HEALTH AND SPORT COMMITTEE

HEALTH AND CARE (STAFFING) (SCOTLAND) BILL

SUBMISSION FROM THE GENERAL MEDICAL COUNCIL

Thank you for the opportunity to respond to this call for evidence. As you will know, the General Medical Council (GMC) is an independent organisation that helps to protect patients and improve medical education and practice across the UK.

- We decide which doctors are qualified to work here and we oversee UK medical education and training
- We set the standards that doctors need to follow, and make sure that they continue to meet these standards throughout their careers
- We take action to prevent a doctor from putting the safety of patients, or the public’s confidence in doctors, at risk.

While regulation of the medical profession is reserved to Westminster, the GMC operates within the legal and legislative structures of the different jurisdictions with the UK. As an example of this, our guidance for doctors reflects the laws of all Scotland, and when a law changes we seek senior counsel’s advice on whether we would need to update our guidance.

We note that, as set out in paragraph 7 of the policy memorandum, the policy aim is to support an open and honest culture, with staff engaged in relevant processes and informed about decisions relating to staffing requirements and feeling safe to raise any concerns about staffing levels. We provide more information and build on this below, and though we await further detail about how the policy would operate in practice, we would support this intention. Particularly, we would draw your attention to paragraphs 22-26 of Good medical practice (please see Annex A), which should place doctors on a good footing to engage with this new policy.

We would also support the guiding principle of health and social care staffing outlined in paragraph 103 of the policy memorandum which says that in providing safe and high quality services, staffing will be arranged whilst being open with service users. This is consistent with the principles outlined in the professional duty of candour*, guidance which applies to every doctor, nurse and midwife in the UK.

We note that whilst the Bill provides a framework to deliver the Scottish Government’s policy intention, the detail of how this is achieved in practice will in a large part depend on

the supporting guidance, tools and protocols yet to be developed. Given the importance of adequate staffing to patient safety it will be vital to ensure that, as a whole, it is measured and evaluated appropriately (as with any new policy).

We also note that the Bill as drafted would only apply to one medical specialty, emergency medicine (alongside various specialties of registered nurse or midwife), although we recognise that it may be the intention is to ensure that other types of health care are included at a later stage. We are aware, including through data we have collected through our annual National Training Survey, that doctors across all specialties are feeling under resourced and under strain. We have included a selection of this data at Annex C. A multidisciplinary approach to this policy would also be important in the context of both patient safety and fairness, so we would therefore urge both the Committee and the Scottish Government to continue to consider how it may be appropriately extended to other disciplines.

We also feel that in the Committee’s scrutiny of the Bill it will be prudent to consider the following points:

**Ethical standards**

As outlined above, *Good medical practice* puts duties on doctors to contribute to and comply with system level initiatives to protect patients. This is expanded upon in our explanatory guidance *Leadership and management for all doctors*, which outlines their responsibilities to work with other people and teams to maintain and improve performance and change systems where this is necessary for the benefit of patients. The guidance also puts responsibilities on doctors to work with colleagues and their organisation to ensure that multidisciplinary or multi-agency team working is clear and effective. Whilst not devaluing the importance of subsequent guidance as to the expectations of health and care professionals in adhering to this new policy, doctors’ existing responsibilities should stand them in good stead to engage with it.

We also have a number of other comments about the Bill and how it relates to our guidance:

- We welcome that paragraph 11 of the Bill supports local decision-making, flexibility and the ability to redesign and innovate across multi-disciplinary and multi-agency settings. This will be important to the success of the policy, but we recognise that it may be difficult to ensure that the balance is right. Whilst we are aware that the detail of how the tools will work in practice and how a common tool would translate across all contexts is still to be finalised, it would be helpful to understand more about this when possible.

- It will be important that in the development of the professional judgement tool, consideration is given to the potential for conflict between the professional judgement of different members of the healthcare team as to what constitutes safe and proportionate staffing levels, and how final decisions might be made and
reviewed. We note that the intention seems to be to ensure that robust feedback mechanisms will be built into the tool, which will be important.

- The Committee may also wish to note that we would expect doctors to raise concerns where they believe that patient safety or care is being compromised by the practice of colleagues or the systems, policies and procedures in the organisations in which they work (paragraph 7 of our guidance *Raising and acting on concerns about patient safety*). This would include the impact of any new staffing tool or methodology. Whilst we would support the intention to ensure that all health and care staff contribute to the development, implementation and working of the method, it will be important to make sure that doctors are still encouraged to exercise their independent professional judgement where needed.

**GMC oversight of doctors’ education and training**

We set the educational standards for all UK doctors through undergraduate and postgraduate education and training. We promote high standards and make sure that medical education and training reflects the needs of patients, medical students and doctors in training, and the healthcare systems across the UK. Part of our role is also to approve postgraduate medical education and training – this includes approved training programmes, curricula and assessments. Rigorous reviews and regular monitoring activities, such as our annual survey of doctors in training, help us to deal quickly with any concerns and to make sure that doctors are receiving the supervision and experience they need to treat patients safely.

Whilst in principle we are supportive of the policy intention of the Staffing Bill, the Committee should note that it will need to be operationalised in a way in which training providers can meet their requirements under the criteria laid out in our *Generic professional capabilities (GPC) framework* and in *Promoting Excellence: standards for medical education and training*. Please see Annex C for specific requirements on employing organisations contained in *Promoting Excellence* pertaining to safe and effective training environments.

**Generic professional capabilities**

The GPC framework sets out the essential generic capabilities needed for safe, effective and high quality medical care in the UK. At its heart are the principles and professional responsibilities of doctors, and we have translated these into educational outcomes so

they can be incorporated into curricula. Although this framework relates to postgraduate medical education and training, we expect that it will support all phases of UK medical education and continuing professional development.

In particular, we would like to highlight Domain 6 “Capabilities in patient safety and quality improvement,” which outlines that doctors in training must demonstrate that they can participate in and promote activity to improve the quality and safety of patient care and clinical outcomes, and to design and implement quality improvement interventions that improve clinical effectiveness, patient safety and patient experience. The capabilities they must be able to demonstrate under Domain 6 are outlined in Annex B.

Promoting excellence and Outcomes for graduates

Promoting excellence sets out the requirements for the management and delivery of undergraduate and postgraduate medical education and training. Outcomes for graduates, meanwhile, sets out the knowledge, skills and behaviours that new UK medical graduates must be able to show. Updated in 2018, medical schools have until 2020 to make sure their curriculum meets the new outcomes.

The GPC framework informs our requirements in both Promoting excellence and Outcomes for Graduates. We would therefore urge that in addition to the GPC framework, that further development of the policy and supporting guidance takes due account of both of these documents.

Data and quality assurance

The GMC quality assures medical education and training against the standards and requirements as outlined in Promoting Excellence. We do this in a number of ways:

- We work closely with NHS Education for Scotland to ensure training is managed and delivered appropriately
- We undertake visits to regions and countries to assess the quality of education and training (including a review of Scotland in 2017, the results of which have now been published†)
- We deliver national training surveys, which provide extensive data on how training locations, specialties and programmes meet our standards

We take action when standards are not being met, through our enhanced monitoring process*

The surveys in particular are valuable data sources, which provide wide ranging information on how trainees and trainers perceive their training location, specialty and programme. We think that this data is particularly valuable for consideration in moving forward with this Bill (see Annex D).

We will continue to work closely with NES to monitor the quality of training and take action where appropriate. We recommend that the surveys and other available data are monitored closely to ensure that the Bill takes into account the experience of doctors in training and trainers, allowing them ample time to train and learn.

Any data generated as part of tracking the staffing levels in future may be useful to the GMC by contributing to our understanding of risks in different locations, and could be used to inform our quality assurance of education environments by providing us new insights into relative staffing levels in different locations.

* [https://www.gmc-uk.org/education/how-we-quality-assure/postgraduate-bodies/enhanced-monitoring](https://www.gmc-uk.org/education/how-we-quality-assure/postgraduate-bodies/enhanced-monitoring)
Annex A

Selected paragraphs of Good medical practice

Contribute to and comply with systems to protect patients:

■ 22: You must take part in systems of quality assurance and quality improvement to promote patient safety. This includes:
  ■ a. taking part in regular reviews and audits of your work and that of your team, responding constructively to the outcomes, taking steps to address any problems and carrying out further training where necessary
  ■ b. regularly reflecting on your standards of practice and the care you provide
  ■ c. reviewing patient feedback where it is available.

■ 23: To help keep patients safe you must:
  ■ e. respond to requests from organisations monitoring public health.

Respond to risks to safety

■ 24: You must promote and encourage a culture that allows all staff to raise concerns openly and safely.

■ 25: You must take prompt action if you think that patient safety, dignity or comfort is or may be seriously compromised.

  ■ a. If a patient is not receiving basic care to meet their needs, you must immediately tell someone who is in a position to act straight away.

  ■ b. If patients are at risk because of inadequate premises, equipment or other resources, policies or systems, you should put the matter right if that is possible. You must raise your concern in line with our guidance and your workplace policy. You should also make a record of the steps you have taken.

■ 26: You must offer help if emergencies arise in clinical settings or in the community, taking account of your own safety, your competence and the availability of other options for care.
Annex B

Domain 6 of the Generic Professional Capabilities framework

Domain 6: Capabilities in patient safety and quality improvement

Patient safety
Doctors in training must demonstrate that they can participate in and promote activity to improve the quality and safety of patient care and clinical outcomes. To do this, they must:

- raise safety concerns appropriately through clinical governance systems
- understand the importance of raising and acting on concerns
- understand the importance of sharing good practice
- demonstrate and apply basic Human Factors principles and practice at individual, team, organisational and system levels
- demonstrate and apply non-technical skills and crisis resource management techniques in practice
- demonstrate effective multidisciplinary and interprofessional team working
- demonstrate respect for and recognition of the roles of other health professionals in the effective delivery of patient care
- promote and participate in interprofessional learning
- promote patient involvement in safety and quality improvement reviews
- understand risk, including risk identification (clinical, suicide and system), management or mitigation
- understand fixation error, unconscious and cognitive biases
- reflect on their personal behaviour and practice
- effectively pre-brief, debrief and learn from their own performance and that of others
- make changes to their practice in response to learning opportunities
- be able to keep accurate, structured and where appropriate standardised records.
Quality improvement

Design and implement quality improvement projects or interventions that improve clinical effectiveness, patient safety and patient experience by:

- using data to identify areas for improvement
- critically appraising information from audit, inquiries, critical incidents or complaints, and implementing appropriate changes
- developing quality improvement methods (eg plan, do, study, act or action research) and repeat quality improvement cycles to refine practice
- involving patients and public in decision making at group or community level
- engaging with stakeholders, including patients, doctors and managers, to plan and implement service change
- effectively evaluating the impact of quality improvement interventions.
Annex C

Relevant requirements contained in *Promoting Excellence*

R1.1 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.

R1.2 Organisations must investigate and take appropriate action locally to make sure concerns are properly dealt with. Concerns affecting the safety of patients or learners must be addressed immediately and effectively.

R1.7 Organisations must make sure there are enough staff members who are suitably qualified, so that learners have appropriate clinical supervision, working patterns and workload, for patients to receive care that is safe and of a good standard, while creating the required learning opportunities.

R1.8 Organisations must make sure that learners have an appropriate level of clinical supervision at all times by an experienced and competent supervisor, who can advise or attend as needed. The level of supervision must fit the individual learner’s competence, confidence and experience. The support and clinical supervision must be clearly outlined to the learner and the supervisor. Foundation doctors must at all times have on-site access to a senior colleague who is suitably qualified to deal with problems that may arise during the session. This will normally be a doctor, but on some placements it may be appropriate for a senior healthcare professional to take on this role. Medical students on placement must be supervised, with closer supervision when they are at lower levels of competence.

R1.12 Organisations must design rotas to:

a. make sure doctors in training have appropriate clinical supervision

b. support doctors in training to develop the professional values, knowledge, skills and behaviours required of all doctors working in the UK

c. provide learning opportunities that allow doctors in training to meet the requirements of their curriculum and training programme

d. give doctors in training access to educational supervisors

e. minimise the adverse effects of fatigue and workload.

R1.16 Doctors in training must have protected time for learning while they are doing clinical or medical work, or during academic training, and for attending organised educational sessions, training days, courses and other learning opportunities to meet the
requirements of their curriculum. In timetabled educational sessions, doctors in training must not be interrupted for service unless there is an exceptional and unanticipated clinical need to maintain patient safety.

R1.19 Organisations must have the capacity, resources and facilities* to deliver safe and relevant learning opportunities, clinical supervision and practical experiences for learners required by their curriculum or training programme and to provide the required educational supervision and support.

R2.10 Organisations responsible for managing and providing education and training must monitor how educational resources are allocated and used, including ensuring time in trainers’ job plans.

R4.2 Trainers must have enough time in job plans to meet their educational responsibilities so that they can carry out their role in a way that promotes safe and effective care and a positive learning experience.

R4.3 Educators must have access to appropriately funded resources they need to meet the requirements of the training programme or curriculum.

R5.9 Postgraduate training programmes must give doctors in training:

h. a balance between providing services and accessing educational and training opportunities. Services will focus on patient needs, but the work undertaken by doctors in training should support learning opportunities wherever possible. Education and training should not be compromised by the demands of regularly carrying out routine tasks or out-of-hours cover that do not support learning and have little educational or training value.

* Resources and facilities may include: IT systems so learners can access online curricula, work place based assessments, supervised learning events and learning portfolios; libraries and knowledge services; information resources; physical space; support staff; and patient safety orientated tools.
Annex D

Selected data regarding pressures on doctors

The State of Medical Education and Practice 2017

The report*, published annually, analyses data on the medical workforce across the UK. The 2017 report identifies a raft of challenges facing the medical profession today against a backdrop of an increasing and older population, and highlights four priorities for medical training and workforce planning. In it we state that the UK’s medical profession is at ‘a crunch point’. We identify four warning signs:

*The supply of new doctors into the UK medical workforce has not kept pace with changes in demand.*

The number of doctors taking up (or returning to) a licence to practise has remained relatively steady between 2012 and 2017 – an average of around 13,000 doctors every year. This figure must be seen in the context of rising demand on health services across the UK. In England there was a 28% increase in accident and emergency (A&E) attendances between 2012–13 and 2016–17, while Northern Ireland saw an 11% increase over that same period. An analysis by The King’s Fund published in May 2016 found the workload of GPs has grown both in volume and complexity, with a sample showing a 15% increase in the number of consultations from 2010–11, and 2014–15.

*Our dependence on non-UK qualified doctors has increased in some specialties*

Although the proportion of UK graduates on the medical register increased from 63% to 67% between 2012 and 2017, there are specialties that continue to be reliant on non-UK graduates. Emergency medicine, medicine, and paediatrics have seen increases of more than 20% in the number of non-UK qualified doctors between 2012 and 2017 – increases mainly driven by overseas recruitment drives. The specialties with the highest reliance on non UK graduates are obstetrics and gynaecology (55%), ophthalmology (48%), and paediatrics (46%), while psychiatry and pathology have more than 40% of their doctors drawn from this cohort.

*The UK is at risk of becoming a less attractive place for overseas doctors to work – both to those already in the UK and those outside it*

Between 2012 and 2017 the number of licensed doctors who were UK graduates increased by more than 10,700. However, this growth was offset by a reduction in EEA

graduates and international graduates. In 2017 there were 6,000 fewer non-UK graduates on the register compared to six years ago. South Asia (which includes the countries of India and Pakistan) has been the largest source of international graduates for the UK historically and accounts for nearly half of the fall in the number of these doctors (down by 2,500). Meanwhile we have seen the number of licensed doctors from Oceania (which includes Australia and New Zealand) fall from 1,980 in 2012 to 1,252 in 2017 (a drop of 37%). EEA graduates have fallen by more than 1,300 (a drop of 5.9%).

*The strain on doctors training and being trained continues*

This continues to be highlighted in the results of our National Training Surveys (see below).

**The National Training Survey 2018**

The national training surveys (NTS) gather views from doctors in training and trainers across the four countries of the UK on their experiences in training and the environments where they work. The data generated show local and country trends, which drive policy developments and interventions to tackle problems and improve the training experience.

This year, we added new questions to the surveys to help us better understand the extent of burnout amongst doctors in training and trainers. The results* are stark:

- Nearly a quarter of doctors in training and just over a fifth of trainers told us they’re burnt out because of their work
- Almost a third of trainees said that they are often or always exhausted at the thought of another shift. And well over a half of trainees, and just under a half of trainers, reported that they often or always feel worn out at the end of their working day
- A fifth of doctors in training and trainers told us they feel short of sleep when at work.
- Two in five trainees and two thirds of trainers rated the intensity of their work as very heavy or heavy; and nearly half of trainees reported that they work beyond their rostered hours on a daily or weekly basis.
- And around a third of doctors in training and trainers said that training opportunities are lost to rota gaps.