In reply please quote: SR1-1420918531

Dear Dr Watts

I write following your request for a meeting with Professor Terence Stephenson in response to his blog on leadership in May. He is not available to meet at this time, but he has passed your email on to our team to respond to, and I am very sorry for the long delay in doing so.

In your email you ask what the GMC is doing to support doctors to uphold professional standards in the very challenging environment doctors find themselves in. You also call upon the GMC to draw attention to environmental issues that undermine good medical practice, and to provide guidance for doctors on how they can deal with issues that impact on patient care, without fear of recrimination.

We fully recognise the pressures doctors are under and over the last few years we have been shifting the balance of our regulatory activity to focus more on the ways we can help all doctors to make positive changes to UK healthcare, through professional standards, medical education and training, reforms to our own processes and other kinds of ongoing support. We are also increasingly using the information we hold about the environments doctors practice in to improve joint working between professional and system regulators, and to draw attention to the current challenges facing the profession and the systems in which doctors work.

Professional standards and support for doctors

In a time of intense pressure on healthcare services we see it as vital to maintain professional standards. While it is important to find ways of easing the burden on doctors, this cannot be achieved by compromising the standards of good medical practice that patients have a right to expect. Solutions which simply increase the risk for patients will only undermine their trust and confidence in the professionalism of their doctors.

Over the past few years we have therefore focused on providing a framework of good practice that doctors can use to draw attention to systems, processes and practises that are at odds with the professional ethics that are so fundamental to public trust.

As an example, you may be aware of our guidance *Raising and acting on concerns about patient safety*, which sets out the steps we consider it reasonable for doctors to take if local developments are having an adverse impact on patient care. We want to do as much as we can to help doctors feel confident to speak up about patient safety concerns, so the guidance is supported by an online decision making tool which has been designed to give doctors confidence to raise concerns by walking them through the decision making process. You can find the tool on our website here: www.gmc-uk.org/guidance/ethical_guidance/decision_tool.asp. We also provide a confidential telephone helpline for doctors who are worried about clinical practice where they work (0161 923 6399).

We are however aware that doctors can suffer reprisals and victimisation when they raise concerns about the integrity and safety of systems they work in, and that fear of being penalised is one of the biggest barriers to doctors speaking out. Reprisals may take many forms, including disciplinary action and referral to the GMC. In recognition of the potential for our processes to be abused in this way, in 2015 we commissioned a review by an independent expert, Sir Anthony Hooper, to review how we handle cases involving doctors who regard themselves as having raised concerns. You can find his report on our website here: www.gmc-uk.org/Hooper_review_final_60267393.pdf.

Sir Anthony Hooper recommended that we need to obtain more information earlier about the background of referrals from employers and responsible officers, so that we understand the full context of a case when making decisions, and earlier in July we launched a pilot to take forward this recommendation. As part of this pilot we will seek assurance that complaints are made accurately and in good faith. This will help the GMC to assess whether a full investigation is necessary, and will help to reduce the risk of doctors who have acted as whistle-blowers subsequently being disadvantaged. You can read more about the pilot on our blog: gmcuk.wordpress.com/2016/07/19/fitness-to-practise-reforms-a-step-towards-better-protection-for-whistleblowers-in-the-nhs/.

More broadly, we offer an extensive range of materials, including case studies, flowcharts and decision tools, and an advice service to give doctors relevant, accessible support to put our standards into practice. We also offer face to face events to help doctors see how they might tackle specific challenges, helping them to improve, or reinforcing good practice. You may be aware of the work of our liaison services in England, Wales, Scotland and Northern Ireland, which offer free interactive sessions to groups of doctors on all of our professional standards, as well as on other aspects of GMC's work, such as revalidation. The service also offers a 'Welcome to UK Practice' programme for doctors new to medical practice in England, and has recently begun to provide tailored programmes

for NHS Trusts who have requested additional support from us in maintaining and improving professional standards.

Addressing environmental issues

As you say, there is a wealth of evidence that demonstrates how poor working environments and ineffective leadership of an organisation can affect professional standards and we understand the significant impact that environment can have on performance. As were are (for the most part) a professional, rather than system, regulator we need to work collaboratively with system regulators (such as the Care Quality Commission, CQC, in England) to address these kinds of issues.

One of the ways we have been doing this has been by improving how we share the data we gather as part of our regulatory activities (for example through our registration, education and fitness to practise functions) with other bodies that have regulatory and monitoring functions. For example, in 2014 we agreed a data sharing protocol with the CQC and we routinely share information with the CQC to inform its inspections of hospitals and general practices.

You may also be aware that we have an Employer Liaison Service (ELS), which meets regularly with more than 650 Responsible Officers across the UK. The role of the service is to support two way exchange of information with employers, therefore improving patient safety and the quality of referrals to the GMC. The ELS also attends Regional Quality Surveillance Groups and risk summits to discuss and develop action plans where there are specific concerns in an organisation or patterns of concern across a region.

We are also striving to make the data we hold much more public. For example you may be familiar with our annual publication *The state of medical education and practice in the UK*, which sets out what is happening in the education and practice of doctors, and considers some of the current challenges facing the profession and the systems in which it works. The 2015 edition includes a detailed examination of the relationship between the places where doctors work and their professional standards. You can find the report on our website: www.gmc-uk.org/publications/somep2015.asp.

I mentioned that we are chiefly a professional regulator but we are also a system regulator to the extent that we have responsibility for overseeing every stage of a doctor's education, training and professional development throughout the UK. As part of this responsibility we monitor the quality of education and training that medical students and doctors in training receive, using a range of different approaches. These range from visiting medical schools and places where doctors train, to checking that trainers, training programmes and training curricula meet the standards we set.

If we identify areas of risk which need to be investigated we ask the organisation concerned for more information to assure us that any issues are being dealt with appropriately. If we are not satisfied with the response of the organisation we can intervene. We call this intervention enhanced monitoring, and it involves working with all the organisations involved to improve the quality of training. Issues that require enhanced monitoring are those that we believe could adversely affect patient safety, doctors' progress in training, or the quality of the training environment. We publish a database of issues requiring enhanced monitoring, the actions that are being taken to address them, and the current status of the issue, which you can find on our website here: www.gmc-uk.org/education/27111.asp.

Reducing regulatory impact

There is an inevitable burden associated with regulation – the primary focus of the GMC is to protect patients, and it would be misleading to suggest that there will be no burden on doctors arising from this. We do however recognise that it is vital to keep the workload associated with regulation to a minimum.

As an example, we have recently agreed a plan with the CQC and NHS England to reduce the workload and duplication associated with the regulation of general practice in England – you can find details of that here:www.england.nhs.uk/wp-content/uploads/2016/04/gp-reduce-dup.pdf.

More generally we are evaluating the impact of revalidation for all doctors and we recently commissioned Sir Keith Pearson to carry out a review bringing together all the evidence to help us shape revalidation in the future. The recommendations are expected to include ways to minimise burdens on the profession and the system, and avoid duplication with other processes, while still giving patients confidence that doctors are up to date and fit to practise. You can find the terms of reference for that review here: www.gmc-uk.org/RT___Terms_of_Reference___Revalidation_Review___DC8695.pdf_65068756.pdf.

Another recent initiative which reduces the burden of regulation is the publication of a single set of standards for education *Promoting excellence*. For the first time, there is one single document outlining the standards for both undergraduate and postgraduate education. This makes our standards clearer and easier to use for both internal teams and external organisations, reducing the number of criteria and requirements from 230 to 76. While education providers don't need to do less, the document is less repetitive, higher level and less prescriptive, allowing more leeway for providers to choose the right methods for their students and environments.

The new standards have patient safety at their core. Patient safety is inseparable from a good learning environment and culture that values and supports learners and educators. Under the new standards, organisations must demonstrate a culture that allows learners and educators to raise concerns about patient safety, and the standard of care or of education and training, openly and safely without fear of adverse consequences. *Promoting excellence* also requires organisations to design rotas that make sure doctors in training have appropriate clinical supervision and minimise the adverse effects of fatigue and workload. You can read a statement we issued for doctors who might be asked to cover rota gaps which they feel they cannot safely cover on our website here: www.gmc-uk.org/news/28653.asp and the standards themselves are here: www.gmc-uk.org/news/28653.asp.

And finally I should mention the reforms to our fitness to practise functions, to make our processes faster and fairer. We know that investigation by the GMC can place great pressure on the doctor involved and we have made a number of changes over the past few years to improve how we handle complaints about a doctor's fitness to practise.

For example we are now making wider use of provisional enquiries at the earlier stages of our investigation process. Provisional enquiries involve gathering one or two discrete bits of information, such as medical records or a local investigation report. This information can help us decide much earlier whether or not we need to investigate a complaint. Our pilot found that doing so could lead to a 70 per cent cut in the average length of an investigation in some cases. It could also avoid the need for around 250 full investigations that would otherwise have taken place.

Earlier in July we launched a further pilot to extend this approach to cases where doctors are alleged to have made a one off mistake involving poor clinical care. If the evidence shows this was indeed a one-off mistake without an ongoing risk to patient safety, that the doctor accepts his or her error, and takes steps to make sure it will not be repeated, the case is likely be closed. The initiative is expected to avoid the need for a full investigation in around 230 cases a year, as well as significantly increasing the speed with which these cases are handled. Cases dealt with in this way on average conclude within around three months – half the time for most investigations.

I appreciate that this has been a lengthy response, but I hope I have been able to give you a clear picture of the sorts of initiatives being taken by the GMC, often in partnership with others, to be a proactive, proportionate and supportive regulator. We are working hard to become an organisation that is more responsive to the context in which doctors work, imposes fewer burdens on doctors and the healthcare system and does more to support doctors with the professional challenges they face during their careers.

Yours sincerely

Fionnula

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