Health Service Provider Engagement with Stakeholders on Patient Safety and Complaints Questionnaire

As part of our work to deliver the Scottish Government's (SG) commitment to create a Patient Safety Commissioner for Scotland (one of the recommendations of the Cumberlege Review), the SG Quality and Safety Team are seeking to understand how the various healthcare organisations in Scotland with an interest in patient safety and negative patient feedback engage with each other and with the patients they serve.

To help us do this, we would be grateful if you could take some time to answer the following short questionnaire.

In some cases, it may help us to follow up some of these questions by phone or virtual meeting. Please indicate below if you would be content for us to do this.

If you have any questions about this questionnaire please contact the Team at PSC@gov.scot.

Part 1 – Contact details

Name of organisation and business area	General Medical Council (GMC)
Name of contact person	Nicola Cotter - Head of GMC Scotland
Email address for contact	nicola.cotter@gmc-uk.org
Phone number for contact if available	0131 525 8715
Would you be happy for us to contact you to discuss further?	Yes ☒ No ☐

Part 2 – Questions

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<td>1. Please give us a summary of the services you provide in relation to patient safety and/or complaints about healthcare and treatment.</td>
<td>The GMC is an independent regulator that helps to protect patients and improve medical education and practice across the UK.

• We decide which doctors are qualified to work here and we oversee UK medical education and training.
• We set the professional standards that doctors need to follow and work to make sure that they continue to meet these standards throughout their careers.
• We take action to prevent a doctor from putting the safety of patients, or the public's confidence in doctors, at risk.

This includes investigating concerns raised about doctors and, if necessary, carrying out performance and health assessments. Where a doctor fails to meet expected standards, we decide what action to take - in some cases we may issue a warning or refer the doctor to a fitness to practise hearing at the Medical Practitioners Tribunal Service (MPTS).

Our primary purpose is to protect patients and the public.</td>
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<td>2. In relation to these services, how does your organisation engage with and involve
a) NHS Boards
b) other healthcare providers
c) patients and the general public.</td>
<td><u>NHS Boards and Healthcare Providers</u>
Our Outreach Team in Scotland, comprised of one Employer Liaison Adviser (ELA) and two Liaison Advisers (LAs), regularly meet with all of the Health Boards (including Special Boards) across Scotland. They explain how our processes work and promote our standards. They also collaborate with the service to understand the issues faced at local level.

Our Scotland ELA works with employers of doctors, in particular Responsible Officers, and medical managers to help them understand what they need to do if they have concerns about a doctor. They also advise on professional issues, including revalidation.

Our LAs present and facilitate workshops on the GMC's ethical guidance, role and policies to frontline doctors, medical students and others.</td>
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	To summarise, our ELA and LAs collaborate with doctors, healthcare providers, educators and other regulators to: • improve understanding of the role and value of the GMC • promote and support excellence in medical education, training and practice • learn about the environments in which doctors practice to identify and address risks to patients and doctors before harm occurs • work with responsible officers to address concerns about doctors and support management with concerns at a local level • support the continuous development of local clinical governance systems, ensuring that revalidation continues **Patients and General Public** Despite the challenges stemming from the pandemic, we have continued to involve patients and the public in our work, so we can continuously improve our interactions and processes. In 2019, we launched a Patient Charter to demonstrate how we aim to provide a high standard of service to those who have raised concerns about their doctor. It illustrates our commitment to treat every person who contacts us fairly and with dignity, and to make sure that all complaints are handled in the most appropriate way. We also have a Patient Liaison Service which gives dedicated, personal support to patients, their relatives, or members of the public who have raised a concern about a doctor's fitness to practise. This includes offering patients face to face meetings with Patient Liaison Advisers at our Edinburgh office (when pandemic lockdown measures allow). In addition to this, we also host a bi-annual large-scale roundtable event across the four countries of the UK to engage with patient organisations and patient representatives. This not only enables us to hear what matters to them, but it also provides an opportunity for our partners to share their views with each other and hear about areas of good practice.

	We're also in the process of developing a long-term approach to our patient and public involvement work, to align with our corporate strategy. We want to embed patient experience across the organisation.
3. Do you link or regularly communicate with other organisations or teams who are involved in patient safety or complaints about healthcare and treatment? If yes, who?	To be an effective, relevant four country regulator we listen to the views of our partners across the UK. This has never been more important as the health service continues to deal with the pressures of the pandemic and is still likely to for some time. We have a comprehensive stakeholder engagement plan and regularly meet with other organisations involved in patient safety or complaints about healthcare and treatment at all levels. This includes regular engagements at Chief Executive and Chair Level and also via our Head of Scotland Office, Nicola Cotter. We regularly meet with other Professional Regulators (Including Nursing and Midwifery Council, General Dental Council and General Pharmaceutical Council) as well as a number of stakeholders in organisations such as - BMA Scotland, Healthcare Improvement Scotland, NHS Education for Scotland, Royal Colleges, Patient Organisations, Medical Defence Organisations and the Scottish Public Services Ombudsman. We also have regular engagements scheduled for our Chief Executive to meet with both the Chief Medical Officer and the Cabinet Secretary for Health and Social Care. We have also met with the Health and Sport Committee and regularly meet with Scottish Government Officials across a number of departments, including the Regulation Unit. We have a number of memoranda of understanding agreements in place with organisations across the UK - including system regulators, public protection bodies, NHS agencies and others – to share knowledge. Our existing agreements can be found here. We are also awaiting the final draft of an Emerging Concerns Protocol for Scotland. The protocol will provide a clearly defined mechanism for the sharing of information and intelligence that may indicate risks to users of services, their carers, families or professionals.

	We also have ad-hoc engagements with patient advisers and would like to explore how we expand the support we offer. Our previous engagement has included providing training to Patient Advice and Support (PASS) Officials to support effective patient signposting and attending the annual PASS/NHS Complaints Personnel Association Scotland (NCPAS) event - where on occasion we have presented to them on the role of the GMC.
4. How do you link or communicate with them (e.g. meetings, emails, etc.)? Do you have a named contact?	We liaise with these stakeholders via scheduled meetings (currently all virtual) and also via email. We have a list of direct contacts that we engage with, and we would be happy to provide names and contact details, if needed. We also formally consult with our partners in Scotland through our bi-annual UK Advisory Forum. Forum members include the Scottish Government, medical leaders, medical education bodies, HIS, and patient representatives. The Forum offers us an extra channel to engage with our partners and key interest groups in the country. Through the Forum we share and discuss early-stage views on policy development. This allows us to focus on medium and long-term priorities in dialogue with our partners in Scotland.
5. What are your main reasons for linking or communicating with them?	Our team regularly meets with stakeholders in Scotland to raise awareness of our role and functions, develop our policy and guidance and share data and insight to help prevent patient safety risks arising. During the pandemic, we continued to engage with a wide range of partners in a way that didn't place them under undue pressure during the pandemic. We remain strongly committed to working with our partners across the UK to understand new challenges the pandemic has created and what opportunities exist for greater flexibility and innovation within healthcare systems. We will proactively respond to and support any positive changes by working in partnership with our stakeholders in Scotland. As noted above, we also liaise with stakeholders in line with our existing MoUs. This will include routine information sharing, arising from their regulatory activity that may assist the other in its remit, and cross-referral of concerns.
6. Do you have direct contact with patients/service users who have made a	Yes. We communicate directly with our patients/service users who have raised a complaint about our organisation or about another health service provider and continue to do so in various ways.

complaint about your organisation or about another health service provider?	We will write to the patient/service user to acknowledge their concerns/complaint and consider the issues raised within our published service level agreement. We can communicate with patients/service users via: • Telephone; • Postal letters; • Email; • Face to face meeting and virtually (exceptional circumstances). Complaints are considered under a three-stage escalation process, with the first two responses coming from the relevant directorate (e.g. Fitness to Practise), before being escalated to the Corporate Review Team for an intended final response. This means the final stage of the process is entirely separate from anything that's been considered previously. This provides reassurance that the final response is impartial. Once this has been completed, the complaint handler will inform the patient/service user of the outcome of their complaint. For further details please see our complaints policy and process, both available on our website. Though we are only able to consider concerns about doctors, we do often receive complaints from patients/service users about other health service providers and usually such concerns form part of their complaint about the care and treatment received. We will also consider those and respond simultaneously explaining our role and signposting them to organisations that are able to appropriately help them. It may also be helpful to set out here how we consider patient safety concerns received by a patient/service user regarding a doctor - Upon initial receipt of a complaint the documentation will be considered by an Assistant Registrar (individual decision-maker with delegated authority from the Registrar, Charlie Massey) at the initial assessment stage of our processes (Triage), who must determine whether our threshold for investigation has been met, namely whether the alleged conduct, if proven, is capable of impairing a

	doctor's fitness to practice. In other words, whether we need to restrict the doctor's ability to practise or remove it completely. Our Assistant Registrars must make decisions about whether the threshold for investigation is met in accordance with the Medical Act 1983 and the General Medical Council (Fitness to Practise) Rules 2004 ('the FTP Rules'), in addition to the relevant guidance. Our guidance for doctors *Good Medical Practice* set out the professional values, knowledge, skills and behaviours required of all doctors working in the UK. The Assistant Registrar must make their decision having regard to the above legal framework and guidance. They may also at this stage seek clinical input from a medically trained colleague or a legally qualified staff before reaching a final decision. The decision maker guidance is publicly available on our website here.
7. Do you directly inform the patient/service user of the outcome of their complaint? If not, why is this, and how do they find out?	Yes. As noted above, the complaint handler will inform the patient/service user of the outcome of their complaint. We will usually respond in writing, unless we are aware that we need to make a reasonable adjustment. Our response will outline whether the complaint has been upheld or not and whether there have been any learning points identified and fed back to relevant teams within the GMC. Our response will also set out which stage of the complaints process the response relates to and, if it is a final stage response, we will explain we are unlikely to respond further without any new information or new concerns about a doctor. Similarly, once a formal decision has been made regarding concerns raised about a doctor, we will directly contact the patient/service user to communicate the outcome including the decision rationale.
8. Does your organisation record and analyse complaints to identify any recurring themes?	**Complaints About the GMC** Yes. We capture data on a monthly and quarterly basis about the complaints we have received. We consider any trends in the complaints received in a particular period, as well as any anticipated spikes in complaints and how those might be managed. This data is provided twice a year to the Executive Board and Council. As we are committed to openness and transparency the data is publicly available.

	We also provide feedback received via complaints to the relevant teams so that they can take it into account when considering business improvements. As we are committed to openness and transparency the data is publicly available. We have also recently introduced 'hot topics areas', largely to help us quantify concerns arising as a result of/in connection with the pandemic and in the expectation that we'd be asked about it down the line. This is not currently reported externally and remains work in progress. The GMC Customer Complaints Review Group (CCRG) meetings take place 8 times a year where the CCRG working group review the draft Quarterly Complaints Report before this is taken to the Customer Complaints Management Review meeting (attended by the senior management team) and the Directors Meeting. The group discusses complaint trends, best practice in complaints handling, complaints handling, SLA performance, business improvement opportunities and external key issues. **Complaints About Doctors** We also regularly publish data on the trends and patterns in Fitness to Practise referrals, including annual datasets as part of the *State of medical education and practice in the UK* report (SoMEP) series and we share data via the GMC Data Explorer tool on our website. The SoMEP series had historically been used to publish our analyses of FtP patterns, and more recently we publish on our website our own analysis in working papers on specific topics, and we publish our commissioned research there also, such as 'Fair to refer' which led to our commitment to reduce differentials (page 9) in referrals of BME doctors to the GMC by employers.
9. How does your organisation react to multiple complaints about the same service?	Generally speaking, all concerns/complaints are logged to our system and considered individually on a case-by-case basis. We hold regular joint working information group meetings where we bring together a number of teams across the GMC to triangulate any concerns that we have about specific Health Boards or sites. This includes our Scotland Employer Liaison Adviser, Liaison Advisers and our Education Quality Assurance Team. If necessary, concerns are then escalated, and we consider how we are working together internally and externally to resolve these concerns and any action needing to be taken.

	If there are multiple concerns about the same doctor, we will consider a bespoke approach and carry out the necessary steps as appropriate. This can involve but isn't limited to assigning a single point of contact to the subject matter, discussing the issue widely with other areas of the business, escalation to senior management team, sharing information with other organisations under the memorandum of understanding. Our final decision on the matter will be based on an overall assessment and we will directly contact the patient/service user to communicate our decision.
10. Can you think of any gaps or failings in the patient safety or complaints system in Scotland, and how do you think this can be better joined up in future?	We recognise the vital role that Responsible Officers play in the patient safety landscape and believe that further steps should be taken to better support them in their role. Specifically, we believe that The Medical Profession (Responsible Officer) Regulations governing their practice should be strengthened to further improve local clinical governance systems including processes relating to incident reporting, review of outcomes data and monitoring performance. In addition, we believe that: • Responsible Officers should have responsibilities for monitoring the fitness to practise of all doctors within their Designated body rather than just those with a connection. • Responsible Officer responsibilities for ensuring clinical governance systems are in place, and for monitoring the fitness to practise of doctors, should apply to Scotland, Wales and Northern Ireland rather than just England as is the case presently. • Connections of doctors to locum agencies should be reviewed to ensure they are robust and understood by both the agencies and the doctors. • There should be an additional responsibility for Designated Bodies to quality assure governance processes underpinning revalidation to ensure there is board level oversight of the Responsible Officer functions and associated systems. • There is a statutory duty for Responsible Officers to share information at the point of revalidation, when doctors move between organisations and when concerns arise. The Emerging Concerns Protocol will also play a role in promoting early information sharing and collaborative action to mitigate emerging patient safety concerns. We also recognise that our data, particularly that relating to our complaints procedures, presents a fragment of a picture of events that may have occurred some time ago. It is therefore less suited to

	identifying, at scale, emerging issues that are still affecting patients today. Real time data on trends and issues regarding clinical performance will typically be held locally by providers. We would suggest that further consideration be given to how the system can support providers to ensure that such information is being collected and used systematically and consistently. The Emerging Concerns Protocol (referenced above) will also play a role in promoting early information sharing and collaborative action to mitigate emerging patient safety concerns. Explain what is happening hen noted above
11. What products (standards, guidelines etc.) does your organisation create to a) support safety in the treatment of patients? b) Support patients/carers/families to raise a concern or complaint about a patient's healthcare or treatment?	**a) support safety in the treatment of patients?** The GMC provides guidance on the professional standards expected of all doctors registered in the UK. Our standards define what makes a good doctor by setting out the professional values, knowledge, skills and behaviours required of all doctors working in the UK. Supporting and promoting safety in the treatment of patients is at the heart of this. Where there is serious or persistent failure to follow our guidance that poses a risk to patient safety or public trust in doctors, we may take action against a doctor. In our core guidance, Good medical practice (GMP), we say that the duties of a doctor include taking prompt action if they think that patient safety, dignity or comfort is being compromised; and protecting and promoting the health of patients and the public. We also specifically address safety (and quality) within the second domain of GMP. For instance, at paragraphs 22-23 we say: • Doctors must take part in systems of quality assurance and quality improvement to promote patient safety, including: - taking part in regular reviews and audits of their work and that of their team, responding constructively to the outcomes, taking steps to address any problems and carrying out further training where necessary - regularly reflecting on their standards of practice and the care they provide - reviewing patient feedback where it is available. • That to keep patients safe doctors must: - contribute to confidential inquiries - contribute to adverse event recognition

	- report adverse incidents involving medical devices that put or have the potential to put the safety of a patient, or another person, at risk - report suspected adverse drug reactions - respond to requests from organisations monitoring public health. We also publish a range of explanatory guidance and other resources that promote safety in the treatment of patients. Some examples are: • *Raising and acting on concerns about patient safety*, which covers how doctors should raise their concerns and how they can overcome any barriers that might be preventing them from doing so. • On the 'ethical hub' on our website we explain how our guidance can be applied in practice and signpost to relevant resources. (However, the hub doesn't set new professional standards and isn't intended to replace our formal guidance). For instance, our hub pages contain advice on Speaking up and Identifying and tackling sexual misconduct. • *Good practice in prescribing and managing medicines and devices*, which we updated last year. Here we say that if they can't meet our standards through the mode of consultation they're using (for instance, via a remote consultation), doctors should offer an alternative if possible, or signpost to other services. If they think that systems, policies or procedures are, or may be, placing patients at risk of harm, doctors must follow our guidance on raising and acting on concerns. • On the professional duty of candour, which sets out a duty for doctors and other healthcare professionals to be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. **b) Support patients/carers/families to raise a concern or complaint about a patient's healthcare or treatment?** We provide guides and materials that aim to give patients the tools to work in partnership with their doctor, and explain what they can expect from them. We also provide guidance on what to do if patients are unhappy with their care. Our guidance sets out who can raise a concern, whether it in in scope of something we can investigate and who can help with their concern if we can't.

	Our guidance supports patients/carers/families in raising a concern or complaint about healthcare or treatment. For instance, *Good medical practice* says that doctors must listen to patients, take account of their views, and respond honestly to their questions (paragraph 31). And doctors must respond promptly, fully and honestly to complaints and apologise when appropriate. They must not allow a patient's complaint to adversely affect the care or treatment they provide or arrange (paragraph 61). As noted in response to Question 2, we also provide a Patient Liaison Service which gives dedicated, personal support to patients, their relatives, or members of the public who have raised a concern about a doctor's fitness to practise. We also signpost patients to other sources of support, including the Independent Support Service. The service is a free, dedicated support line run by Victim Support and is available to any patient, complainant, witness or family member people affected by a GMC investigation.