



Annual review of performance 2015/16

# General Medical Council



## About the Professional Standards Authority

The Professional Standards Authority for Health and Social Care<sup>1</sup> promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and voluntary registration of people working in health and care. We are an independent body, accountable to the UK Parliament.

We oversee the work of nine statutory bodies that regulate health professionals in the UK and social workers in England. We review the regulators' performance and audit and scrutinise their decisions about whether people on their registers are fit to practise.

We also set standards for organisations holding voluntary registers for people in unregulated health and care occupations and accredit those organisations that meet our standards.

To encourage improvement we share good practice and knowledge, conduct research and introduce new ideas including our concept of right-touch regulation.<sup>2</sup> We monitor policy developments in the UK and internationally and provide advice to governments and others on matters relating to people working in health and care. We also undertake some international commissions to extend our understanding of regulation and to promote safety in the mobility of the health and care workforce.

We are committed to being independent, impartial, fair, accessible and consistent. More information about our work and the approach we take is available at [www.professionalstandards.org.uk](http://www.professionalstandards.org.uk).

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<sup>1</sup> The Professional Standards Authority for Health and Social Care was previously known as the Council for Healthcare Regulatory Excellence.

<sup>2</sup> *Right-touch regulation revised (October 2015)*. Available at [www.professionalstandards.org.uk/policy-and-research/right-touch-regulation](http://www.professionalstandards.org.uk/policy-and-research/right-touch-regulation).

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## About the General Medical Council

The General Medical Council (the GMC) regulates doctors in the United Kingdom. Its work includes:

- Setting standards for education and training of doctors, accrediting education and training providers, approving qualifications and assuring the quality of medical education and training
- Setting and maintaining standards of conduct, ethics and performance for doctors
- Managing a register of qualified professionals. Only those registered with a licence to practise can practise medicine in the UK<sup>3</sup>
- Taking action to restrict or remove from practice individual registrants who are considered not fit to practise.

As of 30 June 2016, the GMC was responsible for a register of 274,060 doctors. The fee for registration with a licence to practise is £425. For registration without a licence to practise, the fee is £152.

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<sup>3</sup> Doctors who wish to practise medicine in the UK need to hold a registration with a licence to practise. If a doctor does not wish to practise medicine in the UK, but wishes to retain GMC registration to demonstrate good standing with the GMC, they can choose to hold registration without the licence to practise.



# At a glance

Annual review of performance

Regulator reviewed: **General Medical Council**

## Standards of good regulation

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### Core functions

**Met**

Guidance and Standards

**4/4**

Education and Training

**4/4**

Registration

**6/6**

Fitness to Practise

**10/10**

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# 1. The annual performance review

- 1.1 We oversee the nine health and care professional regulatory organisations in the UK, including the GMC.<sup>4</sup> More information about the range of activities we undertake as part of this oversight, as well as more information about these regulators, can be found on our website.
- 1.2 An important part of our oversight of the regulators is our annual performance review, in which we report on the delivery of their key statutory functions. These reviews are part of our legal responsibility. We review each regulator on a rolling 12 month basis and vary the scope of our review depending on how well we see the regulator is performing. We report the outcome of reviews annually to the UK Parliament and the governments in Scotland, Wales and Northern Ireland.
- 1.3 These performance reviews are our check on how well the regulators have met our *Standards of Good Regulation* (the Standards) so that they protect the public and promote confidence in health and care professionals and themselves. Our performance review is important because:
- It tells everyone how well the regulators are doing
  - It helps the regulators improve, as we identify strengths and weaknesses and recommend possible changes.

## The Standards of Good Regulation

- 1.4 We assess the regulators' performance against the Standards. They cover the regulators' four core functions:
- Setting and promoting guidance and standards for the profession
  - Setting standards for and quality assuring the provision of education and training
  - Maintaining a register of professionals
  - Taking action where a professional's fitness to practise may be impaired.
- 1.5 The Standards describe the outcomes we expect regulators to achieve in each of the four functions. Over 12 months, we gather evidence for each regulator to help us see if they have been met.
- 1.6 We gather this evidence from the regulator, from other interested parties, and from the information that we collect about them in other work we do. Once a year, we collate all of this information and analyse it to make a recommendation to our internal panel of decision-makers about how we believe the regulator has performed against the Standards in the previous

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<sup>4</sup> These are the General Chiropractic Council; the General Dental Council; the General Medical Council; the General Optical Council; the General Osteopathic Council; the General Pharmaceutical Council; the Health and Care Professions Council; the Nursing and Midwifery Council; and the Pharmaceutical Society of Northern Ireland.

- 12 months. We use this to decide the type of performance review we should carry out.
- 1.7 We will recommend that additional review of their performance is unnecessary if:
- We identify no significant changes to the regulator’s practices, processes or policies during the performance review period; and
  - None of the information available to us indicates any concerns about the regulator’s performance that we wish to explore in more detail.
- 1.8 We will recommend that we ask the regulator for more information if:
- There have been one or more significant changes to a regulator’s practices, processes or policies during the performance review period; but
  - None of the information we have indicates any concerns or raises any queries about the regulator’s performance that we wish to explore in more detail.
- 1.9 This will allow us to assess the reasons for the change(s) and the expected or actual impact of the change(s) before we finalise our performance review report. If the further information provided by the regulator raises concerns, we reserve the right to make a further recommendation to the panel that a ‘targeted’ or ‘detailed’ review is necessary.
- 1.10 We will recommend that a ‘targeted’ or ‘detailed’ performance review is undertaken, if we consider that there are one or more aspects of a regulator’s performance that we wish to examine in more detail because the information we have (or the absence of relevant information) raises one or more concerns about the regulator’s performance against one or more of the Standards:
- A ‘targeted’ review may be carried out when we consider that the information we have indicates a concern about the regulator’s performance in relation to a small number of specific Standards, usually all falling within the same performance review area
  - A ‘detailed’ review may be carried out when we consider that the information we have indicates a concern about the regulator’s performance across several Standards, particularly where they span more than one area.
- 1.11 We have written a guide to our performance review process, which can be found on our website [www.professionalstandards.org.uk](http://www.professionalstandards.org.uk)

## 2. What we found – our decision

2.1 During September 2016 we carried out an initial review of the GMC's performance for the period from 1 April 2015 to 30 June 2016.<sup>5</sup> Our review included an analysis of the following:

- Council papers, including performance reports and updates, committee reports and meeting minutes
- Policy and guidance documents
- Statistical performance dataset (see paragraphs 2.6 to 2.8 below)
- Third party feedback
- A check of the GMC register
- Information available to us through our review of final fitness to practise decisions under the Section 29 process.<sup>6</sup>

2.2 As a result of this assessment, we decided that a targeted review was required of the GMC's performance against Standard 6 of the *Standards of Good Regulation* for Fitness to Practise.<sup>7</sup>

2.3 We sought and obtained further information from the GMC in relation to this Standard, and carried out a detailed analysis. As a result, we decided that this Standard was met. The reasons for this are set out in the following sections of this report.

### Summary of the GMC's performance

2.4 For 2015/16 we have concluded that the GMC:

- Met all of the *Standards of Good Regulation* for Guidance and Standards
- Met all of the *Standards of Good Regulation* for Education and Training
- Met all of the *Standards of Good Regulation* for Registration
- Met all of the *Standards of Good Regulation* for Fitness to Practise.

2.5 The GMC has maintained its performance since last year.

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<sup>5</sup> This year's review covered a longer period than usual due to the change in our performance review process.

<sup>6</sup> Each regulator we oversee has a 'fitness to practise' process for handling complaints about health and care professionals. The most serious cases are referred to formal hearings in front of fitness to practise panels. We review every final decision made by the regulators' fitness to practise panels. If we consider that a decision is insufficient to protect the public properly we can refer them to Court to be considered by a judge. Our power to do this comes from Section 29 of the [NHS Reform and Health Care Professions Act 2002 \(as amended\)](#).

<sup>7</sup> The sixth *Standard of Good Regulation* for Fitness to Practise: Fitness to practise cases are dealt with as quickly as possible taking into account the complexity and type of case and the conduct of both sides. Delays do not result in harm or potential harm to patients and service users. Where necessary the regulator protects the public by means of interim orders.

## Key comparators

- 2.6 We have identified with all of the regulators the numerical data that they should collate, calculate and provide to us, and which items of data we think provide helpful context about each regulator's performance.
- 2.7 We expect to report on these comparators both in each regulator's performance review report and in our overarching reports on performance across the sector. We will compare the regulators' performance against these comparators where we consider it appropriate to do so.
- 2.8 Set out below is the comparator data which the GMC has provided to us for the period under review.

	Comparator	Annual 2015/16 <sup>8</sup>	Quarter 1 2016/17 <sup>9</sup>
1	The number of registration appeals concluded, where no new information was presented, that were upheld	Data not available <sup>10</sup>	Data not available <sup>10</sup>
2	Median time (in working days) taken to process initial registration applications for <ul style="list-style-type: none"> <li>• UK graduates</li> <li>• EU (non-UK) graduates</li> <li>• International (non-EU) graduates</li> </ul>	<p style="text-align: center;">1</p> <p style="text-align: center;">31</p> <p style="text-align: center;">19</p>	<p style="text-align: center;">1</p> <p style="text-align: center;">30</p> <p style="text-align: center;">17</p>
3	Time from receipt of initial complaint to the final Investigation Committee/Case Examiner decision <ul style="list-style-type: none"> <li>• Median</li> <li>• Longest case</li> <li>• Shortest case</li> </ul>	<p style="text-align: center;">35.6 weeks</p> <p style="text-align: center;">453.7 weeks</p> <p style="text-align: center;">0.7 weeks</p>	<p style="text-align: center;">29.1 weeks</p> <p style="text-align: center;">391.1 weeks</p> <p style="text-align: center;">0.9 weeks</p>
4	Time from receipt of initial complaint to final fitness to practise hearing <ul style="list-style-type: none"> <li>• Median</li> <li>• Longest case</li> <li>• Shortest case</li> </ul>	<p style="text-align: center;">99.7 weeks</p> <p style="text-align: center;">727.3 weeks</p> <p style="text-align: center;">10.4 weeks</p>	Data not available <sup>11</sup>
5	Median time to an interim order decision from receipt of complaint	7.6 weeks	8.1 weeks

<sup>8</sup> From 1 April 2015 to 31 March 2016.

<sup>9</sup> From 1 April 2016 to 30 June 2016.

<sup>10</sup> The GMC is currently unable to report on this data but is considering how it can do so in the future.

<sup>11</sup> We collect this data annually rather than quarterly.

6	Outcomes of the Authority's appeals against final fitness to practise decisions		
	<ul style="list-style-type: none"> <li>Dismissed</li> </ul>	0	0
	<ul style="list-style-type: none"> <li>Upheld and outcome substituted</li> </ul>	0	0
	<ul style="list-style-type: none"> <li>Upheld and case remitted to regulator for re-hearing</li> </ul>	1	0
	<ul style="list-style-type: none"> <li>Settled by consent</li> </ul>	1	0
	<ul style="list-style-type: none"> <li>Withdrawn</li> </ul>	0	0
7	Number of data breaches reported to the Information Commissioner	0	0
8	Number of successful judicial review applications	7	Data not available <sup>11</sup>

### 3. Guidance and Standards

3.1 The GMC has met all of the *Standards of Good Regulation* for Guidance and Standards during 2015/16. Examples of how it has demonstrated this are shown below each individual Standard.

**Standard 1: Standards of competence and conduct reflect up-to-date practice and legislation. They prioritise patient and service user safety and patient and service user centred care**

3.2 The GMC last revised *Good Medical Practice* (its core guidance for doctors) in April 2014 to include a new duty about doctors' knowledge of the English language. We have not seen any evidence that this needs further revision.

**Standard 2: Additional guidance helps registrants apply the regulators' standards of competence and conduct to specialist or specific issues including addressing diverse needs arising from patient and service user centred care**

3.3 The GMC published several pieces of guidance to help registrants understand their obligations around specific issues. Following a change in the law,<sup>12</sup> new rules came into effect on 1 August 2015, giving the GMC the power to check whether doctors have appropriate insurance or indemnity in place.<sup>13</sup> The GMC contacted doctors to inform them of the new legal requirement, and published further information on its website.

<sup>12</sup> The Health Care and Associated Professions (Indemnity Arrangements) Order 2014.

<sup>13</sup> This was already included as a professional duty in *Good Medical Practice*; however, this is now a legal requirement.

- 3.4 Other advice issued included:
- Reporting concerns to the Driver and Vehicle Licensing Agency (DVLA)
  - Responding to cases of female genital mutilation
  - Supporting transgender patients
  - Guidance for doctors offering cosmetic interventions.
- 3.5 The GMC continued to review and update guidance on its webpages dedicated to such issues as *Better Care for Older People* and *Treatment and care towards the end of life*. These pages bring together a number of online resources.
- 3.6 As we reported last year, the GMC worked with the Nursing and Midwifery Council on joint guidance for their registrants on the practical application of the professional 'duty of candour'. The guidance, *Openness and honesty when things go wrong: the professional duty of candour*, was developed in response to Sir Robert Francis QC's call for a more open and transparent culture within healthcare following the failures in patient care at Mid Staffordshire NHS Foundation Trust.<sup>14</sup> This guidance was published in June 2015.
- 3.7 To help doctors understand how *Good Medical Practice* and additional guidance can be used in practice, the GMC has a number of online tools. During this review period, the GMC added a mental capacity decision support tool to help doctors decide what to do when they doubt their patient's capacity to make decisions about their care. This draws on the principles from the guidance, *Consent: patients and doctors making decisions together* and *Treatment and care towards the end of life: good practice in decision making*.

**Standard 3: In development and revision of guidance and standards, the regulator takes account of stakeholders' views and experiences, external events, developments in the four UK countries, European and international regulation and learning from other areas of the regulators' work**

- 3.8 The GMC carried out several public consultation exercises during the performance review period. These included consultations on:
- The guidance on the duty of candour. This was published in June 2015.
  - The guidance for doctors who offer cosmetic procedures. This was published in April 2016.
  - Revised guidance on confidentiality. This was published in January 2017, and is to come into force on 25 April 2017.
- 3.9 We have seen evidence that the GMC engages with stakeholders in developing guidance and standards. As outlined above, the GMC issued

<sup>14</sup> Francis, R. (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, chaired by Robert Francis QC, 2013*. [Online] Available at: [webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/report](http://www.midstaffspublicinquiry.com/report) (Accessed: 28 November 2016)

advice to doctors on how to support transgender patients. The British Medical Association (BMA)<sup>15</sup> raised concerns that this guidance suggested that GPs should consider prescribing medication outside of their expertise and competence, undermining the principles of *Good Medical Practice*. The GMC revised the wording of the guidance, taking into account the BMA's concerns, to make clear the exceptional circumstances when prescriptions should be considered.

- 3.10 During this performance review period, the GMC made a number of statements and issued advice to doctors considering industrial action over the Department of Health's decision relating to new contracts for junior doctors. It also issued advice about the industrial action to employers, doctors in leadership roles, senior doctors, and those not in training.

**Standard 4: The standards and guidance are published in accessible formats. Registrants, potential registrants, employers, patients, service users and members of the public are able to find the standards and guidance published by the regulator and can find out about the action that can be taken if the standards and guidance are not followed**

- 3.11 The GMC continues to publish its guidance and standards on its website, together with information about how to make a complaint if these are not followed. The guidance and standards are available in English as well as Welsh. They can be requested in other formats or languages. The website, including the section on guidance and standards, can be read in varying text sizes and colours and is 'Browsealoud'<sup>16</sup> enabled. The GMC continues to promote awareness of its guidance and standards through a variety of means including blogs, social media, events and newsletters.

## 4. Education and training

- 4.1 The GMC has met all of the *Standards of Good Regulation* for Education and Training during 2015/16. Examples of how it has demonstrated this are shown below each individual Standard.

**Standard 1: Standards for education and training are linked to standards for registrants. They prioritise patient and service user safety and patient and service user centred care. The process for reviewing or developing standards for education and training should incorporate the views and experiences of key stakeholders, external events and the learning from the quality assurance process**

### Education standards

- 4.2 The GMC sets the educational standards for undergraduate and postgraduate education and training. In January 2016 a single set of standards the GMC expects education providers to meet came into effect.

<sup>15</sup> The British Medical Association is the trade union and professional body for doctors in the UK.

<sup>16</sup> Assistive technology that adds text-to-speech functionality to websites.

*Promoting excellence: standards for medical education and training* combines and replaces standards for undergraduate medical education (*Tomorrow's Doctors*) and standards for postgraduate training (*The Trainee Doctor*).

- 4.3 These standards address recommendations from the Berwick Review<sup>17</sup> around ensuring medical education and training focuses on patient safety and quality improvement. They are designed to ensure that patients' safety, experience and quality of care, as well as fairness to learners based on the principles of equality and diversity, lie at the core of teaching and training. The standards set out how organisations must promote and encourage a learning environment and culture that allows learners and trainers to raise concerns about patient safety, and the standard of training, without fear of negative consequences.

### Postgraduate medical education and training

- 4.4 After completing a medical degree, medical graduates enter practice at 'foundation' level. Once they have completed foundation year one (F1) and foundation year two (F2), they move into GP or speciality training. As part of its work in quality assuring medical education and training, the GMC approves postgraduate medical education curricula and programmes of assessment to make sure that they meet the GMC's registration requirements. Currently the GMC approves 66 specialties and 32 sub-specialties. In deciding whether to approve the curricula of each discipline, the GMC uses its *Standards for curriculum and assessment systems*.
- 4.5 During this performance review period, the GMC began a project to review these standards to ensure they are up to date (they were written almost 10 years ago) and to take into account developments in postgraduate training and assessment.
- 4.6 So far the GMC has engaged with various stakeholders, including the medical Royal Colleges and faculties; identified areas of concern from its own internal review of postgraduate medical curricula; and commissioned expert advice on key principles in the design of modern professional curricula and assessment frameworks. A public consultation on the draft set of standards closed in October 2016.
- 4.7 The GMC aims to publish its new standards in 2017, which will be used in conjunction with *Promoting excellence: standards for medical education and training*.
- 4.8 There are a number of other areas of the GMC's work that are linked to the development of these standards, which we discuss below and at paragraph 5.12:

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<sup>17</sup> Professor Don Berwick, an international expert in patient safety, carried out a review into patient safety following the publication of the Francis Report into the breakdown of care at Mid Staffordshire Hospital. Berwick, D. (2013) *A promise to learn – a commitment to act. Improving the Safety of Patients in England*. [Online] Available at: [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/226703/Berwick\\_Report.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf) (Accessed: 8 November 2016)

- The Generic Professional Capabilities framework
- The introduction of regulated credentials
- Addressing differences in educational attainment.

### Generic Professional Capabilities

- 4.9 To ensure its standards for education and training prioritise patient and service user safety, the GMC has developed a framework for Generic Professional Capabilities (GPC). These are broader skills such as communication and team working needed by doctors across all medical specialities to help provide safe and effective patient care. The *Shape of Training review*<sup>18</sup> into postgraduate medical education and training recommended the development of such a framework to ensure greater consistency in training outcomes across the medical workforce.
- 4.10 During 2015 the GMC jointly consulted with the Academy of Medical Royal Colleges<sup>19</sup> on the draft framework. The GMC agreed on the GPC framework in February 2016. It introduces core educational outcomes, common to all specialty and general practice training in the UK. The GPC framework will slot into all postgraduate medical curricula using the revised curricula and assessment standards. The GMC is now working with the Academy of Medical Royal Colleges to help medical Royal Colleges and faculties embed GPC into all postgraduate medical curricula in 2017.
- 4.11 The development of GPC is part of a wider project the GMC is carrying out to review how doctors in training can gain flexibility in changing specialisms which was agreed as part of the agreement reached between the Government and the BMA in May 2016 about the junior doctors' contract. Although the contract was subsequently rejected, the GMC decided to continue with this work in light of support for the project from representatives of doctors in training. The GMC hopes this will address the problem of the inflexibility in the current training pathways as identified in the *Shape of Training review*. The GMC plans to present its report to the four Governments across the UK by the end of March 2017. This will follow engagement with the Royal Colleges in England and Scotland, doctors in training across the UK, as well as Health Education England, NHS Education for Scotland, the Wales Deanery and the Northern Ireland Medical and Dental Training Agency.

### Differences in educational attainment

- 4.12 Last year we reported on the GMC's work in trying to better understand the differential in the examination results of black and minority ethnic (BME) UK

<sup>18</sup> Greenaway, R. (2013) *Shape of Training. Securing the future of excellent patient care*. [Online] Available at: [www.shapeoftraining.co.uk/static/documents/content/Shape\\_of\\_training\\_FINAL\\_Report.pdf\\_53977887.pdf](http://www.shapeoftraining.co.uk/static/documents/content/Shape_of_training_FINAL_Report.pdf_53977887.pdf) (Accessed: 28 November 2016)

<sup>19</sup> The Academy of Medical Royal Colleges is the coordinating body for the UK and Ireland's 24 medical Royal Colleges and faculties. They ensure patients are safely and properly cared for by setting standards for the way doctors are educated, trained and monitored throughout their careers.

and international medical graduates (IMG) compared with those of white UK graduates.

- 4.13 In July 2016 the GMC published its annual data on the progression of doctors through key stages in their training gathered through its quality assurance activity. Initial analysis of this showed that white UK medical graduates remain more likely to pass specialty exams than their BME counterparts, whilst doctors whose primary qualification was gained outside the UK or European Economic Area (EEA) are even less likely to do well in exams or recruitment.
- 4.14 The GMC also published the report, *Fair training pathways for all: understanding experiences of progression*,<sup>20</sup> based on independent research it commissioned University College London to conduct. This research found that BME UK graduates and doctors who qualified overseas faced risks of unconscious bias in assessments, recruitment and day-to-day working.
- 4.15 The GMC plans to work with others to continue to address this issue, including in reviewing its *Standards for curriculum and assessment systems* by introducing specific requirements for medical education and training organisations to show they include fairness and equality in all aspects of their work. We note the GMC's ongoing commitment to helping ensure fairness and a diverse workforce.

#### **Guidance for medical students and schools**

- 4.16 The GMC worked with the Medical Schools Council (MSC)<sup>21</sup> to develop two guidance documents on dealing with fitness to practise concerns in medical schools and universities.
- 4.17 Following a public consultation, the final versions of *Achieving good medical practice: guidance for medical students and Professional behaviour and fitness to practise: guidance for medical schools and their students* were published in May 2016, and came into effect in September 2016.

**Standard 2: The process for quality assuring education programmes is proportionate and takes account of the views of patients, service users, students and trainees. It is also focused on ensuring the education providers can develop students and trainees so that they meet the regulator's standards for registration**

- 4.18 There were no significant changes to the GMC's process for quality assuring education programmes in this performance review period.
- 4.19 The GMC quality assures education and training providers by region and reviews new medical schools and programmes to ensure they comply with the GMC standards for undergraduate and postgraduate medical education. It also carries out small specialty reviews (tailored reviews into a medical specialty with relatively few doctors in training).

<sup>20</sup> General Medical Council. (2016) *Fair training pathways for all: understanding experiences of progression*. [Online] Available at: [www.gmc-uk.org/2016\\_04\\_28\\_FairPathwaysFinalReport.pdf](http://www.gmc-uk.org/2016_04_28_FairPathwaysFinalReport.pdf) 66939685.pdf (Accessed: 6 January 2017)

<sup>21</sup> The Medical Schools Council represents the interests and ambitions of UK Medical Schools.

- 4.20 During this performance review period, the GMC undertook an exercise to ensure that quality assurance processes were updated to reflect the new standards, *Promoting excellence: standards for medical education and training*.
- 4.21 The GMC has created a *Sharing good practice* web page. Sharing learning in this way assists education and training providers to meet the GMC's Standards.

### **Standard 3: Action is taken if the quality assurance process identifies concerns about education and training establishments**

#### **Enhanced monitoring**

- 4.22 The GMC introduces 'enhanced monitoring'<sup>22</sup> if there are concerns about a medical school, deanery, local education and training board or local education provider. The GMC publishes on its website the issues which it identifies as requiring enhanced monitoring. For each issue the GMC summarises:
- The nature of the issue
  - What action has been taken locally and by the GMC
  - How progress is monitored
  - What the status of the issue is.
- 4.23 The information on this dedicated page on the website is updated every three months. The GMC publishes issues that require enhanced monitoring with the aim that greater transparency will drive improvements.
- 4.24 During this review period, the GMC identified concerns about the safety of the environment for patients and for doctors in training at an emergency department of an NHS Trust and placed it under its enhanced monitoring process. We saw evidence that the GMC took action and has worked closely with Health Education England (HEE), NHS England, NHS Improvement and other parties to address the issues identified.
- 4.25 In May 2016 the GMC issued HEE with a pre-statutory notice of its intention to withdraw doctors in training from the NHS Trust if the situation did not improve. On 16 June 2016 the GMC issued the HEE with a letter informing it that it would be placing formal conditions on the approval of all training posts within the emergency department. The GMC continues to work with HEE, NHS England, NHS Improvement and other parties to make sure the progress made at the NHS Trust is sustainable so that doctors in training receive the support they need.

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<sup>22</sup> The enhanced monitoring process is used where there are concerns about the training of medical students and doctors. The GMC works with all the organisations involved to improve the quality of training. Issues that require enhanced monitoring are those that the GMC believes could adversely affect patient safety, doctors' progress in training, or the quality of the training environment.

#### **Standard 4: Information on approved programmes and the approval process is publicly available**

- 4.26 The GMC continues to publish information on its website about approved training programmes. It also provides details of its approval and quality assurance process, including inspection reports.

## **5. Registration**

- 5.1 The GMC has met all of the *Standards of Good Regulation* for Registration during 2015/16. Examples of how it has demonstrated this are shown below each individual Standard.

#### **Standard 1: Only those who meet the regulator's requirements are registered**

- 5.2 We have not seen any information which suggests that the GMC has added anyone to its register who has not met the registration requirements. This Standard continues to be met.

#### **Standard 2: The registration process, including the management of appeals, is fair, based on the regulator's standards, efficient, transparent, secure, and continuously improving**

- 5.3 The GMC has not reported any significant changes to its registration processes and we note that the number of appeals against decisions to refuse registration are in line with previous years.

#### **Medical Licensing Assessment**

- 5.4 In June 2015 the GMC decided to work with experts and partners to develop a model for the Medical Licensing Assessment (MLA) prior to formal consultation. The aim of the MLA is to reduce variation and inconsistency by introducing a common threshold for safe practice that those seeking entry to the UK medical register would have to meet.
- 5.5 There are currently three separate routes to registration with the GMC:
- UK graduates: All UK medical schools set their own curricula and methods of assessment, meaning that UK graduates are not assessed in a common way
  - European Economic Area (EEA) graduates: EEA doctors can work in the UK based on a Directive from the European Commission that requires the GMC to recognise primary and specialist medical qualifications. The GMC is not permitted to check the skills and competence of EEA doctors when they register to practise in the UK. This may change depending on the outcome of the negotiations on the UK leaving the European Union
  - International medical graduates (IMGs): Some IMGs take the two part Professional and Linguistic and Assessments Board (PLAB) test. Others

can join the UK register through, for example sponsorship arrangements approved by the GMC; or an acceptable postgraduate qualification.

- 5.6 As part of this engagement, the GMC has visited all of the UK medical schools to discuss its proposals for the MLA, met with the four Governments of the UK, held a series of workshops with GMC associates and other experts, and met with key stakeholders such as the BMA and the MSC.
- 5.7 In the model developed for consultation, applicants would be assessed on their applied knowledge and clinical and professional skills. The GMC launched a formal consultation in January 2017, and plans to conduct investigation, testing and pilots between 2018 and 2021, with full implementation of the MLA expected from 2022.

**Standard 3: Through the regulator's registers, everyone can easily access information about registrants, except in relation to their health, including whether there are restrictions of their practice**

- 5.8 As part of our performance review we checked a sample of entries on the GMC's register, the List of Registered Medical Practitioners (LRMP). We did not find any errors or other evidence to suggest the GMC's register is not accurate or accessible.

**The online register**

- 5.9 The information available on the register was reviewed by the GMC in 2014/15. It published research which found that there was a public interest in making more information available. The research also found that the register had limited information compared to that made available by other regulators inside and outside of the health and social care sector, nationally and internationally, and that the information available had not kept pace with changes in the GMC's functions.
- 5.10 Since 30 January 2016 more information has been made available. The register now shows:
- Which doctors are in approved training programmes, which specialty programme they are in as well as their deanery or local education and training board
  - For doctors with a licence to practise who are connected to a designated body,<sup>23</sup> the name of that body and their responsible officer is shown
  - Which doctors are recognised as GP trainers.
- 5.11 A further consultation on additional proposed changes to the information available on the register closed in October 2016. We responded to this consultation, and agreed that the register needs to change to adapt to new requirements in the interest of public protection, and that the GMC's plans align with numerous findings from our paper, *Health professional regulators registers, Maximising their contribution to public protection and patient*

<sup>23</sup> The 'designated body' is generally the organisation the doctor works for (for example, the designated body for GPs is NHS England). Each designated body has a 'responsible officer' (usually the medical director).

safety.<sup>24</sup> However, we also stated that having more voluntary information on the register may mean there are disparities in information provided by different groups of professionals. Some professionals may provide less information and the public could feel less confident about seeking care from those professionals than they would from other groups who provide more information.

### Credentialing

- 5.12 From 1 July to 7 October 2015 the GMC ran a consultation on the broad principles and processes for a credentialing model.<sup>25</sup> The GMC decided in April 2016 that it will work with a small number of specialty areas in order to evaluate and test the cost-effectiveness and efficacy of the credentialing model during 2016/17. The GMC is planning further discussion before it decides which specialty areas will test the model.

### Publication of fitness to practise sanctions

- 5.13 Between July and September 2015, the GMC held a public consultation on its fitness to practise publication and disclosure policy. The proposals included introducing time limits for publication of fitness to practise sanctions, and limiting the information provided to employers about a doctor's fitness to practise history.
- 5.14 We responded to this consultation.<sup>26</sup> For the most part, we considered the GMC's proposals would result in greater transparency and clearer information for the public and employers. The proposed timeframes were above the minimum we recommended.<sup>24</sup>
- 5.15 However, we said in our response that we would have concerns if the new time limits for publication were combined with new limitations on disclosure to employers. Our view is that when information is no longer available on the public-facing register, it must continue to be made available to prospective employers for reasons of public protection. We felt strongly that the GMC should continue to disclose information routinely about past sanctions to prospective employers – as well as to current employers and overseas regulators.
- 5.16 In response to the GMC's proposal to stop publishing fitness to practise information after a doctor dies, we said that there were important reasons

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<sup>24</sup> Professional Standards Authority. (2010) *Health professional regulators registers, Maximising their contribution to public protection and patient safety*. [Online] Available at: [www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/health-professional-regulators-registers-2010.pdf?sfvrsn=8](http://www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/health-professional-regulators-registers-2010.pdf?sfvrsn=8) (Accessed: 5 December 2016)

<sup>25</sup> Credentialing is defined as 'a process which provides formal accreditation of competences (which include knowledge, skills and performance) in a defined area of practice, at a level that provides confidence that the individual is fit to practise in that area...'. Credentialing will be particularly relevant for doctors who work in areas of medical practice that are not covered by the GMC's existing standards for training and in new and emerging areas of medical practice.

<sup>26</sup> Professional Standards Authority. (2015) *Response to the General Medical Council consultation on Changes to the information they publish and disclose about a doctor's fitness to practise*. [Online] Available at: [www.professionalstandards.org.uk/docs/default-source/publications/consultation-response/others-consultations/2015/gmc-changes-to-information-about-doctors-fitness-to-practise.pdf](http://www.professionalstandards.org.uk/docs/default-source/publications/consultation-response/others-consultations/2015/gmc-changes-to-information-about-doctors-fitness-to-practise.pdf) (Accessed 28 November 2016)

why the information may continue to be needed: it may be relevant to an ongoing complaint, investigation or enquiry that the GMC may not be aware of. We considered that information relating to a sanction – in other words, the notice of determination – should be kept in the public domain so that the functions of maintaining public confidence in the profession and upholding professional standards can be fulfilled. Beyond a certain date, any identifiable information could be removed if necessary.

5.17 We note that following the consultation the GMC has decided that it will not disclose fitness to practise information to prospective employers. It says this is to prevent a disproportionate effect on a doctor's career prospects when the incident took place a long time ago and there are no other ongoing concerns. However, it will continue to disclose information to employers as part of their checks once a doctor has accepted an offer of employment. It has also decided to stop publishing fitness to practise information about doctors who have died. This information will continue to be available on request within the relevant time limits.

5.18 The GMC aims to implement these changes in early 2017.

**Standard 4: Employers are aware of the importance of checking a health professional's registration. Patients, service users and members of the public can find and check a health professional's registration**

5.19 The register remains prominently displayed on the GMC's website. There is a page on the GMC's website dedicated to helping employers understand their obligations when employing and contracting doctors. There is also advice for the public on the role of the GMC, including in maintaining the register. The register allows employers, patients and members of the public to check a doctor's registration.

**Standard 5: Risk of harm to the public and of damage to public confidence in the profession related to non-registrants using a protected title or undertaking a protected act is managed in a proportionate and risk-based manner**

5.20 We have not identified any changes to the GMC's approach to managing this risk. The GMC has guidance on its website on the activities which can only be carried out by a person who is registered and holds a licence to practise. It is clear that those without a licence to practise cannot carry out those activities.

## Standard 6: Through the regulator's continuing professional development/revalidation systems, registrants maintain the standards required to stay fit to practise

### Revalidation

- 5.21 As of June 2015, 148,143 of the 224,938 doctors who were required to revalidate<sup>27</sup> by March 2018 had done so. Where doctors had not engaged in the process, steps were taken to withdraw their licence. This happened in 2,846 cases.
- 5.22 The GMC appointed an independent UK-wide collaboration of researchers, UMbRELLA (UK Medical Revalidation Evaluation collaboration), to carry out a long-term evaluation of revalidation. Its aim is to explore the impact of revalidation and ways to help shape it in the future. This started in 2014 and is due to conclude in 2018. In April 2016 it published an interim report.<sup>28</sup> Some of the key findings were that 4 out of 10 doctors are changing their practice as a result of their last appraisal but that there was also scepticism amongst doctors about whether revalidation has led to improved patient safety, and about whether the process will identify doctors in difficulty at an earlier stage. Responding doctors had mixed views about whether revalidation would improve standards of practice.
- 5.23 In addition to this research, the chair of the GMC's Revalidation Advisory Board conducted a review of revalidation, which was published in January 2017. This examined evidence on the operation and impact of revalidation since its launch in 2012 and looked at how it can be improved. The GMC aims to implement recommendations for change during 2017.

## 6. Fitness to Practise

- 6.1 We were unable to assess the GMC's performance against Standard 6 in this area and so carried out a targeted review. The reasons for this, and what we found as a result, are set out under the relevant Standard below. Following the review, we concluded that this Standard was met and therefore the GMC

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<sup>27</sup> Revalidation is the process by which all licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise in their chosen field and able to provide a good level of care. Doctors are normally required to revalidate every five years. In order to do so, they must have a regular appraisal based on the principles in *Good Medical Practice*, for which they must provide and reflect on supporting information such as patient feedback. Doctors have a connection to a 'designated body' which is often the organisation the doctor works for and that body is required to ensure that the doctor has access to an appraisal. Each designated body has a 'responsible officer' (usually the medical director) who makes a recommendation to the GMC that a doctor should be revalidated. The GMC will then carry out further checks before making the decision to revalidate the doctor. If the responsible officer is unable to make a recommendation to revalidate because the doctor needs to provide more evidence or is subject to an ongoing local investigation, they may ask the GMC for a 'deferral' to allow more time for the recommendation decision to be reached. Doctors who do not or are unable to meet the requirements for revalidation may have their licence to practise withdrawn but may remain on the register without a licence to practise. Revalidation was introduced in December 2012.

<sup>28</sup> UMbRELLA. (2016) *Shaping the future of medical revalidation – interim report*. [Online] Available at: [www.gmc-uk.org/UMbRELLA\\_interim\\_report\\_FINAL.pdf\\_65723741.pdf](http://www.gmc-uk.org/UMbRELLA_interim_report_FINAL.pdf_65723741.pdf) (Accessed: 28 November 2016)

has met all of the *Standards of Good Regulation* for Fitness to Practise in 2015/16.

**Standard 1: Anybody can raise a concern, including the regulator, about the fitness to practise of a registrant**

- 6.2 There is a 'Concerns about doctors' section on the GMC website. This provides details of the types of complaints that the GMC can look at, as well as a link to an online form to submit a complaint. There are email and telephone contact details. There is also information for patients, including about the complaints process and other organisations that can assist. This information can be requested in different languages.

**Standard 2: Information about fitness to practise concerns is shared by the regulator with employers/local arbitrators, system and other professional regulators within the relevant legal frameworks**

- 6.3 The Employer Liaison Service<sup>29</sup> continues to provide support and information to employers and responsible officers in relation to fitness to practise and to revalidation.
- 6.4 The GMC referred 91 cases to other investigatory bodies/regulators in 2015/16<sup>8</sup> and 20 cases for quarter 1 of 2016/17.<sup>9</sup>
- 6.5 The GMC has memoranda of understanding with a number of organisations, including the Care Quality Commission, Healthcare Improvement Scotland, Healthcare Inspectorate Wales, Monitor, National Clinical Assessment Service, NHS Counter Fraud and NHS Improvement.
- 6.6 We have seen no evidence of failures to share information.

**Standard 3: Where necessary, the regulator will determine if there is a case to answer and if so, whether the registrant's fitness to practise is impaired or, where appropriate, direct the person to another relevant organisation**

- 6.7 Following an investigation, two case examiners (one medical and one non-medical) will consider a case. The options open to them are:
- Conclude the case with no further action
  - Issue a warning
  - Refer the case to the Medical Practitioners Tribunal Service (MPTS) for a final fitness to practise hearing
  - Agree undertakings with the doctor.<sup>30</sup>

<sup>29</sup> The Employer Liaison Service was set up to help employers understand what they need to do if they have concerns about a doctor. The GMC's employer liaison advisers work with employers of doctors, in particular responsible officers.

<sup>30</sup> Undertakings are an agreement between the GMC and the doctor about the doctor's future practice. Undertakings will only be agreed with a doctor when both the medical and non-medical case examiners are satisfied that they are sufficient to protect patients and the public, and are an effective way of addressing the concerns about the doctor. The GMC will not offer undertakings where there is a realistic

- 6.8 No case can be concluded or referred to the MPTS for a fitness to practise hearing without the agreement of both the medical and non-medical case examiner. If they do not agree, the matter will be considered by an Investigation Committee, which has the same powers as the case examiners.
- 6.9 Where the GMC decides not to investigate a complaint, it may be referred to the registrant's responsible officer to progress through the local complaints process and/or to take into account as part of the annual appraisal system. In addition, the GMC provide information to patients about other organisations which may be able to assist, should the GMC not investigate or not find a case to answer.
- 6.10 We have not identified any concerns with the GMC's performance against this Standard during 2015/16.

**Standard 4: All fitness to practise complaints are reviewed on receipt and serious cases are prioritised and where appropriate referred to an interim orders panel**

- 6.11 We ask the regulators to provide us with (1) the median time from receipt of a complaint to the interim order decision and (2) the median time from receipt of information indicating the need for an interim order and the decision. The former is an indicator of how well the regulator's initial risk assessment process is working – whether it is risk assessing cases promptly on receipt, identifying potential risks and prioritising higher risk cases so that further information can be obtained quickly; the latter indicates whether the regulator is acting as quickly as possible once the need for an interim order application is identified.
- 6.12 The GMC's performance for both measurements has improved since last year. The median time taken from receipt of a complaint to an interim order decision for 2015/16 was 7.6 weeks from last year's 9.9 weeks, and the median time from receipt of information indicating the need for an interim order and the hearing was 2.3 weeks for 2015/16 from last year's 2.7 weeks.

**Standard 5: The fitness to practise process is transparent, fair, proportionate and focused on public protection**

**Failure to follow directions of the High Court**

- 6.13 During this performance review period we became aware of two instances where the GMC made errors which resulted in it failing to follow the directions of the High Court. These errors are of concern as they could have had implications for public protection and undermine confidence in the GMC.
- In the first case the GMC failed to organise a review hearing which had been agreed as part of a High Court settlement that occurred in the 2014/15 performance review year. The GMC should have notified us of this issue as we had been a party to the settlement in response to our

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prospect that a doctor might be erased from the register if the case was referred forward for a final fitness to practise hearing.

Section 29 appeal but it did not do so even though it had identified the error in January 2015. Although these events took place in the previous performance review period, we were not aware of them until this period.

- In the second case we were in the process of appealing a fitness to practise decision under our Section 29 powers<sup>6</sup> when the GMC erroneously granted the doctor voluntary erasure<sup>31</sup> before the start of the High Court hearing. The GMC did not become aware of this error until the High Court judgment had been handed down. The GMC explained that this error occurred due to a failure in communication between teams as a consequence of seeking to limit access to information between Directorates to that which was relevant and material to respective roles.

6.14 The GMC conducted Serious Event Reviews into both of these errors. The GMC has advised that it has identified and implemented manual changes to its processes and in due course will embed these revisions in its system to ensure that similar errors do not occur in future. In addition to this the GMC has noted a lack of clarity within the General Medical Council (Fitness to Practise) Rules 2004 about the process for considering a voluntary erasure application where the case has been concluded by a Medical Practitioners Tribunal but there is a potential, under Section 29 or Section 40A,<sup>32</sup> for the case to be sent back to the Tribunal for further consideration. The GMC will raise this issue with the Department of Health.

6.15 Whilst these are serious errors which have the potential to undermine confidence in the GMC as a regulator, they do not suggest that there is a wider pattern of concern.

**Standard 6: Fitness to practise cases are dealt with as quickly as possible taking into account the complexity and type of case and the conduct of both sides. Delays do not result in harm or potential harm to patients and service users. Where necessary the regulator protects the public by means of interim orders**

6.16 Last year the GMC met this Standard. However, we were concerned about the discrepancy between the overall median timeframe of 92.6 weeks<sup>33</sup> and the median times for each of the two stages that make up this overall timeframe, namely 35 weeks from receipt of the complaint to the final decision by the Investigation Committee or case examiners, and 30.3 weeks from the final decision by the Investigation Committee or case examiners to the final fitness to practise hearing decision. We were also concerned about the length of the overall median timeframe of 92.6 weeks.

6.17 This year, we carried out a targeted review of this Standard as we were concerned about the increase in the overall median timeframe to 99.7 weeks in 2015/16.<sup>8</sup> We also wanted to assess the impact of 'provisional enquiries' (see below for more details).

<sup>31</sup> The process by which a doctor chooses to give up their registration with the GMC.

<sup>32</sup> This gives the GMC the power to appeal fitness to practise decisions of the Medical Practitioners Tribunal Service (MPTS) to the High Court where it considers the original decision not sufficient for the protection of the public.

<sup>33</sup> From receipt of a complaint to the final fitness to practise hearing decision.

## Provisional enquiries

- 6.18 Following a pilot in September 2014, the GMC rolled out the use of 'provisional enquiries'. A provisional enquiry is an enquiry at the initial assessment stage of the fitness to practise process, which helps the GMC to decide whether it needs to open a full investigation. The enquiry involves asking for more information about the concern. They are used in cases where:
- The allegation is unclear
  - It is unclear whether the allegation is serious enough to raise a question about the doctor's fitness to practise
  - Where the supporting information may be unlikely to support the concern about the doctor's fitness to practise.
- 6.19 A further pilot started in July 2016 to allow provisional enquiries (including contact with a registrant's responsible officer)<sup>Error! Bookmark not defined.</sup> where a single instance of poor clinical care had been reported. These type of cases, in general, would previously have been opened as full investigations.
- 6.20 Provisional enquiries can be closed or upgraded to full investigations. As provisional enquiries allow further information to be obtained, unnecessary full investigations are avoided. One of the aims of this new process is to speed up investigations, both by reducing the numbers of investigations (thereby freeing resources) but also by achieving decisions in cases where provisional enquiries are made without the need for a full investigation.
- 6.21 The GMC reports that in 2015 it identified 351 complaints where it could use provisional enquiries, and 75 per cent of those complaints were closed down without a full investigation.<sup>34</sup>
- 6.22 The evidence provided by the GMC shows that the provisional enquiries process allows it to conclude cases quicker than through a full investigation. The GMC reports that these investigations have taken on average 10 weeks compared to 26 weeks for full investigations. It also appears that the GMC has taken appropriate steps to assure itself of the quality of the decisions made through the use of audit. We note the positive impact provisional enquiries are having on the processing of cases through the pilot.

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<sup>34</sup> General Medical Council. (2016) A new way to deal with complaints about single instances of poor clinical care. [Online] Available at: [www.gmc-uk.org/publications/29306.asp](http://www.gmc-uk.org/publications/29306.asp) (Accessed: 9 January 2017)

### Timeliness of fitness to practise case progression

6.23

This table below sets out the time taken to progress cases and the number of older cases the GMC holds.

Measure	2013/14 <sup>35</sup>	2014/15 <sup>36</sup>	2015/16 <sup>8</sup>	Quarter 1 2016/17 <sup>9</sup>
Median time from initial receipt to Investigation Committee/Case Examiner decision (weeks)	29.2	35	35.6	29.1
Median time from final Investigation Committee/Case Examiner decision to final fitness to practise hearing decision (weeks)	34.4	30.3	28.8	Data not available <sup>11</sup>
Median time from receipt of initial complaint to final fitness to practise hearing decision (weeks)	97	92.6	99.7	Data not available <sup>11</sup>
Cases older than 52 weeks	919	598	477	468
Cases older than 104 weeks	330	223	205	166
Cases older than 156 weeks	76	125	140	158

<sup>35</sup> From 1 April 2013 to 31 March 2014.

<sup>36</sup> From 1 April 2014 to 31 March 2015.

6.24 The GMC told us that the increase in the timescales in its overall fitness to practise process (time from receipt of initial complaint to final fitness to practise hearing decision) was due to closing increased numbers of older cases and the complexity of its cases, as well as external factors outside of its control. We go on to consider these reasons below.

#### *Closure of older cases*

6.25 When providing us with its performance data, the GMC said that the increase in its overall fitness to practise timeframe was because it was closing more older cases. It said that 47 per cent of cases closed under this measure were over two years old in 2015/16 compared to 39 per cent of cases in 2014/15.

6.26 The GMC's dataset reflects the increased closure of cases older than 52 weeks. By the end of 2015/16 there was a 13 per cent decrease in the total number of cases older than 52 weeks than at the end of 2014/15, from 946 cases to 822 cases. By the end of quarter 1 for 2016/17<sup>9</sup> the number of cases older than 52 weeks had decreased further to 792 cases (a 16 per cent decrease on the 2014/15 figure).

6.27 The GMC provided details as to how cases older than 52 weeks had been closed. This shows that about 30 per cent of its cases older than 52 weeks were closed at a final fitness to practise hearing. The majority were closed by the case examiners or Investigation Committee.

#### *Complexity of cases*

6.28 The GMC also argues that the time taken to progress fitness to practise cases is a result of the complexity of the cases it deals with. The GMC identifies a number of factors which may make a case more complex to handle and therefore present challenges in undertaking a timely investigation. These include:

- Multi-factorial cases such as multiple allegations about misconduct, performance and health
- Any case where new information is received that introduces additional allegations and requires another full investigation
- Cases involving multiple doctors or multiple complainants
- Cases where a doctor was prosecuted and acquitted
- Cases where there are extremely vulnerable witnesses
- Cases that require a performance assessment due to the number of concerns about a doctor's practice
- Cases where the doctor is litigious and seeks to challenge any decision or fails to cooperate with the investigation.

6.29 The GMC estimated that, as of 31 October 2016, over 53 per cent of its caseload could be considered to include one or more of these criteria. The GMC states that its older caseload is even more complex.

6.30 In our 2014/15 performance review report we accepted that the GMC's overall median timeframe had increased because the cases being referred

for a final fitness to practise hearing were more complex and took longer to investigate. The GMC closed greater numbers of more straightforward cases at an earlier stage of the fitness to practise process through the use of undertakings.

#### *External factors affecting case progression*

- 6.31 The GMC told us that its overall median timeframe reduces to 91.4 weeks if the figure is adjusted to take into account external factors beyond its control such as when it needs to await police or court proceedings.
- 6.32 The GMC has the following internal targets:
- To conclude or reach a case examiner decision within 12 months
  - If the case examiner refers the case to a final fitness to practise hearing and it is case ready, the target is six months from the date of the referral to the hearing start date
  - If the referral is not case ready, the target is nine months from the date of the referral to the hearing start date.
- 6.33 The adjusted figure of 91.4 weeks is therefore broadly in line with its internal targets (although the actual median of 99.7 weeks exceeds this internal target).

#### *Monitoring of delays*

- 6.34 As it did in 2014/15, the GMC commissioned two senior lawyers in 2015/16 to review all of its cases over a year old that had not yet reached a case examiner decision, to ensure that they were progressed quickly where possible and identify any learning. Once a case had been reviewed, the lawyers continued to monitor the progress of those cases against set targets and required regular update reports from the Investigation Officer or Investigation Manager until the case reached a case examiner decision.
- 6.35 Following this review, a further review was undertaken by the same lawyers to consider all cases over three years old. This review excluded any cases already considered in the first review and those subject to enhanced case monitoring, but it included cases which had been referred to a final fitness to practise hearing. These reviews included those cases that could not be progressed because of ongoing criminal proceedings or because the GMC was waiting for the outcome of third party investigations. The senior lawyers considered whether any other investigation tasks could be completed pending the outcome of the third party investigations.
- 6.36 We understand that some delays occurred because effective pressure may not have been consistently applied by GMC staff to ensure that third party investigations, such as NHS counter-fraud or police investigations, were progressed as quickly as possible. The GMC explains it has taken steps to ensure staff are aware of and employ best practice in escalation principles to include earlier use of its legal powers, more effective engagement with external providers and greater awareness of time pressures on investigations.

6.37 Investigation Managers review all cases with the Investigation Officer every two weeks, and once cases reach nine months they are discussed at least every other month with the Head of Section. The Assistant Director conducts periodic, targeted reviews; for example, looking at all cases over two years old, or cases where the GMC is waiting for third party investigations to conclude. The Director of Fitness to Practise sees a summary of all cases that go over 12 months.

6.38 We consider that the GMC is taking suitable steps to assure itself that it is doing all it can to progress older cases where it is within its power to do so.

*Conclusion on performance against this Standard*

6.39 We note that the GMC has maintained timeliness in the initial and final stages of the fitness to practise process. Although we remain concerned about the median time taken from receipt of a complaint to a final fitness to practise hearing decision, we have accepted the GMC's argument that the increase in its overall fitness to practise timeframe is a result of closing increased numbers of older cases. We are also satisfied that the GMC is taking steps to monitor and progress such older cases. We also note external factors which impact on case progression, and that the GMC deals with a complex caseload.

6.40 We, and the GMC, would hope to see a reduction in its overall median timeframe in the next performance review period as the GMC deals with reduced numbers of older cases. If this reduction does not happen, we may need to do some more detailed work to understand how far factors beyond the GMC's control (such as those listed at paragraph 6.28) impact on timeliness.

6.41 However, on the basis that greater numbers of older cases are being concluded, there have been significant reductions in timescales for dealing with less complex cases and the GMC is taking active steps to progress cases, we have decided that the GMC has met this Standard this year.

**Standard 7: All parties to a fitness to practise case are kept updated on the progress of their case and supported to participate effectively in the process**

**Reducing the impact of investigations on doctors**

6.42 In last year's report we reported that the GMC commissioned an internal review by an independent consultant of cases where doctors had committed suicide while subject to a fitness to practise investigation. The GMC has continued its work to reduce the impact its investigations have on doctors. For example, it has made changes to the language and tone of the letters the GMC sends to doctors as part of its investigation.

6.43 In December 2015 the GMC appointed a leading mental health expert to provide independent advice on how it can support vulnerable doctors and work with the GMC to review the stages of the investigation process to identify further changes that could be made to support vulnerable doctors.

- 6.44 Following a two-year pilot, the GMC has commissioned the BMA to provide its Doctor Support Service, a confidential support service for any doctor involved in a fitness to practise case.

#### **Protection for whistleblowers**

- 6.45 Following the review commissioned by the GMC<sup>37</sup> into the GMC's handling of cases involving whistleblowers, the GMC has launched a pilot which requires designated bodies, such as NHS organisations and independent healthcare providers, to disclose whether the doctor being complained about to the GMC has previously raised any patient safety issues. The person referring the concerns will also have to make a declaration that the complaint is being made in good faith, and that steps have been taken to make sure it is fair and accurate.
- 6.46 The aim of this is to help the GMC assess whether a full investigation is necessary, and will help reduce the risk of doctors who have acted as whistleblowers subsequently being disadvantaged.

#### **Meetings with doctors and complainants**

- 6.47 Following a pilot, a scheme providing an opportunity for complainants to meet with trained Patient Liaison Officers was rolled out to all GMC regional offices in 2015/16. For complainants who are unable to attend in person, meetings are also available by telephone.
- 6.48 In last year's report we commented on the pilot and expressed concern that the independent evaluation had highlighted dissatisfaction with meetings at the end of the investigation (including that complainants did not understand how decisions had been made). The GMC advised that it would be reviewing ways to address this dissatisfaction including whether investigation officers or case examiners (the decision makers) could attend the meetings, which might assist complainants in understanding how the decision was made.
- 6.49 The GMC has reported that it considered how to improve satisfaction with the end stage meetings, including involvement of investigation officers and/or case examiners and concluded that this would not add significantly to satisfaction while having a significant impact on timeliness and efficiency of investigations (as the volume of meetings held with patients far exceeds the volume of those held with doctors).
- 6.50 The GMC made the following changes to address the issues raised:
- Asking complainants to send questions in advance of the meeting
  - Providing for Principal Legal Advisers (PLAs) to do detailed preparation for the meetings including discussion with any staff (triage, investigation, legal and case examiners) with relevant information about the key issues in the case

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<sup>37</sup> Sir Anthony Hooper. (2015) *The handling by the General Medical Council of cases involving whistleblowers*. [Online] Available at: [www.gmc-uk.org/Hooper\\_review\\_final\\_60267393.pdf](http://www.gmc-uk.org/Hooper_review_final_60267393.pdf) (Accessed: 19 December 2016)

- A review (including of the legal constraints) of the provision of expert reports to complainants to enable Patient Liaison Officers to provide clear information.

- 6.51 The GMC reports that interaction with complainants suggests this has significantly increased satisfaction with end stage meetings.
- 6.52 A Doctor Liaison Service has also been rolled out in the London and Manchester offices following a pilot. This allows doctors to meet case examiners and GMC lawyers on completion of an investigation (but prior to consideration by the case examiners). The GMC provides information to registrants during these meetings including a summary of the concerns identified during the investigation. Registrants are able to provide further information for consideration by the GMC during these meetings. The GMC offers these meetings to doctors in cases which are likely to be referred to a hearing, and may exclude cases where a meeting is not likely to add value (for example in serious cases where erasure is likely).
- 6.53 In last year's report, we raised concerns that the difference between the format and the purpose of the meetings with complainants and the meetings with doctors may undermine public confidence in the transparency and impartiality of the GMC, as doctors are able to meet with the decision maker prior to a decision being made, and complainants are not. The GMC has argued that the meetings serve different purposes: for complainants it is to ensure that (a) they have understood the GMC's role and process; (b) the GMC has understood their concerns; and (c) the final decision is explained. Whereas, for doctors it is to ensure that the doctor's response provides all the relevant evidence required to support a decision about whether a hearing is needed. This appears to us to be similar to the second purpose of the meeting with complainants and complainants might well feel that, for them, this meeting comes too late and so gives a perception that the doctor has an early opportunity to influence the GMC.
- 6.54 We remain concerned about the process and, particularly, the perceptions that complainants may gain from this. However, this does not prevent the GMC from meeting this Standard.

**Standard 8: All fitness to practise decisions made at the initial and final stages of the process are well reasoned, consistent, protect the public and maintain confidence in the profession**

- 6.55 The Authority sees all final fitness to practise decisions and is able to refer to court decisions which we consider to be insufficient to protect the public.<sup>6</sup> In 2014/15 we received 391 decisions from the GMC. Of these we held case meetings for nine decisions (2.3 per cent of the total) and appealed one decision (0.2 per cent). For 2015/16 and quarter 1 of 2016/17<sup>9</sup> we received 413 decisions from the GMC. Of these we held case meetings for 15 decisions (3.6 per cent) and appealed two decisions (0.4 per cent).
- 6.56 In the course of our examination of the cases, we see a number where we have concerns about the reasoning and consistency of some panel decisions

and, when we do, we inform the GMC about these through learning points. The GMC engages constructively with these points.

- 6.57 The GMC and MPTS updated the Indicative Sanctions Guidance, which took effect from 29 July 2016. This followed a public consultation the GMC held from August to November 2014 on its review of the guidance it gives to medical practitioner tribunals run by the Medical Practitioners Tribunal Service. The guidance is also available to the GMC's case examiners who decide whether a case should proceed to a tribunal hearing.

**Standard 9: All fitness to practise decisions, apart from matters relating to the health of a professional, are published and communicated to relevant stakeholders**

- 6.58 The MPTS' website has a decisions section. This has a search function to allow the public to find fitness to practise panel decisions (including interim orders decisions). Individual entries on the GMC's register also contain information about restrictions (suspensions and conditions) and show if a doctor has been erased.
- 6.59 In January 2016 the GMC implemented the European Alert Mechanism. This is a system where the regulators of healthcare professions across Europe share information about professionals who might present a risk to the public (for example, because their fitness to practise is impaired). As of 9 March 2016 the GMC reported that it had received 18 incoming alerts regarding actions taken by other European regulators. However, none of these alerts related to doctors registered with them. The GMC has sent approximately 1500 alerts via the alert mechanism since 18 January 2016.
- 6.60 As part of our performance review we checked a sample of the entries on the GMC's register. We had no concerns that the GMC is failing to publish or communicate fitness to practise outcomes.

**Standard 10: Information about fitness to practise cases is securely retained**

- 6.61 The GMC holds ISO 27001:2013 certification. This is the international standard for information security management. Holding this certification demonstrates that the GMC has robust systems in place to prevent data breaches and effectively address any that do occur. In 2015/16 and the first quarter of 2016/17,<sup>9</sup> the GMC did not report any data breaches to the Information Commissioner's Office.

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