THE IMPACT OF OUR WORK

Working with doctors Working for patients
Foreword

We are an independent body that exists to help protect patients and set the standards all 280,000 doctors on our medical register must follow.

We decide which doctors are qualified to work in the UK and we oversee their medical education and training, taking action when doctors or educational establishments fall short of our standards.

And just as doctors need to be accountable for their practice, so we at the General Medical Council (GMC) must be accountable for what we do.

Regulation isn’t an end in itself – regulators must explain and justify what they do and how they are adding value.

This is all the more important when doctors working in the UK’s healthcare systems are under severe pressure because of well-documented demands on the service across all four UK countries.

Supporting doctors in testing times

It was clear in 2016, from exploration of our own data, that doctors in the UK are facing an extraordinarily testing and uncertain environment.

We published our sixth The state of medical education and practice in the UK report in October 2016. It noted how increasing pressures on the nation’s healthcare systems have led to a state of unease across the UK’s medical profession, which risks affecting patients as well as doctors.

The results of our national training survey highlighted how these pressures are also threatening the quality of the training that doctors need to become the next generation of GPs and consultants. Medical training is often a bellwether for the quality and safety of patient care, and patients are directly at risk if support and supervision of doctors in training is inadequate.

While we have no view on the vote to leave the EU, we are clear that doctors from the EEA and other parts of the world make an immense contribution to the UK’s healthcare systems, and inevitably there is
considerable uncertainty about what Brexit will mean for our health services.

That our doctors continue to deliver outstanding care and support for each other in such difficult and uncertain circumstances is testament to their professionalism and dedication.

**Protecting patients through effective regulation**

We exist to protect patients. In this report we describe some of the many ways in which we do so, including working directly with members of the public who raise concerns about a doctor.

We strongly believe we can protect patients by supporting the vast majority of doctors who are determined to make sure the quality of patient care is as high as it can be – in addition to dealing firmly, fairly and quickly with the minority whose practice falls seriously short.

So in 2016 we stepped up our support for doctors in delivering good practice. We produced updated, more-accessible guidance on confidentiality as well as creating a new standards app and issuing advice on cosmetic interventions. And we have worked to reduce the burden of regulation on doctors by making our fitness to practise and registration processes more streamlined.

We want to do much more to support doctors in the interest of patients.

For this to happen, we need fundamental legislative reform, so we can shift our focus towards promoting good medical practice, while using our data to identify and act on emerging risk to patients and the quality of education and training environments.

There has been talk for many years of reform – action is now long overdue.

**Highlighting our real-life achievements from 2016**

We engaged in several innovative activities over the past year.

Our 2016 business plan set out in detail our work programmes across all our functions, and the GMC and Medical Practitioners Tribunal Service (MPTS) annual reports give a summary of work and performance over the past year. The purpose of this report is to complement these documents by offering specific, real-life examples of how that work is making a difference – to...
patients, to doctors, to employers, to the healthcare systems in which we work and to the public as a whole.

Measuring regulatory impact is very challenging, however. On one hand, some regulatory interventions are immediate – for example intervening to address patient safety in an educational environment, preventing a dangerous doctor from practising, or refusing to grant a licence to practise. On the other hand, the effect of other interventions, such as raising standards of practice through appraisal and revalidation, may only become visible over several years.

We are also conscious that we are just one part of the wider healthcare system. A key part of our contribution to safety and quality comes from working closely with other organisations. This report attempts to illustrate some of our distinctive, real-life achievements in 2016. But we should never forget that what matters most is the outcome achieved – for patients, for doctors and for healthcare.

As a learning organisation, we’re also committed to learning more on how we can best document our impact. In this sense, this report also represents a baseline against which to measure our ability to ascertain and document impact over the coming years.

The report is organised around four main themes:

1. Protecting the safety of patients and supporting doctors
2. Helping doctors maintain and improve standards
3. Assuring the quality of education and training
4. Learning from our environment.

We recommend you read it together with the GMC and MPTS 2016 annual reports, which contain more general information about activities and performance over the past year.

In the meantime, we’ll continue to work with doctors, patients and health services across the UK, playing our part in maintaining high quality healthcare systems and learning from our experience to continuously improve what we do.

“A key part of our contribution to safety and quality comes from working closely with other organisations.”

Professor Terence Stephenson
Chair of Council

Charlie Massey
Chief Executive and Registrar
Protecting the safety of patients and supporting doctors

Protecting the safety of patients is our primary responsibility. One key way we do this is by supporting doctors – as in most instances the two go hand in hand: if doctors are well supported they are more likely to be able to give patients the best possible care.

In the following cases we give examples of how support for doctors has improved patients’ safety. We also show how revalidation – the process for licensed doctors to show on an ongoing basis that they are up to date and fit to practise in their chosen field and able to provide a good level of care – has made tangible differences to doctors’ practice.
Responding to trainees raising concerns

Members of our Regional Liaison Service regularly hold sessions with doctors in training about patient safety issues. At a recent meeting for doctors in the second year of the Foundation Programme on our guidance about acting on concerns about patient safety, one doctor revealed that on several occasions she worked unsupervised in the department.

She told the session there was no consultant, registrar or fellow trainee working with her in the endocrinology department. A consultant was on call but was in another hospital. The doctor had reported the situation to colleagues but no action had been taken.

Our regional liaison adviser immediately raised the matter with the medical education manager, which led to a rapid response. The director of medical education met the doctor to offer support. On her next round, the doctor was working with a consultant, a registrar and another trainee.

In an email the following day, the medical education manager told our adviser there were systems in place to make sure this sort of incident didn’t occur ‘but it seems [they aren’t] 100% robust. I am confident that this will be used to tighten this further.’

The incident has led to a review of clinical supervision procedures at the hospital. Leave for consultants is now monitored through the service manager’s office and work on setting minimum numbers to assure adequate service in departments is being rapidly completed to prevent this happening again. In addition, the leave of trainees is now monitored by general managers rather than the rota coordinator’s office alone.

Sharing data to help improve patient safety

As part of our commitment to collaboration, we provide health and social care watchdog the Care Quality Commission (CQC), as well as its equivalents in other parts of the UK, with a wealth of data from our own investigations into standards of care and education.

The information is proving valuable for the CQC, which uses it to evaluate whether to intervene in specific cases to ensure patient safety.

We have set up protocols and agreements so we can share six different types of data with the CQC. This includes sharing of routine information, such as our annual national training survey, our enhanced monitoring work and the weekly analysis of recent judgements on fitness to practise. But it
also covers emergency and urgent concerns, liaison services and risk and quality summit meetings.

This allows us to give CQC inspectors routine reports on the organisations for which they are responsible. They then use their professional judgement to decide whether specific matters need urgent intervention or can be raised at the next scheduled visit.

We are now working closely with other healthcare regulators and organisations across the UK to develop systems for collective sharing of data and intelligence. This will help to ensure the earliest possible identification, and mitigation, of risks to patients or the quality of medical education.

Revalidation: having a real impact on doctors’ practice

Revalidation is a system of regular checks that makes sure doctors are up to date and fit to practise medicine. It consists of annual appraisals, together with revalidation at least once every five years.

Four years after we introduced it, revalidation is having a real impact on doctors’ practice and behaviour as well as patient safety.

Last year Sir Keith Pearson, chair of Health Education England and chair of our Revalidation Advisory Board, carried out a wide-ranging review to examine how revalidation was progressing. He found:

- evidence of more reflective practice
- a significant increase in appraisal rates
- revalidation is helping to identify poor practice
- areas where improvement is needed if revalidation is to realise its full potential.
Reflective practice

Doctors said they appreciated the feedback they received from patients and colleagues as part of the appraisal process and were using it to change their practice.

Four out of ten doctors said they have changed their practice, behaviour or learning as a result of their most recent appraisal, according to a survey of 26,000 doctors by the UMbRELLA consortium, which was part of the independent study we funded as part of our revalidation evaluation.

Most of those that didn’t make changes said this was because the appraisal had not identified anything that needed changing or they were reflecting on an ongoing basis.

Lead appraisers in Scotland felt doctors were now more reflective. ‘Most professionals are keen to do a good job and just need the support to do it,’ said one. ‘They are now getting the recognition for their constant learning – they appreciate that.’

One consultant surgeon in an independent practice said: ‘The very fact of having to explain my practice and aspirations to my appraiser was helpful in requiring me to analyse what was going on in an objective way.’

Colleagues’ feedback has helped some doctors realise they could be seen as intimidating or unapproachable, for instance. In other cases it helped them improve their time management or communication skills.

One lead appraiser said: ‘Patient care is already safer as a result of the focus that revalidation places on professional standards, probity, personal health and the doctor’s duty of care.’

Identifying poor performance

Revalidation is helping to highlight poor practice and do something about it, says Sir Keith.

One in ten appraisers said they had formally escalated a concern about a doctor they were appraising, according to the UMbRELLA survey. Another 23% had identified concerns, but hadn’t had to escalate them because they could be dealt with through the appraisal process.

From the sample analysed by UMbRELLA, the most common reason for escalating a concern was lack of reflective practice (45%) followed by poor relations with colleagues (29%) and out of date clinical knowledge and skills (26%).

The role of responsible officers includes taking steps to make sure doctors under their responsibility have an annual appraisal and making recommendations about a doctor’s revalidation to us. They said the requirement in revalidation to gather and reflect on evidence has resulted in some poorer performing doctors leaving the profession altogether.
Revalidation has also had a major impact on the number of doctors who now receive regular, properly structured appraisals, according to Sir Keith’s review. This is particularly noticeable among those who are not GPs and consultants – whose performance levels were not monitored closely in the past.

Before revalidation, some groups of doctors had appraisals that were already well developed. But for others, the approach was irregular and unstructured.

One retired trust chair described it as ‘just a cup of coffee and a chat now and then’.

Now, according to the UMbRELLA survey, almost 90% of doctors received an appraisal in the past year. In Scotland 92% of doctors were appraised in 2015–16, compared with 88% of doctors in England. In Wales the figure rose from just 53% in 2012–13 to 82% in 2015–16. In Northern Ireland rates ranged between 71% and 100% in the previous two years. *

Appraisal rates have risen steeply in all four countries of the UK since the introduction of revalidation.

* Data provided by NHS England, Wales Deanery, HIS in Scotland and RQIA in Northern Ireland.
Influencing policy responses to female genital mutilation

We’ve worked closely with the Department of Health as it implements new legislation and policies on female genital mutilation (FGM) in England and Wales. Our expertise helped the Government to implement the legislation effectively, while making sure its policies don’t conflict with patients’ rights or doctors’ duties.

Legislation introduced in October 2015 imposes a mandatory duty on doctors and other professionals to report cases of FGM in girls under 18 to the police. As part of the FGM enhanced dataset, doctors in most settings in England must also submit information about all cases of FGM they become aware of.

We were concerned about how these new policies might fit with our own guidance, specifically our guidance on confidentiality, the possible impact on patients’ trust in doctors and the associated risk of women and girls avoiding seeking medical help.

Since October 2015, we’ve been doing work to ensure the accuracy of materials and to help the Government implement the policies in a way that minimises any possible conflict with ethical principles. We suggested ways the new procedures for reporting FGM could be aligned more closely with our professional standards and wider safeguarding procedures. We also raised our concerns about the implementation of mandatory reporting at a roundtable event on the subject hosted by Jane Ellison MP.

We’ve worked closely with the Department of Health to make sure the policies are implemented as effectively as possible and achieve the aim of tackling FGM while protecting the needs and rights of individual patients.

We have contributed to a redrafted patient leaflet about the enhanced dataset to make it clearer to patients how their information will be used and what they should do if they don’t want it to be shared. We also suggested improvements to the wording of the information sent to doctors by NHS Digital.

At the same time, we’ve updated our ethical guidance and published support on our website. Our regional liaison advisers also signpost these to doctors.
Supporting refugee doctors applying for a licence in the UK

The UK’s health services depend heavily on the contribution of doctors from abroad, including professionals who had to leave their country due to safety and security issues.

Refugee doctors face a number of difficulties in applying for registration to practise in the UK. For example, their original documents may have been lost or destroyed. In these cases we try to verify documents directly with the awarding body if possible or look for alternative ways of establishing their authenticity.

In addition, refugee doctors may not be able to give us evidence of other documentation we need, such as passports, in the standard way. In these situations, we will look at every application on a case by case basis and see if we can accept alternative evidence instead – while making sure it’s robust and reliable.

Our Registration and Revalidation directorate supports doctors with refugee status who may have valuable skills to offer, but who often face enormous obstacles in becoming registered here.

We are also working directly with several refugee organisations to give advice to their clients before they submit an application for registration. And we attend the twice-yearly Refugee Doctors and Dentists Liaison group meeting hosted by the British Medical Association.

There is no doubt that our support in this area is making a difference. Refugee support organisation RAGU (Refugee Assessment and Guidance Unit) thanked us for our ‘considerable help with the many refugee doctors over 2016. All [our] managers appreciate this greatly.’

And a refugee doctor praised our ‘help and patience. It has been a nerve-wrecking process as you can imagine but you have been a great help.’

As a result of this experience, we now also recommend that before they apply for registration, refugee doctors should contact an organisation that can give appropriate careers advice and support them through the process.

Helping refugee doctors with registration and licensing not only benefits the doctors in question, it also helps address skills shortages in the UK healthcare system (and therefore patient safety), as the doctors may possess skills that are particularly in demand.
Maintaining standards to ensure patient safety

If our standards are not being met by doctors and we need to step in to protect patients, we take action. This includes controlling who is licensed to practise as a doctor in the UK.

In 2016, we granted registration to 21,132 doctors. But we also:

- rejected 89 applications to the medical register
- rejected 283 applications to the specialist and GP registers
- refused to grant a licence to 739 doctors because of nonexistent or insufficient proof of English language proficiency.

In addition, the Medical Practitioners Tribunal Service (MPTS) made decisions on a doctor’s registration in over 1,800 hearings. In many cases no further action was needed. But where patient safety is threatened or the reputation of the profession has been brought into jeopardy the tribunal takes appropriate action. Last year this included:

- 70 doctors being erased from the medical register
- 250 doctors having conditions placed on their registration
- 151 doctors being suspended.

We also withdrew the licences of 949 doctors who failed to engage with revalidation.

Supporting doctors attending a fitness to practise hearing

We’re piloting a support service for doctors appearing at MPTS hearings, particularly those on their own or without representation.

Latest figures indicate that nearly 12% of doctors attend the hearings without any legal representation.

The main aim of the Doctor Contact Service, which is staffed by MPTS members, is to reduce doctors’ stress and sense of isolation. The service also signposts doctors undergoing hearings to useful support material and services as well as giving information about the hearing process itself.

Most doctors who are offered the service take advantage of it and so far the response has been very positive. ‘I appreciated that my stress and distress had been noted and that someone was available to talk through matters,’
said one. Another commented: 'It is reassuring that there is someone available to give you help, advice and explanations if needed.'

The service is still being trialled and we want to raise awareness of its availability. Any doctor who has a hearing scheduled at the MPTS can email doctorcontact@mpts-uk.org to find out more about how we can assist.

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**Supporting a doctor in recognising his ability to perform**

Our Employer Liaison Service works with responsible officers (licensed doctors who are usually medical directors or their deputies in an organisation) and their teams to support two-way exchange of information about underperforming doctors. This improves patient safety and the quality of referrals that are sent to us to investigate.

Dr K had returned to part-time work after a serious illness, which included several months in intensive care. He had a supervisor to support him but it soon became clear this wasn’t working out. Two patients complained about Dr K being too slow and not following up on tests.

When Dr K and his responsible officer discussed this, Dr K initially said he felt the placement was working well. He went on to say he was planning to retire from regular practice but wanted to keep his hand in with ad hoc private work.
The responsible officer was concerned that Dr K seemed to have limited insight into his situation. He was especially worried about Dr K’s plans to work in private practice, where he wouldn’t be supervised or have access to the wider support system.

Dr K’s responsible officer was due to make a recommendation to us as part of revalidation, but he felt he wouldn’t be able to make a positive recommendation.

The responsible officer sought support from our employment liaison adviser, which gave him a better understanding of the options for Dr K. After this, the responsible officer had another meeting with the doctor. Dr K said he wanted to continue to do some work because he wasn’t old enough to retire fully. But he was relieved and grateful that someone was talking to him about this ‘because [I] really wanted to stop but needed someone to say it was OK’.

The result is that Dr K has now relinquished his licence to practise, but remains registered. This means he doesn’t need to take part in revalidation and can’t practise in the UK. But importantly for him, his name remains on the medical register, which shows that he remains in good standing with us. It also means the potential to restore his licence remains open if his personal situation changes.
Helping doctors maintain and improve standards

Every patient should receive a high standard of care. Our role is to help achieve that by setting the standards doctors need to follow and then giving support to put them into practice.

We work in many different ways to make this a reality. We engage directly with doctors to promote our guidance, we work to influence policy, and we produce learning materials to support the use of these standards in daily practice including, for example, our new mobile apps. The case studies below show the impact this is already having – on doctors, employers and patients.
Promoting professionalism across the UK

Each year we help to promote professional standards by engaging directly with thousands of doctors, employers, educators, medical students and patients.

In England, this work is led by our Regional Liaison Service.

In June 2015, we reinforced our capacity to engage with the medical profession in Scotland, Wales and Northern Ireland through interactive sessions based on our guidance. Throughout 2016 we continued to work with our partner organisations to develop a programme to promote medical professionalism across these three countries – as part of this, we held interactive sessions and face-to-face meetings with over 3,700 doctors and 4,400 medical students.

Among other approaches, and often in partnership with the wider health system, these sessions include interactive group training for doctors and medical students.

The sessions:

- improve their understanding of our guidance
- explain how to put the guidance into practice to support the quality and safety of care
- share the learning from the complaints we receive
- explain what happens if doctors fall short of the standards we set for them.

The sessions provide support for medical professionals at all stages of their careers, across the range of our professional standards. They give attendees an opportunity to reflect on their professionalism and share best practice.

And they result in significant changes in how doctors reflect on and intend to change their practise for the better. After attending one or more of these sessions, 65% of doctors said they would change their practice. In addition, 75% said the experience had improved their knowledge of the GMC.

The response to our professionalism sessions in all parts of the UK has been generally very positive. One attendee commented: ‘This feels more like the GMC is “on side” with doctors and not out to get us.’

‘It’s useful to see a more friendly and supportive face of our organisation,’ said one participant, while another said the session showed ‘that the GMC is willing to listen, acting for doctors’.

“65% of doctors will change their practice as a result of engaging with us.”
Others welcomed the opportunity to discuss practical examples. One consultant commented: ‘This will increase my reflective practice.’

**Medical professionalism matters**

Across 2015–16, we also led an 18-month programme of events called *Medical professionalism matters*, which we developed with a group of healthcare organisations.

The events explored some of the challenges facing the medical profession, to help us better understand the challenges the profession faces and ways to overcome them. We ran six events across the UK, which focused on ethics, resilience, collaboration, compassion, scholarship and patient safety.

Almost 600 doctors and other healthcare staff and patient representatives attended the events, which included presentations, panel debates and facilitated table discussions. Hundreds more joined the discussion online, taking part through videos, blogs and social media exchanges – using the hashtag #gooddoctors.

In December 2016, we published a final report that brought together recommendations from the programme. These included recommendations that we work more closely with the medical royal colleges, that we help...
Helping doctors maintain and improve standards

Working with doctors to develop confidence in their duties

Doctors working in Jersey can feel quite isolated because of their relatively remote location, which can create real difficulties in accessing continuing professional development (CPD) events off the island.

So Jersey’s specialty and associate specialist (SAS) and consultant doctors welcomed our initiative to offer a special course on the duties of a doctor on home territory. They appreciated, they said, that we ‘went to them’.

The course, which lasted from September 2016 to January 2017, consisted of five sessions covering a wide range of our guidance on professional issues.

As a result of the course, most participants said they felt better prepared and more confident about many professional issues. Two thirds felt equipped to deal with patient confidentiality issues afterwards compared with none before the course started.

“Two thirds felt equipped to deal with patient confidentiality issues afterwards compared with none before the course started.”

Images from our final Medical professionalism matters report

The doctor as scholar

The compassionate doctor
with none before the course started. There were also big leaps in confidence on discussing personal beliefs, acting as a leader and raising concerns.

One doctor commented of the sessions: ‘I found them inspiring and would be willing to be more involved in the work of the GMC’. And another said: ‘I have found this course really professionally reinvigorating’.

Participants also discussed ways in which Jersey law might affect some of the guidance. As a result, we are now looking at producing a supplement to our guidance for Crown dependencies.

Running face-to-face training on duty of candour

What are a doctor’s ethical obligations when things go wrong? Should they apologise? And if so, in what way?

These were some of the issues our Regional Liaison Service addressed in a series of train the trainer sessions in south London, which centred on professional duty of candour guidance that we developed with the Nursing and Midwifery Council.

The Regional Liaison Service team developed a training package for the sessions, including interactive games and group activities, in conjunction with South London’s Health Innovation Network (HIN) duty of candour community of practice.

The team has used these training materials with over 200 members of staff in one south London trust.

If you intend to cascade this training, approximately how many people do you think you will share this information with?

* Responses included: as many as possible; small number initially; and then cascade; cannot say; unsure.
Working with the HIN, they have also run five train the trainer sessions in the area, attended by over 70 doctors and other professionals.

Each participant was given a package of relevant material to help train clinical staff in their workplace. Nearly all (95%) said they would use the materials in their workplace.

Meanwhile, our Scottish office has been working with the British Medical Association and NHS bodies to help professionals understand the distinction between individuals’ and organisations’ duty of candour. A new organisational duty of candour is being introduced for health boards in Scotland, and we expect it to take into account the inputs and advice we gave as part of the Scottish Government’s consultation process on the subject.

Influencing the Scottish Government to amend policy on information sharing

The Supreme Court’s July 2016 ruling that the Scottish Government’s named person policy was incompatible with Article 8 of the European Convention of Human Rights has significant implications for doctors in Scotland.

In particular, the court said the policy, as it stood, would allow some confidential information on young persons to be shared with a wide range of public authorities without the knowledge of the young persons involved or their families.

Our Scottish office and Standards team worked with the Government to advise them on revisions to the policy, to make sure it meets doctors’ legal and professional duties while upholding the public’s confidence in the profession.

As a result, new legislation, due to come into effect in 2018, has been proposed by the Scottish Government. This will make sure information shared between a named person and a doctor involves the young person and their family and that disclosure is consistent with data protection, confidentiality and human rights. Importantly, on the basis of the new legislation doctors would only need to share information without consent in exceptional circumstances – for instance, where an individual is at risk of harm.

We’ll continue to engage with the Scottish Government as it legislates on this policy.

“95% of doctors who took part will use the training materials in their practice.”
Launching mobile apps to increase the impact of our guidance

We recently launched two mobile apps – My CPD for professional development and My GMP for professional standards. Both have proved very popular, having been downloaded thousands of times.

Most of those surveyed say the apps are quick and easy to use and many say My CPD is the only app they now use for professional development.

My CPD

Most people using My CPD say it helps them capture learning more efficiently, with three quarters saying it has helped them reflect on their practice and 70% saying it has made it easier to prepare for appraisals.

Nearly half (44%) say My CPD is the only app they now use to log their CPD and 78% would be likely to recommend the app to others. This rises to 100% among doctors in training and those aged 25 to 34.

We were also keen to learn how we could improve the app and received very helpful responses. As a result, we’re planning to implement a number of modifications, including enabling users to import and attach files and, if possible, making the app compatible with other platforms.

We are also considering more targeted marketing of the app to GPs. We only had a small sample of GPs in our evaluation but they were very enthusiastic with half using this app exclusively and 83% likely to recommend it to colleagues. We also recommend more targeted marketing of the app to appraisers as a way of reaching more doctors.

Those appraisers who do already use My CPD appeared enthusiastic. One commented: ‘I have recommended it to many of my appraisees. I feel it makes them reflect and demonstrates impact better than any other CPD logs.’
My GMP

The first phase of this new professional standards tool was only launched at the end of 2016, but a survey of those who used the app indicates it has been well received.

One doctor called it very professional as well as being a clear, easily useable and accessible guide to our standards. Another said they were much more likely to use an app that could be accessed on a mobile phone rather than searching for a website.

The social media response has also been positive. One commented: 'This is a lovely app useful even for responsible officers and appraisers. I would recommend this for all doctors as a reference tool.'

Sahil Chandra, third year student at Barts and The London, says the app has helped him understand and apply the ethical guidance for doctors set out in our core guidance, *Good medical practice*.

‘For me ethics lectures and pages of guidance never really sink in and personally, when faced with a dilemma, I wouldn’t feel confident enough to rely on what I vaguely remembered from lectures and talks. I would want to check the guidance again. Then and there.

‘The My GMP app made it much easier and quicker for me to look up answers on potential ethical issues. It’s reassuring to know that if I am ever uncertain about an ethical issue, all I have to do is quickly check an app on my phone.

‘While on placement, I have found it very easy to engage with and useful in helping to provide up-to-date guidance on scenarios that involve complex decisions, both on the wards and in clinic.’
Assuring the quality of education and training

We set the standards for medical education and training across the UK. These standards help to make sure the learning environment is safe for patients, medical students and doctors in training, and of sufficient quality for learners to progress.

In this section we show how our work is making a difference to medical students and doctors in training and how this in turn affects patient safety.

The initiatives featured include our annual national training survey, enhanced monitoring processes and in-depth regional and national reviews, with case studies highlighting how education and practice have changed as a result.
Enhanced monitoring processes to maintain educational standards

Each year we institute enhanced monitoring processes at education and training sites where we have serious concerns about the quality or safety of medical education and training.

Enhanced monitoring means we participate in visits to educational and training settings to support deaneries and Health Education England (HEE) local offices to manage concerns. And we work with other bodies to encourage them to make the improvements needed to meet our standards.

The issues that trigger this sort of intervention relate to patient safety, the safety of doctors’ training and the quality of the learning environment. It will also be clear that the problems can’t be resolved locally.

In most cases, this process leads to a turnaround with NHS employers, deaneries and HEE local offices all working together to make good the failings. But when none of this happens our ultimate sanction allows us to withdraw approval for training.

In 2016 we dealt with 95 issues that needed enhanced monitoring. By working in partnership with deaneries and HEE local offices, we found evidence of improvements and were able to close enhanced monitoring processes for 17 organisations.

Case study

Leicestershire Partnership NHS Trust

We were asked to become involved after a Health Education England East Midlands (HEE EM) visit in 2013 found that doctors in core and higher specialty training in child and adolescent psychiatry had an unstructured teaching programme and were working in an unsupportive environment. Learners said they were subject to undermining behaviour by some trainers.

HEE EM visited several times in 2013 and a local survey later that year suggested significant improvements had been made. However, similar issues cropped up again in 2014, leading to the development of an action plan to resolve them.

When HEE EM met trainees in November 2015 it found they were now happy with the training they were receiving. Results from our 2015 national training survey confirmed this, while the 2016 survey showed ratings for overall satisfaction and a supportive environment had both improved. We removed the trust from enhanced monitoring in December 2016.
Case study

**Chelsea and Westminster Hospital NHS Foundation Trust**

We were asked to intervene at Chelsea and Westminster Hospital's neonatology unit after reports that some doctors in training were being undermined in the unit. These concerns were managed locally from 2012 when they were initially raised. Responses to the 2014 national training survey then indicated that a more comprehensive investigation was appropriate, as there was some evidence that the quality of training had worsened.

When we visited in November 2014 with Health Education England North West London (HEE NWL) we saw some improvements, but bullying and undermining remained an issue, with allegations received from resident consultants and trainees. This raised concerns about patient safety and the overall training experience. By the time of our next visit with HEE NWL in May 2015 we were pleased to see that doctors in both training and non-training grades reported an improvement in the culture and environment. Steps had also been taken to relieve the workload pressures on trainees. Regular departmental interventional meetings were now held to analyse and discuss behaviour and its impact on patients, staff and families.

As a result of all these improvements, we were able to remove the trust from enhanced monitoring in August 2016.

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Case study

**Barnsley Hospital NHS Foundation Trust**

We referred Barnsley Hospital to enhanced monitoring after a visit in October 2014, where we learnt that doctors in the second year of the Foundation Programme (F2) on the general surgery ward were being supervised by a non-resident on call middle grade doctor after 9 pm.

We were concerned that as a result, potentially very sick patients might not be seen by a senior doctor for 12 hours or more if the F2 doctor didn’t consider the problem serious enough. The trust took immediate steps to provide on-site support – since then additional middle grade cover has been included in the out of hours rota.

An internal quality assessment visit by the trust in October 2015 confirmed that a middle grade doctor is now always on site. Meanwhile, a survey by HEE Yorkshire and the Humber found that all F2 general surgery trainees were happy with their clinical supervision and none now had concerns about admissions or being able to escalate issues to a senior member of staff. 11 out of 12 foundation trainees said they enjoyed their post and would recommend it to colleagues.

We removed the trust from enhanced monitoring in March 2016.
How our national training survey has brought about change

Our annual national training survey with doctors in training has been running for ten years now. In that time it has been a vital tool in telling us just what is happening in medical education and training across the UK. That in turn has enabled us to take action where necessary to make sure our standards are upheld. Since 2013, the annual response rate of doctors in training has been on average 98%.

In 2016, we expanded the national training survey to include a survey of clinical and educational supervisors, with an initial response rate of over 50%. This gives us a more comprehensive understanding of medical education and training across the UK.

In raising concerns about patient safety, doctors in training highlighted rota gaps – which is why, in the 2017 national training survey, we’ve tested new questions about rota gaps to help us better pinpoint where problems exist.

Case study

Cardiff and Vale University Health Board

Our 2015 national training survey revealed significant levels of dissatisfaction among doctors in training in the core psychiatry cohort at the Cardiff and Vale University Health Board. The board was in the middle of introducing a revised rota and many of the concerns seemed to revolve around how this was being communicated to doctors.

Once the problem was highlighted through the survey, the board introduced a range of measures, including meetings with doctors in training and trainers to discuss issues and raise concerns at an early stage. Workshops for doctors in training helped to pinpoint where problems exist.

Doctors in training also gathered feedback from previous cohorts to improve the induction process, leading to a new three-day induction programme.

As a result, there appears to have been a change in culture. Doctors in training now feel like a valued part of the team.
Case study

Aberdeen Royal Infirmary

Our 2013 and 2014 national training surveys highlighted a number of concerns about patient safety within Aberdeen Royal Infirmary’s A&E department and surgical unit.

In the 2013 national training survey, the surgical unit received red flags for overall satisfaction, adequate experience, workload and local teaching for higher specialty doctors in training.

In August 2014 we brought the hospital within our enhanced monitoring process. A series of visits from different authorities followed, leading to an action plan that triggered a number of changes. Within the emergency department, for instance, improvements were made to rotas, consultant availability, clinical supervision and protected teaching time.

We’ve also delivered a number of promoting professionalism sessions during this time on a range of our guidance, including leadership and management, and raising and acting on concerns about patient safety. Over 200 consultants and trainees have attended these workshops, which are now a regular part of NHS Grampian’s continuous professional development and educational programmes.

The 2015 national training survey highlighted clear improvements and, following a deanery revisit, the 2016 survey showed further progress with a number of green (positive) outliers instead of red (negative) ones. In June 2016, we removed Aberdeen Royal Infirmary from enhanced monitoring.
In 2015, we published new standards for medical education and training, *Promoting excellence*. In the same year, results from our national training survey showed that trainees at Tayside Acute Medical Unit were unhappy with their training experience. These results triggered a quality assurance visit from the deanery.

Achyut Valluri, a former GMC clinical fellow, began working at the Acute Medical Unit at the start of 2016. In his role as a consultant, he took on responsibility for postgraduate training in the department. 'Rather conveniently, day one of my job coincided with the new standards for

Our 2015 national training survey flagged up significant dissatisfaction among F2 doctors in emergency medicine, specifically around issues of handover, workload and access to educational resources.

When HEE Yorkshire and the Humber visited in April 2015, they were told the newly opened emergency department had improved patient care. But because it was still extremely busy with no extra staff, it remained a poor learning environment. There were particular concerns that F2 doctors in training were regularly expected to stay well beyond their shift finish time. The work intensity also meant they sometimes missed out on educational opportunities.

Following this, the trust decided to put a senior trainer in charge of promoting training delivery within the department and supervising the education programme. They also managed to recruit extra staff.

When HEE visited again they found that significant progress had been made. Although the department is still busy, the workloads were now more manageable.

Our 2016 national training survey showed big improvements on a number of indicator scores. The mean score for handover, for example, rose from 40.39% in 2015 to 70.24% in 2016. The trust is implementing changes and we will continue to monitor progress in collaboration with HEE.

**Using new standards to improve trainee satisfaction**

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Achyut Valluri, a former GMC clinical fellow, began working at the Acute Medical Unit at the start of 2016. In his role as a consultant, he took on responsibility for postgraduate training in the department. 'Rather conveniently, day one of my job coincided with the new standards for
medical education and training coming into effect,' he explains. 'Promoting excellence provided the framework for our own way forward.'

Among the changes inspired by the new standards, the department:

- revamped its induction package
- redefined roles and responsibilities, to allow everyone to act up to their level of capability, rather than acting down to their level of competence
- trained healthcare assistants to support routine tasks, so trainees can spend more time seeing and treating people
- revised team structures to improve opportunities for teaching, feedback and formal assessments
- developed a formal teaching programme, including simulation work and daily ten-minute tutorials
- introduced a standing agenda item in the weekly senior clinical team meeting to discuss each trainee, with comments fed back to their clinical supervisors
- developed workshops to support consultants' personal development as trainers.

**Addressing workload issues**

Dr Valluri says 'problems with educational standards in an organisation may reflect wider systemic issues – the canary in the coalmine.' Suspecting that trainee dissatisfaction stemmed from the daily workload in the department, he decided to measure the capacity of the department’s workforce to see new patients against the daily workload.

His results show that workload often exceeded workforce capacity. 'This means that our registrars and consultants have to act down to ensure safe and timely patient care – leaving little opportunity for teaching/training,' he explains.

To address this problem, the department is looking into developing the roles of nurses and physician associates, to give registrars and consultants more time to deliver training. It has also used our guidance Building a supportive environment to form a checklist of its aims for trainees.

The result of this work was that the 2016 national training survey showed a marked improvement in the satisfaction of trainees at Tayside Acute Medical Unit. The mean score for overall satisfaction rose from 53.6% in 2015 to 72% in 2016.
Assuring the quality of education and training

The General Medical Council

Giving medical students effective guidance

Together with the Medical Schools Council we produced a completely revised version of our guidance for medical students last year, outlining the standards they should follow in and out of medical school.

The guidance shows how the principles and values of our core guidance for doctors, *Good medical practice*, apply to students. Much is specifically relevant to work on clinical placements but the guidance also includes other elements of academic study as well as stressing the need to be trustworthy and honest at all times.

*Achieving good medical practice: guidance for medical students* places greater emphasis than previous advice on areas that students may need particular support with – such as use of social media, managing their health or raising concerns.

It includes examples of what true professionalism involves as well as instances of unprofessional behaviour such as rudeness, dishonesty, poor time management, aggressive behaviour and cheating or plagiarising. It is accompanied by guidance for medical schools, universities and placement providers.

The publication was promoted through a student competition to design a training session that would engage peers in a conversation about professional values. Around 100 students took part and many expressed enthusiasm about the guidance. One said it should be ‘on the recommended reading list for all medical students’. Another described it as ‘very accessible and directly relatable to medical students’ day-to-day practice’.

Others said it had made them rethink issues such as social media and patient confidentiality as well as their own responsibilities. ‘As medical students, it is easy to feel that responsibility for patients only starts after graduating,’ commented one entrant. ‘The guidance clearly outlines that this is not the case.’
Learning from our environment

We are a learning organisation, and we see impact as a two-way street: we impact on the quality of healthcare, and in turn the environment we work in impacts on us, and we respond to that.

Just as we expect doctors to reflect on their practice to do their job better, so we aim to learn from what people tell us to improve the services we offer.

In this section we focus on how we learn from our external environment and on our ability to listen to those our work affects and respond to their needs. We give examples of how we are using the data we hold to inform our own work and that of others. We show how we are listening to what doctors, patients and partner organisations are telling us and changing or providing training where required.

We also document how we can respond to findings on some negative impacts of our work. One thing we have learned in our 159-year history is that a regulator must not only seek to achieve positive impact, but also guard against negative impacts its activities may have.
Supporting international doctors to maintain and improve standards

In the last year over 1,500 international doctors planning to practise in this country have attended Welcome to UK practice, our half-day introductory courses about UK medical practice open to all European Economic Area (EEA) and international medical graduates – and the results have been very positive.

We developed the sessions, which take place across the UK, to respond to the disproportionately high number of doctors who have qualified outside the UK who have been the subject of complaints or investigations about their fitness to practise.

Welcome to UK practice seeks to address this issue upfront. The course is offered to all international medical graduates or EEA doctors who join the register. It is widely publicised, and all international doctors waiting for their ID checks are shown a short video promoting the programme.

Our evaluation of the sessions held in 2016 showed 94% of respondents said the course had been good or very good and 90% said it would change their practice.

Among the comments were: 'It has been one of the most interesting courses/education days I have ever attended', 'There are huge differences in practising medicine in my home country and the UK – this session helped me to realise that' and 'This programme has a very positive impact on my care towards patients'.

“90% of participants said the course would change their practice.”

There are huge differences in practising medicine in my home country and the UK – this session helped me to realise that.
Introducing podcasts to reach a wider audience

In Somerset, our Regional Liaison Service has recorded the engagement sessions it runs with local GPs as podcasts to help spread knowledge about our guidance.

The idea of the podcast came after Somerset Local Medical Committee (LMC) asked us to run a series of sessions for GPs last year on different aspects of our guidance. As the rural and remote setting of many GPs in Somerset makes it more difficult for them to attend the LMC offices, the LMC suggested recording these sessions as podcasts, so GPs who had difficulties in visiting their offices would still be able to benefit.

The podcasts – on topics such as confidentiality, using social media and raising and acting on concerns – are now accessible on the LMC website. As a result our liaison team are receiving more invitations to run sessions for LMC members and GPs in Somerset. They were also invited to address all Somerset GPs on the subject of child safeguarding leads.

So far, 168 people have visited the page on the LMC website containing the podcasts, adding to those who attended the sessions in person.

168 people have visited the LMC website to check out the podcast.

For Sameer Mashrequi, just starting out as a trainee at Leeds Teaching Hospital’s A&E department, the Welcome to UK practice course has been invaluable.

‘I was expecting it would be good,’ he says, ‘but it was very good!’ Having qualified as a doctor in Pakistan and obtained his UK registration late last year, he found the focus on the doctor-patient relationship and confidentiality especially useful.

‘These aspects are not given the same importance in Pakistan and we don’t have exposure to these guidelines,’ he says. He also found the scenarios that were played out really helpful. ‘These are exactly the things that doctors have difficulties about. The scenarios encourage you to question and to think about these things.’

Dr Mashrequi has no doubt that the course will influence his work in A&E. ‘It will definitely change my practice from what I did back home. Working in the UK is a big step and a big challenge. These are the things that help us adapt more quickly.’
Providing data on EEA doctors in response to demand

Following the UK’s decision to leave the European Union (EU) we received a large number of requests for more information about European Economic Area (EEA) doctors working in the UK’s healthcare systems. As a result, we wrote a report that gives a detailed breakdown of the data we hold on these doctors.

Our analysis, which shows roughly 10% of the UK’s medical workforce come from EEA countries*, has been welcomed by bodies representing several specialties and will be helpful to us as we plan for the implications of Brexit.

The report gives details of demographic characteristics, years of experience and areas of work of all EEA graduate doctors, and highlights sections of the profession where there is a particularly high concentration (for example, one in six hospital consultants holds a EEA qualification). It also gives a data profile of EEA graduates in each country in the UK and looks at how many have joined or left practice in the period under analysis.

One of the key findings in the report is that following our introduction of English language requirements for EEA doctors wishing to register in 2014 (unrelated to Brexit), the numbers of new EEA graduates joining the profession halved. In addition, the number of EEA-qualified doctors leaving the profession doubled between 2011 and 2014, from 1,810 to 3,373.

The Royal College of Anaesthetists has expressed particular interest in the implications of the findings for anaesthetists. The Royal College of Radiologists has asked for further breakdowns of the number of registration applications made by EEA-qualified doctors on the basis of equivalence of qualifications, to assess what Brexit and the related possibility that medical qualifications obtained in the UK and in the EEA may not be considered equivalent anymore may mean for the profession.

The number of licensed and registered EEA graduates on the UK medical register

* The EEA covers Norway, Iceland and Liechtenstein as well as all EU countries. As Swiss citizens enjoy free movement across the EEA, we also included Switzerland in our analysis for the report.
Supporting vulnerable doctors

As a learning organisation, we also review our own internal processes – particularly where we have a negative impact on those we work with and for.

At the end of 2015, we appointed Professor Louis Appleby from the University of Manchester as an independent expert to advise us on how we can better improve our approach to investigating vulnerable doctors.

As well as working closely with staff at the GMC, Professor Appleby has engaged with doctors who have been through the fitness to practise process, along with people with an interest in the area. He has been listening to people’s experiences and views on the process and their suggestions for how it might be improved.

As a result of his work, Professor Appleby made a number of recommendations that we are now working to implement – to make our investigation processes less stressful for doctors.

Together, we drafted a series of proposals with the aim of reducing stress for doctors, particularly those who may be vulnerable. Professor Appleby’s encouragement for people to share their experiences with him has been valuable when developing the proposals.

The proposals we have implemented include:

- Increasing awareness of our Doctors Support Service by revising web content and messaging in our correspondence, and working with the British Medical Association to deliver training sessions to GMC staff. This aims to increase the number of doctors who use the service – providing them with emotional support to help reduce some of the stress associated with an investigation or hearing.

- Piloting a new Doctor Contact Service to support doctors during a hearing (see also page 12). Feedback so far indicates that the service is well received and will reduce stress for doctors going to a hearing and improve our service.

- Setting up a specialist investigation team to handle cases where the doctor has a known health concern. This involves more sensitive case handling, signposting to support organisations and a personalised communication approach.

- Carrying out provisional enquiries in health-related cases. Using some of the capabilities we have available in determining the priority of cases, we can make some initial enquiries before deciding whether to promote
Learning from our environment

THE IMPACT OF OUR WORK

a complaint to a full investigation. This will reduce the number of complaints leading to full investigations, and should reduce the pressure for doctors who already have health concerns.

Commenting on his work, Professor Appleby said ‘the GMC has recognised the problem and is committed to doing more to support doctors who may be vulnerable or at risk, to make the process more compassionate’.

Supporting members of the public who raise concerns about a doctor

Raising concerns about a doctor can be a stressful experience for some.

To address this issue, in January 2015 we launched a Patient Liaison Service offering patients the opportunity to meet with us across the UK.

The meetings provide dedicated opportunities for personal communication for patients, relatives of patients or members of the public who have made a complaint to us about a doctor’s fitness to practise medicine. They usually take place in one of our offices in London, Manchester, Cardiff, Edinburgh or Belfast, but we can also discuss concerns on the phone if patients or their representatives are unable to travel.

Our patient liaison officers listen to concerns and explain how our investigation process works and its possible outcomes. They also make sure that patients or their representatives understand what we do, signposting other organisations that may be able to help where we can’t.

Case study

A patient liaison officer met with parents of a patient who sadly passed away from undiagnosed type 1 diabetes. The death led to GMC investigations on a number of GPs, all of which were closed with no action apart from one, where the GP in question had a specialist interest in diabetes and should therefore have recognised the symptoms.

The meeting was particularly emotional, and focused especially on why only one doctor was referred to a tribunal.

After the case the family were grateful for being able to meet with someone face to face who was able to give reassurance around the investigation process and what to expect from the tribunal. They felt reassured that their concerns were taken seriously, and that the GMC had handled the case appropriately.
Learning from our environment

Revising our confidentiality guidance to reflect a changing world

In 2016, we worked with doctors, patients and the public to revise our guidance on confidentiality, to better reflect people’s wishes as well as the changing nature of aspects of healthcare.

Much has changed since we published our previous guidance in 2009, particularly in the way data – usually in electronic rather than written form – is shared. As a result, we decided we needed to update our guidance.

The principles that inspired us in this exercise were openness and transparency at all times, and making sure the guidance review was driven from the bottom up rather than top down.
The new guidance has, for instance, been partly informed by the many inquiries doctors made to us about the previous guidance.

As part of our review we also conducted surveys to get feedback from doctors, patients and patient organisations. We also met bodies that had a particular interest in confidentiality issues and held two roundtable events to explore patients' views.

We then held a formal consultation on the draft guidance we had produced. This consisted of questionnaires and a widespread engagement programme, led by our Regional Liaison Service, involving over 1,000 doctors and patients. We also commissioned a MORI Ipsos poll of patient and public attitudes on the subject.

The overall response has been very positive and we published the revised guidance in April 2017. We believe that, as a result of our extensive consultation process, the new guidance will be easier for doctors and patients to understand and should address more fully major areas of concern.

One particularly thorny issue, for instance, is how doctors can reassure people that their loved ones are receiving the right care without breaching confidentiality. The new guidance contains more detailed advice on how they can have these discussions with families without overstepping the mark.

Healthcare law professor, Jonathan Montgomery, who chaired the expert group that oversaw the review of our Confidentiality guidance for doctors, said: 'I'd compliment the GMC on the intelligence with which they approached how to get to grips with different doctor and patient experiences and views, particularly those of seldom-heard groups.'
In summary

The case studies and examples presented in this report demonstrate how our work can impact in many different ways on patient safety and the quality of care.

In particular, we have seen how helping doctors maintain and improve standards, and assuring the quality of education and training, are key elements of effective regulation in the interest of patient safety.

Be this through our national training survey, our support to doctors in understanding and using our guidance, or our revalidation process, we strive to deliver supportive, workable and well informed regulation of the sector.

In the report we have also seen how as a learning organisation, we are on a constant journey of discovery, adapting and innovating the way we work in response to our learning about the ever evolving needs of patients and other groups we work with.

Importantly, this learning trajectory also applies to our approach to impact. Over the next years we intend to continuously improve our ability to measure and document the impact of our work, refining our approach and opening it progressively more to inputs and insights from our external environment.

In doing this, we will continue to keep patient safety as the focus of our endeavour – working with doctors, for patients, in everything we do.

For more information on our activities see also our Annual report 2016, and previous versions of both our annual and impact reports at www.gmc-uk.org/corporate.
The GMC conference gave medical professionals an opportunity to network.

Over 250 people attended our GMC conference.

During themed workshops attendees discussed professionalism in detail.

Professor Kevin Fong was the keynote speaker at our GMC conference 2016 – Promoting and protecting medical professionalism in uncertain times.
Applying to practise in the UK – international medical graduates take the Professional and Linguistics Assessment Board test.

Medical professionalism matters – attendees at our Cardiff event focusing on the compassionate doctor.

Medical professionalism matters – attendees in Birmingham focusing on the doctor’s dilemma.

Applying to practise in the UK – international medical graduates take the Professional and Linguistics Assessment Board test.