GfK NOP Social Research

GfK. Growth from Knowledge

Research into Fitness to Practise referrals
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A report for: **General Medical Council**

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Executive summary

Background

The annual volume of Fitness to Practice enquiries made to the GMC has increased by 30% since 2004, by 14% since 2006 and by 11% between 2008 and 2009. Many enquiries come from Persons Acting in a Public Capacity (PAPCs), that is people acting on behalf of a public organisation, and a majority of those are from public healthcare bodies. Whilst PAPC enquiries are not solely responsible for the increase in enquiries, they are believed to be a key contributory factor, increasing from 394 in 2006 to 1,030 in 2009. Research was commissioned to investigate the rise in PAPC enquiries. A survey was carried out by GfK NOP involving a quantitative online survey, a series of in-depth interviews and a desk review of the GMC's in-house Siebel CRM database.

How are Fitness to Practice cases handled?

In the context of referrals made by PAPC, the primary source of Fitness to Practice concerns are doctors at the Trust/Board (43% said this was where they came from mostly in the quantitative research, a finding confirmed by the qualitative survey). Independent contractors such as GPs (16%) and members of the public/patients (14%) were the next highest mentions.

A committee or group responsible for reviewing doctors' performance had the highest mention for who undertook the initial investigation of performance concerns and this was particularly high (75%) at PCTs. Other mentions at lower levels included another member of staff such as the individual's line manager or the respondent themselves. The precise approach is primarily governed by the structure of the clinical management team, and the procedures and practices that each trust had developed to implement national policy.

A majority undertook a formal procedure from the start, with lower mentions of an informal talk with colleagues or an informal talk with the person concerned. Most said that they involved the National Clinical Assessment Service and around two fifths that they consulted a GMC representative.

Making the decision to refer a case to the GMC is complex since it clearly has a major impact on the doctor under investigation. Where conduct presents a high risk to patient safety, where a criminal offence has been committed or if a doctor fails to comply with internal measures to rectify an issue, a referral to the GMC is almost certain. Professional incompetence is looked at on a case by case basis commonly and may be dealt with within the Trust.

The ability to consult external organisations is highly valued by Medical Directors. As mentioned above, use of NCAS was widespread but views are polarised on attitudes to the GMC. Those with GMC Employer Liaison were much more positive and happy with the GMC as a source of advice and guidance than those without.

What is happening to the number of cases?

The desk review of the GMC's in-house Siebel CRM database came to the following conclusions. After taking account of the coding and procedural effects there has not been an exceptional increase between 2008-9 in enquiries initiated by PAPCs and "Public Organisations". Between 2007 and 2010 the number of referrals has increased at around 6.5% per year and enquiries initiated by organisations (rather than private individuals) have increased at about twice the overall rate.

While the proportion of enquiries from provider trusts in relation to other sources has remained roughly constant, the proportions from PCOs, Primary Care Agencies and regulatory bodies are increasing.

What is driving the increase in referrals?

A third of medical directors who had made a referral to the GMC in 2010 said that the number they had made had increased since the previous year and a slightly higher proportion (4 out of 10) said it had increased since five years ago. Those increases in concerns were mostly from members of the public/patients or doctors.

Reasons for the rise in referrals was an issue explored both quantitatively and qualitatively and the overall opinion was that any increase was as a result of improved systems within organisations for detecting and dealing with performance issues rather than diminishing standards by medical professionals.

More specifically the increase was attributed to three key areas:-

- an increased management ethos: maintaining high professional standards, the introduction of clinical governance systems and a procedure for reporting incidents
- changes in general public attitudes: patients feel more empowered to complain, part driven at least by awareness of some high profile cases in the press
- changes in colleague attitudes: the increased management ethos has led to recognition amongst medical colleagues that performance concerns should be highlighted. There are also more effective methods to lodge confidential complaints

Management of Fitness to Practise referrals in the future

Medical directors thought referrals were likely to keep increasing as improved management of the health service meant improved detection of performance concerns and the implementation of effective systems to deal with them.

Respondents were also clear that they would like clarity of policy and procedure, particularly useful would be guidance on whether or not concerns should be referred to the GMC. It is here that the difference between those with a GMC Employer Liaison and those without is so evident. Those with Employer Liaison felt they had a sense of relationship with the GMC, felt more confident around procedures for referral and valued the informal dialogue they could have without instigating a full referral. The quantitative research found that more than half with a GMC Employer Liaison made contact at least once every three months and nearly all considered the informal discussion with the GMC useful.

All those who do not currently have a GMC contact would find it useful to have one. Other ways medical directors would like to receive support include information or a training session run by the GMC about fitness to practise issues, and a third would like information provided by email from the GMC.

Conclusions and recommendations

- Increases in Fitness to Practise referrals are thought to be attributable to a changing ethos amongst management and staff in the NHS, and amongst the general public.

- Medical Directors face uncertainty and conflicting priorities when making referrals to the GMC.

- This is particularly in cases where professional competency is the key concern, rather than behavioural misconduct or criminality.

- An increased sense of relationship with the GMC would help overcome this uncertainty, and provide desired reassurance to referrers.

- Desired support could take the form of training and guidance on Fitness to Practise, or informal advice and support via a local Employer Liaison.

1. Introduction

1.1 Background and objectives

The General Medical Council is the independent regulator for doctors in the UK. The GMC's statutory purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. The GMC has four main functions under the Medical Act 1983:

• Keeping up-to-date registers of qualified doctors

• Fostering good medical practice

• Promoting high standards of medical education and training

• Dealing firmly and fairly with doctors whose Fitness to Practise is in doubt.

The investigation of concerns about doctors is the responsibility of the GMC's Standards and Fitness to Practise Directorate. Fitness to practise investigations are triggered by complaints and referrals, collectively called 'enquiries'. The enquiries that trigger this process can come from a variety of sources, including individual members of the public. Many enquiries come from Persons Acting in a Public Capacity (PAPCs), that is people acting on behalf of a public organisation; the majority of enquiries from this source come from public healthcare bodies. In 2006, such enquiries represented 8 per cent of the total; in 2009, they represented 18 per cent. They tend to relate to more serious matters and therefore disproportionately drive volumes at the investigation and hearing stages of the GMC's Fitness to Practise processes.

The annual volume of Fitness to Practise enquiries made to the GMC has increased by 30% since 2004, by 14% since 2006 and by 11% between 2008 and 2009. Research was commissioned in order to investigate the background to this increase.

The objectives for the research are:

- Why has there been an increase in referrals to the GMC from public healthcare bodies?

- Is this increase consistent nationally or are there local or regional differences, and if so what are the causal factors?

- To what extent have changes in local or national clinical governance contributed to the increases?

- Is there a link between the increases and the recent introduction of licensing and/or the forthcoming roll-out of revalidation?

- Are there areas where the GMC's profile been significantly more prominent and has this influenced the changes we are seeing? For example what has been the impact of the Affiliates programme?

- Do the increases indicate that there is a need for more guidance, targeted at public healthcare bodies, as to what types of enquiries should be referred to the GMC?

1.2   Method

A three-stage research method was employed, involving:

- A desk review of the GMC's in-house Siebel CRM database

- A series of qualitative in-depth interviews

- A quantitative online survey

1.2.1   Qualitative research

40 qualitative in-depth interviews were conducted amongst medical directors from trusts across the UK and Northern Ireland. The sample included:

- Acute trusts

- Care trusts

- Foundation trusts

- Mental health trusts

- Primary care trusts

- Scottish Consolidated Health Boards

- Welsh Consolidated Health Boards

Interviews each lasted one hour, and were conducted face to face or via telephone. Interviews were conducted by Amrita Sood, Rezina Chowdhury and Caroline Flanagan (GfK Qualitative researchers).

1.2.2   Quantitative research

As the qualitative work was underway an online survey was conducted amongst 203 medical directors, each of whom had referred doctors to Fitness to Practise procedures between 2006 – 2010. Responses were received from 94 participants. The questionnaire was designed by GfK NOP in conjunction with the GMC and scripted by GfK NOP's online department (a copy can be found in the appendices). The medical directors were based in NHS Trusts, Foundation Trusts, Primary Care Trusts and Health Boards across the UK and Northern Ireland.

When reading the quantitative findings it should be noted that this data is not representative of all medical directors at Trusts and Health Boards as only those who had made a referral were included in the sample. The data should be treated with caution due to the low sample size however that being said the sample is a high proportion of the medical directors at Trusts and Health Boards who had made a referral to the GMC between 2006 to 2010.

2. How are Fitness to Practise cases handled?

This section details the processes followed when dealing with Fitness to Practise concerns at a local level, from detection through to escalation to the GMC. This section includes findings from the qualitative and quantitative research.

The qualitative research indicated that procedures and practices for dealing with performance concerns tended to follow a similar pattern across organisations, although the detail of policy and practice varied depending on application of national policy at a local level, and on management styles. This section includes qualitative and quantitative research findings relating to the way that trusts dealt with performance issues.

2.1 Detection of performance concerns

There were a number of routes for detection of performance concerns, both internally within the trust, and externally from other bodies. All medical directors said that they would be aware of performance concerns that had been raised about doctors working within the trust.

In the quantitative research, eighty-five per cent of medical directors reported that they had made a Fitness to Practise referral or had been involved in the process of making a Fitness to Practise referral to the GMC on behalf of their Trust or Board within the last five years.

Those who had made, or had been involved in the process of making, a Fitness to Practise referral, were asked to consider the sources from which Fitness to Practise concerns had been raised within the last five years at their Trust/Board. Chart 1 shows the sources from which *any concerns* had been raised over the last five years, as well as the sources that had raised the *most concerns* in this period.

More than half mentioned that doctors at their Trust/Board (63 per cent) and members of the public (53 per cent) had raised Fitness to Practise concerns, whilst 43 per cent said that doctors at their Trust/Board had raised the most concerns over the last five years.

Chart 1. Sources from which Fitness to Practise concerns have been raised over the last five years (any concern raised and most concerns raised)
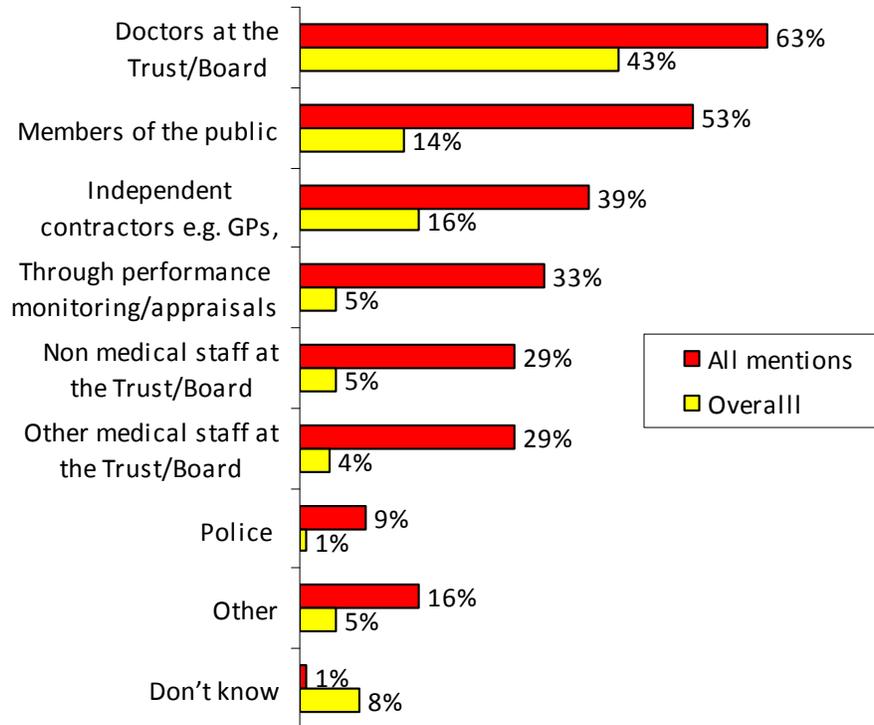
	All mentions	Overalll
Doctors at the Trust/Board	63%	43%
Members of the public	53%	14%
Independent contractors e.g. GPs,	39%	16%
Through performance monitoring/appraisals	33%	5%
Non medical staff at the Trust/Board	29%	5%
Other medical staff at the Trust/Board	29%	4%
Police	9%	1%
Other	16%	5%
Don't know	1%	8%

Base: All who have been involved in making a Fitness to Practise referral to the GMC on behalf of their Trust/Board within the last five years (80)

Although sub-group base sizes were very small and therefore any findings at this level should be treated with caution, there were some differences by type of Trust, which would be expected given their different structures and roles:

- Concerns at Primary Care Trusts were less likely to have been raised internally by colleagues (i.e. doctors or other medical and non-medical staff at the Trust) (54% of medical directors at Primary Care Trusts said that colleagues had been responsible for raising concerns, compared with 95 per cent of those at Foundation or NHS Trusts)

- Instead, medical directors at Primary Care Trusts were more likely to report that independent contractors (such as GPs and Community Pharmacists) had raised concerns (79 per cent compared with 13 per cent of those at an NHS Trust and 5 per cent at a Foundation Trust). Half of those at Primary Care Trusts said that independent contractors had raised the most concerns in the last five years (46 per cent compared with none at Foundation or NHS Trusts).

- Those at Primary Care Trusts were also more likely to cite the involvement of the police in having raised concerns (30% of medical directors at a Primary Care Trust compared with 5% at a Foundation Trust and none at an NHS Trust).

In the qualitative research, medical directors referred to a number of routes to detecting performance concerns within the organisation, and these broadly reflected those identified in the quantitative research.

> *"It is rarely one persons fault should a problem arise. It is frequently a systems failure. One person didn't do this, the other person didn't check up on it…it's not just the one thing but at the same time there is still the blame culture around."*   [Medical Director, NHS Trust]

Colleagues were thought to be the key route to detection of performance concerns. This could include whistleblowing, but also complaints or discussion between the medical director and a doctor's colleagues. A number of medical directors referred to the importance of having their 'ear to the ground', in order to ensure that they have a good awareness of the concerns of professional staff about their colleagues.

> *A concern about a practitioner can arise from a variety of different sources. It may be a patient complaint…it may be a colleague that they work with, either a clinical colleague or sometimes a non-clinical colleague like a practice manager, it sometimes is anonymous, though obviously we try to discourage anonymous complaints…* [Medical Director, Primary Care Trust]

Some said that they were aware of a cohort of doctors within their trust about whom concerns had been raised, and who were therefore foremost in their awareness in relation to performance concerns. Others said that when they had first arrived in a new medical director role, they had made a proactive effort to identify such concerns and deal with them, where previous leadership had not done so. In this sense, a change of personnel was thought to have led to a change in management ethos resulting in a more rigorous or proactive approach to managing performance concerns.

Another key route was via patient complaints, and these were thought to have increased in recent years. The introduction of the Patient Advice and Liaison Service (PALS) was thought by some to have driven this increase, where others thought that this was driven by an increased propensity for patients to complain about doctors (discussed further in section 4). Patient complaints could be brought directly to the trust, or via the GMC.

> *"[The complaints are initiated from] a wide variety of sources; patients' complaints, i.e. about groping; problems with outcomes, brought to our attention via Quality systems, or from outside, i.e. patients complaining directly to the GMC, or where there've been problems in another organisation with a doctor who's now with us and we've been asked to comment."* [Medical Director, NHS Foundation Trust]

Formal reporting mechanisms and performance monitoring were thought to play a role in detection of concerns, although this was thought to be secondary to routes such as colleague or patient complaints. Performance data was thought to have a more important role in providing evidence to support the investigation of complaints, rather than in their detection. However, the reporting of Serious Untoward Incidents (SUIs) had highlighted concerns in some cases.

The most common referral method over the last couple of years would be most likely: a serious incident, as defined by the Dept of Health and the SHAs, would occur, and investigating that incident, using appropriate decision tools, we would find that somebody may be culpable for it and may be not acting at a level of competence that we would expect them to be. [Medical Director, NHS Trust]

2.2   Process of dealing with concerns

The quantitative research explored the processes that were followed when dealing with Fitness to Practise concerns. Those who had been involved in making a Fitness to Practise referral were asked about whom within the Trust or Board is involved in the initial investigation when a concern is raised.

As shown by chart 2, 38 per cent reported that this is handled by a committee responsible for reviewing doctors' performance, whilst 25 per cent stated that it is delegated to another member of staff, such as the individual's direct line manager. A similar proportion reported being responsible for handling the initial investigation themselves, although mostly with other members of staff (21 per cent).

Chart 2.   Personnel within the Trust/Board involved in the initial investigation of a Fitness to Practise concern
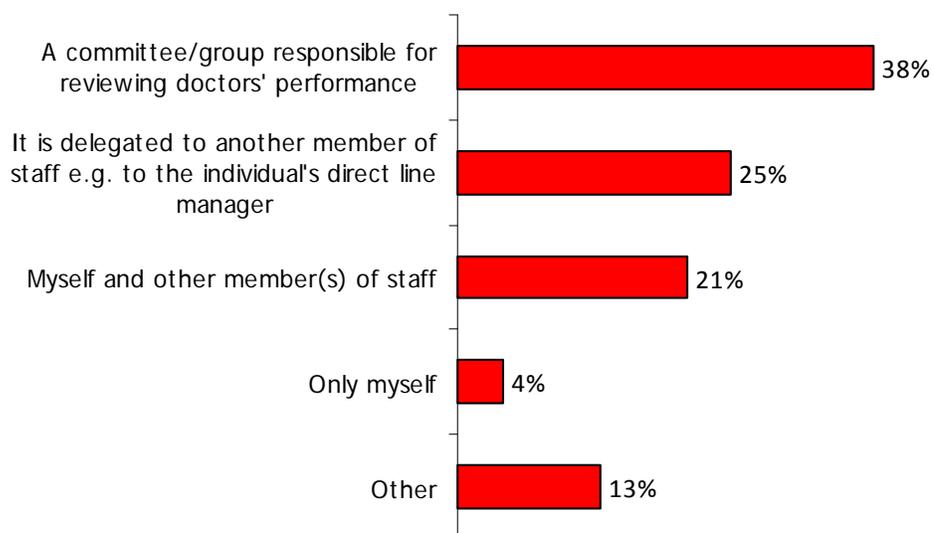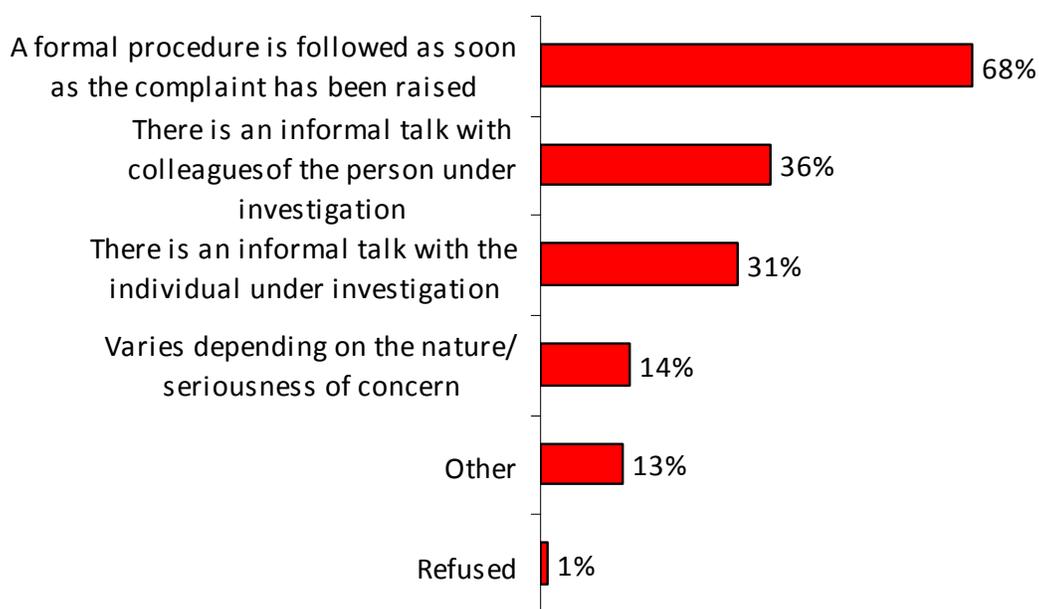

Base: All who have been involved in making a Fitness to Practise referral to the GMC on behalf of their Trust/Board within the last five years (80)

The data suggested that Primary Care Trusts were more likely to refer an initial investigation to a committee responsible for reviewing doctors' performance. Seventy-five per cent of medical directors at a Primary Care Trust gave this response compared with 30 per cent of those at an NHS Trust and 5 per cent of those at a Foundation Trust.

Medical directors were also asked about how the initial investigation was undertaken. Two-thirds (68 per cent) responded that they followed a formal procedure as soon as the complaint has been raised. Four in ten (39 per cent) followed any kind of informal procedure: 36 per cent held an informal talk with the colleagues of the person under investigation and 31 per cent with the person under investigation themselves (chart 3).

Chart 3. Process by which the initial investigation is undertaken

Category	Percentage
A formal procedure is followed as soon as the complaint has been raised	68%
There is an informal talk with colleagues of the person under investigation	36%
There is an informal talk with the individual under investigation	31%
Varies depending on the nature/ seriousness of concern	14%
Other	13%
Refused	1%

Base: All who have been involved in making a Fitness to Practise referral to the GMC on behalf of their Trust/Board within the last five years (80)

When asked about which formal procedures are followed when a complaint is made, around half (55 per cent) stated that a committee is made aware and a formal investigation is launched. Chart 4 shows the responses to this question.

Chart 4. Formal procedures followed when a complaint is made
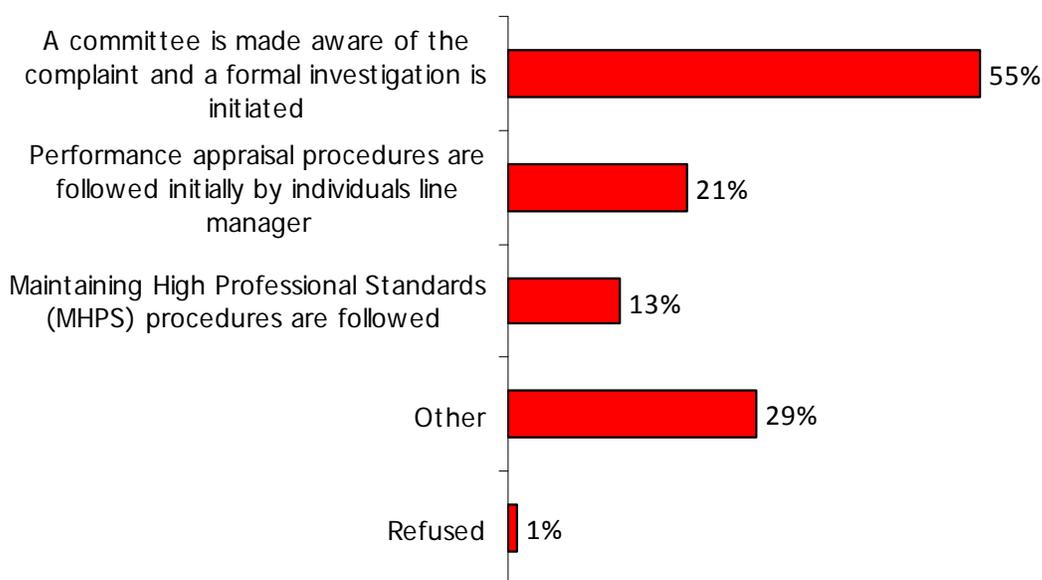
A committee is made aware of the complaint and a formal investigation is initiated — 55%

Performance appraisal procedures are followed initially by individuals line manager — 21%

Maintaining High Professional Standards (MHPS) procedures are followed — 13%

Other — 29%

Refused — 1%

Base: All who have been involved in making a Fitness to Practise referral to the GMC on behalf of their Trust/Board within the last five years (80)

Responses to this question varied by the type of Trust:

- Nine in ten (89 per cent) medical directors at Primary Care Trusts said that they made a committee aware of the complaint, compared with 48% of NHS Trusts and 15 per cent of Foundation Trusts

- Twenty-two per cent of medical directors at a Foundation Trust and 17 per cent of those at an NHS Trust stated that Maintaining High Professional Standards (MHPS) procedures were followed (compared with none of those at a Primary Care Trust)

Medical directors were also asked whether any external organisations were consulted or spoken to (either informally or formally) whilst their Trust or Board decided whether to make a Fitness to Practise referral. Almost all (95 per cent) said that they consulted or spoke with the National Clinical Assessment Service, whilst just 3 per cent (2 respondents) did not consult any external organisations. Four in ten (43 per cent) mentioned that they consulted a GMC affiliate or representative, as shown by chart 5 below.

Chart 5. Whether any external organisations are consulted or spoken to, either informally or formally, whilst deciding whether to make a Fitness to Practise referral
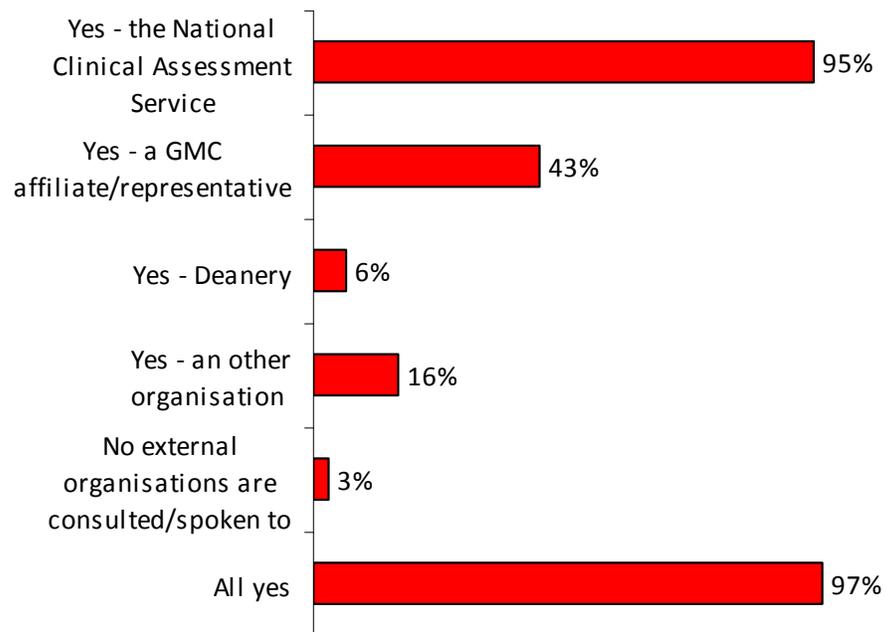

Base: All who have been involved in making a Fitness to Practise referral to the GMC on behalf of their Trust/Board within the last five years (80)

The qualitative research indicated that precise approaches to dealing with performance concerns varied between trusts according to the structure of the clinical management team, and the procedures and practices that each trust had developed to implement national policy. However, the following key steps were usually followed:

- Initial referral to the medical director;

- Investigation by a committee or panel within the trust;

- Decision to suspend the doctor, to monitor their performance or implement remediation.

> *"If an issue was raised where it concerned a doctor's competence or about their behaviour then I would review the headline comment which either comes through an email or via a letter for example. Or it might be a number of letters, or a phone call from somebody. I review the situation and if I'm sufficiently concerned then I would appoint an investigator to conduct a short investigation."* [Medical Director, NHS Foundation Trust]

> *"The PCT developed a committee that was chaired by one of the non-executive directors. I sat on it with other directors of the PCT, and there were other representatives from General Practice. We would review any concerns or complaints that came up, and decide how severe and important they were to follow up."* [Associate Medical Director, Primary Care Trust]

> *"It's very rare that we pass an issue to the GMC without us taking action ourselves."* [Associate Director, Primary Care Trust]

In addition, some consulted other organisations including NCAS, and the GMC. This is discussed further in section 2.4.

Performance concerns were generally referred to a dedicated panel or committee within the trust for investigation, and this group would be responsible for making an initial investigation and deciding upon the correct course of action. This could include performance monitoring, implementing a procedure for remediation, or in some cases deciding to suspend the doctor. In these cases, NCAS would often be involved in making recommendations on managing the case.

> *"...if we've got concerns about somebody's capability, if we're worried about excluding a doctor, we'd routinely refer that to NCAS, they're very helpful."* [Co-Medical Director, NHS Trust]

When describing processes, there was some variation in the emphasis on personal judgement or on policies and procedures. Where some discussed the issue purely in terms of implementing national policies such as National Frameworks for Conduct and Capability, Quality and Patient Safety, and Maintaining High Professional Standards, others focused on taking into account their own view of the merits of each case, and on active involvement in investigation, such as informal discussion with the doctor's colleagues.

> *"All our processes are based on the 'Maintaining Higher Professional Standards in the NHS' document, which outlines the disciplinary policy for doctors. We've had a few local tweaks to reflect our management structure, but fundamentally it's based on that."* [Medical Director, NHS Trust]

Although all were clearly aware of national policy, there appeared to be a variation in the extent to which medical directors expressed a strong personal philosophy around management of performance concerns, and a desire to make changes and improvements to detection and management of professional standards.

2.3   Context of the decision to refer to the GMC

In the qualitative research, medical directors described the process of making a decision to refer to the GMC. It was clear that this was a complex decision, with a number of priorities to take into account, some of which competed to create uncertainty around the decision.

> "... *so many of these cases are unique in some respect or another....it's not an exact science, and every case has got its own quirks and unique aspects.*" [Medical Director, Primary Care Trust]

All medical directors were aware of the seriousness of a GMC referral for the doctor concerned, in terms of the ignominy associated with such a referral, and the potential to jeopardise the doctor's future career. Many described the acute stress and worry that any doctor facing a referral would be likely to suffer, and some mentioned examples they were aware of where doctors had suffered health problems resulting from the stress of having been referred to the GMC.

This awareness had the result that medical directors generally preferred to deal with professional concerns within the trust except where a GMC referral was unavoidable. There were some individual exceptions to this, however. In one case a medical director felt under a great deal of time pressure in his role, and unable to manage the process of deciding between cases. His view was that a referral should be made where there was any doubt about a doctor's Fitness to Practise.

Professional expediency did come in to the decision, however, and medical directors were keen to follow policy and best practice in relation to Fitness to Practise concerns, and to make referrals correctly and appropriately. There appeared to be some confusion and lack of clarity, however, about the decision to refer to the GMC in certain cases. Where cases of serious behavioural misconduct were concerned, there was a clear risk to patients and therefore the decision to refer was straightforward. In cases of professional competence, however, the decision was more difficult and there was less clarity on the appropriateness of a referral.

"I've referred one person today and I'm about to refer a second because they've been through internal disciplinary hearings relating to their conduct which compromised patient safety." [Medical Director, NHS Trust]

Patient safety was of paramount importance for all, and this was the key factor taken into account in deciding which action to take as a result of each concern. Medical directors therefore tended to consistently apply a set of conditions or rules to guide them in their decision, based on their assessment of whether there was a risk to patient safety. The conditions where a referral would almost certainly be made were:

- Where a doctor was leaving the trust and could go on to be employed elsewhere, creating a potential risk to patient safety;

- Where a doctor had not complied with remediation, or appeared to lack insight into their problems;

- Where there had been serious behavioural misconduct resulting in harm to a patient or colleague, or criminality.

*"I suppose one area [is] where when doctors leave us and we don't know where they're going to work – we refer to the GMC as the port of last call, because the regulator's regulating these doctors wherever they're working in Britain."* [Medical Director, NHS Trust]

"There were two assaults and drink driving [cases]. Those were no brainers [to refer to the GMC] – the police notified the GMC anyway." [Medical Director, NHS Trust]

In the quantitative research, Medical directors who had been involved in making a Fitness to Practise referral were asked about the factors which prompt their Trust or Board to escalate cases and make a Fitness to Practise referral to the GMC.

As shown by chart 6, the presence of a high risk to patients was almost universally mentioned (96 per cent), whilst criminal offences (89 per cent) and failure to comply with internal measures to rectify the issue (84 per cent) were both mentioned by more than four-fifths.

Chart 6. Factors which prompt the Trust or Board to escalate cases and make a Fitness to Practise referral to the GMC
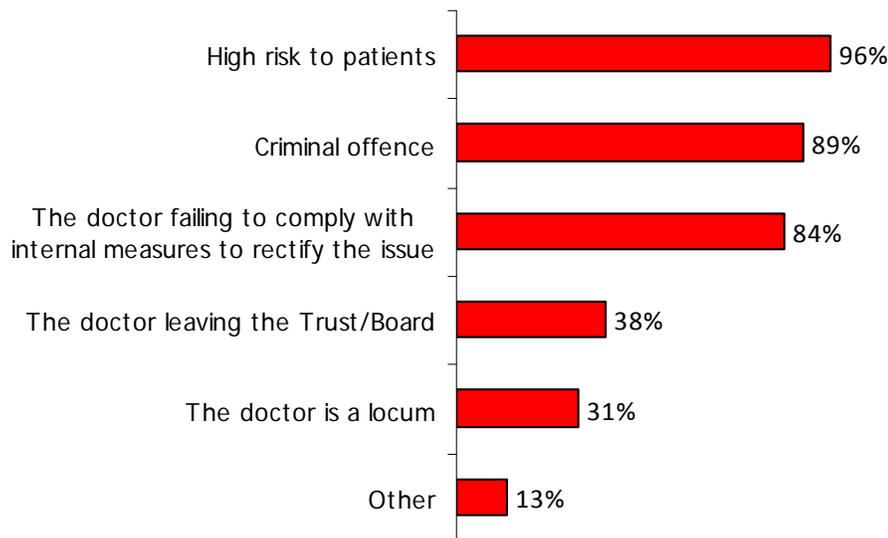
Base: All who have been involved in making a Fitness to Practise referral to the GMC on behalf of their Trust/Board within the last five years (80)

A series of statements were also asked of those who had been involved in making a Fitness to Practise referral, with medical directors asked to state their level of agreement or disagreement with each on a five-point scale ranging from 'strongly agree' to 'strongly disagree'. Responses are shown by chart 7.

Chart 7. Levels of agreement with statements about the escalation of cases to the GMC
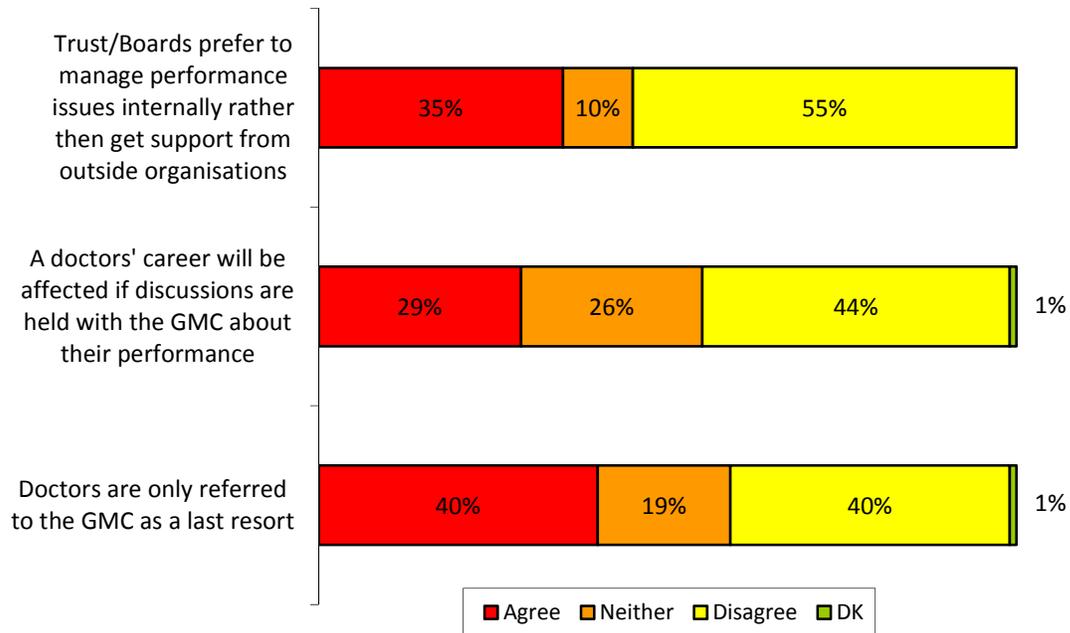
	Agree	Neither	Disagree	DK
Trust/Boards prefer to manage performance issues internally rather then get support from outside organisations	35%	10%	55%	
A doctors' career will be affected if discussions are held with the GMC about their performance	29%	26%	44%	1%
Doctors are only referred to the GMC as a last resort	40%	19%	40%	1%

Base: All who have been involved in making a Fitness to Practise referral to the GMC on behalf of their Trust/Board within the last five years (80)

Whilst the qualitative research found some evidence that Trusts felt they could only go to the GMC as a last resort, as it would tarnish a doctor's reputation, the quantitative research provided a mixture of opinions, where:

- 40 per cent agreed that doctors are only referred to the GMC as a last resort

- 29 per cent agreed that a doctor's career will be affected if discussions are held with the GMC about their performance

2.4   Role of the GMC & other organisations

The qualitative research suggested that the desire for clarity and reassurance when dealing with professional concerns resulted in a need for advice and support from an external organisation for some. The ability of external organisations to provide informal guidance, discussion and support was highly valued by medical directors.

> *"Quite a lot of the ones [cases] I've described are conduct, aren't they - if you're a drunk or a drug addict or a lecher or a fraudster or a liar, I'd regard all that as being incompatible with being a doctor. However, if your outcomes after surgery aren't as good as they should be, or repeatedly not as good as, the GMC Fitness To Practise procedures have more difficulty dealing with that sort of case."* [Medical Director, NHS Trust]

A number had consulted the National Clinical Assessment Service (NCAS) in relation to specific cases, seeking advice on the best way to proceed. There were mixed views on the role that NCAS had taken in helping them to resolve cases. Some reported that they had had a very positive experience, and received the desired guidance and practical support in implementing remediation and monitoring. Others had a less positive experience, and pointed to the onerous reporting required in order to receive an NCAS assessment. Others, however, had been able to have an informal discussion with NCAS, and this was highly valued as it had reassured them about the correct course of action to be taken.

Attitudes to the GMC were polarised, and differed strongly between those who currently had access to GMC Employer Liaison, and those who did not. The value of informal advice and liaison was clear, and those with access to this found that they utilised this frequently to discuss cases, and felt a sense of relationship with the GMC as a result. Medical directors with access to GMC Employer Liaison tended to regard the individual officers as knowledgeable and to respect them, and a number were very positively mentioned by name. This group appeared to have fewer concerns and anxieties around GMC referrals.

By contrast, those without access to Employer Liaison were more critical of the GMC in relation to Fitness to Practise, and more likely to feel disconnected from the GMC. This group were more likely to be critical of the timescales for investigating Fitness to Practise, and to perceive that the GMC's Fitness to Practise decisions were inconsistent. Notably, this group were more likely to fear that an informal enquiry to the GMC could result in a full referral. As a result, they would be reticent to make contact with the GMC to access desired informal discussion and liaison.

3. What is happening to the number of cases?

3.1 Introduction

The original focus of the project was to ask why the GMC statistics had shown a large increase between 2008 and 2009 in the numbers of enquiries from Persons Acting in a Public Capacity (PAPC). At the time, it was assumed this may be due to a disproportionate increase in enquiries from certain types of organisations, including NHS Trusts.

The project explored possible reasons for the increase using data from the GMC's Customer Relationship Management system (CRM), installed by Siebel in 2006. Because of the scope and timetable of the project, we were limited to analysing anonymised data relating to the sources of enquiries, rather than data on the characteristics of doctors who were subjects of the enquiries. In this way our work differs from that of Lloyd-Bostock (2009) and York Health Economics Consortium HEC (2006).

The methods used to analyse these data, and how they differ from the approach routinely used by the GMC, are described in detail in an Appendix. Because we were given data for the period April 2006 (the start of use of the Seibel system) to October 2010 we were able to put the changes between 2008 and 9 in a broader context which rather changed the focus of the project.

3.2 Changes between 2008 and 2009 in enquiries coded as coming from PAPCs

When we began to explore the CRM data we found that a number of effects due to coding and reporting procedures may have led to the perceived increase in PAPC sourced enquires between 2008 and 2009. These include:

- Some of the increase will be due to changes in the use of the PAPC code which has varied considerably since 2006. When the CRM system was introduced (in 2006) the "Public Organisation" code was used more often than PAPC to describe these types of sources, but by 2010 almost all of these were coded as PAPC. So referring to PAPC statistics for this period is misleading unless numbers for PAPC and Public Organisation are combined: otherwise it is impossible to distinguish real increases from increases in the use of the PAPC code.

- An approach used by the GMC to produce enquiry statistics, counting the number of completed triages, may make the figures more susceptible to internal GMC processes than the project approach: counting the number of new enquiries. It will also produce larger figures than our approach because the number of triages refers to the number of doctors cited and more than one doctor may be involved in a single enquiry.

- When we count new enquiries (rather than completed triages), the increase in those initiated by PAPCs from 2008-2009 is less striking than in the published GMC figures and broadly consistent with the overall rate of increase over the years for which we were given data.

There were several more specific issues we noted in relation to the period 2008-9, including:

- A localised reduction in the use of the PAPC code ("Public Organisation" was preferred) for Foundation Trust initiated enquiries in 2008 tends to inflate the 2008-9 differences by reducing the 2008 PAPC numbers.

- GMC referrals increased from low level prior to 2009 to a much higher level in 2009 and 2010. This makes a substantial contribution to the PAPC increase between 2008-9: accounting for approximately 35% of the total.

- Both the original GMC figures and our re-analysis show that numbers of new enquiries were unexpectedly low in 2008 – especially towards the end of the year. This led us to wonder whether some of the late 2008 caseload might have been recorded or counted in 2009 also contributing to the 2008-9 increase appearing unusually high.

After taking account of these various coding and procedural effects, and looking at the 2008-9 increase in the wider context of trends from 2006 and 2010, we concluded that there had not been an exceptional increase between 2008-9 in enquiries initiated by PAPCs and "Public Organisations". The first ten months caseloads plotted in chart 8 confirm that the scale of the 2008/9 increase is consistent with the general rate of increase between 2007 and 2010. These results suggested that the project should focus on longer term trends.

Chart 8. New enquiries (2007-2010)

New enquiries in first ten months (2007-2010)
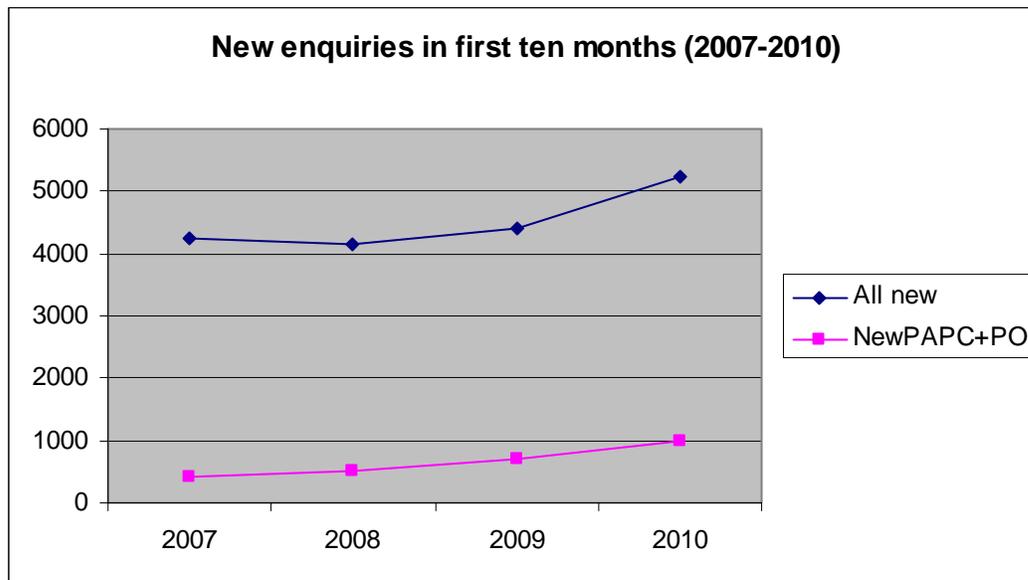
3.3 Trends in the types of organisation initiating enquiries

The third part of this section examines whether certain types of organisation have disproportionately contributed to the overall increase in FtP enquiries.

3.3.1 Coding of organisation type

Because of the changing use of the PAPC code, we decided to check the coding of the type of organisation before starting the analyses. We found problems with the coding, not least that 30% or more of the NHS Trust entries in the organisation type field had been miscoded: 340 of the 1153 records where the organisation was described as an NHS Trusts were either Primary Care Trusts (which is a separate category) or Primary Care Support Agencies. We have recoded the organisation type in these cases and introduced a new category for Primary Care Support Agencies.

There are also problems with the use of the "Health Authority" code. We had time to only partially correct the use of this code before carrying out the analyses.

3.3.2 What types of organisation initiate enquiries – and is the pattern changing?

To explore any changes in the numbers of enquiries initiated by different types of organisation, we looked at both the full year and first ten months figures for the period from the start of the Siebel CRM system until October 2010. The ten monthly figures are shown in table 1 and a subset for high volume referrers are plotted in chart 9. The full year figures for 2007-9 are in the Appendix.

From both the chart and the table we see that:

- Although the year by year figures are uneven, there is an overall increase in numbers of enquiries from PAPCs and Public Organisations from 2007-2010

- There is a slight reduction in numbers from some types of organisation in 2008

- There are no large anomalous changes between 2008 and 2009 and the figures for these two years are broadly consistent with general trends from 2007 to 2010.

Table 1. Numbers of new enquiries by organisation and year (Jan-Oct data)

	2007	2008	2009	2010
Blank	290	265	227	257
3rd Party Solicitor	16	15	11	29
Education – Deanery	3	8	22	23
External Solicitors	28	39	55	48
Foundation Trust*	28	27	52	68
Government Dept	10	34	12	19
Health Authority	26	36	32	92
Locum Agency	3	9	19	18
NHS Trust*	153	155	118	166
Other	71	76	98	110
Police	111	153	143	135
Primary Care Agency	11	4	20	60
Primary Care Trust	76	76	109	178
Private Company	4	17	25	18
Private Health Organisation	18	8	25	14
Regulatory Body	37	37	114	132
Statutory Body	51	42	33	28
Trust Headquarters*	14	25	46	55
Unspecified - mostly private individuals	3285	3138	3252	3798
Total	**4235**	**4164**	**4413**	**5248**
*All Trusts (Foundation, NHS + HQs)	195	207	216	289

Chart 9. Numbers of new enquiries by organisation and year (Jan-Oct data) – higher volume organisations only
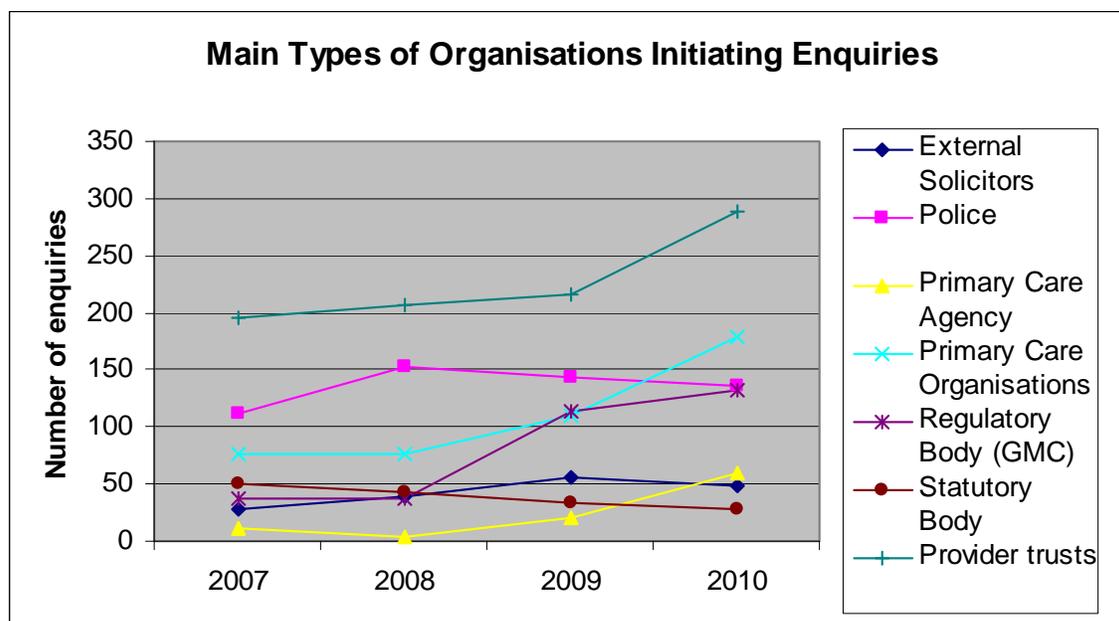
In more detail:

- In 2010, NHS Trust referrals increased to a figure slightly greater than those for 2007 and 2008 after an unusually low count for 2009. But given uncertainty in the coding, it may be better to group all Trust related figures: for NHS and Foundation Trusts and Trust Headquarters. The combined Trust figures are at the bottom of table 1. The numbers rise slightly from 2007 to 2009, with a much larger increase between 2009 to 2010.

- Enquiries from PCTs and regulatory bodies increase more rapidly than those from provider Trusts – though the increases are uneven.

- Enquiries from the police decline from a maximum in 2008.

- Proportionately large increases amongst the smaller volume referrers between 2008 and 2009 were noted for Deanery, Foundation Trusts, Locum Agencies, Primary Care Agencies and Private Health Organisations. But care should be taken when interpreting such small numbers (see below).

A key point to note is that all these differences, especially among the smaller volume enquirers, should be interpreted cautiously. Many would not be statistically significant. Some differences between years are on a smaller scale than some coding problems we have noted; and all differences between 2008 and 2009 may be distorted or inflated by the unusually low figures for 2008.

We have attempted to fit linear statistical models to these results to identify the strongest trends. Details of the calculations are in the Appendix.

The higher volume referrers showing the strongest increases over these years are:

- Provider Trusts (by approx 13% per year) – with an above average increase from 2009 to 2010.

- PCOs – mostly PCTs (by 31% per year)

- the GMC (by 45% per year).

The scale of these increases needs to be compared with the overall rate of increase over the same period (including all enquiries from members of the public). From table 2 we see that the total of all new enquiries for the first ten months of 2009 and 2010 was 13% higher than the total for 2007 and 2008. The increase in the "organisation unspecified" (mostly enquiries from private individuals) is lower: just under 9%; and the approximate increase from all types of organisation is 24%.

Table 2 Per cent increase in numbers of new enquiries in the first ten months of 2009-10 combined when compared with combined figures for 2007-8.

Source	Total for 2007+2008	Total for 2009+2010	Per cent increase over two years
All new enquiries	8399	9661	13.1
Enquiries where organisation type is unspecified - mostly private individuals	6423	7050	8.9
All where organisation type is specified	1976	2611	24.3
All provider trusts	402	505	20.4

These figures suggest that

- Enquiries initiated by organisations are increasing faster than those from members of the public.

- The rate of increase for provider trusts is slightly lower than that for organisations as a whole.

Another way of exploring how the different organisations contribute to the overall increase is to look at the proportion or percentage that each type contributes to the total. These percentages are shown in chart 10.

Chart 10. Percentages of all PAPC and Public Organisation sourced enquiries initiated by the higher volume referrers (data for Jan-Oct)
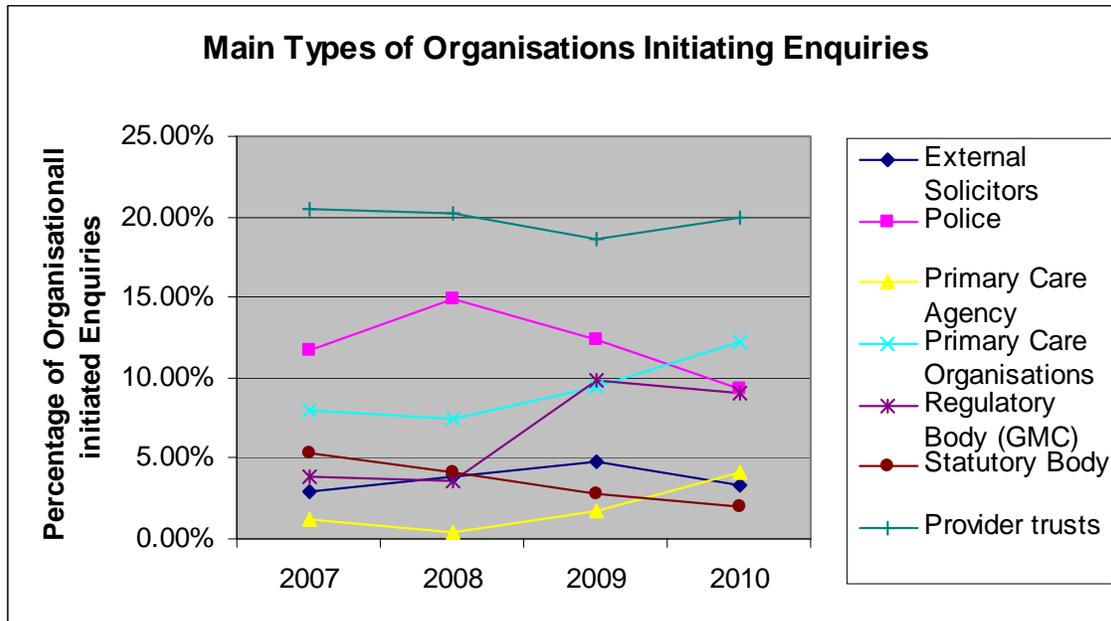
The main results when the figures are presented in this way are:

- There is no evidence that the combined proportion from provider trusts (NHS Hospital Trusts, Foundation Trusts and Community and Mental Health Provider Trusts) is increasing.

- The proportion from the police is declining

- The proportions from PCOs, Primary Care Agencies and regulatory bodies (almost entirely the GMC) are increasing

3.4   Conclusions

Much more detail of these analyses of the CRM data can be found in the Appendix. The main results described here are as follows:

- On average, (based on the figures in table 2) the total number of Fitness to Practice enquiries to the GMC have increased at a rate of approximately 6.5% per year since 2007

- Enquiries initiated by organisations (rather than private individuals) have increased at about twice the overall rate

- While the total numbers of enquiries is steadily increasing, there is no evidence that the combined proportion from provider trusts (NHS Hospital Trusts, Foundation Trusts and Community and Mental Health Provider Trusts) is increasing.

- The proportions from PCOs, Primary Care Agencies and regulatory bodies (almost entirely the GMC) are increasing.

- After taking account of the coding and procedural effects discussed in section 3.2, and looking at the 2008-9 increase in the wider context of trends from 2006 and 2010, we concluded that there had not been an exceptional increase between 2008-9 in enquiries initiated by PAPCs and "Public Organisations".

- Some serious issues of data coding were detected during the project. Two fields "source" and "organisation type" were examined in detail. In the former, the use of the codes had changed dramatically since 2006; in the latter there was widespread miscoding.

- For these reasons we would encourage the GMC to consider a comprehensive audit and validation of its data coding.

4.   What is driving the increase in referrals?

This section explores medical directors' views of the factors driving the increases in Fitness to Practise referrals.

4.1   Patterns of referrals over recent years

Chart 11 shows the number of Fitness to Practise referrals made during 2010. Two-thirds (66 per cent) of medical directors who had been involved in making a Fitness to Practise referral reported that their Trust or Board had made one or two referrals in 2010.

Chart 11. Number of Fitness to Practise referrals made in 2010
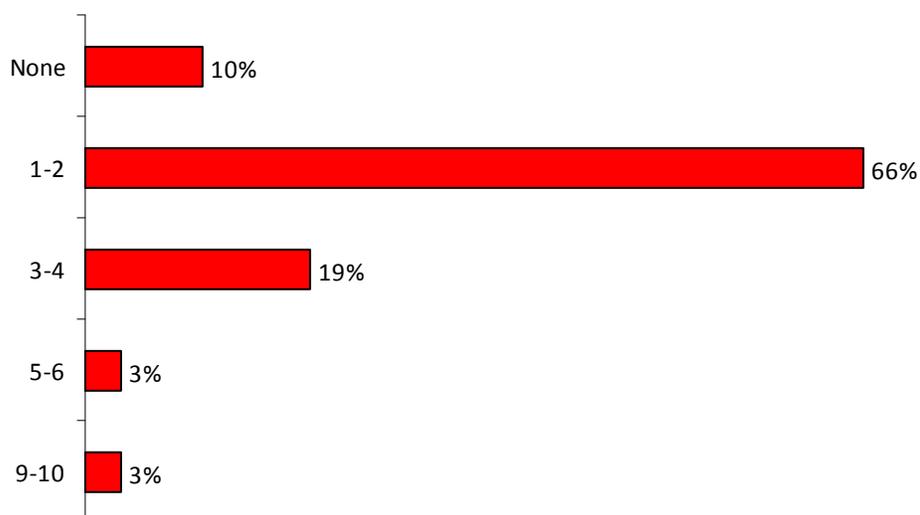
Base: All who have been involved in making a Fitness to Practise referral to the GMC on behalf of
        their Trust/Board within the last five years (80)

Of those whose Trust or Board had made a Fitness to Practise referral in 2010, one-third (32 per cent) said that this represented an increase compared with 2009. Half (53 per cent) stated that the number was about the same as 2009, whilst just four per cent felt it was lower. When asked whether the number of referrals made in 2010 represented an increase or a decrease compared with five years ago, patterns of response were broadly similar (chart 12).

Chart 12. Whether the number of Fitness to Practise referrals made in 2010 was higher or lower than in 2009/the previous five years
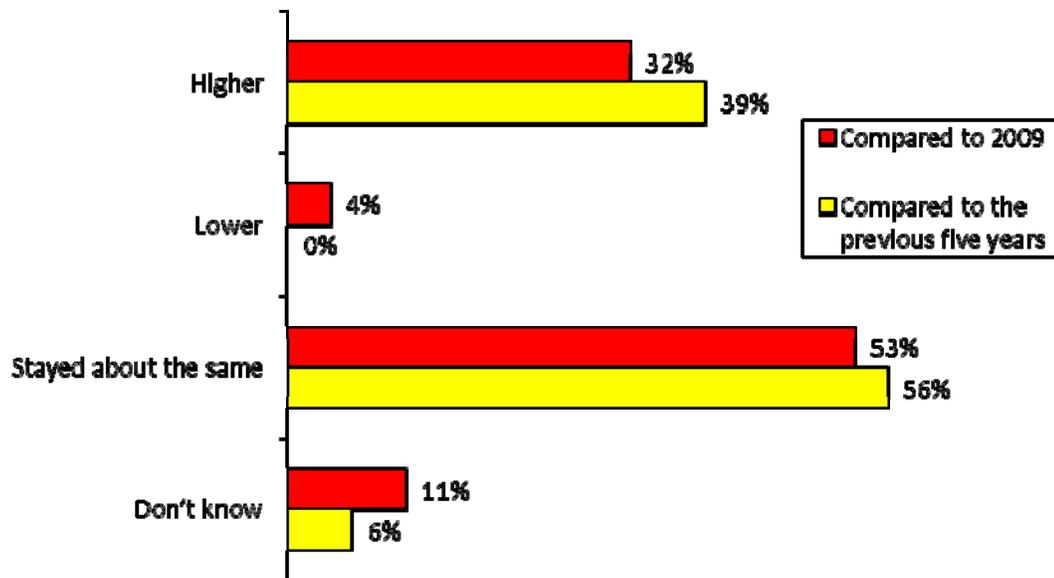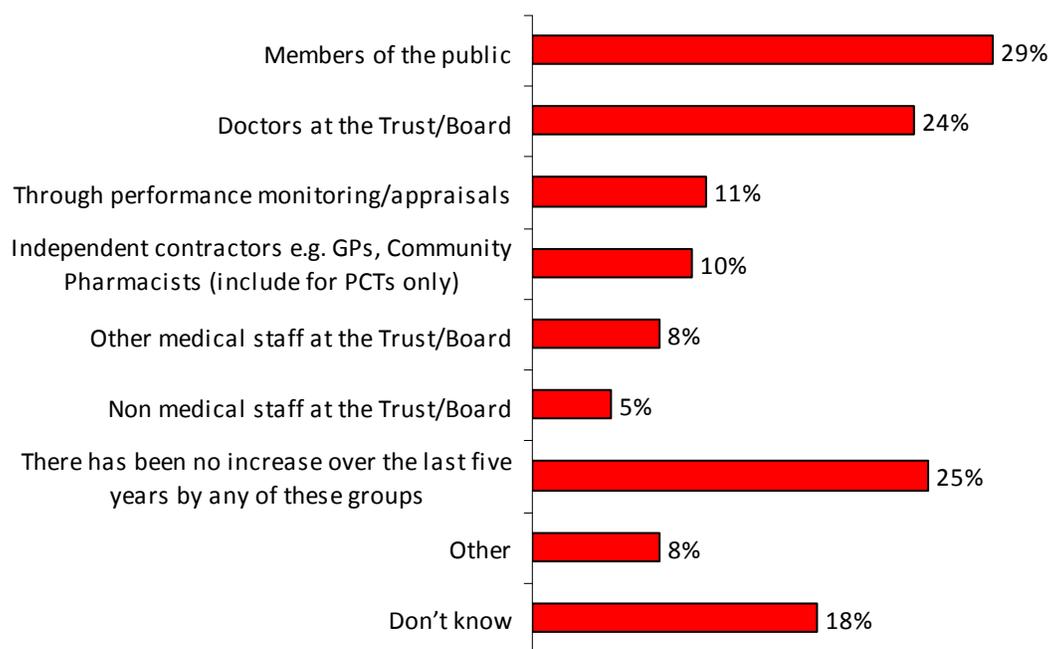

Base: All whose Trust/Board made at least one Fitness to Practise referral in 2010 (72)

All medical directors who had been involved in making a Fitness to Practise referral were also asked whether there had been an increase in the number of Fitness to Practise concerns raised through the sources shown in chart 13 over the last five years.

Three in ten (29 per cent) responded that there had been an increase in the number of concerns raised by members of the public, whilst a quarter (24 per cent) mentioned an increase by doctors at the Trust or Board. However, a quarter (25 per cent) reported no increases in the last five years by any of the sources.

Chart 13. Whether, over the last five years, there has been an increase in the number of Fitness to Practise concerns raised by various groups

Group	%
Members of the public	29%
Doctors at the Trust/Board	24%
Through performance monitoring/appraisals	11%
Independent contractors e.g. GPs, Community Pharmacists (include for PCTs only)	10%
Other medical staff at the Trust/Board	8%
Non medical staff at the Trust/Board	5%
There has been no increase over the last five years by any of these groups	25%
Other	8%
Don't know	18%

Base: All who have been involved in making a Fitness to Practise referral to the GMC on behalf of their Trust/Board within the last five years (80)

4.2   Summary of key factors

All medical directors who reported that the number of referrals made in 2010 was higher than either the previous year or five years ago were asked their reasons for this, as well as being asked what they thought was the *main reason* for it. The findings are shown by chart 14.

It should be noted that the number of respondents eligible to answer these questions was very low (just 28 respondents were eligible to answer). Therefore findings should be interpreted with caution.

Chart 14. Reasons/main reason for increases in referrals at specific Trusts

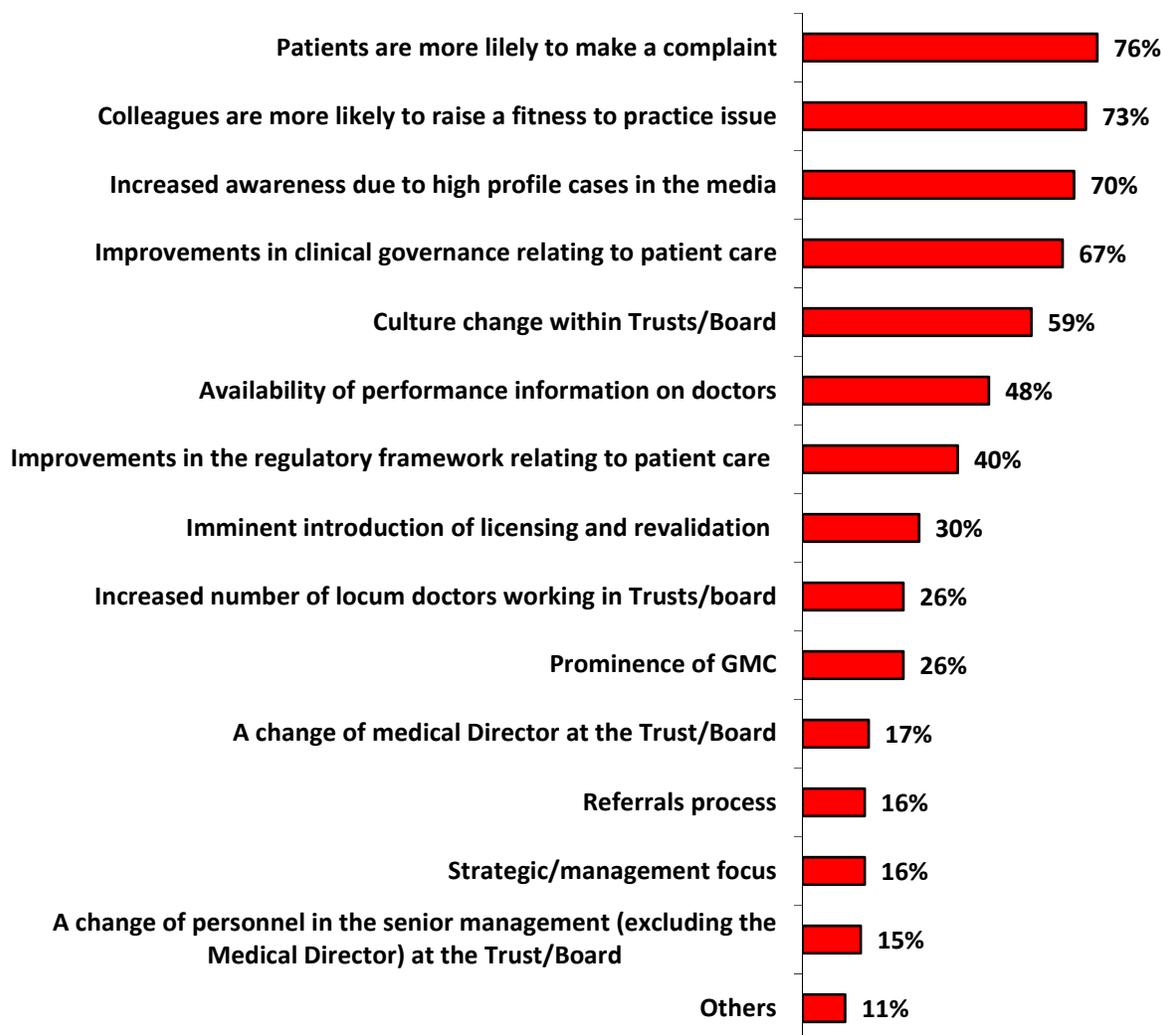| Reason	All reasons	Main reason
Colleagues are more likely to raise a fitness to practice issue	71%	21%
Improvements in clinical governance relating to patient care	64%	18%
Culture change within Trusts/Board	61%	11%
Patients are more lilely to make a complaint	54%	18%
Increased awareness due to high profile cases in the media	43%	
Availability of performance information on doctors	36%	7%
A change of medical Director at the Trust/Board	32%	7%
Increased number of locum doctors working in Trusts/board	29%	4%
Improvements in the regulatory framework relating to patient care	25%	4%
A change of personnel in the senior management (excluding the Medical Director)…	25%	4%
Imminent introduction of licensing and revalidation	14%	0%
The standard of doctors is dropping	14%	7%
Strategic/management focus	14%	0%
Prominence of GMC	11%	0%
Referrals process	4%	0%

Legend:
- ■ All reasons
- □ Main reason

Base: All whose Trust/Board are referring more Fitness to Practise enquiries to the GMC than in previous years (28)

All medical directors were asked if, before being invited to take part in the research, they were aware that there had been a steady increase in the number of Fitness to Practise referrals made to the GMC in the last five years. Three-quarters (77 per cent) stated that they were aware of this fact prior to participating in the survey.

They were subsequently asked to consider (from a list of possible reasons) what they thought had led to this increase. The top mentions (shown by chart 15) related to three key areas:

- **Changes in public attitudes:** Three-quarters (76 per cent) felt that patients are more likely to make a complaint, perhaps linked with the fact that there is increased awareness due to high profile cases in the media (mentioned by 70 per cent)

- **Changes in colleagues attitudes**: A similar proportion (73 per cent) considered that their colleagues are more likely to raise a Fitness to Practise issue

- **Improved governance and management:** Two-thirds (67 per cent) cited improvements in clinical governance relating to patient care, whilst 59 per cent identified the contribution of culture change within Trusts or Boards

Chart 15. Perceived reasons for increases in referrals to GMC in the last five years

Patients are more lilely to make a complaint	76%
Colleagues are more likely to raise a fitness to practice issue	73%
Increased awareness due to high profile cases in the media	70%
Improvements in clinical governance relating to patient care	67%
Culture change within Trusts/Board	59%
Availability of performance information on doctors	48%
Improvements in the regulatory framework relating to patient care	40%
Imminent introduction of licensing and revalidation	30%
Increased number of locum doctors working in Trusts/board	26%
Prominence of GMC	26%
A change of medical Director at the Trust/Board	17%
Referrals process	16%
Strategic/management focus	16%
A change of personnel in the senior management (excluding the Medical Director) at the Trust/Board	15%
Others	11%

Base: All (94)

The following differences were observed by the type of Trust medical directors worked for:

- Two-thirds of medical directors at NHS Trusts (67 per cent) and Foundation Trusts (64 per cent) cited a culture change within Trusts or Boards, compared with four in ten (40 per cent) of those at a Primary care Trust

- Medical directors at an NHS Trust were also more likely to mention the increased number of locum doctors working in Trusts than those at Primary Care Trusts (33 per cent compared with 10 per cent)

The qualitative research also explored medical directors' perceptions of the key reasons for the increase in referrals to the GMC. The qualitative research included those who had and had not seen an increase in their own trust, and so perceptions were based on general perceptions as well as on personal experience.

The following factors were thought to be key in driving the increase in referrals, mirroring those identified in the quantitative research:

- Improved governance and management ethos;

- Changes in general public attitudes;

- Changes in colleague attitudes.

> *"I certainly wasn't aware of the...increase [in referrals]. It doesn't surprise me, however, with the onset of appraisal and the maturation of the appraisal process - and the dovetailing, if you like, or integration of the appraisal process with the overall governance structures within the Health Board. So it doesn't surprise me that people in my position ... are more inclined now to be referring on - because the amount of governance intelligence available...much greater and more robust than it has been in the past...."* [Clinical Director, Health Authority]

Overall, it was agreed that the increase in referrals was not driven by diminishing standards amongst medical professionals, but that improved systems within organisations for detecting and dealing with performance concerns had led to the increase in referrals. These key factors were explored further in the qualitative research.

4.3   Increased management ethos

The NHS was thought to have made a transition over a period of several years, towards an increased focus on implementing strategic management. A number of the medical directors had been in post for some time, and had been able to observe this change and its impact on the profession.

This was thought to have driven a change in the approach to performance issues in general, in particular relating to the way that doctors are regarded within the trusts. Research participants commented that where once a doctor may have been able to rely upon the discretion, and even protection, of their colleagues and organisational leadership, the new environment was one where there was an expectation that concerns about professional competency would be effectively managed.

> *"Whistle blowing is changing, yes culture is changing, but it is still not perfect."* [Medical Director, NHS Trust]

A number of key policies were thought to have played an important role in driving this transformation, and Maintaining High Professional Standards was mentioned frequently. Another factor was the incidence of high profile cases of professional misconduct reported in the media, in particular the Shipman case, thought to have driven a policy focus on performance issues.

> *"...there was the Maintaining Higher Professional Standards document, quite a few years ago now, on which all hospital, medical and dental capability procedures are based. So I think it's all of these things that lead to the same kind of...increased awareness."* [Medical Director, NHS Trust]

The introduction of clinical governance systems was thought to have played a role, in terms of providing practical support in investigations, in the form of outcomes monitoring data and other performance measures. An important element was the introduction of procedures for reporting incidents, and a resulting increase in the likelihood that performance issues could be identified and escalated in the appropriate way.

However, the introduction of these systems was also thought to have resulted in a shift in mindset amongst colleagues and across trusts, towards a focus on outcomes and maintaining high standards of patient safety.

To a lesser extent, the introduction of the responsible officer role, and the forthcoming introduction of licensing and revalidation were thought by some to be likely to drive future change. However, this was seen as just one element of a wider movement to improve management systems and maintain high performance standards. Some were sceptical that these specific policy changes would have an effect, although others thought that anticipation of revalidation could encourage trusts to attempt to 'weed out' poorly performing doctors in anticipation that they would fail to be revalidated.

4.4   Changing attitudes amongst the public and professionals

An important result of the change towards a management ethos was an increased recognition amongst medical colleagues that performance concerns should be highlighted. Medical directors reported that colleagues were more likely to feel confident that if they raised a concern, it would be dealt with appropriately, and that action would be taken as a result.

> *"[The organisation had a] new Chief Executive, Chair, new Medical Director and a new Director of HR all at the same time, about 4 years ago. [We] all had a much harder attitude to doctors' performance than our predecessors...I think that does breed a cultural change, because people do come forwards with things they probably wouldn't have 8-10 years ago, because there was no point; nobody would [have done] anything. At least now, they understand somebody will do something if the concerns are genuine, so we do tend to get more doctors coming to us with concerns about a colleague's performance than a few years ago..."* [Medical Director, NHS Foundation Trust]

Some also pointed to a shift in the culture of colleague relationships amongst doctors. It was thought that where once, doctors working together would be tolerant of each other's' behaviour and would even cover up each other's' mistakes, colleagues now would feel fewer qualms about reporting a fellow doctor who was not performing to a high standard. One or two suggested that this was because of an increased focus on team-working, meaning that one colleague's mistakes would make others vulnerable to criticism.

In addition, systems for whistleblowing and confidential complaints were thought to be effective, with the result that colleagues did not feel at risk of personal detriment as a result of making a complaint.

"The whistle-blowers tend to highlight poor documentation, poor referral, misdiagnosis..." [Medical Director, PCT]

"I think there's certainly the whistle-blowing...I think the profession's aware of their own individual responsibility to address poor performance, I think that's the first thing [affecting increased referrals]." [Medical Director, Primary Care Trust]

The majority of participants in the qualitative research thought that this shift in colleague attitudes had been a positive one, but one or two medical directors were not in favour of this, feeling that it created opportunities for unscrupulous colleagues to victimise one another.

"It's always difficult - reporting a fellow clinician to the GMC or to a PCT is a brave thing to do, it's not something that doctors themselves naturally would wish to see happen, and that's really quite difficult because we know from the Bristol case and all the other cases - the high profile stuff - the whistle-blower often gets pretty damaged as a result of being the whistle-blower. You know, so there's a leadership aspect in relationship to being prepared to actually put your head above the parapet and say 'I'm not happy about the clinical practice that's going on'." [Medical Director, Primary Care Trust]

A culture shift was also thought to have taken place amongst the general public. Where once patients did not feel empowered to make a complaint about their doctor, they were now thought to be far more likely to speak out if they felt aggrieved about their experiences with doctors. This was thought to be in part driven by public awareness of high profile cases in the media, creating the awareness that medical professionals are fallible and empowering patients to speak out.

> *"I'm sure that's influenced the views of patients and carers. I suppose the Shipman case is still very prominent in lots of people's minds, isn't it? – as well as a series of other notorious ones: the psychiatrists who were having sex with their patients, the gynaecologist doing likewise… so I think that probably makes patients that bit more likely to think 'Well, maybe my doctor's bad as well'."* [Medical Director, Primary Care Trust]

One or two attributed this to the introduction of PALS, which provided patients with access to more opportunities to raise their concerns. One or two highlighted the increased prominence of the GMC, although others disputed this, feeling that the GMC had gained prominence amongst the profession but not amongst the general public. However, it was agreed that the public were more aware of the opportunity to complain, and were more likely to pursue this if dissatisfied with their medical care than they may have been in the past.

Some pointed to an increasingly litigious culture amongst the general public, which could cause people to seek to gain financially through making a complaint about a doctor. One or two cited incidences where a patient had used information from a GMC complaint as evidence to support their legal action against the trust. This was a lesser concern for most however, and although there was a recognition that public complaints were not always well-founded, most did not cite financial gain as a key motivation for members of the public.

"I mean my sense of [the increase in referrals] is that there are increased expectations from patients about what could and should be expected from their doctors - and I guess that is on a technical level, but also on a attitudinal, behavioural level - and should they feel that their contact with a doctor falls short, I think there is probably, in common with many other areas of public life...an increasing challenging of professional practice and roles and that the deference that perhaps in the past may have prevented people viewing something as unacceptable, falling below, is now being removed, or is being lessened." [Mental Director, Foundation Mental Health NHS Trust]

Some also referred to an increase in the use of locums as a potential reason for increasing referrals. Some mentioned that they had increased their reliance on locums in recent years, and others that they expected locums to be disproportionately highly represented amongst referrals to the GMC. The key reason for this was the fact that the performance of locums could not be restricted or managed by the trust as they were free to work elsewhere, and that a referral to another body was essential to maintain patient safety.

"There are lots of issues around locums, I mean I'd much rather we never had to use a locum...And to cap it all, when you do come into a problem, they're usually gone before you can do anything about it...there's all sorts of issues around locums. It makes life more difficult for everybody from beginning to end." [Medical Director, Mental Health and Community NHS Trust]

Some also pointed to the likelihood of locums to be non-UK trained, and that this could result in increased performance concerns where acceptable norms and standards of practice differed from those expected in the UK. Cultural differences were also thought to have the potential to give rise to problems with the patient relationship as a result of differing cultural norms.

"They [locums] come from overseas, not all of them but some of them, and they're very difficult to assess and you don't always know what you're getting when you hire them, some are excellent, I wouldn't want people to think that they're not but because they're not in a state of permanence, it's very hard for people to manage them." Medical Director, NHS Trust]

5. Managing Fitness to Practise referrals in future

5.1 Expectations and needs

It was clear from the qualitative research that medical directors expected the increase in referrals to continue as the improvements in management of the health service reaped further rewards in the form of improved detection of performance concerns and implementation of effective systems to deal with these.

It was also clear that medical directors currently experience a level of uncertainty around Fitness to Practise, and a desire to clarify policies and procedures. It was felt that a clearer understanding of the system would provide them with greater confidence in referring appropriately. In particular, medical directors would value support and guidance in making decisions on whether or not to refer to the GMC.

> *"[I] look forward to having an employer liaison person…I'm an experienced medical director but I could still do with more support. I have all the guidance; I just need the person to talk to. Having someone [to talk to] who has the broader view, who has already handled 50 similar cases before."* [Medical Director, NHS Trust]

The differences that could be observed between those with access to Employer Liaison, and those without, highlighted the effectiveness of Employer Liaison in creating a sense of relationship with the GMC, and an improved understanding of Fitness to Practise procedures. There was a desire for clarification of the criteria and thresholds around Fitness to Practise, but those with access to Employer Liaison felt more confident in their understanding of this, or that they could get access to the desired information if needed from their GMC representative.

A further key benefit of Employer Liaison was to allow informal dialogue without initiating a full Fitness to Practise referral. Those without this liaison expected that any level of engagement with the GMC would result in a referral, where they would like an informal sounding board to provide crucial reassurance.

"What it [Employer Liaison] is doing at the moment is right. Regular visits [and] regular conversations about the problem doctors is a good thing."
[Medical Director, NHS Trust]

A number of medical directors sought clarification from the GMC about licensing and revalidation, and reassurance that they would be guided on implementing this in advance of its introduction.

The qualitative findings were supported by the quantitative research. Six in ten (60 per cent) medical directors surveyed stated that they had a contact at the GMC with whom they could discuss Fitness to Practise referrals, either formally or informally. Of those that did not have such a contact, the vast majority (91 per cent) said that they would like one.

Amongst those who did have a GMC contact, over half (57 per cent) communicated with their contact at least once every three months, as shown by chart 16.
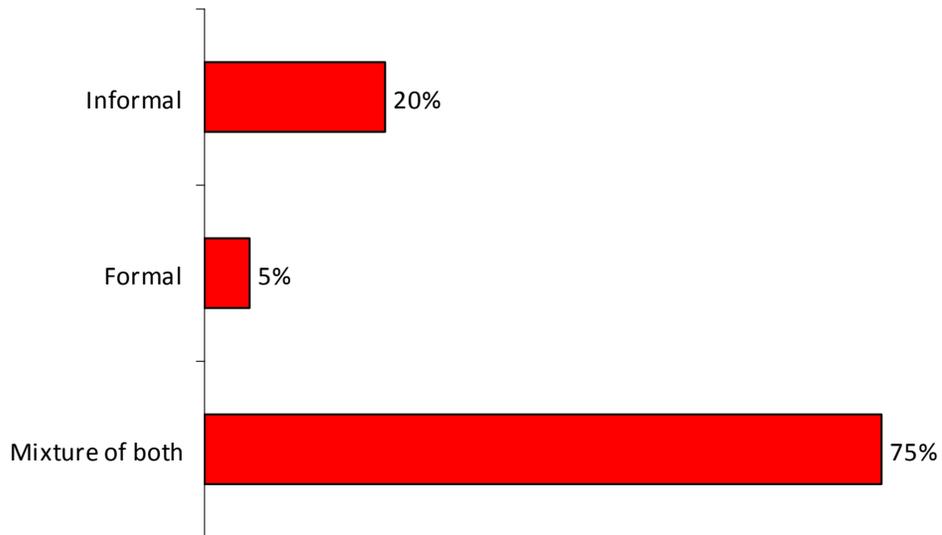
Chart 16. Frequency of contact with GMC contact
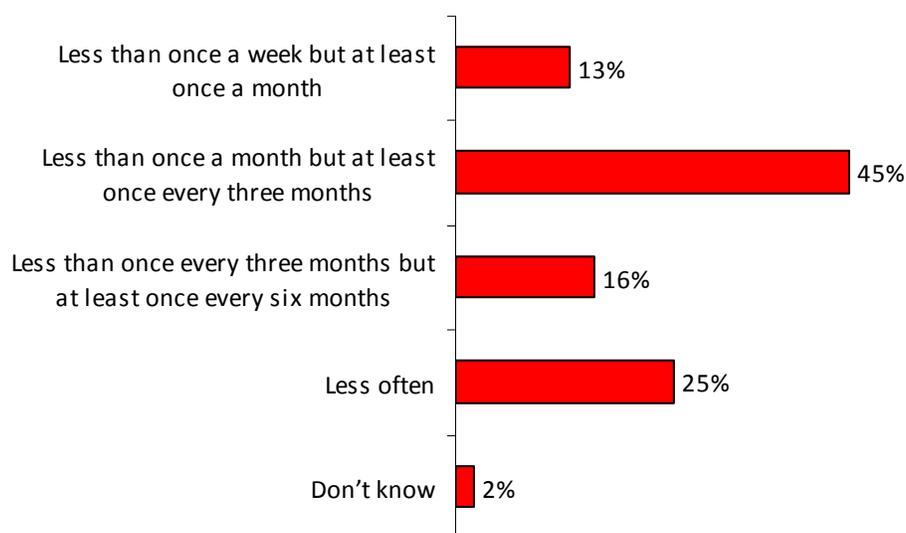
Base: All who have a contact at the GMC with whom they can discuss Fitness to Practise referrals (56)

As shown by chart 17, communications with GMC contacts about Fitness to Practise referrals tended to be a mixture of informal and formal communication (75 per cent). Overall, 95 per cent had some informal communication.
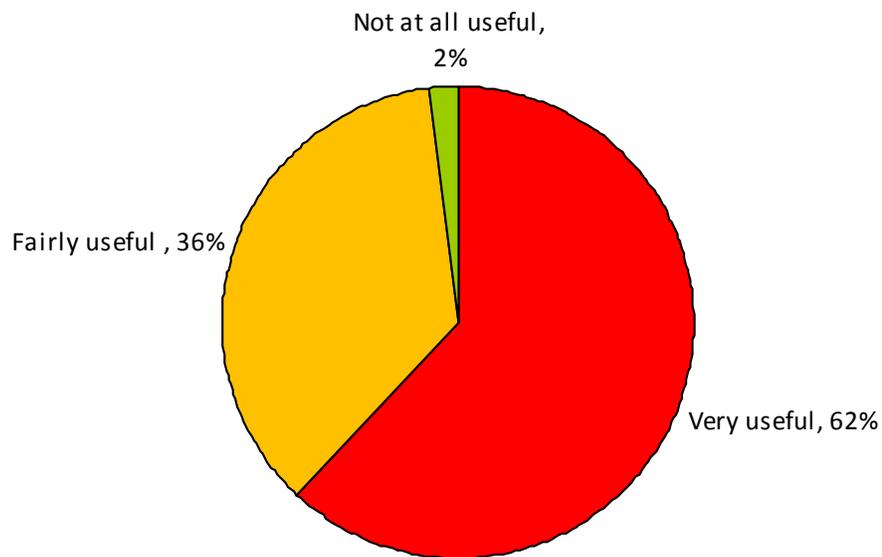
Chart 17. Whether communications with GMC contact were formal or informal

Base: All who have a contact at the GMC with whom they can discuss Fitness to Practise referrals (56)

Amongst those who had informal communications with their GMC contact, almost two-thirds (62 per cent) felt this was very useful, whilst a third (32 per cent) considered it to be fairly useful. Just 2 per cent (1 respondent) felt that their informal discussions were not at all useful.

Chart 18. Usefulness of communications with GMC contact

Not at all useful, 2%

Fairly useful , 36%

Very useful, 62%

Base: All who have a contact at the GMC with whom they can discuss Fitness to Practise referrals (56)

5.2   Future support desired from the GMC

As described in the previous section, the research indicated a desire for the GMC to provide:

- Guidance and clarification on Fitness to Practise thresholds and criteria;

- Reassurance to medical directors in making decisions about Fitness to Practise referrals;

- Opportunity for informal dialogue about Fitness to Practise.

Most said that they would value further training or guidance on Fitness to Practise, which could help to provide the desired clarifications. For some, this could take the form of written guidance. Others felt that the nuance of cases could not be effectively communicated via written guidance, and that a face to face session would be more suitable.

> *"It's one of these areas where one's constantly needing guidance and advice... A one to one relationship would be extremely useful."* [Medical Director, NHS Trust]

Those participants who did not currently have access to GMC liaison said that they would find this kind of one-to-one contact with a local representative very useful. This would be most useful in order to discuss cases and receive feedback and reassurance about their referral decisions.

It was notable that participants felt some isolation in making the decision about whether to refer, and that this may indicate that peer-group contact would be beneficial. This could take the form of regional meetings where participants could discuss Fitness to Practise issues.

Quantitative findings on the need for support from the GMC reflected those from the qualitative in-depth interviews. Medical directors who did not have a GMC contact but would like one, or who only had formal discussions with their contact, were asked the extent to which they thought it would be useful to have a GMC with whom they could discuss Fitness to Practise referrals informally. As shown by chart 19, two-thirds (68 per cent) considered this would be very useful whilst a third (32 per cent) responded that it would be fairly useful.

They were also asked specifically whether, during their last investigation into a Fitness to Practise concern, they would have liked a GMC contact with whom they could have discussed the case informally. The vast majority (86 per cent) responded that they would have liked this opportunity.

Chart 19. Perceived usefulness of having a GMC contact

Fairly useful
32%

Very useful
68%
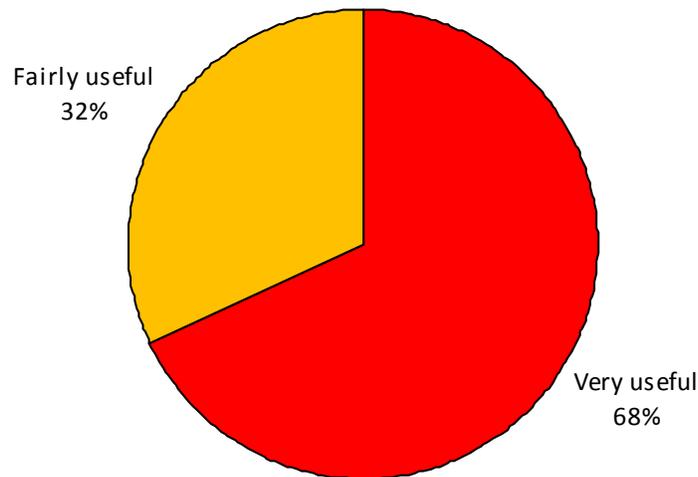
Base: All who don't have informal discussions about Fitness to Practise concerns, or who do not have a contact at the GMC with whom they can discuss Fitness to Practise referrals but would like one (37)

All those surveyed were asked whether they would like to receive more support from the GMC to help them manage Fitness to Practise concerns. Exactly half (50 per cent) stated that they would like to receive more support from the GMC. In contrast, just over one-third (37 per cent) felt they already received enough support from the GMC and 12 per cent received enough support from another source (chart 20).

Chart 20. Whether medical directors would like to receive more support from the GMC to help them manage Fitness to Practise concerns
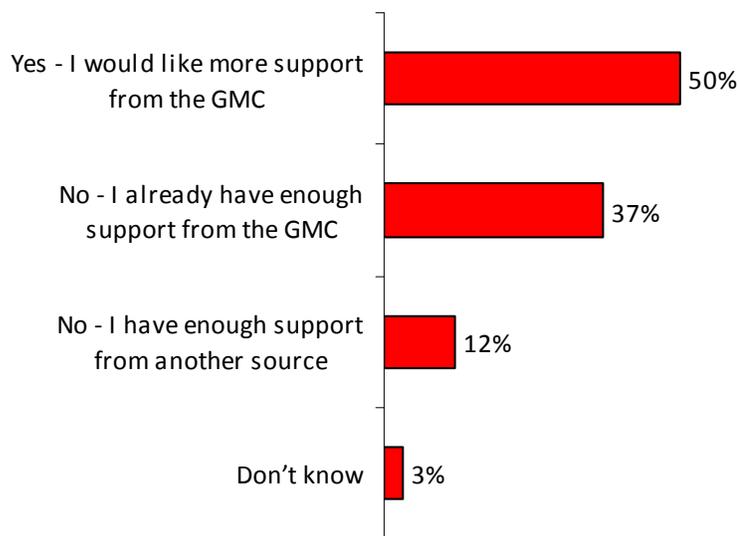
Base: All (94)

When asked how they would like to receive support from the GMC, 85 per cent of medical directors answered 'through discussions with a local GMC affiliate/representative'. Half (51 per cent) would welcome information or training sessions run by the GMC about Fitness to Practise issues and a third (31 per cent) would like to receive information via email (chart 21).

Chart 21. Ways in which medical directors would like to receive support from the GMC
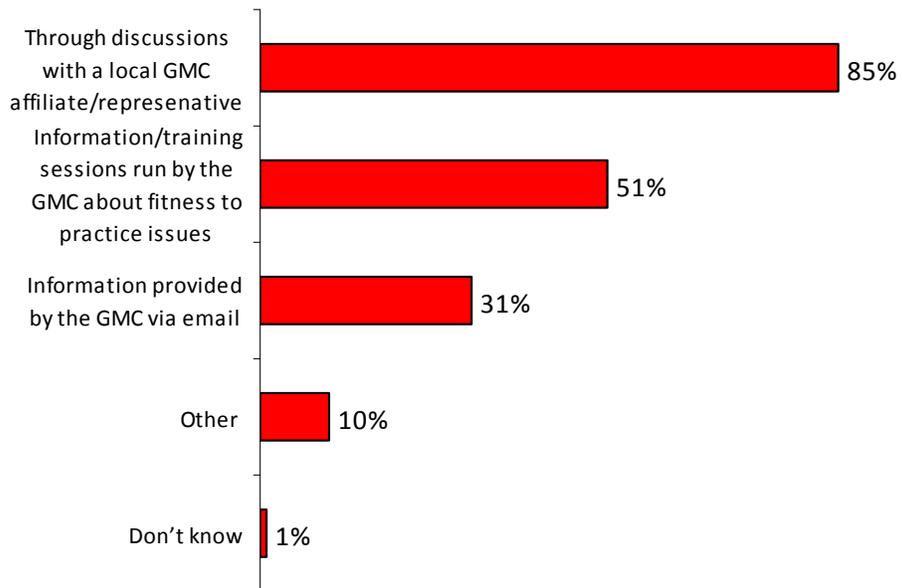
Base: All (94)

6.   Conclusions & recommendations

- Fitness to Practice enquiries from PAPCs have increased by around 6.5% a year since 2006, driven by a rise in enquiries from Primary Care organisations, Primary Care agencies and regulatory bodies (the GMC).

- Increases in Fitness to Practise referrals are thought by medical directors to be attributable to a changing ethos amongst management and staff in the NHS. This includes the introduction of clinical governance systems and procedures for reporting incidents. It has also led to recognition amongst medical colleagues that performance concerns should be highlighted. A change in public attitude is also an issue, driven in part by awareness of some high profile cases.

- Medical Directors face uncertainty and conflicting priorities when making referrals to the GMC, since a referral can have a negative impact on a doctor's career. This is particularly in cases where professional competency is the key concern, rather than behavioural misconduct or criminality, which would almost certainly lead to a referral.

- An increased sense of relationship with the GMC would help overcome this uncertainty, and provide desired reassurance to referrers. This would be most helpful in an informal setting where discussion could take place between referrers and the GMC around specific cases and on Fitness to Practice issues more generally. This is currently provided in the form of Employer Liaison, which is valued by those who have access to it.

- Additional desired support for referrers includes training and guidance on Fitness to Practise.

Annex 1 : Characteristics of the quantitative research sample

Ninety-four medical directors were interviewed during the quantitative research. This section provides an overview of the characteristics of the interviewed sample.

Areas of responsibility

All medical directors were asked whether they were responsible for overseeing any of the procedures shown in chart 22. The vast majority (93 per cent) said that they were responsible for the quality of patient care.

Chart 22. Responsibility for overseeing specific procedures
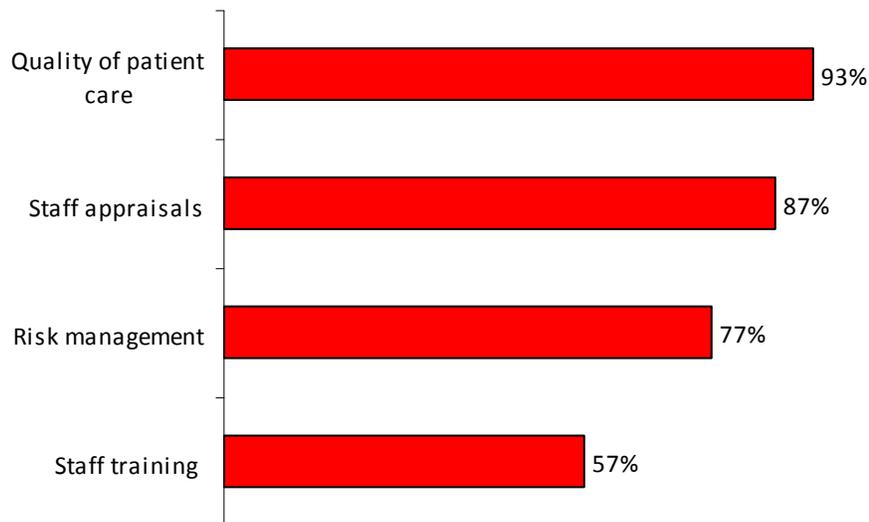
Base: All (94)

Length of time in post

Chart 23 shows that the medical directors included in the sample reported having been in their current post for a variety of lengths of time, with an average of 6.2 years.

Chart 23. Length of time in current post

Category	Percentage
Less than 1 year	5%
1 year but less than 3 years	34%
3 years but less than 5 years	19%
5 years but less than 10 years	24%
10 years but less than 15 years	6%
15 years or more	11%
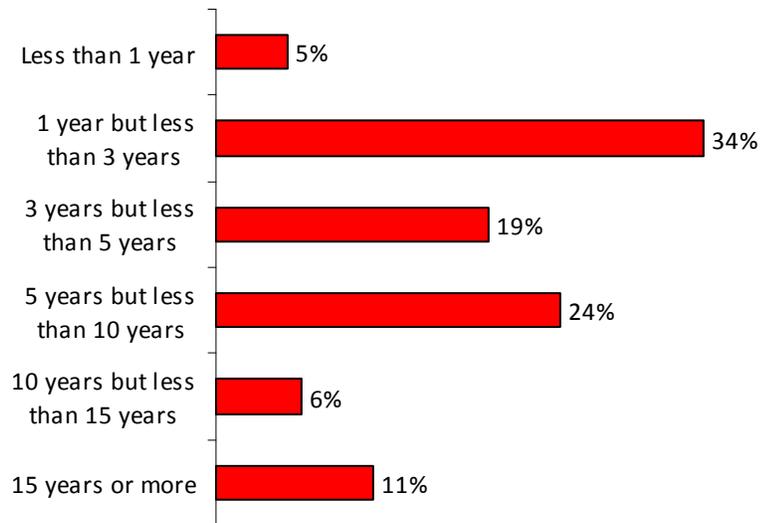
Base: All (94)

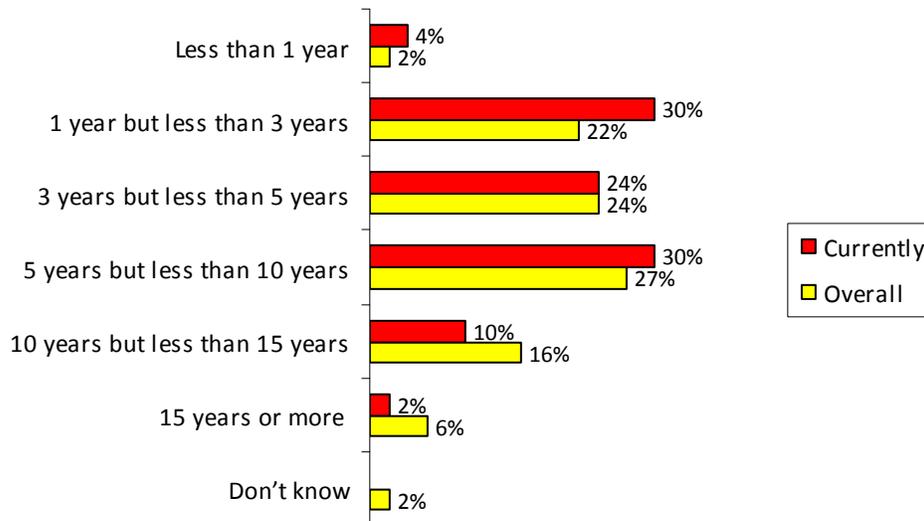Similarly, chart 24 shows the length of time that medical directors had spent to date in a post which has involved making Fitness to Practise referrals, both at their current NHS Trust, and overall.

Chart 24. Length of time in a post which has involved making Fitness to Practise referrals to the GMC (current and overall)
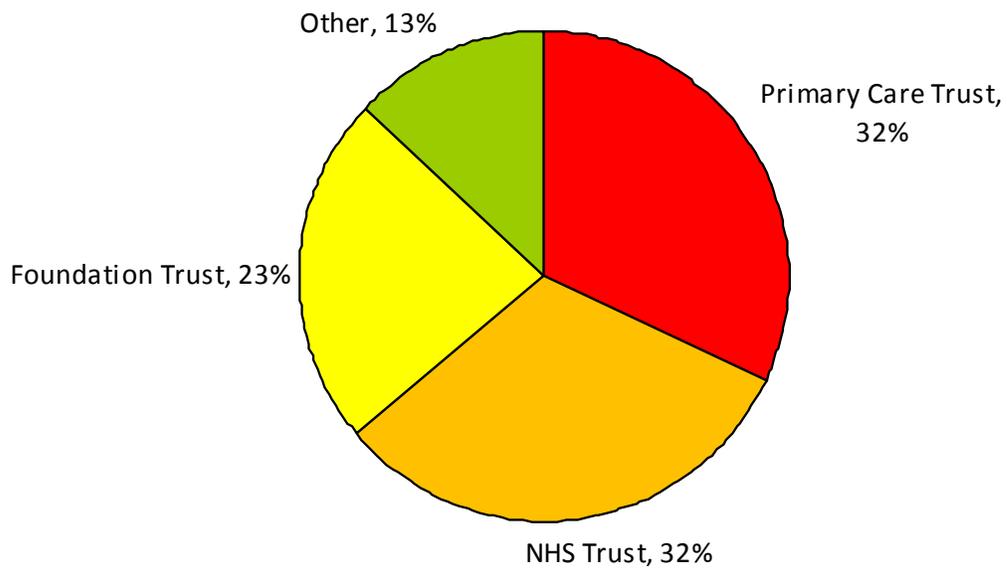

Base: All (94)

Types of Trust medical directors worked for

As shown by chart 25, a third of the sample of medical directors worked for Primary Care Trusts (32 per cent), the same proportion for NHS Trusts (32 per cent) and a quarter for Foundation Trusts (23 per cent).

Chart 25. Type of Trust medical directors worked for

Base: All (94)

Annex 2 : Analysis of data extract from Seibel (CRM) system

Introduction

An extensive set of analyses were carried out on a data extract from the GMC CRM system. Key results are presented in the main report. This Appendix presents more details of the methods used and some of results that were omitted from the main report on grounds of space or relevance. For the most part, material from the main report is not repeated here, so the Appendix should not be seen as a stand-alone report on the data analysis.

There are three sections covering:

- Basic data handling and coding issues.

- Supplementary material from the analyses of which organisations contributed to the increase in enquiries.

- Work on preliminary hypotheses carried out when the project focus was to understand the differences between 2008 and 2009.

Basic data handling and methods of counting

Record handling and basic counts

Data for the preliminary analyses were received on January 26th. 2011. The main worksheet contained 37,081 records covering enquiries opened between April 2006 (the start of use of the Seibel system) and October 2010. The numbers of records per year are shown below. The first point to note is that despite the general trend for the numbers to increase, there are less records for 2008 than 2007.

Table 1 – Numbers of records in the CRM dataset supplied to the project

Year	2006 (Apr-Dec)	2007	2008	2009	2010 (Jan-Oct)
Number of records	5,439	7,404	7,240	8,632	8,366

These numbers are the records in the dataset, not the numbers of enquiries. As each enquiry could generate more than one record, we used the unique enquiry code to count the number of records per enquiry: 11,769 enquiries were represented by a single record, 11,349 had two records, 509 had three and the remainder (257) four or more.

This method produced annual totals different from those published by the GMC because the GMC annual statistics refer to the number of completed triages per annum and is not static data, whereas our figures are the numbers of new enquiries. The latter will be smaller because the number of triages is based on the number of doctors and there can be more than one doctor cited in each enquiry.

For the present project it was agreed with the project commissioners that the number of (new) enquiries would an appropriate basis for analysis.

Table 2 Numbers of new enquiries per year

	All year	Jan-Oct	Apr-Dec
2006	3460*	2755*	3460
2007	5008	4235	3697
2008	4816	4164	3642
2009	5350	4413	3939
2010	5248*	5248	3778*
Total	23882	20815	18516

These counts are incomplete as the data covers April 2006 to October 2010

When aggregated by enquiry ID, the total number of enquiries in the data is 23,882. As the data runs from April 2006 to October 2010, numbers of enquiries for full calendar years can only be compared for 2007-9. So Table 2 also shows counts for the last 9 and first 10 months of each year. Again, it is worth noting that in all these counts the figures for 2008 are less than for 2007; and in the Jan to October counts (including all the data we have for 2010) the largest increase in volume is not between 2008 and 2009, but 2009 and 2010. From more detailed monthly breakdowns it appears that numbers were low in the last 2 months of 2008, causing us to speculate whether some of that caseload was recorded in 2009.

Whatever the reason, the temporary drop in 2008 will contribute to the 2008-9 increase appearing unusually high.

As the method of counting will also influence the scale of the difference, Table 3 compares the numbers based on completed triages and new enquiries.

In the GMC figures (based on completed triages) there is an increase of 136 PAPC sourced enquiries between   2007 and 2008 and an increase of 402 between 2008 and 2009. Our estimates of the increases for the same periods (based on new PAPC sourced enquiries) are 138 and 323. Our 10 month figures (which allow us to include 2010) show

increases of 104 and 211 for the same pairs of years and 261 for 2009-2010. So the 2008-9 increase is less than that for 2009-2010.

Table 3 Numbers of closed triages (GMC figures) and our estimates of the number of new enquiries – by year

	2006	2007	2008	2009	2010
Closed triages (1)	5085	5168	5195	5773	X
Closed triages from PAPC (1)	394	492	628	1030	X
New enquiries: all year (2)	X	5008	4816	5350	X
New enquiries from PAPC: all year (2)	X	472	610	933	X
New enquiries: Jan-Oct (2)	X	4235	4164	4413	5248
New enquiries from PAPC: Jan-Oct(2)	X	399	503	714	975

X = figures incomplete or unavailable

Sources:

(1) GMC Annual Fitness to Practice Statistics - 2009 (Table 2)

(2) PD analysis for GfK

This re-computation suggests several factors that may lead to the high 2008-9 difference reported by the GMC

- Some of the workload from the end of 2008 may have been counted in 2009 and the unusually low figure for 2008 will inflate the difference with 2009.

- Counting closed triages, rather than numbers of enquiries, will always lead to higher figures than counts of new enquiries – though this effect is less for PAPC sourced enquiries than most other types, since PAPC sourced enquiries usually involve a single triage.

- When we count new enquiries (rather than closed triages), the increase between 2008 and 2009 in those initiated by PAPCs 2008-2009 is less striking.

- Annual counts based on closed triages, rather than new cases may be more susceptible to fluctuations in case handling within the GMC – though this effect should be negligible as triages should be completed within four weeks of the start of the enquiry.

The second effect that may influence the 2008-9 difference is the change in the use of the PAPC code.

Changing Use of the PAPC code

Enquiries initiated by bodies such as provider trusts, health authorities and PCTs are almost all coded as being sourced by a PAPC or a "Public (Organisation)". Lloyd-Bostock (2009) notes that these codes seem to be used interchangeably. We investigated whether the relative use of these two codes has changed over time and whether some of the increase in the number of PAPC enquiries might be due to a change in coding.

Figure 1 (based on a subset of the data in table 4) shows there have been dramatic changes in coding practice. For example, in 2006 approx 30% of enquiries from Foundation Trusts and Health Authorities that were either coded as Public (Organisation) or PAPC were coded "PAPC". By 2010 the Public Organisation code was very rarely used for these organisations and 94% of these were coded "PAPC".

We were unsure whether the PAPC versus "Public (Organisation)" distinction might reflect differences in the roles and responsibilities of people initiating the enquiries, but were unable to find any evidence for this – and have to conclude that there has been a major change in coding practice.

Figure1 Changing use of the PAPC code to describe the source of enquiries from 4 types of organisation
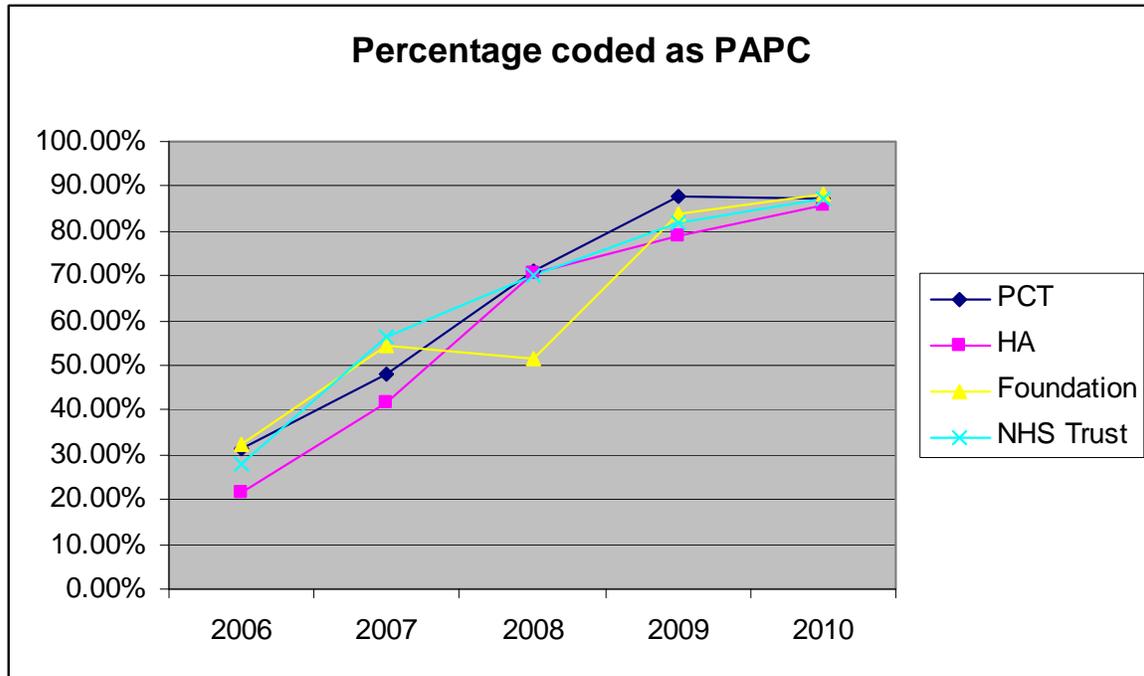
Percentage coded as PAPC

Table 4 Enquiries coded PAPC from these types of organisations as percentage of enquiries coded either PAPC or "Public (Organisation)"

Data from first 10 months of each year

	2006*	2007	2008	2009	2010
	Percentage of enquiries coded as PAPC rather than Public Organisation				
Foundation Trust	32%	62%	59%	88%	94%
Health Authority	28%	50%	76%	87%	93%
NHS Trust	35%	62%	77%	94%	92%
Police	2%	43%	74%	71%	72%
Primary Care Trust	21%	44%	81%	87%	90%
Regulatory Body	43%	65%	84%	95%	99%
Statutory Body	24%	51%	79%	78%	54%
Trust Headquarters	33%	50%	96%	93%	94%
Unspecified	25%	38%	33%	39%	47%

*2006 data starts from April – only April to September have been used for 2006

This change in the use of the PAPC code will partly explain the large 2008-9 increase in two ways:

- The continuing increase in the use of the PAPC (rather than the "Public (Organisation)") code between 2006 and 2010 is bound to inflate the differences between any two years.

- The dip in the use of PAPC rather than "Public (Organisation)" for Foundation Trust initiated enquiries in 2008 will also inflate the 2008-9 differences

The more general implication is that because the "PAPC" code has increasingly replaced "Public (Organisation)" when coding organisations such as hospital trusts and regulatory bodies from 2006-2010, presenting figures for PAPC in isolation will confuse referral trends with trends in coding.

Hence we recommend that any comparative statistics over this period should not use the category PAPC and results should only show figures for PAPC and "Public (Organisation)" combined.

Numbers of GMC initiated enquiries

When we examined the types of organisation that initiated more PAPC sourced enquiries in 2009 than 2008 we found that the largest increase was due to "Regulatory Bodies": from 47 in 2008 to 128 in 2009. The GMC was responsible for almost all of these: 46 in 208 and 124 in 2009.

From the figures for the first ten months of 2007-2010 (Table 5), it looks as though the numbers of these types of GMC referrals were steady in 2007-8 and increased to a higher level for 2009-10. This makes a substantial contribution to the PAPC increase between 2008-9: accounting for approximately 35% of the total.

Table 5 Numbers of GMC (PAPC) initiated referrals in first ten months of 2007-2010

	2007	2008	2009	2010
GMC	34	36	110	127

Overall influence of PAPC coding and procedural effects.

After taking account of these various coding and procedural effects, and looking at the 2008-9 increase in the wider context of trends from 2006 and 2010, we concluded that there had not been an exceptional increase between 2008-9 in enquiries initiated by PAPCs and "Public Organisations" and that the 2008 figures are consistent with the overall trend.

Basic data handling and methods of counting

Most of the main findings from these analyses are presented in the main report. This section of the Appendix provides three types of supplementary material

- More information on the coding of organisations and the recoding we carried out before the analyses

- A table of the full year figures – showing the numbers of new enquiries from each type of organisation. The main report concentrates on figures for the first ten months of each year.

- Some details of the simple linear modelling used to estimate the rate of change of enquiries initiated by different types of organisation.

Coding of organisation type

While exploring these data, we became interested in how the "organisation type" codes had been applied: for example, what types of organisation had been coded as "Health authorities" or NHS Trusts. We investigated the coding of those groups of organisations that initiated most enquiries.

We found that at least 30% of the NHS Trust entries in the organisation type field had been miscoded: 340 of the 1153 records where the organisation was described as an NHS Trusts were either Primary Care Trusts (which is a separate category) or Primary Care Support Agencies. We have recoded the organisation type in these cases and introduced a new category for Primary Care Support Agencies.

By 2010, another category "Health Authority" emerges as a higher volume referrer, initiating 92 enquiries in the first 10 months. Examining the names of the organisations that are given this code we find 19 PCTs (for which there is a separate code) and others including Welsh LHBs, a firm of solicitors and hospital trusts. Some of the types of organisation coded as "Health Authority" as shown in Table 6. We have recoded the PCTs, but given the variety in the remainder we recommend that any results for the "Health Authority" code are ignored.

Table 6 Types of organisations coded as "Health Authorities" in the data provided

PCTs	19
Local Health Boards (Wales)	41
FHSA and other entries incl "Family"	56
Hospitals	13
Other	130
All	259

In the earlier discussion of the changing use of the PAPC code, we argued that analyses of the changing pattern of enquiries from public bodies should use a combination of records with the PAPC and Public (Organisation) code because the use of the codes had changed. As we further explored the coding, we are now think that there are some analyses where it would by unwise to limit the selection in this way. For example, 6% of records referring to PCTs had source type codes that were neither PAPC nor Public (Organisation). As a result, and where possible, we have tried to choose appropriate filters for our analyses.

What types of organisation initiate enquiries – and is the pattern changing – supplementary figures

The numbers of new enquiries for the three years for which we have full data are shown in Table 7. Looking are the figures in the Table we find:

- Of the types of organisation making the highest volume of enquiries, NHS Trust and Police figures remained roughly constant between 2008 and 2009 – though there would be a small increase in overall referrals from Trusts if the Trust Headquarter figures are added to the NHS Trust figures.

- The largest increases amongst the higher volume organisations between 2008 and 2009 were in enquiries from PCTs and regulatory bodies.

- Proportionately large increases amongst the smaller volume referrers between 2008 and 2009 were noted for Deanery, Foundation Trusts, Locum Agencies, Primary Care Agencies and Private Health Organisations

Table 7 Numbers of new enquiries by organisation and year (full year data)

Coding algorithms have been used to recode PCTs, Health Authorities and introduce a new group: Primary Care Agencies.

	2007	2008	2009
Blank	337	308	282
3rd Party Solicitor	20	16	15
Education – Deanery	3	9	26
External Solicitors	35	48	67
Foundation Trust*	33	31	62
Government Dept	13	41	13
Health Authority	36	41	48
Locum Agency	5	11	22
NHS Trust*	182	180	172
Other	87	86	115
Police	148	172	179
Primary Care Agency	12	5	41
Primary Care Trust	87	90	147
Private Company	10	22	32
Private Health Organisation	22	9	25
Regulatory Body	38	47	128
Statutory Body	64	50	39
Trust Headquarters*	18	30	59
Unspecified – mostly private individuals	3858	3620	3878
Total	**5008**	**4816**	**5350**
*All Trusts (Foundation, NHS + HQs)	233	241	293

Changing numbers of enquiries initiated by organisations: trends over time expressed as rates of change

Section 3.3.2 of the main report discusses the numbers of enquiries initiated by different types of organisation. To explore the strength of any trends over time we fitted linear statistical models to the first 10 months figures for 2007-2010. The results had to be treated with caution not least because:

- only 4 data points are modelled

- many of the numbers are small and vary substantially from year to year

- the underlying trend may not be linear.

For these reasons the full details of the models and associated correlation coefficients are not presented here.

However, the results helped us identify eight moderate to high volume referrers where the changes in the number of referrals most closely approached linearity during the period studied. For these agencies we have computed an approximate measure of change (increase or decrease in the number of referrals) based on the slope of the best fit straight line.

Results are shown in Table 8 where, for example, for PCTs it can be seen that there was an average of 109.8 referrals per year across the first 10 months of 2007-2010 and that these increased by just under 34 per year – or approximately 31% of the average ten monthly rate.

More generally in Table 8, we see that the highest increase in the number of referrals was found for PCTs, Regulatory Bodies and the combination of NHS and Foundation Trusts and Trust Headquarters. However the fastest rates of changes were recorded for Primary Care Agencies and Deaneries.

Table 8 Rate of change in numbers of referrals – by organisation type

Limited to higher volume referrers with best approximation to a linear trend across 4 ten month data points 2007-2010.

Organisation	Average N per 10 months	Rate of change (N per 10 months)	Change as % of av value
Education - Deanery	14.0	7.4	52.9%
External Solicitors	42.5	7.6	17.9%
Foundation Trust	43.8	14.5	33.1%
Primary Care Agency	23.8	16.3	68.6%
Primary Care Trust	109.8	33.9	30.9%
Regulatory Body	80.0	36.2	45.3%
Statutory Body	38.5	-7.8	-20.3%
Trust Headquarters	35.0	14.4	41.1%
All trust	226.8	29.1	12.8%