Summary note of the meeting on 20 May 2021

GMC Attendees:
Clare Marx (Chair); Charlie Massey; Nicola Cotter; Robert Khan; Paul Knight; Anthony Omo; Willie Paxton; Dan Wynn; Ashley Pheely; Ian Somerville (notes).

External Attendees:
Scott Anderson, BMA Scotland; Susan Gibson-Smith, Medical and Dental Defence Union of Scotland; Tracey Gillies, Scottish Association of Medical Directors; Alisdair Gilmour, BMA Scotland; Ian Hunter, Scottish Directors of Medical Education Group; Amjad Khan, NHS Education for Scotland; John Paul Leach, Scottish Deans Medical Education Group; Anthea Martin, Medical Protection Society; Lynne Meekison, NHS Education for Scotland; Lucy Mulvagh, Health & Social Care Alliance; Donna O’Boyle, Scottish Government; Robbie Pearson, Healthcare Improvement Scotland; Tina Ryan, Scottish Academy Trainee Doctors Group; Alison Smith, Independent Healthcare Providers Network; Hugh Stewart, Medical Defence Union; Jill Vickerman, BMA Scotland; Tony Weetman, Board for Academic Medicine; Vipin Zamvar, British Association of Physicians of Indian Origin

Welcome and Chair’s introduction
1 The Chair welcomed attendees to the UK Advisory Forum (UKAF). She thanked members for attending and welcomed those attending for the first time.

Action from the previous UKAF meeting
2 An update on the action from the last meeting on 14 October 2020 was provided. This was to continue conversations with HIS and others on leadership and regulatory alignment. We have held conversations with HIS as they advance their quality framework and will explore how our insights can support the leadership domain that includes governance, wellbeing, and professionalism. We are also feeding into ongoing work and discussions with the Scottish Government, NES and the Scottish Academy, including on support for leaders as we recover from the pandemic, and ensuring health and welfare support is available to doctors.

Chief Executive’s Update
3 The GMC’s Chief Executive provided an update on our work. He noted:
Our emergency powers, granted to support the response to Covid-19, remain in place. Approximately 2,500 doctors in Scotland continue to hold Temporary Emergency Registration.

We are working with partners to consider the continuing impact of Covid-19 on working environments and implications for education and training.

We recognise the challenge and hard work the pandemic has caused for doctors, and the impact on wellbeing. Work with the Scottish Government on leadership and wellbeing has therefore been particularly important.

We welcome the Department of Health and Social Care (England) (DHSC) consultation, Regulating Healthcare Professionals, Protecting the Public. We have been calling for regulatory reform which will allow us to protect patients and support doctors in the best way.

Equality, Diversity & Inclusion

Anthony Omo provided his reflections on differential rates of fitness to practice referral and training attainment faced by Black and Minority Ethnic (BME) doctors. We have known for a long time that doctors and patients from ethnic minorities experience a different NHS to their white counterparts and more so during the pandemic. We are making progress, but things need to be more focussed and quicker. He noted that the context in which doctors work can influence things for the better or worse, for example the overrepresentation of BME doctors in employer referrals to the GMC could be caused by a variety of factors including lack of timely feedback, gaps in induction, and cultures. We also know that some BME doctors experience less support and more barriers in their training.

He noted that to make progress we need to track what we are doing, and the GMC has therefore set two targets:

- To eliminate disproportionate fitness to practise referrals in relation to ethnicity and origin of medical qualification by 2026.
- Eliminate discrimination, disadvantage and unfairness in undergraduate and postgraduate medical education and training, by 2031.

To do this the GMC needs to do several things. These include reviewing our engagement and support for Responsible Officers (ROs) as their gateway role in referrals to the GMC makes them vital partners to help address issues in the system, using our data to help our partners address the issues within their sphere of influence, and collaborate on shared areas of work which will support us to achieve these targets. We are pleased with early interaction in Scotland, and think progress is possible.
Four external speakers were invited to provide their reflections on the issues from their distinct vantage points:

- Vipin Zamvar spoke about the perception that many BME doctors have of differential referral outcomes. He provided context to the fear doctors have of raising concerns about racism and possible retaliation from colleagues. He then made a few suggestions: that the GMC require RO referrals to include additional information on advice and support that had been offered to doctors; that information on how similar incidents involving white doctors had been handled should also be collected by the GMC; and that as the principle of ‘insight’ can be subjective and something which some cultures struggle with more than others, then the use of objective templates should be considered.

- John Paul Leach spoke about some of the measures the Scottish medical schools are taking, including continual review of differential attainment. A number of schools have established ED&I committees, with the BMA’s ‘A charter for medical schools to prevent and address racial harassment’ at the heart of them. Scottish schools are also looking at their raising concerns policies, looking at the institutional nature of barriers faced by doctors, and providing active bystander training for all students.

- Ian Hunter provided some thoughts from the postgraduate training perspective. He noted the complexity of the situation. He spoke of the importance of data to demonstrate where the problems lay and as a lever to ensure people are engaged. He also spoke of the factors which may influence differential attainment, including supervisors interacting differently with various colleagues, empowerment of all in asking questions and seeking support, and ensuring BME colleagues have enough time to thrive. He suggested possible solutions. Unconscious and active bystander training is being provided, as well as other programmes which are not always tagged as ED&I. These include ‘Civility saves lives’, various wellbeing initiatives, and the Chief Resident programmes. Collaboration is also key, as is sharing data and best practice.

- Tracey Gillies provided a view from the health service, reflecting that the training and the structures that are created need to reflect people’s day to day experience. She questioned how we work to build a better culture, noting the importance of feedback. She spoke about the importance of good feedback which is not ‘done’ to people, but is done in real time, is two-way, and leads to constructive development. She noted that colleagues can be worried about giving feedback, and this can lead to nothing being said or done, division arising in teams and avoidable problems emerging.

GMC Scotland Outreach colleagues then provided some reflections on the work they are doing with colleagues in the health service and individual doctors to provide support.
Willie Paxton spoke about discussions he has been having with ROs using the ‘Fair to refer?’ report. The report enables threshold discussions to focus increasingly on contexts including the environment, culture and induction and support provided when considering referrals. He spoke about the ladder of escalation, whereby when issues get to the level of the RO and then the GMC, it is already too late, so addressing problems early is particularly important. He also spoke about discussions on tracking local alternatives to GMC referrals, particularly where the issues relate to BME doctors.

Dan Wynn described his role in providing workshops on GMC guidance to doctors. Sessions are tailored to the ‘Fair to Refer?’ report to ensure they consider the experience of BME doctors. He highlighted that we are liaising with stakeholders through our BME forum and using our Welcome to UK Practice Programme to support induction. Sessions on the GMC’s leadership and management guidance are focusing on leaders as ‘culture carriers’ with duties around ED&I, and sessions on raising concerns are aiming to support BME doctors to do so constructively and safely. He finished by speaking about collaboration with the Scottish medical schools and Directors for Medical Education.

The Chair thanked the speakers for their input, and then facilitated a wide-ranging discussion. Themes raised included:

- **Collaboration** There is a great deal of good and quite distinct work going on in Scotland to address the problems, which will be aided by closer joint-working by those responsible. It was also commented that work should be joined up across professions, both at the professional level and between regulators.

- **Training and development** Several members spoke about the provision of training and development of students, trainees, and staff. Particular mention of active bystander and unconscious bias training was made, and the need to ensure that this is not only provided to both today’s and tomorrow’s doctors. The importance of clear leadership and establishment of a receptive culture that ensured learning was implemented and actions taken was noted.

- **Data** The importance of both qualitative and quantitative data, not only in demonstrating where targeted intervention is necessary, but in supporting colleagues to engage with the issues.

- **Feedback** The importance of feedback conversations and them being done in a two-way manner and at an early stage.

- **Induction** How this can support doctors in belonging and being part of a team and to be able to access formal and informal support structures. The importance of doctors new to the UK being supported to understand the culture of medical practice and patient care was also noted, as was an induction framework for SAS doctors which has been developed by NES.
■ **Representation** It was noted that a disproportionate number of doctors who turn up to tribunal hearings without medical defence representation are BME, and so encouraging more doctors to join medical defence organisations or professional bodies may also ensure they are supported.

10 The Chair thanked Members for their contributions to the discussion. She noted that the GMC’s Outreach team is trying to work with health boards on professional behaviours. She said that if there are areas that people are struggling with or need input, they should contact the Scotland team, who can run bespoke courses.

11 Summarising the main themes discussed by the Forum, the Chief Executive provided some reflections on the discussion.

■ This is a shared agenda with a strong commitment to improving ED&I in Scotland. It is complicated to address, with issues that are system-wide and multifactorial, but there is power in collective effort. We must demonstrate that people have not only been heard but engaged.

■ A commitment that the GMC would never be complacent about whether there is discrimination in our processes. We recognise we don’t own all the levers to address the change we want to see, but we will continue to share our insights from our data and soft intelligence as these are key in helping us to see uncomfortable truths and take action.

■ There is a need to focus not only on today’s doctors but also future doctors. We recognise training needs to be embedded in clinical governance arrangements as well as in undergraduate and postgraduate training.

■ The importance of formative, not summative feedback. The GMC has a role to play as we restart revalidation and we commit to continue to explore with others how to think about appraisal.

■ Regulatory alignment is important. We have a responsibility to align what good looks like with others in the regulatory system.

■ The pandemic provides a reset opportunity to how we engage with the profession. This issue will require us being impatient for many years. It is not a once and done discussion but will need sustained energy and effort from all. We are committed to playing our part in tackling the challenges of recovery.

*Actions the GMC will take forward include:*

■ Use our data to inform areas for collaboration to make improvements where possible, and highlight areas of good practice, and work collaboratively with stakeholders, including our regulatory partners, Health Boards and the Scottish Government.
- Broaden our engagement with groups, including the new BMA Scotland Race Equality Forum, to understand the key issues and discuss how we can best support.

- Help improve the quality of inductions through Outreach teams working with NES SAS APG Dean to support the rollout of the SAS induction framework.

- We will enhance our outreach workshop on team based reflective practice to encourage constructive feedback models.

12 The Chair thanked Members for their input at this meeting, noting that she looked forward to seeing them again at the autumn UKAF meeting.

13 The next Scotland UKAF meeting is scheduled to take place on 6 October 2021; however, this is subject to change.