable data about when specific interventions commenced and what else was happening in the organisation at the time. This suggests that there is the opportunity to share more intelligence on what is perceived to work and why amongst the RO community, but that formal, longitudinal evaluation of such interventions may be challenging to conduct.

4.9. **Considerations for Future Research:** A key consideration for future research into the reasons for disproportionate rates of referral is the availability and granularity of outcome data. A majority of DBs (approximately 75%) did not make enough referrals in the period to determine if their referrals were

proportionate or disproportionate. Some DBs with limited referrals may be doing innovative things during early management of concerns that ensure referrals remain as proportionate as possible. Other DBs may have limited referrals because FtP referrals are not being made when they should be, so the outcome of limited or proportionate referrals does not truly reflect their reality. For example, it remains possible that disproportionality results from a group being underrepresented in the local disciplinary process and in referrals to the GMC, rather than from another group being overrepresented. If DBs capture data as described in 4.7, this would facilitate internal monitoring of conversion of incidents into local disciplinary processes, of these into referrals to the GMC, and how this relates to proportionality in their own context. As more issues are dealt with in local disciplinary processes than are referred to the GMC, this may help reveal if disproportionality in referrals originates at an earlier stage.

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Appendices

Appendix A - The Original BEST Model

Background Evidence

Score	Score descriptors
1	• Anecdotal evidence (concept has been noted in general conversations, e.g. within the department, feedback in supervision meetings)
2	• Concept noted through surveys and interviews that have not been published
3	• Emerging concept in literature and research
4	• Core concept in literature and research

Evaluation

Score	Score descriptors
1	• Consensus from expert opinion that intervention is perceived to be effective • No evidence of evaluation
2	• Consensus from expert opinion that intervention is perceived to be effective • Immediate evaluation demonstrating positive impact
3	• Consensus from expert opinion that intervention is perceived to be effective • Immediate evaluation demonstrating positive impact • Interval follow-up evaluation demonstrating positive impact
4	• Consensus from expert opinion that intervention is perceived to be effective • Immediate evaluation demonstrating positive impact • Interval follow-up evaluation demonstrating positive impact • Long-term evaluation demonstrating positive impact and embedded changes in behaviour

Sustainability

Score	Score descriptors
1	• No funding • Single point of failure, e.g. one person running intervention with no record on how to run intervention
2	• Limited funding for under 1 year • Some distributed knowledge on how the intervention is run
3	• Limited funding but for a multi-year scheme • Guidance/policy document on how to run the intervention, without active involvement or training of more people
4	• Business As Usual (standing item on budget) • Guidance/policy document on how to run the intervention, actively involving or training more people to keep it sustainable

Team engagement in intervention design

Score	Score descriptors
1	• No consultation with stakeholders • External delivery of intervention (no direct involvement with the concept/target group)

2	• Sporadic consultation with stakeholders • Internal delivery of intervention (direct involvement with the concept/target group)
3	• Regular consultation with stakeholders • Internal delivery of intervention (direct involvement with the concept/target group)
4	• Co-production and delivery

Appendix B – Revised BEST Criteria for Survey

Within the survey, data was captured for each intervention in place in relation to two scales included within the survey as a way of capturing BEST data on interventions. Scales were the Evidence and Evaluation Scale and the Intervention Implementation Scale, both adapted from the BEST criteria (Singhal and Yosef, 2024). These scales were included to aid interpretation of other analyses (e.g. is there evidence to suggest that more evidence is available for interventions that are most popular across DBs, or that key interventions have higher ratings on one or both scales?). On inspection, no clear patterns were identified between the ratings on either scale and the presence of each intervention. Scale data for each intervention is provided in Appendix I.

Evidence/Evaluation Scale	Original values	Recoded as
Don't Know	1	Missing
Anecdotal: Intervention design was based on informal feedback or opinions; No formal evaluation - anecdotal or internal-only evidence	2	2
Emerging: Some internal validation of the design; Evaluation consists of internal surveys/interviews and is focused on short-term/ immediate timepoint	3	3
Validated: Intervention is supported by external or published evidence; follow-up evaluation activity has provided validation of the intervention's efficacy	4	4
Proven: Intervention design based on strong evidence-base; longer-term evaluation has shown embedded behavioural or systemic change	5	5

Implementation Status Scale	Original values	Recoded as
Don't Know	1	Missing
Early Stage: Intervention is being trialled; Limited support or stakeholder involvement; No funding secured; Responsibility sits with a single individual	2	2
In Development: Intervention is being developed further, in consultation with stakeholders; Short-term funding; Responsibility sits with an individual or small team	3	3
Structured: Intervention is documented and partially embedded within the DB; Multi-year funding; some training or guidance available to share responsibility for intervention provision	4	4
Embedded: Sustainable intervention fully embedded; BAU funding in place; ongoing stakeholder engagement and responsibility shared across team	5	5

Appendix C – Classification of DB Types for Research Purposes

The GMC hold basic data on each Designated Body in the UK, including the type of DB (using a list of 26 types). In this research, the 26 types were grouped into 7 broader categories to support analysis. A 'Centralised/Decentralised' grouping was also created, based on the type and signifying the level of oversight that the DB has (e.g. a centralised DB is usually single or close-proximity multi-sites, with doctors employed by the DB; a decentralised DB may be multiple sites with doctors employed by a range of employers).

DB Type in GMC Classification	Used DB Type (7 categories)	DB Centralisation
Charity/NGO	Rest of	Centralised
Cosmetic/Aesthetic	Rest of	Centralised
Diagnostics	Rest of	Centralised
Fertility Clinic	Rest of	Centralised
Government Department	Rest of	Decentralised
Hospice	Rest of	Centralised
Independent Ment. Health/Rehab	Rest of Independent/Private	Centralised
Independent Other	Rest of Independent/Private	Centralised
Independent Primary Care	Rest of Independent/Private	Centralised
Independent Prov. RMO Agency	Rest of Independent/Private	Decentralised
Independent Secondary Care	Rest of Independent/Private	Centralised
Medical Education	Medical Education	Decentralised
Locum Agency	Locum Agency	Decentralised
Membership Body	Rest of	Decentralised
Mix of Independent Services	Rest of Independent/Private	Centralised
NHS / HSC Health Board	NHS/HSC	Centralised
NHS Acute Trust	NHS Acute or Non-Acute	Centralised
NHS England Region	NHS Acute or Non-Acute	Decentralised
NHS Non-Acute Trust	NHS Acute or Non-Acute	Centralised
NHS Primary Care	NHS Primary Care	Decentralised
NHS/HSC Other	NHS/HSC	Centralised
NHS/HSC Special Board/Trust	NHS/HSC	Centralised
Occupational Medicine	Rest of	Centralised
Pharmaceutical Medicine	Rest of	Centralised
Regulator	Rest of	Decentralised
Suitable Person	Rest of	Decentralised

Appendix D – Interview and Survey Sampling

Table A: Interviews Target and Sample Breakdown – Size and Location of DB

Sample	Total	Size			Location				
		<100 Connected Doctors	100-1000 Connected Doctors	1000+ Connected Doctors	England	Scotland	Wales	NI	Isle of Man / Channel Islands / Unspecified
Interviews Conducted	**21**[10]	**4**	**8**	**8**	**15**	**1**	**2**	**1**	**1**
Interview Target	30	4	13	13	20	3	3	3	1

Table B: Interviews Target and Sample Breakdown – Type of DB

Sample	Total	Type						
		NHS Acute or Non-Acute	NHS Primary Care	NHS/ HSC	Medical Education	Locum Agency	Rest of (Independent)	Rest of (Others)
Interviews Conducted	**21**[11]	**8**	**3**	**4**	**1**	**1**	**2**	**1**
Interview Target	30	8	5	5	4	4	2	2

Table C: Interviews Sample Breakdown – Proportionality Outcome

Sample	Total	Proportionality		
		Disproportionate	Proportionate	Not enough Data
Interviews Conducted	**21**[5]	**6**	**10**	**4**

Table D: Survey Target and Achieved Sample – Size and Region of DB

Sample	Total	Size			Region				
		<100 Connected Doctors	100-1000 Connected Doctors	1000+ Connected Doctors	England	Scotland	Wales	NI	Isle of Man / Channel Islands / Unspecified
DB Responses	106[12]	27	58	21	90	6	1	4	5
Responses as % of Sample		26%	55%	20%	85%	6%	1%	4%	5%
Survey Target	150	20%	40%	40%	80%	5%	5%	5%	5%

[10] Data was missing for N=1 RO, therefore interview statistics only refer to a sample of N=20.

[11] Data was missing for N=1 RO, therefore interview statistics only refer to a sample of N=20.

[12] N=106 was the total number of responses received which includes partially complete responses. The total of complete responses was N=53. Please note that due to rounding the statistics may not add up to 100%.

Table E: Survey Target and Achieved Sample – Type of DB

Sample	Total	Type						
		NHS Acute or Non-Acute	NHS Primary Care	NHS/HSC	Medical Education	Locum Agency	Rest of (Independent)	Rest of (Others)
DB Responses	106[6]	55	2	10	4	3	18	14
Responses as % of Sample		52%	2%	9%	4%	3%	17%	13%
Survey Target	150	25%	15%	20%	15%	15%	5%	5%

Table F: Survey Target and Achieved Sample – Proportionality Outcome

Sample	Total	Proportionality		
		Proportionate	Disproportionate	Not enough Data
DB Responses	106[6]	68	7	31
Responses as % of Sample		64%	7%	29%

Appendix E – List of 52 Interventions and Initiatives Included within the Survey, Identified to Support Fair Referrals[13]

Theme	Intervention/Initiative
Category 1: Performance	• Clear mechanisms for providing informal feedback • Transparent performance management processes • Providing tools/training to have difficult conversations with others • Clear mechanisms for individuals to anonymously raise concerns or whistle-blow • Clear guidance for doctors new to the DB on expectations about conduct and accountability for their own actions, and how their performance will be monitored and managed. • Mentoring from an experienced clinician • Focused supervision or enhanced opportunities to develop skills and obtain feedback if concerns have been raised
Category 2: Group-specific Support	• Provision of a corporate induction for all new starters to the DB • Provision of a paid supernumerary induction to clinical work area / clinical team • Inductions with a specific focus on Foundation trainees or international graduates new to the DB • Meet and greet events for new starters to make connections with existing staff • Required completion of GMC provided "Welcome to UK Practice" training • Pool of supervisors for international graduate doctors, who are sensitised to advantages and challenges international graduates might experience • Easily accessible information, such as a single website dedicated to international graduates (focusing on things such as registration, relevant insurance, general information such as UK customs/culture, information on the local area such as local amenities, housing and banking information) • Training for doctors new to the UK (who have previously worked in different systems) on how to appropriately raise concerns • Communication skills for international graduate doctors with a focus on the local area (e.g. Lists of commonly used local phrases; links to resources to watch to become familiar with local accents and language use) • More generic communication skills training tailored for international graduates who are new to practising medicine in the UK • Peer mentorship programmes • Links to local networks (e.g. Allyship HUB programme) • Specific training provision for certain roles to support inclusion (e.g. training opportunities for SAS or locally employed doctors) • Networks or groups for specific career points (e.g. groups for new consultants, first five GP schemes)
Category 3: Diversity, Equity, Inclusion and Belonging	• Networks for BAME staff • Networks for international graduate staff • Reverse mentoring programme for Board members, or between senior staff and members of a BAME network • Programme offering BAME staff secondments into leadership positions or expansion of responsibilities (e.g. delivery of Leadership Team appraisals)

[13] The title of the interventions and initiatives are provided as they were presented within the survey.

Theme	Intervention/Initiative
	• Programme offering international graduates secondments into leadership positions or expansion of responsibilities (e.g. delivery of Leadership Team appraisals) • Training sessions on topics such as race equality, bullying, micro-aggressions, anti-bias, and how not to be a bystander • Active programmes to specifically promote BAME / international graduate doctors into positions of leadership (e.g. inclusion of SAS doctors in leadership roles) • Regular trend monitoring and analysis of any gaps in attainment/pay/benefits gap across groups • Diverse hiring practices - intentionally seeking and including candidates from various backgrounds and demographics • Training on how to create supportive workforce cultures (e.g. Professional behaviours patient safety training programme) • Role modelling - individuals from diverse backgrounds represented in leadership roles or performance management processes • Inclusive culture / DEI objectives incorporated as an objective for line-managers • Embedding models (e.g. Just Culture model/Being Fair tool), cultural ambassadors, or other cultural touchpoints, into disciplinary processes
Category 4: Management of Concerns	• Early warning systems where concerns about doctors are triaged or discussed before concerns escalate • Informal, but documented, conversations with staff over lower-level concerns • Rapid scoping exercise after an initial incident/concern to understand extent of investigation required • Independent panels to review anonymised case information before a referral is made • Coordination with the GMC ELAs to get advice before referrals are made • Collaboration with other organisations (e.g. NHS Resolution) • Provision of support for practitioners about how investigation of concerns/complaints works and what support they can access • Provision of information for practitioners during investigation of concerns/complaints • Training for clinical leaders / managers about effective early management of concerns • Clear guidance or checklist for clinical leaders / managers for handling concerns or complaints, including how to support practitioners during the process
Category 5: Culture of Learning	• Formal incident and complaint reporting system, with a focus on reflection and learning • Training for, and processes that support, having compassionate conversations with practitioners • Policies and procedures that reinforce the importance of learning • Promotion of decision making as a collective process that welcomes challenge and incorporates feedback from those more at risk at being overrepresented in disciplinary processes • Refresher/reflection sessions to explore decision making and any potential bias within it

Theme	Intervention/Initiative
	• Clinical simulation labs for human factors training • Training videos to facilitate understanding of the roles of other team members • Participation in an RO Advisory Group; peer learning opportunities with other ROs or discussion of anonymised past referrals

Appendix F – Key Interventions Evidence Triangulation

	Interventions	Source of Evidence		
		Literature*	Quantitative Analysis	Qualitative Analysis
1	Clear mechanisms for providing informal feedback	xx		x
2	Required completion of GMC-provided "Welcome to UK Practice" training	x	x	x
4	Informal, but documented, conversations with staff over lower-level concerns	xx		x
4	Rapid scoping exercise after an initial incident/concern to understand the extent of investigation required	x		x
4	Coordination with the GMC ELAs to get advice before referrals are made	x		x
5	Promotion of inclusive consulting in the lead-up to decisions, that welcomes challenge and incorporates feedback from those more at risk of being overrepresented in disciplinary processes	x	x	x

Key	
1	Performance
2	Group-specific Support
3	DEIB
4	Management of Concerns
5	Culture of Learning

Literature Key*

x = Some evidence available

xx = Substantial evidence available

Appendix G – 17 Additional Interventions for Supporting Fairer Referrals – Practical Tips

1. **Transparent performance management processes**
    - **Establish clear, accessible criteria -** define performance expectations, goals, and evaluation metrics upfront, and make them easily accessible to all employees. This ensures everyone understands what success looks like and how it will be measured.
    - **Document Decisions –** maintain documented records to promote accountability and trust.
    - **Effective use of 360^{o} appraisal –** and other feedback tools can enhance performance management processes and pick up concerns early.

2. **Providing tools and training to have difficult conversations with others**
    - **Make training available for all –** try to support all employees to develop their skills in this area, not just managers.
    - **Create a supportive practice environment –** providing alternative methods, such as peer coaching, allows employees to rehearse difficult conversations in a safe, low-stakes setting.

3. **Clear mechanisms for individuals to anonymously raise concerns or whistle-blow**
    - **Create a clear policy document -** Draft a short, plain-language guide explaining how employees can raise concerns anonymously, what issues can be reported, and what protections apply.
    - **Assign a trusted point of contact –** nominate one impartial individual as a single point of access for individuals to approach if they have concerns or would like to discuss a situation. For example, the Freedom to Speak Up Guardians (NHS England, 2022b).

4. **Provision of a corporate induction for all new starters**
    - **Include self-service resources –** provide links to FAQs, templates and process guides in advance so that stakeholders can familiarise themselves with the content and get the most out of the session.

5. **Inductions with a specific focus on Foundation programme trainees, or IMGs new to the DB**
    - **Signpost to external resources –** there are many pre-existing resources which can be used to avoid duplication of work and limit resources in delivering such inductions.

6. **Networks for BAME staff**
    - **Establish a voluntary staff network with clear purpose and sponsorship –** invite BAME employees to shape group aims and secure an executive sponsor to ensure visibility, resources, and organisational support.
    - **Provide protected time and space for meetings –** schedule regular sessions (virtual or in person), ensure they are recognised as part of working hours, and create safe, confidential environments for discussion and peer support.
    - **Facilitate opportunities for influence –** involve the network in policy reviews, EDI initiatives, and decision-making forums.

7. **Networks for IMG staff**
    - **Use informal tools –** use free, accessible tools such as WhatsApp or MS Teams to provide a virtual space for IMG staff to connect.
    - **Nominate volunteer champions –** identify more experienced staff from similar backgrounds to act as champions for these networks.
    - **Encourage links with established national networks –** these include The British Association of Physicians of Indian Origin (BAPIO), for example.

8. **Training sessions on topics such as race equality, bullying, micro-aggressions, anti-bias, and how not to be a bystander**
    - **Integrate regular, bite-sized training into existing learning pathways –** deliver short, interactive sessions during induction and annual mandatory training where possible, seeking to make these topics part of the organisation's core expectations rather than optional add-ons. This could involve live or digital role-play as part of scenario-based learning.
    - **Use freely available, high-quality learning materials –** Draw on publicly available materials (NHS, GMC, etc.) that explain concepts like micro-aggressions, bystander action, and anti-bias in clear, practical terms.

9. **Regular trend monitoring and analysis of any gaps in attainment/ pay/ benefits across groups**
    - **Review available data –** review what data you have available to monitor these trends. National monitoring by the GMC is available on some key metrics, such as exam and training progression and FtP referrals, which can help identify further topics to explore in a specific DB.
    - **Larger organisations may have access to statistical or data analytics expertise –** increasingly, AI could be used to analyse or visually depict trends in data that otherwise may not have been identified by identifying relationships across multiple organisational datasets.

10. **Diverse hiring practices - intentionally seeking and including candidates from various backgrounds and demographics**
    - **Diversify hiring panels where possible –** Invite colleagues from different roles, levels, or departments to join interview panels. This can help reduce the risk of unconscious bias and ensure a broader range of perspectives in decision-making.
    - **Consider the nature of patient representation on hiring panels –** whilst many panels now have at least one patient/service-user/carer representative, again, it may be helpful to consider drawing from under-represented or marginalised groups served by the healthcare provider.

11. **Role modelling – individuals from diverse backgrounds represented in leadership roles or performance management processes**
    - **Highlight existing diversity in leadership –** showcase diversity in leadership or similar roles.
    - **Role models in induction –** feature role models in induction and training.

12. **Early warning systems where concerns about doctors are triaged or discussed before concerns escalate**

- **Use a risk framework –** use of a framework to prioritise concerns and encourage consistency in triage.
- **Such frameworks should include guidance for actions –** also, when no formal or informal action is taken at the time, the reasons should be clearly documented (e.g. insufficient or conflicting evidence).

13. Collaborations with other organisations (e.g. NHS Resolution)

- **Explore what is available –** speak to other ROs or your ELA to explore what support is available and how/when ROs could use it.
- **Other external mediation or arbitration services may be available (e.g. "Trust Mediation") –** though their use may incur a cost, the avoidance of even a small number of formal or legal disputes is likely to save considerable resources.

14. Provision of support for practitioners about how the investigation of concerns / complaints works, and what support they can access

- **Make information readily available –** ensure that, where possible, information about support is freely available and easy to access. This increases the likelihood that individuals will be aware of it and have access to it if the need arises.
- **Consider duty of care –** DBs need to take into account the likely impact on a doctor of being subject to complaints/disciplinary processes and offer or signpost to appropriate support.
- **The role of Employer Liaison Advisors (ELAs) –** GMC ELAs are asked to remind Responsible Officers (ROs) to flag any vulnerability concerns when a referral is made or likely.

15. Clear guidance or checklist for clinical leaders / managers for handling concerns or complaints, including how to support practitioners during the process

- **Knowledge sharing –** sharing knowledge and experience about processes across DBs could help reduce the work to create new processes. It would also facilitate better sharing of lessons learned and opportunities for continuous improvement.

16. Training videos to facilitate understanding of the roles of other team members

- **Alternative options** – if videos are not feasible, short written biographies could be an alternative, though even the addition of static/photos/cartoons and audio voiceovers can make such material more engaging. The important thing is to promote a shared understanding of different roles within the organisation. A 'Day in the Life' style often makes these types of resources more accessible and meaningful.
- **Share one small snippet at a time –** gradually develop the library of examples or start at a role level rather than an individual level.
- **Making such material emotionally engaging –** going beyond simple factual descriptions of roles to first-person descriptions of the rewards and challenges of the work could help build empathy between different disciplines.

17. **Participation in an RO Advisory Group; peer learning opportunities with other ROs or discussion of anonymised past referrals**
    - **Use case studies or examples to encourage learning** – group reflections on past referrals and their management can identify opportunities where processes can be improved or learning from other similar DBs can be applied.
    - **Engage with RO networks-** there is a comprehensive network for ROs, primarily coordinated by the NHS, with regional and local networks also supporting ROs. The GMC provides additional support and resources.

Appendix H - Additional Quantitative Findings

This section includes some additional findings on the prevalence of interventions across the sample. A full breakdown of intervention implementation by different DB characteristics is shown in Appendix I.

The least popular interventions were defined as those implemented in fewer than 30% of sampled DBs. There are a number of factors that could lead to an initiative or intervention achieving low uptake across DBs, such as the resources required to implement and sustain it, or access to the different types of support required. A summary of each of these initiatives and interventions is provided below, along with any data on the DB types that are more or less likely to have this in place. Most less popular interventions fell within the ***DEIB*** or ***Group-specific Support*** groups.

The Least Popular Initiatives or Interventions

- **Communication skills for IMG doctors with a focus on the local area (e.g. lists of commonly used local phrases; links to resources to watch to become familiar with local accents and language use) (Group-specific Support):** Only 27% of DBs currently have this intervention in place, making it one of the least popular interventions, and it was rarely mentioned within the RO interviews. When looking at which DBs had it in place, Locum Agencies and Primary Care were the least likely to have it in place.
- **Links to local networks (e.g. Allyship HUB programme) (Group-specific Support):** Only 27% of DBs have this intervention in place, making it one of the least popular interventions, and it was rarely mentioned within the RO interviews. Locum Agencies and Primary Care were the least likely to have it in place.
- **Reverse mentoring programme for Board members, or between senior staff and members of a BAME network (DEIB):** Only 28% of DBs had this intervention in place. Reverse mentoring was mentioned during interviews as some DBs have introduced it for senior leaders, often in partnership with BAME networks. However, whilst some reported positive experiences, some described limited uptake or uncertainty about its ongoing use.
- **Programme offering BAME staff secondments into leadership positions or expansion of responsibilities (e.g. delivery of Leadership Team appraisals) (DEIB):** Only 10% of DB had this intervention in place, and it was rarely mentioned during the interviews. The literature emphasises the importance of going beyond one-off events or interventions if such interventions are to be successful.
- **Programme offering IMGs secondments into leadership positions or expansion of responsibilities (e.g. delivery of Leadership Team appraisals) (DEIB):** Only 8% of DBs had this intervention in place, and it was not mentioned during the RO interviews. It is quite a niche initiative, and there is very limited literature on this intervention. It is possible that participants did not differentiate between this intervention and the intervention above, as they serve some of the same population.
- **Active programmes to specifically promote BAME / international graduate doctors into positions of leadership (e.g. inclusion of SAS doctors in leadership roles) (DEIB):** Only 27% of DBs had this intervention in place, and it was not mentioned during the interviews. No specific evidence or literature was found on this initiative or intervention in relation to referrals.
- **Clinical simulation labs for human factors training (Culture of Learning):** Only 30% of DBs currently have this intervention in place. Smaller DBs (<100 connected doctors) and Primary Care or Locum Agencies were the least likely to have it in place. Evidence suggests that a human factors approach could support a better understanding of systemic and individual-level causes of complaints or issues.

The analysis also explored which interventions were previously in place but have been discontinued across DBs. The information below highlights any initiatives or interventions discontinued by more than one DB. Due to the small sample size, it is not possible to draw any conclusions about patterns in the characteristics of those DBs that have discontinued these interventions.

Discontinued Interventions	
Meet and greet events for new starters to make connections with existing staff	Discontinued by 3 out of 70 DBs
Reverse mentoring programme for Board members, or between senior staff and members of a BAME network	Discontinued by 5 out of 51 DBs
Programme offering BAME staff secondments into leadership positions or expansion of responsibilities (e.g. delivery of Leadership Team appraisals)	Discontinued by 2 out of 49 DBs
Training sessions on topics such as race equality, bullying, micro-aggressions, anti-bias, and how not to be a bystander	Discontinued by 4 out of 57 DBs

Appendix I: Detailed Statistical Output

The information below shows the quantitative analysis performed for each intervention, showing the distribution of each intervention across all DBs, across only DBs with disproportionate referrals, and across only DBs with proportionate referrals[14]. Where the intervention was statistically significantly related to the proportionality outcome, the result is highlighted green: * denotes significant at p<.05, ** denotes significant at p<.01.

Interventions	DB Outcome	% Organisations with Intervention					Evidence/ Evaluation Scale[15]		Implementation Scale	
		N	Yes, currently in place	No; planned but not yet implemented	No; was in place but discontinued	No; never in place	N	Mean	N	Mean
Group 1: Performance - Preventative interventions to support good performance at work at your DB										
Clear mechanisms for providing informal feedback	All[16]	98	92%	3%	0%	5%	69	2.8	65	3.4
	Disprop	6	100%	0%	0%	0%	5	3.2	5	3.2
	Prop	63	89%	5%	0%	6%	41	2.7	39	3.3
Transparent performance management processes	All	103	84%	11%	0%	6%	64	3.0	62	3.8
	Disprop	7	86%	0%	0%	14%	4	3.5	4	4.0
	Prop	65	85%	9%	0%	6%	38	2.9	38	3.7
Providing tools/training to have difficult conversations with others	All	101	67%	17%	0%	16%	53	3.1	52	3.6
	Disprop	6	67%	17%	0%	17%	4	3.8	4	3.8

[14] Some percentage counts may not add up to 100% due to rounding.

[15] The Evidence/Evaluation scale and Intervention Implementation scale are both on a 2-5 scale as outlined in Appendix B.

[16] All includes; proportionate, disproportionate and not enough referrals.

Interventions	DB Outcome	% Organisations with Intervention					Evidence/ Evaluation Scale[15]		Implementation Scale	
		N	Yes, currently in place	No; planned but not yet implemented	No; was in place but discontinued	No; never in place	N	Mean	N	Mean
	Prop	64	70%	19%	0%	11%	32	3.0	32	3.7
Clear mechanisms for individuals to anonymously raise concerns or whistle-blow	All	105	95%	2%	1%	2%	65	3.6	65	4.2
	Disprop	7	100%	0%	0%	0%	5	4.0	5	4.8
	Prop	67	97%	2%	2%	0%	39	3.7	41	4.3
Clear guidance for doctors new to the DB on expectations about conduct and accountability for their own actions, and how their performance will be monitored and managed.	All	98	76%	14%	1%	9%	59	3.0	57	3.5
	Disprop	7	57%	29%	0%	14%	4	3.3	4	4.0
	Prop	61	77%	13%	2%	8%	34	2.8	34	3.3
Mentoring from an experienced clinician	All	100	67%	15%	1%	16%	54	3.1	54	3.5
	Disprop	6	83%	0%	0%	17%	4	4.0	4	3.8
	Prop	63	65%	21%	0%	14%	31	2.9	33	3.3
Focused supervision or enhanced opportunities to develop skills and obtain feedback if concerns have been raised	All	83	84%	2%	0%	13%	64	3.0	56	3.5
	Disprop	6	100%	0%	0%	0%	5	3.2	5	3.4
	Prop	51	88%	2%	0%	10%	38	2.9	31	3.5
Group 2: Groups-specific Support - Preventative interventions or provision of support for different groups										
	All	74	92%	1%	0%	7%	59	3.4	57	4.4

Interventions	DB Outcome	% Organisations with Intervention					Evidence/ Evaluation Scale[15]		Implementation Scale	
		N	Yes, currently in place	No; planned but not yet implemented	No; was in place but discontinued	No; never in place	N	Mean	N	Mean
Provision of a corporate induction for all new starters to the DB	Disprop	6	100%	0%	0%	0%	4	3.5	4	4.5
	Prop	44	96%	2%	0%	2%	36	3.4	34	4.5
Provision of a paid supernumerary induction to clinical work area / clinical team	All	70	54%	6%	1%	39%	39	3.2	37	4.0
	Disprop	5	60%	0%	0%	40%	4	3.5	3	4.0
	Prop	40	65%	3%	0%	33%	25	3.1	24	4.2
Inductions with a specific focus on Foundation trainees or international graduates new to the DB	All	74	66%	3%	0%	31%	43	3.2	44	4.0
	Disprop	5	100%	0%	0%	0%	4	3.5	4	4.0
	Prop	44	77%	5%	0%	18%	27	3.3	28	4.1
Meet and greet events for new starters to make connections with existing staff	All	70	70%	6%	4%	20%	43	3.2	41	3.8
	Disprop	5	100%	0%	0%	0%	4	3.0	4	4.0
	Prop	40	65%	10%	8%	18%	24	3.1	21	3.9
Required completion of GMC provided "Welcome to UK Practice" training	All	63	44%*	8%	0%	48%	29	3.4	26	3.7
	Disprop	3	100%	0%	0%	0%	3	4.0	2	4.5
	Prop	36	58%	8%	0%	33%	19	3.4	18	3.7
	All	69	48%	13%	1%	38%	32	3.0	31	3.6

Interventions	DB Outcome	% Organisations with Intervention					Evidence/ Evaluation Scale[15]		Implementation Scale	
		N	Yes, currently in place	No; planned but not yet implemented	No; was in place but discontinued	No; never in place	N	Mean	N	Mean
Pool of supervisors for international graduate doctors, who are sensitised to advantages and challenges international graduates might experience	Disprop	4	80%	0%	0%	20%	3	3.0	2	4.0
	Prop	40	53%	18%	3%	28%	20	2.9	21	3.4
Easily accessible information, such as a single website dedicated to international graduates (focusing on things such as registration, relevant insurance, general information such as UK customs/culture, information on the local area such as local amenities, housing and banking information)	All	65	39%	9%	2%	51%	24	3.1	27	3.8
	Disprop	2	100%	0%	0%	0%	2	3.0	3	4.0
	Prop	40	48%	10%	3%	40%	17	2.9	17	3.9
Training for doctors new to the UK (who have previously worked in different systems) on how to appropriately raise concerns	All	67	51%	13%	2%	34%	37	3.2	39	3.7
	Disprop	3	60%	40%	0%	0%	3	2.7	4	3.3
	Prop	39	64%	10%	3%	23%	27	3.0	27	3.8
Communication skills for international graduate doctors with a focus on the local area (e.g. Lists of commonly used local phrases; links to resources to watch to become familiar with local accents and language use)	All	67	27%	22%	0%	51%	24	3.0	22	3.4
	Disprop	4	25%	50%	0%	25%	1	3.0	2	2.5
	Prop	39	31%	26%	0%	44%	15	2.8	13	3.3
More generic communication skills training tailored for international graduates who are new to practising medicine in the UK	All	67	21%	22%	2%	55%	24	3.0	24	3.2
	Disprop	4	0%	50%	0%	50%	1	3.0	2	2.5
	Prop	39	23%	28%	0%	49%	16	2.9	15	3.3

Interventions	DB Outcome	% Organisations with Intervention					Evidence/ Evaluation Scale[15]		Implementation Scale	
		N	Yes, currently in place	No; planned but not yet implemented	No; was in place but discontinued	No; never in place	N	Mean	N	Mean
Peer mentorship programmes	All	69	44%**	10%	1%	45%	31	3.2	31	3.6
	Disprop	5	100%	0%	0%	0%	4	2.8	4	3.3
	Prop	41	39%	12%	0%	49%	17	3.2	16	3.5
Links to local networks (e.g. Allyship HUB programme)	All	59	27%	12%	0%	61%	20	3.1	19	3.7
	Disprop	3	67%	33%	0%	0%	2	3.0	2	4.5
	Prop	34	32%	12%	0%	56%	13	3.1	12	3.6
Specific training provision for certain roles to support inclusion (e.g. training opportunities for SAS or locally employed doctors)	All	67	54%	9%	2%	36%	34	3.1	35	3.3
	Disprop	4	100%	0%	0%	0%	1	4.0	2	4.0
	Prop	40	60%	13%	3%	25%	23	3.1	23	3.3
Networks or groups for specific career points (e.g. groups for new consultants, first five GP schemes)	All	64	47%	11%	0%	42%	29	3.0	28	3.6
	Disprop	3	67%	0%	0%	33%	1	4.0	1	4.0
	Prop	37	51%	16%	0%	32%	18	2.9	17	3.5
Group 3: DEIB - Preventative interventions to build a culture underpinned by DEIB (Diversity, Equity, Inclusion and Belonging)										
Networks for BAME staff	All	57	65%	4%	0%	32%	33	3.0	37	3.8
	Disprop	4	100%	0%	0%	0%	2	3.5	3	4.0

Interventions	DB Outcome	% Organisations with Intervention					Evidence/ Evaluation Scale[15]		Implementation Scale	
		N	Yes, currently in place	No; planned but not yet implemented	No; was in place but discontinued	No; never in place	N	Mean	N	Mean
	Prop	32	75%	3%	0%	22%	22	3.0	25	3.8
Networks for international graduate staff	All	49	41%	4%	0%	55%	22	2.9	23	3.4
	Disprop	3	100%	0%	0%	0%	2	2.5	2	4.0
	Prop	28	43%	7%	0%	50%	14	2.9	15	3.3
Reverse mentoring programme for Board members, or between senior staff and members of a BAME network	All	51	28%	6%	10%	57%	20	3.0	18	3.2
	Disprop	3	33%	33%	0%	33%	2	2.5	1	4.0
	Prop	27	19%	4%	15%	63%	11	3.2	11	3.0
Programme offering BAME staff secondments into leadership positions or expansion of responsibilities (e.g. delivery of Leadership Team appraisals)	All	49	10%	6%	4%	80%	12	3.0	10	3.2
	Disprop	3	33%	0%	0%	67%	1	3.0	0	
	Prop	29	10%	7%	3%	79%	7	2.9	7	3.1
Programme offering international graduates secondments into leadership positions or expansion of responsibilities (e.g. delivery of Leadership Team appraisals)	All	49	8%	8%	0%	84%	10	3.1	10	3.0
	Disprop	2	0%	0%	0%	100%	0		0	
	Prop	28	11%	0%	0%	89%	5	3.0	6	3.2
	All	57	74%	7%	7%	12%	37	3.1	41	3.7
	Disprop	4	100%	0%	0%	0%	3	3.3	3	4.0

Interventions	DB Outcome	% Organisations with Intervention					Evidence/ Evaluation Scale[15]		Implementation Scale	
		N	Yes, currently in place	No; planned but not yet implemented	No; was in place but discontinued	No; never in place	N	Mean	N	Mean
Training sessions on topics such as race equality, bullying, micro-aggressions, anti-bias, and how not to be a bystander	Prop	32	75%	9%	6%	9%	22	3.0	26	3.6
Active programmes to specifically promote BAME / international graduate doctors into positions of leadership (e.g. inclusion of SAS doctors in leadership roles)	All	52	27%	6%	2%	65%	17	2.8	19	3.4
	Disprop	4	50%	25%	0%	25%	1	4.0	3	3.3
	Prop	29	38%	3%	3%	55%	12	2.6	11	3.5
Regular trend monitoring and analysis of any gaps in attainment/pay/benefits gap across groups	All	51	61%	8%	0%	31%	31	3.6	32	4.0
	Disprop	4	75%	0%	0%	25%	3	3.7	2	4.0
	Prop	28	71%	11%	0%	18%	21	3.5	23	3.9
Diverse hiring practices - intentionally seeking and including candidates from various backgrounds and demographics	All	44	48%	2%	0%	50%	19	3.2	16	3.8
	Disprop	3	67%	0%	0%	33%	2	3.0	1	4.0
	Prop	26	46%	4%	0%	50%	10	3.3	9	3.7
Training on how to create supportive workforce cultures (e.g. Professional behaviours patient safety training programme)	All	55	62%	7%	0%	31%	32	3.0	31	3.6
	Disprop	4	75%	0%	0%	25%	3	3.0	1	3.0
	Prop	30	60%	13%	0%	27%	17	2.9	20	3.6
	All	46	65%	4%	0%	30%	28	3.1	29	3.6

Interventions	DB Outcome	% Organisations with Intervention					Evidence/ Evaluation Scale[15]		Implementation Scale	
		N	Yes, currently in place	No; planned but not yet implemented	No; was in place but discontinued	No; never in place	N	Mean	N	Mean
Role modelling - individuals from diverse backgrounds represented in leadership roles or performance management processes	Disprop	3	100%	0%	0%	0%	3	2.3	3	3.7
	Prop	26	69%	8%	0%	23%	17	3.0	18	3.6
Inclusive culture / DEI objectives incorporated as an objective for line-managers	All	48	54%	13%	0%	33%	27	3.1	30	3.5
	Disprop	4	75%	0%	0%	25%	3	2.7	3	3.0
	Prop	25	52%	20%	0%	28%	15	3.1	18	3.5
Embedding models (e.g. Just Culture model/Being Fair tool), cultural ambassadors, or other cultural touchpoints, into disciplinary processes	All	49	57%	16%	2%	25%	31	3.3	35	3.7
	Disprop	2	50%	0%	0%	50%	2	3.0	3	3.0
	Prop	28	75%	14%	0%	11%	21	3.4	24	4.0
Group 4: Management of Concerns - Time-specific interventions to manage concerns as they arise										
Early warning systems where concerns about doctors are triaged or discussed before concerns escalate	All	54	85%	4%	0%	11%	42	3.0	7	4.3
	Disprop	3	67%	0%	0%	33%	3	2.3	0	
	Prop	31	90%	3%	0%	7%	24	3.1	3	3.7
Informal, but documented, conversations with staff over lower-level concerns	All	54	96%	2%	0%	2%	46	3.0	5	3.6
	Disprop	3	100%	0%	0%	0%	3	2.0	0	
	Prop	31	97%	3%	0%	0%	26	3.0	2	2.0

Interventions	DB Outcome	% Organisations with Intervention					Evidence/ Evaluation Scale[15]		Implementation Scale	
		N	Yes, currently in place	No; planned but not yet implemented	No; was in place but discontinued	No; never in place	N	Mean	N	Mean
Rapid scoping exercise after an initial incident/concern to understand extent of investigation required	All	52	92%	4%	0%	4%	42	3.0	7	4.3
	Disprop	3	100%	0%	0%	0%	3	3.3	0	
	Prop	30	97%	3%	0%	0%	24	3.0	3	4.0
Independent panels to review anonymised case information before a referral is made	All	54	43%	13%	0%	44%	25	3.4	27	3.7
	Disprop	3	67%	0%	0%	33%	2	3.5	1	2.0
	Prop	31	45%	10%	0%	45%	13	3.4	14	3.4
Coordination with the GMC ELAs to get advice before referrals are made	All	54	94%	2%	0%	4%	45	3.7	3	4.7
	Disprop	3	100%	0%	0%	0%	3	3.7	0	
	Prop	31	97%	3%	0%	0%	26	3.8	0	
Collaboration with other organisations (e.g. NHS Resolution)	All	54	80%	2%	0%	19%	39	3.6	8	4.3
	Disprop	3	67%	0%	0%	33%	2	3.5	1	4.0
	Prop	31	84%	3%	0%	13%	23	3.7	3	4.3
Provision of support for practitioners about how investigation of concerns/complaints works and what support they can access	All	54	87%	9%	0%	4%	42	3.3	9	3.4
	Disprop	3	100%	0%	0%	0%	3	3.0	0	
	Prop	31	97%	3%	0%	0%	24	3.2	2	3.5

Interventions	DB Outcome	% Organisations with Intervention					Evidence/ Evaluation Scale[15]		Implementation Scale	
		N	Yes, currently in place	No; planned but not yet implemented	No; was in place but discontinued	No; never in place	N	Mean	N	Mean
Provision of information for practitioners during investigation of concerns/complaints	All	53	89%	6%	0%	6%	41	3.1	8	4.1
	Disprop	3	100%	0%	0%	0%	3	2.3	0	
	Prop	31	94%	3%	0%	3%	24	3.2	3	4.0
Training for clinical leaders / managers about effective early management of concerns	All	54	72%	9%	0%	19%	38	3.3	18	3.9
	Disprop	3	33%	33%	0%	33%	1	3.0	2	4.5
	Prop	31	81%	10%	0%	10%	23	3.3	9	3.4
Clear guidance or checklist for clinical leaders / managers for handling concerns or complaints, including how to support practitioners during the process	All	52	65%	15%	2%	17%	38	3.2	16	3.6
	Disprop	3	100%	0%	0%	0%	3	2.7	0	
	Prop	29	76%	14%	3%	7%	23	3.1	7	3.4
Group 5: Culture of Learning - Ongoing interventions to support a culture of continuous learning										
Formal incident and complaint reporting system, with a focus on reflection and learning	All	53	89%	8%	0%	4%	48	3.5	43	4.3
	Disprop	3	100%	0%	0%	0%	3	3.7	3	4.3
	Prop	30	93%	3%	0%	3%	26	3.5	25	4.4
Training for, and processes that support, having compassionate conversations with practitioners	All	50	72%	8%	0%	20%	38	3.1	34	3.8
	Disprop	2	50%	50%	0%	0%	2	2.0	1	5.0

Interventions	DB Outcome	% Organisations with Intervention					Evidence/ Evaluation Scale[15]		Implementation Scale	
		N	Yes, currently in place	No; planned but not yet implemented	No; was in place but discontinued	No; never in place	N	Mean	N	Mean
	Prop	29	83%	3%	0%	14%	22	3.1	20	3.8
Policies and procedures that reinforce the importance of learning	All	52	87%	5%	0%	8%	44	3.4	43	4.1
	Disprop	3	100%	0%	0%	0%	3	3.3	3	4.3
	Prop	29	93%	3%	0%	3%	25	3.3	26	4.1
Promotion of decision making as a collective process that welcomes challenge and incorporates feedback from those more at risk at being overrepresented in disciplinary processes	All	52	72%*	8%	0%	21%	36	3.2	34	4.0
	Disprop	3	33%	67%	0%	0%	2	2.5	1	5.0
	Prop	29	79%	3%	0%	17%	22	3.1	22	4.0
Refresher/reflection sessions to explore decision making and any potential bias within it	All	49	51%	12%	0%	37%	30	3.3	27	3.7
	Disprop	3	33%	33%	0%	33%	1	2.0	1	5.0
	Prop	28	46%	18%	0%	36%	17	3.2	14	3.6
Clinical simulation labs for human factors training	All	47	30%	9%	0%	62%	20	3.4	18	3.4
	Disprop	3	33%	0%	0%	67%	1	4.0	1	4.0
	Prop	27	33%	11%	0%	56%	11	3.3	12	3.5
Training videos to facilitate understanding of the roles of other team members	All	47	21%	15%	0%	64%	15	3.5	11	3.5
	Disprop	3	33%	0%	0%	67%	0		0	

Interventions	DB Outcome	% Organisations with Intervention					Evidence/ Evaluation Scale[15]		Implementation Scale	
		N	Yes, currently in place	No; planned but not yet implemented	No; was in place but discontinued	No; never in place	N	Mean	N	Mean
	Prop	28	25%	14%	0%	61%	8	3.6	7	3.9
Participation in an RO Advisory Group; peer learning opportunities with other ROs or discussion of anonymised past referrals	All	53	79%	4%	0%	17%	38	3.2	36	4.1
	Disprop	3	67%	33%	0%	0%	2	3.0	2	4.5
	Prop	30	77%	3%	0%	20%	19	3.4	21	4.2