



Annual review of performance 2016/17

# 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
- Maintaining a register of qualified professionals. Only those registered with a licence to practise can practise medicine in the UK<sup>3</sup>
- Requiring doctors to keep their skills up to date through continuing professional development
- Taking action to restrict or remove from practice registrants who are not considered to be fit to practise.

As at 30 June 2017, the GMC was responsible for a register of 281,018 doctors. Its annual retention fee for registrants is £425. For registration without a licence to practise, the fee is £152. (From 1 April 2018, the annual retention fee will be £150.)

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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 12 months. We use this to decide the type of performance review we should carry out.

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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.

- 1.7 When considering information relating to the regulator's timeliness, we consider carefully the data we see, and what it tells us about the regulator's performance over time. In addition to taking a judgement on the data itself, we look at:
- Any trends that we can identify suggesting whether performance is improving or deteriorating
  - How the performance compares with other regulators, bearing in mind the different environments and caseloads affecting the work of those regulators
  - The regulator's own key performance indicators or service standards which they set for themselves.
- 1.8 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.
- 1.9 We will recommend that we ask the regulator for more information as part of a targeted review 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); or
  - We consider that the information we have indicates a concern about the regulator's performance in relation to one or more Standards.
- 1.10 This targeted review will allow us to assess the reasons for the change(s) or concern(s) and the expected or actual impact of the change(s) or concern(s) before we finalise our performance review report.
- 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 judgement

2.1 During September 2017, we carried out an initial review of the GMC's performance from 1 September 2016 to 31 August 2017. 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 sections 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>5</sup>

2.2 As a result of this assessment, we decided that a targeted review was required of the GMC's performance against Standards 1, 3, 6 and 7 of the Standards of Good Regulation for Fitness to Practise

2.3 We obtained further information from the GMC relating to these Standards. Following a detailed consideration of this further information, we decided that the GMC had met all of the Standards.

### Summary of the GMC's performance

2.4 For 2016/17 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 good performance since last year.

### 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 what data we think provides helpful context about each regulator's performance. Below are the items of data identified as being key comparators across the Standards.

2.7 We expect to report on these comparators both in each regulator's performance review report and in our overarching reports on performance

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<sup>5</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 \(as amended\)](#).

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 provided by the GMC for the year from April 2016 to March 2017, the last full year for which the comparator data is available. The annual data covers the period 1 April 2016 to 31 March 2017, some of which falls into our previous review period. Where we took data into account in making decisions about the GMC's performance against the Standards last year, we have not used it again this year.

	<b>Comparator</b>	<b>Q2<sup>6</sup></b>	<b>Q3<sup>7</sup></b>	<b>Q4<sup>8</sup></b>	<b>2016/17<sup>9</sup></b>	<b>Q1<sup>10</sup></b>
1	The number of registration appeals concluded, where no new information was presented, that were upheld	Data not available <sup>11</sup>				
2	Median time (in working days) taken to process initial registration applications for					
	UK graduates	26	3	1	1	1
	EU (non-UK) graduates	32	31	29	31	28
	International (non-EU) graduates	18	18	17	17	16
3	Time (in weeks) from receipt of initial complaint to the final Investigating Committee/Case Examiner decision					
	Median	38	42	34	37	32
	Longest case	270	324	300	391	316
	Shortest case	5	1	1	1	1
4	Time (in weeks) from receipt of initial complaint to final fitness to practise hearing	2016/17 <sup>12</sup>				
	Median	107				
	Longest case	423				
	Shortest case	18				

<sup>6</sup> 1 July 2016-30 September 2016

<sup>7</sup> 1 October 2016-31 December 2016

<sup>8</sup> 1 January 2017-31 March 2017

<sup>9</sup> 1 April 2016-31 March 2017

<sup>10</sup> 1 April 2017-30 June 2017

<sup>11</sup> The GMC has been unable to provide this data as it does not record whether new information is received and considered by its appeals panel.

<sup>12</sup> Annual data available only.



5	Median time (in weeks) to an interim order decision from receipt of complaint	6	11	14	10	10
6	Outcomes of the Authority's appeals against final fitness to practise decisions	2016/17 <sup>13</sup>				
	Dismissed			0		
	Upheld and outcome substituted			1		
	Upheld and case remitted to regulator for re-hearing			0		
	Settled by consent			2		
	Withdrawn			0		
7	Number of data breaches reported to the Information Commissioner	1	0	0	1	0
8	Number of successful judicial review applications	2016/17 <sup>14</sup>				
				2		

### 3. Guidance and Standards

3.1 The GMC has met all the *Standards of Good Regulation* for Guidance and Standards during 2016/17. Examples of how it has demonstrated this are indicated 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 its core guidance, *Good Medical Practice*, which sets out professional standards of practice for doctors, in April 2014. We have not seen any evidence that this needs further revision.

3.3 The GMC website has a series of case studies to highlight current topics and to illustrate the application of *Good Medical Practice*. It also has a 'hot topic' section, which is a series of frequently asked questions about various issues which the GMC considers have current relevance.

<sup>13, 14</sup> Annual data available only.

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

- 3.4 In April 2017, the GMC published revised guidance on confidentiality. The core guidance, *Confidentiality: good practice in handling patient information*, is supported with a series of detailed explanatory guidance. This includes guidance on reporting gunshot and knife wounds and guidance on disclosing information for employment, insurance and other similar purposes.
- 3.5 The GMC published a briefing paper on its website for those using the guidance to familiarise themselves with key changes to the previous guidance on confidentiality. For example, stronger emphasis is placed on the importance of sharing information appropriately for direct care, recognising the multi-disciplinary and multi-agency context doctors usually work in.

**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**

- 3.6 The GMC worked with other healthcare regulators to develop a joint statement on avoiding, managing and declaring conflicts of interests.<sup>15</sup> This was published in August 2017 and outlines how health professionals are expected to manage conflicts of interests and declare them when they arise.
- 3.7 The GMC has initiated a review of its guidance on consent, to update it and reflect changes in working environments. The GMC describes on its website the increasing pressures and demands on doctors which make it difficult for them to seek and record a patient's consent in line with GMC guidance and the law. Throughout 2017, the GMC worked with a group made up of members including legal, medical, health, social care, and patient representatives to redraft the guidance. The GMC expects to hold a public consultation on the revised guidance in March 2018.

**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**

- 3.8 Standards and guidance documents remain available on the GMC website in English as well as in Welsh, and can be requested in other languages. The GMC website, including all the standards and guidance, can be read in varying text sizes and colours, and is 'Browsealoud'<sup>16</sup> enabled.

<sup>15</sup> [www.gmc-uk.org/news/29062.asp](http://www.gmc-uk.org/news/29062.asp)

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

- 3.9 The GMC launched its free 'My GMP' app in December 2016, to allow registrants to access its standards and guidance, online and offline. This follows the earlier development of its 'My CPD' app for registrants, which allows them to log training, and access case studies and advice.

## 4. Education and Training

- 4.1 The GMC has met all the *Standards of Good Regulation* for Education and Training during 2016/17. Examples of how it has demonstrated this are indicated 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**

- 4.2 The GMC sets the educational standards for undergraduate and postgraduate education and training. We reported last year that in January 2016, a single set of standards for education providers came into effect. *Promoting excellence: standards for medical education and training* combined and replaced standards for undergraduate medical education (*Tomorrow's Doctors*) and standards for postgraduate training (*The Trainee Doctor*).
- 4.3 In May 2017, the GMC published *Excellence by design - standards for postgraduate curricula*. Applicable to both general practice and specialty post-graduate training curricula, these standards contain five principles:
- Patient safety
  - Maintaining standards across the UK
  - Encouraging excellence
  - Embedding fairness
  - Current and future workforce and service needs.
- 4.4 The GMC said in its April 2017 paper '*New standards for curricula, new assessment guidance and a refined approvals process*'<sup>17</sup> that during its approval processes, educational organisations must describe and give evidence to show how its standards and requirements have been met in their proposed curriculum. The curriculum must address the following factors:
- Clinical safety
  - Expected levels of performance
  - Maintenance of standards
  - Patient experience

<sup>17</sup>[www.gmc-uk.org/M6\\_\\_New\\_standards\\_for\\_curricula..pdf\\_70950698.pdf](http://www.gmc-uk.org/M6__New_standards_for_curricula..pdf_70950698.pdf)

- Equality and diversity requirements
- Strategic workforce issues and system coherence
- Operational and professional perspectives.

4.5 The *Generic professional capabilities* framework was published in May 2017. The GMC said on its website<sup>18</sup> that this framework describes the interdependent essential capabilities that support professional medical practice in the UK, and is a fundamental and integral part of all postgraduate training programmes.

4.6 The GMC said in its April 2017 paper '*New standards for curricula, new assessment guidance and a refined approvals process*' that previously there was significant variability of core professional content across many postgraduate medical curricula and that there was a need to develop a consistent approach that embeds common generic outcomes and content across all postgraduate medical curricula. The new framework prioritises themes such as patient safety, quality improvement, safeguarding vulnerable groups, health promotion, leadership, team working, and other fundamental aspects of professional behaviour and practice.

4.7 The GMC has provided a range of supplementary guidance, which includes advice about assessment and generic professional capabilities, and a guide to making changes to curricula.

**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**

4.8 We have not identified any significant changes to the GMC's process for quality assuring education programmes during the period of this performance review. Since the last review, the GMC has added one new educational institution to the list of organisations that can award UK primary medical qualifications.

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

4.9 The GMC receives regular reports from medical schools, deaneries and local education and training boards, and royal colleges and faculties about the medical education and training that they provide. It can also identify matters of concern through its annual National training survey.<sup>19</sup> If the GMC identifies potential concerns about the quality of training provided, it asks the organisation for more information. If the GMC is not satisfied with the

<sup>18</sup> [www.gmc-uk.org/education/postgraduate/GPC.asp](http://www.gmc-uk.org/education/postgraduate/GPC.asp)

<sup>19</sup> The national training survey is carried out by the GMC each year, to monitor and report on the quality of postgraduate medical education and training in the UK.

response of the organisation it can intervene and undertake enhanced monitoring.<sup>20</sup>

- 4.10 During 2016/17, the GMC has continued its enhanced monitoring of those hospital trusts where concerns about the standard of training have been identified.

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

- 4.11 There have been no significant changes during the period under review to how the GMC publishes information about approved programmes or the approval process. It has maintained and updated the section of its website dedicated to its training courses and quality assurance process.

## **5. Registration**

- 5.1 The GMC has met all the *Standards of Good Regulation* for Registration during 2016/17. Examples of how it has demonstrated this are indicated below each individual Standard.

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

- 5.2 During this performance review period, we have not seen any information which suggests that the GMC has added anyone to its register who has not met its registration requirements.

#### **Primary source verification scheme**

- 5.3 In April 2017, the GMC agreed in principle to the introduction of a pre-registration primary source verification scheme (PSV) to verify the validity of international graduates' medical qualifications. The proposed new scheme would be administered by a verification agency separate to the GMC and would require international graduates to provide evidence that their medical qualifications have been verified independently in advance of registration. The aim of this is to address the risk of registering and licensing individuals who do not hold an appropriate primary and/or postgraduate medical qualification for the purposes of registration in the UK. The GMC cannot, by law, systematically verify documents from EEA nationals.
- 5.4 We understand that the GMC is planning to announce the introduction of the PSV scheme at the beginning of 2018.

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<sup>20</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 relevant 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 2: The registration process, including the management of appeals, is fair, based on the regulator’s standards, efficient, transparent, secure, and continuously improving**

- 5.5 The GMC receives applications for registration from UK graduates, European Union (EU)/European Economic Area (EEA) graduates and international (non-EU/EEA) graduates. The table below sets out the time the GMC has taken to process applications for registration for each of these groups.
- 5.6 Between 2015/16 and 2016/17, the annual median time taken to process initial registration applications has remained consistent for UK and EU graduates but has improved slightly for international (non-EU/EEA) graduates (down from 19 days in 2015/16 to 17 days in 2016/17). This is despite the number of international (non-EU/EEA) applications increasing from 3,338 in 2015/16 to 3,965 in 2016/17.

Annual median time to process registration applications	2015/16 annual	Q2 2016/17	Q3 2016/17	Q4 2016/17	2016/17 annual	Q1 2017/18
<i>UK graduates</i>	1	26	3	1	1	1
<i>EU/EEA graduates</i>	31	32	31	29	31	28
<i>International (non-EU/EEA) graduates</i>	19	18	18	17	17	16

**Medical Licensing Assessment**

- 5.7 Last year, we reported that the GMC planned a public consultation on the proposed Medical Licensing Assessment (MLA). 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. The GMC have also told us that the aim of the MLA is to introduce a set of assessments that demonstrate that those granted registration with a licence to practise medicine in the UK can meet a common threshold for safe practice. We noted that in the model developed for consultation, applicants would be assessed on their applied knowledge and clinical and professional skills. We concluded by stating that the GMC had launched a formal consultation in January 2017, and planned to conduct investigation, testing and pilots between 2018 and 2021, with full implementation of the MLA expected from 2022.
- 5.8 The consultation ended in April 2017. The GMC wrote in its summary of the consultation,<sup>21</sup> that there was broad acceptance (64 per cent of respondents)

<sup>21</sup> [www.gmc-uk.org/education/29034.asp#11](http://www.gmc-uk.org/education/29034.asp#11)

of its proposal that those applying for registration with a licence to practise medicine in the UK should meet a common threshold for safe practice.

- 5.9 The GMC is now continuing to develop proposals for the MLA in light of the consultation response and a model has been devised and approved by its Council.

**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**

- 5.10 As part of our performance review, we conducted a check of a sample of the entries on the GMC's List of Registered Medical Practitioners (LRMP) and did not identify any errors or inaccuracies.

### Changes to the LRMP

- 5.11 Between July and October 2016, the GMC held a public consultation on expanding the LRMP to include more information about registrants, with options for the register to include information about a registrants' credentials, employment history, photographs and links to places of work. The GMC said in its February 2017 paper 'Developing the UK medical register'<sup>22</sup> that the majority of responses to the proposal were negative,<sup>23</sup> with themes including but not limited to:

- An extension of the register was thought to be 'over regulation'
- Concerns about safety and privacy
- Concerns about accuracy and validity of the information
- A number of respondents referred to potential cost implications of the proposals and the resources required to maintain and verify any additional information, which might result in increased fees.

- 5.12 In light of the consultation response, the GMC has decided to limit the further development of the LRMP for the time being. It will work instead on enhancing its functionality in relation to the information it already holds, and exploring with the Academy of Medical Royal Colleges<sup>24</sup> the desirability and feasibility of collecting and recording information about doctors' scope of practice.

### Credentialing

- 5.13 In last year's performance review report, we noted that in 2015, the GMC had consulted on the broad principles and processes for a credentialing model<sup>25</sup>

<sup>22</sup> [www.gmc-uk.org/M06\\_\\_\\_Developing\\_the\\_UK\\_medical\\_register.pdf\\_69417294.pdf](http://www.gmc-uk.org/M06___Developing_the_UK_medical_register.pdf_69417294.pdf)

<sup>23</sup> In its February 2017 Council paper 'Developing the UK medical register', the GMC wrote that 5,886 responses to the consultation (out of a total of 7,741 responses) did not agree with further information about registrants being added to the LRMP.

<sup>24</sup> The Academy of Medical Royal Colleges is the coordinating body for the UK and Ireland's 24 Medical Royal Colleges and Faculties.

<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.

and, in April 2016, had decided to work with a small number of specialty areas to evaluate and test the cost-effectiveness and efficacy of the model during 2016/17.

- 5.14 In June 2017, the GMC said in its June 2017 paper '*Chief operating officer's report*'<sup>26</sup> that it would be taking forward its plans for modelling credentialing for cosmetic surgery with the Royal College of Surgeons of England.<sup>27</sup> The GMC said this would address the patient safety concerns in this area of clinical practice. There were other interpretations of the use of credentials which the GMC would also be considering.

### **Publication of fitness to practise sanctions**

- 5.15 In last year's performance review report, we commented that the GMC held a public consultation, between July and September 2015, on its fitness to practise publication and disclosure policy. It had proposed to introduce time limits for publication of fitness to practise sanctions, and to limit the information provided to employers about a doctor's fitness to practise history.
- 5.16 We said in our consultation response that we would have concerns if the new time limits for publication were combined with new limitations on disclosure to employers. We said that when information was 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
- 5.17 In September 2017, the GMC published its Publication and disclosure policy.<sup>28</sup> This states that all sanctions on a doctor's registration, imposed by either a medical practitioner's tribunal or interim orders tribunal (except where there is a finding of no impairment or no warning), including erasure, suspension and conditions and any undertakings agreed with a doctor, would remain indefinitely on their fitness to practise history on the LRMP. In addition to the information published on the LRMP, the GMC may provide current employers with a summary of any fitness to practise concerns which were currently under investigation but were not subject to an interim order and information about any warnings which were more than five years old.
- 5.18 The policy states that warnings are published on the GMC's website on a doctor's record on the LRMP for a period of five years and disclosed to any enquirers. After five years, warnings will cease to be published on the LRMP or disclosed to general enquirers. However, they are kept on record and disclosed to employers on request indefinitely. The GMC said on its website that this approach sought to achieve an appropriate balance between the need to be transparent and open with the public, with its duty to be fair to the doctor.

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<sup>26</sup> [www.gmc-uk.org/M04\\_\\_\\_Chief\\_Operating\\_Officer\\_s\\_Report.pdf\\_70601469.pdf](http://www.gmc-uk.org/M04___Chief_Operating_Officer_s_Report.pdf_70601469.pdf)

<sup>27</sup> The Royal College of Surgeons of England is a professional membership organisation and registered charity. Its website can be accessed at: [www.rcseng.ac.uk/](http://www.rcseng.ac.uk/)

<sup>28</sup> The GMC Publication and disclosure policy can be viewed at [www.gmc-uk.org/DC4380\\_Publication\\_and\\_disclosure\\_policy\\_36609763.pdf](http://www.gmc-uk.org/DC4380_Publication_and_disclosure_policy_36609763.pdf)



**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 We have not identified any changes to the GMC's approach to managing this risk. The GMC issues guidance on activities which require a person to be registered and hold a license to practise. Its website states that it is a criminal offence in the UK for a person to give the impression that they hold registration or a licence if they do not. There is also information available on the GMC's website for employers on the checks that should be performed on employees (or potential employees).

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

- 5.20 As of July 2017, the GMC had revalidated<sup>29</sup> 218,375 doctors out of 235,209 since the process was first introduced in December 2012.
- 5.21 In January 2017, the GMC published its independent review of revalidation.<sup>30</sup> This examined evidence on the operation and impact of revalidation since its launch in 2012 and looked at how it could be improved. Among its recommendations were to:
- Update guidance on the supporting information required for appraisal for revalidation to make clear what is mandatory, what is sufficient, and where flexibility exists
  - Ensure consistency and compatibility across different sources of guidance
  - Identify ways to improve the input of patients into the revalidation process by developing a broader definition of feedback which harnesses technology and makes the process more 'real time' and accessible to patients
  - Consider bringing forward the date of first revalidation for newly-licensed doctors
  - Continue working with the Care Quality Commission<sup>31</sup> in England to reduce workload and duplication for GPs
  - Work with relevant organisations in Northern Ireland, Scotland and Wales to identify and respond to any similar issues if they emerge.

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<sup>29</sup> The GMC describes revalidation as the process by which licensed doctors will be required to demonstrate to the GMC, through regular local appraisal, that they are up to date and fit to practise and that they are complying with the relevant professional standards.

<sup>30</sup> [www.gmc-uk.org/Taking\\_revalidation\\_forward\\_Improving\\_the\\_process\\_of\\_relicensing\\_for\\_doctors.pdf](http://www.gmc-uk.org/Taking_revalidation_forward_Improving_the_process_of_relicensing_for_doctors.pdf) 68683704.pdf

<sup>31</sup> The Care Quality Commission regulates and inspects health and social care services in England.

- 5.22 In April 2017, the GMC said on its website that it would be working to implement the recommendations, with most improvements to be in place before the second cycle of revalidation in Spring 2018.

## 6. Fitness to Practise

- 6.1 As we set out in Section 2, we conducted a targeted review of the GMC's performance against Standards 1,3, 6 and 7. The reasons for this, and what we found as a result, are set out under the relevant Standards below. Following the review, we concluded that these Standards were met and therefore the GMC has met all the *Standards of Good Regulation* for Fitness to Practise in 2016/17.

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

- 6.2 We decided to carry out a targeted review of the GMC's performance against this Standard. Further information was required to better understand the GMC's provisional enquiry procedure and its impact on the fitness to practise process.

#### **Provisional enquiries**

- 6.3 A provisional enquiry is an enquiry at the initial stage of the fitness to practise process to obtain more information to inform the GMC's decision as to what action it should take. Following receipt of the information, a decision is made on whether to close the case, send forward for investigation or refer to the Responsible Officer and/or employer.<sup>32</sup>
- 6.4 Provisional enquiries were introduced as a pilot in 2014, aiming to speed up investigations by reducing the numbers of investigations (thereby freeing resources) and by reaching decisions expeditiously in cases where a full investigation is not needed. This was intended to minimise the impact on doctors in cases which did not need investigation, as well as resolving these cases quickly for complainants.
- 6.5 We concluded in last year's report that the provisional enquiries process did enable the GMC to conclude cases more quickly. We noted GMC reports that these investigations took on average 10 weeks compared to 26 weeks for full investigations, and observed the positive impact provisional enquiries were having on the processing of cases through the pilot.
- 6.6 The process was expanded in this period of review, to allow provisional enquiries where a single instance of poor clinical care had been reported. This type of case, in general, would previously have been opened as a full investigation.

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<sup>32</sup> A Responsible Officer is usually a senior doctor within an organisation, such as the Medical Director.

## Update on provisional enquiries process

- 6.7 In December 2016,<sup>33</sup> the GMC provided an update on the provisional enquiry process. It said that:
- The number of new full investigations opened fell, from 2,306 in 2015 to 1,296 in 2016<sup>34</sup>
  - The proportion of enquiries closed at triage stage<sup>35</sup> in 2016 increased to 74 per cent, up from 66 per cent in 2015 – this was linked to the increase in complaints from members of the public and the reduction in referrals from employers (the GMC say that, historically, complaints referred by employers are more likely to result in an investigation than complaints from other sources, see paragraphs 6.18 to 6.19 below)
  - 616 cases were identified as being suitable for a provisional enquiry in 2016
  - The proportion of case examiner decisions to close complaints with no further action or close complaints with advice, decreased from 78 per cent in 2015 to 75 per cent in 2016 – this was due to the introduction of provisional enquiries as these cases would previously have been fully investigated

## How provisional enquiries are processed and guidance for staff

- 6.8 In light of the fall in the number of investigations between 2015 and 2016 and the limited information publicly available about the provisional enquiry process, we decided to obtain further information about the process followed by staff and decision-making at the provisional enquiry stage.
- 6.9 The GMC has guidance for investigating officers, managers and decision makers involved in the provisional enquiries process. Internal guidance provides information and instructions about how the registrar can carry out (or delegate to assistant registrars)<sup>36</sup> provisional enquiries before a decision is made whether to refer a case for full investigation.
- 6.10 The guidance sets out the criteria to be considered before making provisional enquiries – for example, the allegation is unclear or may not raise a question about the doctor’s fitness to practice. It also sets out guidance on obtaining sufficient evidence to enable the assistant registrar to make a decision. Such information might include clinical records and, where applicable, coroner’s reports.

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<sup>33</sup> General Medical Council: Annual Fitness to Practise Statistics report (online). Available at [www.gmc-uk.org/2016\\_fitness\\_to\\_practise\\_annual\\_statistics](http://www.gmc-uk.org/2016_fitness_to_practise_annual_statistics)

<sup>34</sup> These numbers relate to the number of cases referred for full investigation at the triage stage of the fitness to practise procedure. Some provisional enquiries are sent forward for full investigation and therefore the number of full investigations opened at the triage stage is lower than the number of full investigations eventually carried out.

<sup>35</sup> Triage involves the assessment of complaints when they are received to decide how they should be handled. For example, referred for full investigation or closed or treated as a provisional enquiry.

<sup>36</sup> Assistant registrars within the GMC are usually managers or experienced caseworkers.

## Decision-making

- 6.11 To assist with the decision-making process, clinical advice can be obtained from medically-qualified independent experts. If the clinical advice raises concerns, the complaint is progressed to a full investigation.
- 6.12 At the end of the process, the provisional enquiry can be closed or passed to a Responsible Officer, or an employer, or accepted for full investigation. The decision is taken by appropriately trained staff who take decisions on cases.
- 6.13 Separate GMC guidance is aimed at assistant registrars acting as decision-makers. The guidance lists criteria which would indicate that the case should not go through the provisional enquiry process. For example, the concerns are such that the GMC would usually close the case or where there is clear information which raises a question about fitness to practise that meets the threshold for a full investigation. The guidance also provides information on what the decision-maker should do if proposing to promote a provisional enquiry to full investigation.

## How provisional enquiry decisions are quality-assured

- 6.14 The GMC provided information, in its response to the targeted review, about audits of its decision making and quality assurance in provisional enquiries. The GMC audit report on provisional enquiries, dated May 2017, was conducted by an independent internal auditor. It sampled cases, and reviewed training and guidance for staff. The audit concluded that there was an effective quality control and quality assurance process, and that the GMC's work on provisional enquiries met best practice standards with minor areas recommended for improvement.
- 6.15 The GMC also described how a sample of provisional enquiry decisions are audited as part of an ongoing routine internal audit programme which is completed every six months by its quality assurance team. The GMC reported that all provisional enquiry decisions have so far been found to be correct.
- 6.16 All provisional enquiry decisions can be reviewed under the GMC's Rule 12 process.<sup>37</sup> The GMC told us that out of 616 provisional enquiry cases in 2016, 27 Rule 12 requests had been received. Out of these requests, two reviews were undertaken, of which one ended in a decision to reopen the case due to a material flaw in that relevant information had not been fully considered by the original decision maker.

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<sup>37</sup> The Rule 12 process allows for the following decisions to be potentially reviewed by the GMC if, among other criteria, the decision may be materially flawed, or that there is new information which might have led to a different decision: to take no further action following an initial review of a complaint about a doctor; not to refer a complaint about a doctor to a Medical Practitioners Tribunal; and to agree undertakings with the doctor or give the doctor a warning.

### Impact of provisional enquiries on the fitness to practise process

- 6.17 As part of the targeted review, information about the volumes and outcomes of its triage decisions since the introduction of provisional enquiries was provided by the GMC:

	2015	2016
Investigation	2,306 (24%)	1,296 (14%)
Provisional Enquiry	351 (4%)	616 (7%)
Refer to Employer/Responsible Officer	553 (6%)	475 (5%)
Closed	6,208 (66%)	6,759 (74%)
<b>Total number of concerns</b>	<b>9,418</b>	<b>9,146</b>

- 6.18 The GMC told us in its response to the targeted review that the number of concerns which resulted in a provisional enquiry remained very low and that the most significant change was the reduction in the number of concerns which resulted in a full investigation. It said that this decrease reflected a continued decline in enquiries from 'Persons Acting in a Public Capacity' (PAPC) (primarily employers), as the table below shows, to 744 in 2016. Referrals from this group were significantly more likely to result in a full investigation than complaints from other sources.

- 6.19 The GMC told us that it thought that this reduction may be explained by the introduction of the Employer Liaison Service (ELS)<sup>38</sup> and Revalidation<sup>39</sup> in 2012.

Source of enquiry	2012	2013	2014	2015	2016
From persons acting in a public capacity (employers)	2,003	1,316	1,200	1,105	744
From members of the public	6,154	6,475	6,572	6,547	6,688
From other sources	2,190	2,075	1,852	1,766	1,714
<b>Total enquiries</b>	<b>10,347</b>	<b>9,866</b>	<b>9,624</b>	<b>9,418</b>	<b>9,146</b>

<sup>38</sup> According to the GMC's website, the ELS creates closer working relationships between the GMC and employers and, among things, establishes good links with Responsible Officers and their teams to support two-way exchange of information about under-performing doctors, therefore improving patient safety and the quality of referrals.

<sup>39</sup> See paragraphs 5.13 to 5.15.

## Conclusion on performance against this Standard

- 6.20 Although we acknowledge that the number of cases processed as provisional enquiries remains relatively small when considered as a proportion of the total cases received (616 of 9,146 total cases received in 2016) the number of cases processed as provisional enquiries when considered as a proportion of those cases which progress past triage is significant (616 of 2,387 cases progressed for investigation, provisional enquiry or referred to the doctor's responsible officer).
- 6.21 The GMC has told us in its response to the targeted review that before the new process was introduced, the cases now treated as provisional enquiries would have been referred for full investigation. Therefore, in 2015, if the provisional enquiry process had not been in place, 2,657 cases would have been referred for full investigation rather than 2,393 cases. In 2016, 1,912 cases would have been referred for full investigation rather than 1,460 cases. These figures represent a notable decrease in cases which were fully investigated and considered by the Investigating Committee/Case Examiners – a decline from 2,984 cases in 2015/16 to 2,265 cases in 2016/17 (this is looked at in more detail under Standard 3 for Fitness to Practise, paragraphs 6.28 to 6.33 below).
- 6.22 The data indicates that the introduction and expansion of the provisional enquiries process has had a significant impact on the number of cases referred for investigation, although we note that the reduction in employer referrals has also made an impact.
- 6.23 However, a decrease in investigations is not necessarily a concern, providing the regulator is not closing complaints before it can make reasoned decisions as to whether they require investigation or regulatory action. The information presented by the GMC provides assurance that public protection is not being compromised by the provisional enquiry process. We note that only specific types of complaints are progressed through provisional enquiries, and clinical advice is sought when applicable. We also note that in cases where the clinical advice raises concerns, the complaint is progressed to a full investigation. Internal guidance is available and decisions are subject to quality assurance.
- 6.24 An independent audit has not identified any significant concerns or threats to public protection. Internal quality assurance checks carried out by the GMC have not identified any incorrect decisions, and the information from the Rule 12 process also does not indicate any concerns with decision-making. If the provisional enquiries process is allowing the GMC to successfully identify and close cases which do not require regulatory action at the early stages of the fitness to practise procedure, then this is a proportionate process and approach. Therefore, we are satisfied that this Standard is met.

**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**

- 6.25 During the period of this performance review, the GMC has referred 50 fitness to practise concerns to another investigating body or regulator.
- 6.26 The GMC agreed a memorandum of understanding with the NHS General Practitioner Health Service in October 2016. This brings to 18 the number of memorandum's of understanding the GMC has with other organisations.<sup>40</sup>
- 6.27 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**

- 6.28 We decided to carry out a targeted review of the GMC's performance against this Standard. We considered that the provisional enquiry process, looked at under Standard 1 of Fitness to Practice (paragraphs 6.2 to 6.24), was also relevant to this Standard in terms of its impact on the number of cases being referred to the Investigating Committee/Case Examiner (IC/CE) stage of the fitness to practise process.

**The number of provisional enquiries**

- 6.29 We reported under Standard 1 that the number of cases treated as a provisional enquiry in 2015 was 351 out of 6,208 cases received by the GMC and in 2016 was 616 out of 6,759 cases received by the GMC. In 2015, 25 per cent of cases treated as provisional enquiries were referred for full investigation, while in 2016, 27 per cent of cases treated as provisional enquiries were referred for full investigation.

**The impact of provisional enquiries on the number of cases progressing to IC/CE**

- 6.30 The table below shows that there has been a reduction in the number and proportion of cases considered by IC/CE between 2015/16 and 2016/17, with a decline of 24 per cent from 2,984 cases to 2,265 cases. The decrease in cases referred to investigation is, as would be expected, impacting on the number of cases reaching consideration by IC/CE.

	2014/15 Annual	2015/16 Annual	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	2016/17 Annual	Q1 2017/18
Number of cases considered by an Investigating Committee/Case Examiner	2,819	2,984	589	521	538	617	2265	525

<sup>40</sup> Further information about these agreements can be obtained at [www.gmc-uk.org/about/partners\\_index.asp](http://www.gmc-uk.org/about/partners_index.asp)

- 6.31 There has been a simultaneous decrease in the proportion of cases in which the IC/CE decided that no further action was needed. In 2015/16, 62 per cent of cases considered by IC/CE resulted in no further action, while in 2016/17, 58 per cent of cases considered resulted in no further action. In quarter one 2017/18 this was 41 per cent. This decrease in no further action decisions suggests that those cases which do not raise fitness to practise matters may be increasingly identified earlier in the process. There is a corresponding increase in the number of cases referred to the fitness to practise committee, from 15.8 per cent of all cases considered by IC/CE in 2015/16 to 16.6 per cent in 2016/17 and 34 per cent in quarter 1 2017/18.

#### **Conclusion on performance against this Standard**

- 6.32 There has been a decrease in the number of cases investigated, as we saw under Standard 1. This is not only due to the introduction of the provisional enquiries process, but also because of the reduction in the number of employer referrals received. This has in turn resulted in a reduction in the number of cases reaching the IC/CE stage. The proportion of cases closed at IC/CE with no further action has decreased, with an increase in the proportion of cases being referred to the fitness to practise committee.
- 6.33 Based on the information we have seen, it may be that less serious concerns are being closed prior to consideration by IC/CE. We cannot be certain that the use of provisional enquiries is solely responsible for this development. However, the GMC has said in its response to the targeted review that one of the aims of the process is to ensure that it is conducting investigations that are proportionate and timely. The indication is that the GMC is achieving this aim without compromising public protection and patient safety. Therefore, we are satisfied that this Standard is met.

#### **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**

- 6.34 We ask the regulators to provide us with the median time from receipt of a complaint to the interim order decision, and the median time from receipt of information indicating the need for an interim order and the decision. The former is often 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.
- 6.35 The median time taken to an interim order committee decision from receipt of a complaint has increased from 7.6 days in 2015/16 to 10 days this year. The median time to interim order decision from decision that there is information indicating the need for an interim order remains constant, with the GMC reporting 2.30 weeks last year and 2.29 weeks this year.
- 6.36 The number of applications, meanwhile, for High Court extensions to interim orders decreased from 356 in 2015/16 to 287 in 2016/17, the second year in succession in which there has been a downward trend.



- 6.37 Although there has been a slight increase in the median time from receipt of complaint to interim order committee decision, we are assured that the time from the receipt of information indicating the need for an interim order to the interim order committee decision remains constant and that the number of extension applications continues to decrease. The small increase therefore does not appear to indicate a concern with the GMC's performance overall under this Standard.

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

- 6.38 Last year we highlighted the GMC's failure in two instances to follow the directions of the High Court. The GMC told us that it had implemented changes to its processes to ensure that similar errors did not occur in future.
- 6.39 We have not identified similar shortcomings during this performance review.

**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**

- 6.40 This Standard was subject to a targeted review in 2015/16, following which we concluded that the Standard was met. However, we remained concerned about the median time from receipt of a complaint to a final fitness to practise decision which had risen from 92.6 weeks in 2014/15 to 99.7 weeks in 2015/16. The GMC told us that the increase in timescales was due to closing increased numbers of older cases, the complexity of its cases and external factors outside its control. We accepted the GMC's explanation but said that we hoped to see a reduction in its overall median timeframe in the next performance review period. If this did not happen, we said we might need to do some more detailed work to understand timeliness factors.
- 6.41 We decided to carry out a targeted review of the GMC's performance against this Standard this year because the data provided by the GMC demonstrated that the median times in each of the three key timeliness indicators – from receipt of complaint to final fitness to practise decision; from investigating committee decision to final fitness to practise decision; and from receipt of initial complaint to final investigating committee decision – had continued to lengthen during 2016/17.
- 6.42 We wanted to understand the GMC's performance in more detail and establish what actions, if any, the GMC was taking to improve timeliness within fitness to practise.

**The dataset**

- 6.43 We collect a set of annual and quarterly performance data from each regulator. The GMC's performance against the key measures of timeliness in fitness to practise cases is shown in the key comparators table at paragraph 2.10 above.

6.44 The table below compares the GMC’s performance against the dataset over the last four years and the first quarter of 2017/18 and shows that the GMC’s performance is worse in 2016/17 than it was in 2013/14 in each of the three measures. In one measure – receipt of complaint to IC/CE decision – performance has deteriorated in each of the last four years, from 29.2 weeks in 2013/14 to 37.1 weeks in 2016/17:

Median times in weeks:	2013/14	2014/15	2015/16	2016/17	2017/18 Q1
From receipt of complaint to final fitness to practise decision	97	92.6	99.7	106.5	99.7 <sup>41</sup>
From final IC/CE decision to final fitness to practise decision	34.4	30.3	28.8	35.7	Not available as reported annually
From receipt of initial complaint to final IC/CE decision	29.2	35	35.6	37.1	32.1

6.45 The dataset also captures the number of open cases which are older than 52 weeks. As the following table demonstrates, the GMC has made notable progress each year in reducing the total number of open cases which are older than 52 weeks:

Number of open cases which are older than:	2013/14	2014/15	2015/16	2016/17	2017/18 Q1
<b>52 weeks</b>	919	598	477	337	344
<b>104 weeks</b>	330	223	205	150	130
<b>156 weeks</b>	76	125	140	149	151
<b>Total</b>	<b>1,325</b>	<b>946</b>	<b>822</b>	<b>636</b>	<b>625</b>

6.46 The number of older cases has continued to decrease during 2016/17, down from 822 cases in 2015/16 to 636 cases in 2016/17. We are aware that closing high numbers of older cases has an impact on the overall median closure times. We needed to understand, however, if the continued closure of older cases was the primary reason for the overall continued decline in timeliness, what other factors might be involved and to establish what

<sup>41</sup> As part of its targeted review response, the GMC provided this quarterly figure. We usually receive this information annually.

actions, if any, the GMC was taking to improve timeliness within fitness to practise.

### **The GMC's investigation process**

- 6.47 The GMC has provided information in its response to the targeted review about its investigation process and how it impacts on the time between case referrals and fitness to practise hearings. The GMC has told us that cases progressed through its national investigation team (NIT) are expected from the outset to be referred to the fitness to practise committee. Although the pre-case examiner stage for NIT cases takes longer as more work is done prior to referral, there should be a concurrent reduction in time between a case examiner decision being made and a case being ready for the fitness to practise committee. Cases progressed through the regional investigation team (RIT) process require, post case examiner referral, further evidence to be gathered prior to the fitness to practise hearing.
- 6.48 The GMC has explained that there are two internal service targets: six months for cases progressed through its NIT process<sup>42</sup> and nine months for cases progressed through its RIT process.<sup>43</sup> These targets relate to the time from CE referral to Tribunal.
- 6.49 The GMC told us that it regularly meets these targets and that there is no backlog of cases. It said that whilst the majority (55 per cent) of cases heard in 2015/16 were NIT cases, the majority (51 per cent) of cases heard in 2016/17 were RIT cases. It suggested that this change resulted in the increase in the median timeframe, as most of the cases heard were RIT cases with their longer target timeframes.
- 6.50 We accept the GMC's explanation that the medians will vary depending on how many cases have progressed through the NIT and RIT routes.

### **Complexity of cases**

- 6.51 In last year's performance review report, we said the GMC had told us that it could take a long time to progress particularly complex fitness to practise cases. This impacts on its median timeframes because these cases take longer to conclude. In response to this year's targeted review, the GMC has told us how all cases over nine months old are reviewed by the senior management team on a regular basis to ensure no cases are delayed inappropriately and that the Director of Fitness to Practise reviews every case which remains open after 12 months.

### **Actions to improve timeliness**

- 6.52 We asked the GMC if it had further measures in place or planned to improve its timeliness, outside of the actions and activities it has described to us over previous years to progress its cases as efficiently as possible. Although the

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<sup>42</sup> Cases progressed through the GMC's national investigation team process are those which have a lawyer attached to the case at the outset and tend to be related to allegations it expects to be referred to tribunal.

<sup>43</sup> Cases progressed through the GMC's regional investigation team process, are those where, post referral, further evidence needs to be gathered to prove the allegations at tribunal.

GMC told us in its response to the targeted review that it would continue to monitor its performance in this area, it did not provide details of any further actions outside of those it has previously reported to us to improve the timeliness of cases in its fitness to practise process.

### **Conclusion on performance against this Standard**

- 6.53 In reaching a decision about how any regulator meets this Standard, we consider carefully the data, and what it tells us about the regulator's performance over time. We consider (where appropriate) any trends that we can identify, as well as contextualising performance against other regulators where we consider that the context is justified.
- 6.54 We recognise that for all regulators, there is often a balance to be achieved between the closing of old cases and the adverse impact that these case closures can have on the median timeframes for progressing cases through the fitness to practise process. Where there has been significant progress in closing old cases, we might expect to see a deterioration in timeliness. The GMC's performance over the last four performance review periods highlights this, in that while it has continued to close a large number of cases older than 52 weeks, its timeliness has deteriorated.
- 6.55 According to the GMC's data, there has been a significant decrease of 52 per cent in the number of cases older than 52 weeks between 2013/14 and 2016/17. Although there was a brief spike in cases older than 156 weeks between 2015/16 and 2016/17, these are more prone to fluctuation given their relatively smaller numbers. Reducing the number of aged cases at such a high rate unavoidably adversely affects the median across all three fitness to practise timeliness measures. The continued decrease in open cases older than 52 weeks, from 1,325 cases in 2013/14 to 636 cases in 2016/17 has coincided with increased median timeframes during the same period.
- 6.56 We accept that the significant reduction in older cases has had an impact on the median times taken to progress cases through the fitness to practise process. We are also reassured by the evidence the GMC has provided to us about how it manages and monitors cases. As the reduction of older cases is a positive indicator, we have balanced this against the concerns we had about the GMC's median timeframes and concluded that although the median timeframes are lengthy, the progress the GMC has made in reducing the number of older cases is sufficient for it to meet this Standard this year. We expect, though, that as the closure of older cases slows down, the median timeframes will improve. In future performance reviews, we will continue to look closely at how the GMC manages the progress of its fitness to practise cases.

### **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**

- 6.57 We decided to carry out a targeted review of the GMC's performance against this Standard. We wanted to know what support, in terms of guidance and processes, was provided for vulnerable witnesses involved in the

GMC/Medical Practitioner Tribunal Service (MPTS) fitness to practise process.

### Witness support

- 6.58 The GMC told us in its response to the targeted review that its witness support service, provided by Victim Support, is primarily aimed at witnesses of fact called by the GMC, but can also be accessed by defence witnesses called by the doctor. It said that it was currently reviewing its Witness Support Service to ensure it was the best fit for its requirements. A number of guidance documents for witnesses attending an MPTS hearing had been developed, which included [Help for witnesses](#) and [Acting as a witness in legal proceedings](#).
- 6.59 Additional support is available to vulnerable witnesses, who may include those under the age of 17 at the time of a hearing, those with a mental health issue, or where the allegation against the doctor is of a sexual nature and the witness is the alleged victim. A private waiting room is available for vulnerable witnesses, and tribunals can agree to special measures being put in place, such as witness screens or giving evidence via video link.
- 6.60 The GMC told us it currently had an ongoing project aimed at enhancing the experience of witnesses. As part of this work, the GMC has undertaken in-depth telephone surveys with approximately 40 witnesses who have given evidence in the previous 12 months. It has collated the outputs of these surveys and identified several improvements which it wished to make to its approach. The first phase of improvements was introduced in October 2017 and includes a standard needs assessment to be completed at the time of taking the witness statement, which would assist the GMC in providing a tailored approach to each witness based on their individual needs. In addition, a new internal guidance tool will be introduced in 2018 to assist GMC staff in providing a high level of service and support to witnesses.
- 6.61 Finally, we were told by the GMC that, as part of induction training for all MPTS tribunal members and Chairs, specific sessions on questioning and listening are delivered. This included not only appropriate questioning as a tribunal member but also explored responses that may be received with reference to those with diverse needs. Chairs were also provided with guidance on how to manage questioning by parties and the induction training of the new Legally Qualified Chairs during 2017 included training sessions on assertiveness to assist in this area. Equality and Diversity training was a standard session at induction training and at regular intervals during tribunal members' terms of office. This training was extended to explore the responsibilities of the tribunal within the hearing environment to support the needs of those within the hearing room, particularly how to support witnesses appearing before the tribunal.

### Conclusion on performance against this Standard

- 6.62 It is appropriate that the GMC is reviewing its witness support programme and continuing to develop guidance for witnesses. The GMC has provided copies of its witness support guidance. It appears that the GMC is aware of

the importance of witnesses and the support they might require. The GMC and MPTS have plans to work together on witness support, while the GMC's website continues to have a dedicated section for witness support, including a link to Victim Support.

- 6.63 While it is necessary to have guidance and policies to support witnesses, these should be adhered to in practice, within a supportive environment. That said, we have not identified any significant shortcomings in the support arrangements in place for witnesses during this performance review period and therefore the Standard is met.

**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**

- 6.64 The Authority sees all final fitness to practise decisions and can refer to the High Court decisions which we consider to be insufficient to protect the public. In 2015/16 and quarter one of 2016/17, we received 413 decisions from the GMC. Of these we held case meetings for 15 decisions (3.6 per cent of the total) and appealed two decisions (0.4 per cent).

- 6.65 This year the proportion of all decisions received which were discussed at case meetings has slightly increased. For 2016/17 and quarter 1 of 2017/18, we received 402 decisions from the GMC. We held case meetings for 17 decisions (4.2 per cent) and appealed five decisions (1.2 per cent). This included three appeals where we joined the GMC in their own appeal against a decision. Although more appeals were lodged this year, the number, as a proportion of all decisions received, remains very small.

**GMC appeals**

- 6.66 The GMC can also appeal fitness to practise decisions of the MPTS to the High Court where it considers the original decision not sufficient for the protection of the public. We can join the GMC in these appeals if we consider that a decision does not protect the public sufficiently and/or if we have an interest in the case.

- 6.67 Since the GMC was given the power to appeal in December 2015, it has lodged 25 appeals with the High Court. We have joined the GMC in three of these appeals.

- 6.68 Of the 18 GMC appeals (involving 16 doctors) which have to date proceeded to a hearing in the High Court, the GMC has succeeded in securing an outcome providing greater public protection in relation to 12 of the 14 doctors' whom those appeals concerned. The GMC also secured an outcome providing greater public protection in relation to two of the other five doctors in respect of whom appeals which has been issued but which did not ultimately proceed to hearing (as they were disposed of by consent prior to hearing).

- 6.69 We will continue to monitor the GMC's approach to appeals both in respect of outcomes and what this tells us for our own processes. The Authority's policy continues to be that it will only join in appeals where it feels that it can bring an important contribution to the process or if matters of law relevant to its

own jurisdiction are raised. We will review the GMC's use of its power of appeal in due course, and set out our views on how this power is working in our own annual report.

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

- 6.70 The GMC continues to publish fitness to practise decisions on its website (apart from those that relate to the registrant's health). We have seen no evidence to suggest that the GMC has failed to publish or communicate any fitness to practise decisions. No concerns have been identified through our check of the register.

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

- 6.71 During the period of this performance review, one data breach was reported to the Information Commissioner's Office, who took no action.<sup>44</sup>
- 6.72 The GMC continue to hold ISO certification and followed the appropriate process in reporting the breach. In light of this, we remain satisfied that the GMC meet this Standard.

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<sup>44</sup> The Information Commissioner's Office is the UK's independent authority set up to uphold information rights in the public interest, promoting openness by public bodies and data privacy for individuals.

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