Note of the Meeting on 4 December 2015

Members present
Professor Iqbal Singh, Chair
Association of Pakistani Physicians and Surgeons UK (APPS UK)
British International Doctors Association (BIDA)
Pakistan Medical Association UK
British Association of Physicians of Indian Origin (BAPIO)

Association of Pakistani Physicians and Surgeons UK
BIDA
British International Doctors Association

Others present
Niall Dickson Chief Executive Officer
Willie Paxton Employee Liaison Advisor
Anna Rowland Assistant Director, Fitness to Practise
Andrea Callender Head of Diversity
Fionnula Flannery Policy Manager, Standards
Elaine Bromberg Equality and Diversity Manager (Note taker)
Aishnine Benjamin Equality and Diversity Manager (Note taker)


Item 1: Welcome and Introductions

1 Professor Singh opened the meeting. He welcomed existing members, and introduced new members to the group.

Item 2: Matters arising from the meeting on 7 July 2015

Suicides review

2 Action 2.0 from the last meeting was for BAPIO to write to Niall Dickson, inviting the GMC to consider calling for a national inquiry into doctors who commit suicide. It was agreed to defer this item until the next meeting as the individual was not present.

Action 2.0: Consider an update on this item at the next meeting.

3 Niall Dickson said that the GMC has already made considerable progress in implementing the recommendations of the Horsfall review*. He referred to the safeguards that are already in place to support vulnerable doctors, and said that the regulator will do as much as it can within the parameters of the regulatory role.

4 One of the report’s recommendations was to change the language and tone of the letters which go out to doctors as part of our investigations. New letters will be introduced early next year following a review which involved the BMA, the medical defence organisations, and the Practitioner Health Programme.

5 Niall also announced the appointment of Professor Louis Appleby, one of the UK’s leading mental health experts, to provide independent advice on how we can improve our procedures when dealing with doctors who may be at risk of taking their own lives. Professor Appleby will review each stage of the GMC’s investigation process to identify what further changes could be made to support vulnerable doctors.

6 The GMC is helping to facilitate the wider conversation about a national support service for vulnerable doctors. Although the regulator will not run this service, it is bringing together some of the key providers and other interest groups to explore the way forward.

7 Professor Appleby’s appointment was welcomed by the Forum. Members noted the existence of the Doctor Support Service run by the BMA, which is providing support in a number of ways, including for those doctors involved in fitness to practice procedures with the GMC/MPTS. It was felt that this scheme is not a substitute for support at a local level, and there is a need to promote other support initiatives, including those being run by Colleges or LETBs. For example, the Royal College of

* Doctors who commit suicide while under GMC fitness to practise investigations, GMC December 2014
Psychiatrists runs a free and confidential support and advice service for members, trainee members and associates of the College who find themselves in difficulty or in need of support. MANSAG also provide a support service for doctors.

8 Members acknowledged the significant progress that the GMC has made in this area, but agreed that doctors may not be aware of this work. It was suggested that the GMC needs to give some thought to how it might raise doctor’s awareness of the positive steps being taken by the regulator. Members also asked about how they could contribute to Professor Appleby’s review. It was agreed to invite him to provide an update at a future meeting of the Forum.

**Action 2.2:** Invite Professor Louis Appleby to provide an update on his review at a future meeting of the Forum (Anna Rowland).

**Action 2.3:** Re-circulate the evaluation report for the Doctors Support Service. *(Secretary’s note: this is available on the GMC website - full evaluation report regarding the Doctor Support Service)*.

9 Action 2.1 from the last meeting was to clarify the data that forum members would like to receive from the GMC, including the statistics for responsible officers (ROs) and medical directors (MD) referred to the GMC.

10 Andrea presented a report on the referrals of ROs and MDs to the GMC since 2006 (when the GMC started recording this information). This report is provided as an annex. She pointed out a number of caveats to be aware of in reflecting on the data provided:

- **a** Some of the numbers involved were very small and could not be provided in line with data protection principles. Some of the cases are still ongoing.

- **b** The data includes any doctor that has held the role of MD or RO at any time. This means that some of the complaints may not relate to doctors acting in these roles.

- **c** It is difficult to draw any conclusions from the data because the wider comparators are not available (and the numbers are very small in some instances). For example, the GMC does not hold the data on the numbers of MDs employed in the UK. When doctors are referred to the GMC it is noted at that point if they are medical directors.

11 The figures indicate that since 2006 there have been 15 cases related to bullying and harassment by 14 ROs. Of these cases 13 were concluded and 2 were concluded with advice. We cannot report on the ethnicity of the ROs who have been referred to the GMC for bullying and harassment because the numbers are too small, and the doctors could be identifiable.
12 Members asked whether the GMC has additional background information (such as medical staff complaints about these ROs and MDs) that might help in interpreting this data. Andrea explained that the regulator does not have access to this type of local information. She added that the data also does not provide information about RO/MD behaviour such as whether the RO or MD has referred more BME doctors to the GMC than white doctors.

13 Members asked whether the profile of these referrals corresponds to the wider profile of referrals for bullying and harassment, and whether there is any data available on medical staff referring these categories of doctors to the GMC. The underlying issue is about trying to address the perception that MDs and ROs are dealt with differently by the GMC when concerns are raised about them.

**Action 2.4:** Look at whether this data correlates with the overall profile of doctors referred to the GMC (Anna Rowland).

14 Action 3.1 from the last meeting was to provide data on the numbers of successful and unsuccessful applications and the number of appeals to join the GP and specialist register, broken down by speciality and ethnicity (Clare Barton).

15 This information has been circulated to members. There will be time on the agenda for the next BME Doctors forum meeting to discuss this and other registration and revalidation matters of interest to members.

**Action 2.5:** Members to email the GMC with any comments and questions on the data which will be used to inform the discussion at the next meeting (All).

**Action 2.6:** To schedule time on the agenda to discuss issues related to revalidation and registration (Andrea Callender).

**Item 3: Fitness to practise update**

16 Anna presented an update on developments in fitness to practise and progress in implementing the extensive programme of reforms. She highlighted a number of changes aimed at streamlining the processes and reducing the time and stress for the doctors involved.

17 There are a number of additional safeguards to ensure that only those doctors who need to be in our procedures are referred in to the GMC and investigated, including the following:

- The introduction of Employee Liaison Advisors (ELAs) that is helping to reduce unnecessary referrals and investigations through their work with MDs and ROs at local level.
Improvements to the process for complaints from patients include changes to the complaints form to help direct complaints to the right place.

Stream 2 complaints are now closed and referred to the RO.

Enhanced use of provisional enquiries before complaints go through to investigation. This avoids the need for an investigation to be opened in about 250 cases a year and for those cases reduces the length of the process significantly and avoids the stress of a formal investigation. There are a number of initiatives planned for 2016 to build on this work, including the following:

- Targeting the use of provisional enquiries for single clinical incidents to avoid doctors unnecessary investigations in these cases.
- Supporting doctors that have raised patient safety concerns locally. NHS trusts will be required to complete a referral form that includes a question about whether the doctor being referred had previously raised concerns locally and if the Trust had taken action.

Cases in full investigation

There are also a number of reforms being implemented that will affect cases in the investigation stage:

- A fundamental review of the process for dealing with concerns about sick doctors. This will be overseen by Professor Appleby as part of the suicide review work.
- We have reviewed the tone of our communication with doctors who are under investigation. This includes revising the content of the letters we send to doctors.
- We continue to fund free, confidential emotional support services for doctors in our procedures provided by the BMA.
- We are considering mechanisms for earlier discussions with doctors during an investigation to improve our understanding of the issues early on, to support faster resolution. In appropriate cases doctors are currently invited to meet with Case Examiners at the end of the investigation to discuss the evidence required from the doctors. This reduces the number of cases that go on to hearings.
- We are moving towards review hearings being done on paper, rather than face to face where the doctor agrees with the proposed outcome.
- This year we ran a public consultation on what information we publish and disclose about the decisions made by fitness to practise and interim orders panels. Sanctions are currently published indefinitely. The proposals are for more

www.gmc-uk.org
proportionate time limits. Anna finished her presentation by stating that our vision for the future is about a greater role for local systems, particularly around performance cases. For example more handling and remediation at a local level.

19 Niall Dickson noted that we are trying to transform an inherited system that was far from ideal, attracting too many complaints. There is often a gap in expectations that is difficult to close. Many patients feel that the GMC is a complaints body that will punish doctors, which is not our remit, although some of our actions are punitive. He reiterated our commitment to speeding up the process for everyone involved, and the Section 60 changes give us a platform to do this. The S60 also gives a statutory basis to the MPTS role, giving confidence of the impartiality of hearings. The GMC can now appeal the decisions made by panels, which reinforces the MPTS’ independence from the regulator.

20 Members asked about the shorter timeframes for an investigation. Niall said that 90% of cases are dealt with in 6 months. Anna added that an average investigation lasts 245 days, and provisional enquires take an average of 160 days. The new letters going out to doctors being investigated will include information about the circumstances that can prolong an inquiry, any police involvement, any new information provided at later stages of the investigation, and the time it takes to acquire medical records.

21 A comment was made that medical defence organisations often advise doctors not to respond or give information to the GMC when they are being investigated. Members also raised concerns about doctors being investigated at local level where the MDs and ROs might not be consistent or fair in their approach. Another issue is where there may not be satisfactory arrangements in place to deal with inquiries at a local level. The group discussed the role of the RO and whether they should have more or whether the GMC should take more responsibility for monitoring their actions and decisions. It was suggested the period of time that investigations take may be linked to suicide of doctors under investigation. The numbers of cases are too small to assess, however the GMC acknowledges the stress caused by delay and is focusing on streamlining the process as far as possible.

22 Members discussed whether closing cases when the doctor has agreed a specific sanction provided enough scrutiny of the evidence in an open hearing. The suggestion was also made that doctors may feel pressured to accept sanctions. Anna responded that this is a risk of any consensual system but given the stress of hearings it must be right to give doctors a choice and ensure that the GMC process does not place pressure on doctors to consent. Anna reiterated that these are ongoing long-term projects and that we will put in place as many safeguards as possible, for example, in the meetings with doctors, doctors are encouraged to bring representation and are given warnings about the dangers of incrimination both before and during those meetings.
23 Several members welcomed the new diagram providing an overview of the fitness to practise process that was included as part of the presentation.

**Action 3.2:** To share this diagram with forum members and their networks via email (Anna Rowland).

24 Members made suggestions for how the GMC could promote what it does and improve the understanding of patients and doctors about its role and how it deals with complaints. Niall acknowledged the issue, and welcomed any suggestions around how to get the messages across more effectively.

25 In response to a question about unrepresented doctors being at a disadvantage when at MPTS hearings, Niall explained that currently legal assessors play a role in supporting those doctors and that legally qualified chairs will do so in future. It was suggested that the GMC could provide information about where to find representation to doctors that are unrepresented.

26 Members discussed the increase in complaints against doctors by doctors, and how it would be helpful to understand which doctors (by grade, age, gender, and ethnicity) are complaining. Niall clarified that the GMC wanted doctors to raise concerns in relation to creating a culture where serious incidents are avoided, and that doctors had been encouraged to this through the confidential helpline. He recognised that there could be malicious complaints, and that these would be considered as part of the Hooper Review.

**Action 3.4:** To consider if it would be possible/useful to break down the data about which doctors (by grade, age, gender, and ethnicity) are complaining about other doctors. (Anna Rowland)

### Item 4: Confidentiality – consultation on our draft guidance

27 Fionnula Flannery provided an overview of the consultation on the revised guidance on confidentiality which ends in January. Members considered the following case study:

> Dr M is treating Patient O, a 21 year old woman with a long-term history of depression that is poorly controlled by medication. O does not always get on well with her step-brother and sister, her only relatives.

> Today, Dr M has received a telephone call from O’s brother. He saw O yesterday and was concerned about her state of mind - she seemed to be having suicidal thoughts. He wants to know whether O’s medication has been changed recently and whether this is contributing to her illness.
The key points raised by members were as follows:

a. Members recognised this as a common situation faced by doctors in both GP and hospital settings. It was felt that a balance needs to be struck between protecting confidential patient information and sharing information appropriately.

b. The patient is the first priority and it is important to speak to the patient at the outset.

c. Members suggested that they would establish the facts and evidence of the case and look at the broader picture to identify whether the patient (or anyone else) might be at risk.

d. Patients are culturally diverse and this has a bearing on how a patient might wish to involve their family in decisions about their care. It is important to establish in this situation whether the patient has given consent for a family member to advocate on their behalf. The prevailing view was that until this has been established no information should be disclosed to this family member.

Action 4.1: Circulate the link to the Confidentiality consultation for members to forward on to their networks and encourage them to respond.

Item 5: Matters forum members wish to raise

Values based leadership

A short presentation was given by a member on values based leadership and its impact on patient safety and professional regulation. He summarised the work that his trust (Wrightington Wigan and Leigh Foundation Trust) has undertaken during the last 5 years. He explained that the values, culture and governance of the trust have been transformed by applying the principles of values based leadership and working with the Trust Board and Chief Executive. For example, staff survey feedback has improved by 33% and all 22 quality measurements have shown improvement. Dr Prabhu also presented data that showed that patient harm had been reduced by 87% and informed that the Trust had been visited by a number of senior health and healthcare leaders in recognition of its achievements. All leaders now have values based discussions, and more time is spent supporting junior doctors.

The member said that if leaders and managers creating positive, supportive environments for staff, translated into staff creating caring supportive environments for patients and delivering higher quality care – and he reiterated the view that leadership is the most influential factor in shaping culture, and that harnessing this to implement a raft of changes across his trust has led to a more open culture where staff feel able to raise concerns.
Niall Dickson noted that the National Training Survey shows that 85% of doctors feel that their training is good. More recently 98% of junior doctors voted in favour of a full strike, and that indicates that this group might be less engaged. He suggested (and members agreed) that the level of clinical engagement demonstrated by the work is not replicated across other trusts, and it may be helpful to share the learnings with other organisations. Niall said that leadership is a challenge facing all healthcare organisations and is a key focus for discussion amongst healthcare leaders.

**Action 5.1:** Circulate the slides from presentation to members. (E&D team)

**Differential Attainment**

This item was not fully discussed due to lack of time. The GMC held a meeting with members of BME doctors’ forum on the 9 November 2015 to update on progress with the work programme to address the variations in performance for some cohorts of doctors on postgraduate examinations. A note of that meeting will be circulated separately.

The BMA also ran a workshop in November on differential attainment looking at progress since its symposium last year. It appears that colleges are still in different places on this issue – some are just beginning their work, whilst others have made progress and are developing activities such as unconscious bias training for examiners. Niall said that he will be writing to colleges to understand the progress that they are making in this area.

**Item 6: Any other business**

Members suggested that the GMC give some thought to how ethnicity and primary medical qualification data are analysed and presented to the group. This would recognise that the data for an ethnic group could be very different if broken down by UK and non-UK qualified categories, for example, UK qualified Pakistani doctors, and Pakistani doctors who qualified in Pakistan.

**Action 6.1:** To consider breaking down PMQ data into additional ethnicity categories. (Anna Rowland and Andrea Callender)

**Action 6.2:** Members to contact the GMC with suggested agenda items for the next meeting. (All)

Following on from Fionnula’s presentation, members suggested that consultations of this type should be promoted as opportunities for development/enabling a doctor to reflect on their practice. Taking part in a consultation might even be seen as something a doctor might include in their CPD portfolio. It was thought that this would really help to encourage more individual doctors to respond.
Members briefly discussed the best way of making the notes of these meeting more widely available to their networks and other interested parties. Andrea explained that a redacted note of the meeting (with individual names removed) is published after each meeting on the GMC website.

**Action 6.3:** It was agreed that the GMC would circulate the full note of the meeting, and a redacted version, in a pack with all the relevant data presented at the meeting, so that members can easily circulate to their networks where appropriate.

Aishnine notified members that from January the GMC will be collecting data from registrants on disability, sexual orientation and religion and belief. This is to help the regulator to understand the profile of the profession in terms of the other protected characteristics and the impact of its activities from doctors from these groups.

Niall Dickson drew attention to the key priorities for the GMC’s work in 2016. These include:

a  Consultation and engagement activity for the Confidentiality guidance.

b  The work being led by Professor Louis Appleby.

c  A review of revalidation as we approach its third anniversary.

d  Work to implement the right of appeal for the GMC against decisions made by MPTS panels.

e  Reflecting the healthcare agenda for each of the 4 countries, given that UK wide regulation is a challenge.

f  Embarking on the consultation for a single assessment for all doctors practising in the UK.

**Date of the next meeting:** To be confirmed.
Annex A: ROs and MDs referred to the GMC

1 The data presented in this report is from 2006 (when the GMC started recording this information) to date. We have not reported this data in percentages due to the very small numbers of doctors involved.

2 This report provides the following data:

   a The numbers of ROs and MDs referred to the GMC since 2006, broken down by ethnicity and gender.

   b The number of ROs and MDs referred to the GMC for bullying and harassment.

   c The overall figures on the outcomes of those cases.

Please note:

3 We are unable to provide some of the data in the format of a table (particularly around case outcomes broken down by ethnicity) because some of the numbers are very small, which means that the doctor could be identifiable. Also because some of the cases are still open/ongoing.

4 The data includes any doctor that has held the role of medical director or responsible officer at any time. This means that some of the complaints may not relate to doctors acting in their MD or RO role.

5 The GMC does not hold the data on the numbers of doctors that are in medical director roles. When doctors are referred to the GMC it is noted at that point if they are medical directors.
Medical Director Data

Enquiries

6 The table below shows the number of medical directors referred to the GMC since 2006, broken down by ethnicity and gender.

Table 1: MDs referred to the GMC- 2006 to 31 October 2015

<table>
<thead>
<tr>
<th>MD ethnicity</th>
<th>Man</th>
<th>Woman</th>
<th>Number of triages</th>
<th>Number of doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian or Asian British</td>
<td>48</td>
<td>7</td>
<td>55</td>
<td>25</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>8</td>
<td>0</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>Mixed</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Other Ethnic Groups</td>
<td>5</td>
<td>0</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Unspecified</td>
<td>59</td>
<td>5</td>
<td>64</td>
<td>37</td>
</tr>
<tr>
<td>White</td>
<td>393</td>
<td>64</td>
<td>457</td>
<td>241</td>
</tr>
<tr>
<td>Grand Total</td>
<td>515</td>
<td>77</td>
<td>592</td>
<td>312</td>
</tr>
</tbody>
</table>

Cases

7 There have been 167 cases about 135 medical directors since 2006. None of these cases has led to erasures, referrals to FTP panels, suspensions, conditions or undertakings being applied, or voluntary erasures.

8 During the same period there were

a 16 cases about 13 Asian or Asian British doctors

b 131 cases were about 105 White doctors

c 17 cases about 14 doctors that we do not have ethnicity data for.

9 The numbers are too low to report on the other ethnic groups.
The outcomes for all of the cases against medical directors are as follows:

a. Cases concluded: 134
b. Cases concluded with advice/ warnings issued: 18
c. 12 cases are currently ongoing.

Bullying and harassment

There have been 23 cases about medical directors related to bullying and harassment. Of these 22 cases were about male doctors. We cannot report on the ethnicity break down of these medical directors as the numbers are too small. All of these cases were concluded or concluded with advice.

Responsible Officer Data

Enquiries

The table below shows the number of ROs referred to the GMC since 2006, broken down by ethnicity and gender.

Table 2: ROs referred to the GMC between 2006 and 31 October 2015

<table>
<thead>
<tr>
<th>RO ethnicity</th>
<th>Man</th>
<th>Woman</th>
<th>Number of triages</th>
<th>Number of doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian or Asian British</td>
<td>28</td>
<td>6</td>
<td>34</td>
<td>23</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>15</td>
<td>0</td>
<td>15</td>
<td>6</td>
</tr>
<tr>
<td>Mixed</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Other Ethnic Groups</td>
<td>11</td>
<td>0</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>Unspecified</td>
<td>63</td>
<td>26</td>
<td>89</td>
<td>41</td>
</tr>
<tr>
<td>White</td>
<td>292</td>
<td>62</td>
<td>354</td>
<td>193</td>
</tr>
<tr>
<td>Grand Total</td>
<td>410</td>
<td>95</td>
<td>505</td>
<td>269</td>
</tr>
</tbody>
</table>
Cases

13 There have been 170 cases about 121 responsible officers since 2006. None of these cases has led to erasures, referrals to FTP panels, suspensions, conditions applied or voluntary erasures.

14 The breakdown of these cases is as follows:

a 15 cases about 12 Asian or Asian British doctors

b 112 cases about 88 White doctors

c 41 cases about 19 doctors that we do not have ethnicity data for.

15 The numbers are too low to report on the other ethnic groups.

16 In all of these cases the outcomes were as follows: the cases were concluded or concluded with advice, warnings were issues or undertakings agreed, and decisions that the doctor’s fitness to practise was not impaired. There are 10 cases currently ongoing.

Bullying and harassment

17 There have been 15 cases related to bullying and harassment by 14 ROs. Of these cases 13 were concluded and 2 were concluded with advice.

18 We cannot report on the ethnicity of the ROs who have been referred to the GMC for bullying and harassment because the numbers are too small, and the doctors would be identifiable.