Could the GMC additionally clarify in the 20 cases where it reportedly took action, in how many of these UHB cases did the action consist only of advice given to the referred doctor?
Where the GMC action comprised solely of advice given to the referred doctor, was a GMC referral really necessary or would a less formal and drastic route of addressing concern have been possible and/or preferable?

With respect to the data that UBH provided, the data on the total number of referrals is correct, however there is an inaccuracy in the data on cases which concluded at triage / concluded with no actions:

UHB reported that of the 22 referrals, *four were concluded at triage, seven were investigated and concluded with no action, 11 were subject to advice, warning, undertakings, suspension or erasure.*

In fact, of the 22 referrals from UHB the outcomes were that three were concluded at triage, eight were investigated and concluded with no action and 11 were subject to advice, warning, undertakings, suspension or erasure.

Turning to Heart of England NHS Foundation Trust (HEFT), the data you were provided with states that six of 16 referrals were signed off by the Medical Director and the remainder were by Deputy or Associate Medical Directors. Our data indicates that the number of referrals by the Medical Director was five.

Finally, one of the nine referrals which was said to have ended by way of *advice, warning, undertakings, suspension or erasure* actually ended by means of being referred to the doctor's Responsible Officer.

Further information on outcomes

Of the 11 investigations stemming from UHB referrals which were subject to advice, warning, undertakings, suspension or erasure, two were closed with advice. The number for HEFT is also two.

In respect of your question as to if referrals which ended in advice were necessary, we don't hold data on whether referrals were necessary but see below our procedures on identifying learning for employers from referrals though our feedback loops.

More generally:

What mechanism(s) does the GMC have in place, if any, to detect whether individual employers are making inappropriate or abusive GMC referrals?

We have various mechanisms in place to help make sure referrals that are made to us are appropriate. For example:

1) **Outreach team**
   Our outreach team works across the UK to improve understanding of our guidance. They explain how our processes work and promote our standards. They also collaborate with the service to understand the issues faced at local level. Our outreach advisers work with responsible officers (ROs) to address concerns about doctors and support management with concerns at a local level.

2) **Guidance for employers and responsible officers (ROs)**

We have guidance in place to support employers when they are considering making a referral to us. These include:

- *RO referral guide* - this sets out:
  - What the ROs should consider before making a referral (paras 9 to 12)
  - Details of the updated referral form which they are strongly encouraged to use as per paras 13 and 14
  - The steps they must take when making a referral (paras 15 to 19)
  - Factors they need to consider in the process to ensure the referral is fair (paras 20 to 24)
  - Specific considerations relating to any doctors who have raised patient safety concerns (paras 25 to 28)
  - The fact that we ask ROs to ensure they speak to their Employee Liaison Adviser (ELA) for advice on how to proceed if a doctor connected to their designated body or working for or contracted by their organisations appears to have reached, or be close to, any of the thresholds (para 29)
- *Threshold guidance* – this guidance provides clarity to ROs, medical directors and others involved in the employment, contracting and management of doctors on what matters we can and cannot take action on.

3) Feedback loops between ROs and the GMC

Case Examiner (CE) / RO feedback loop: The feedback loop between our Case Examiners and the Employer Liaison Service (ELS) was implemented in May 2022 in response to the following recommendation in Fair to Refer? *Where a referral is received from an employer/provider which does not result in the GMC opening an investigation, the ELA and RO should have a discussion to identify learning in relation to the original referral.* If a referral comes in that either doesn't involve an ELA, or does involve an ELA but doesn't get past our initial triage stage, the ELA team scrutinise this to understand what learning can be taken from the referral. For those referrals that get to a CE decision, if the CE identifies learning for the referring organisation about the referral, then that is shared back via the ELA.

Providing feedback is at the discretion of the CEs to do so when appropriate. As of May 2023, there had been three cases where it was appropriate to utilise this feedback loop. A post implementation review of this new process has just been completed and the recommendations from this are being considered as part of the Fairer Employer Referral (FER) project. More information on this project can be found below.

Triage / RO feedback loop: we have also implemented a further feedback loop between the team that initially assess concerns (triage) and our ELS to support further discussion between the ELS and ROs on cases that have been considered and closed by us at triage where there are opportunities to feedback on aspects of the referral that would be useful learning for ROs and their organisations.

4) Training for influencers and decision-makers

We are in the process of rolling out anti-bias training for key decision makers in the investigation process. The aim of this training is to assist staff with:

- developing awareness of the different types of bias and their impact,
- highlighting the importance of remaining vigilant when considering referrals,
- considering how decision-makers might identify an unfair referral.

Further anti-bias training is scheduled for later this year, and we will be scoping out options to extend this to other operational teams in the next phase of the project.

5) Public interest concerns

Where a doctor has raised public interest concerns (PICs), commonly known as 'whistleblowing', we have some additional requirements for responsible officers and suitable persons as part of the revalidation process. This is to give us assurance that revalidation recommendations have been made appropriately. More information on revalidation and PICs can be found here.

In relation to FtP referrals, the usual process for a referral is for employers and/or responsible officers to complete an online employer referral form in which they are also asked to confirm whether the doctor they're referring has previously raised public interest concerns and if those concerns have been investigated. The referrer must also declare that the referral is being made in good faith and is accurate and fair.

In the cases where a doctor has raised concerns in the public interest, we seek independent corroboration of the concerns raised by the employer before deciding whether to open an investigation. If a full investigation is needed, we ensure the investigation focuses on independent corroboration of concerns raised by the employer and we also make our decision makers aware of the whistleblowing history, so they can take this into account when deciding what action to take. You can find more details regarding this under paragraphs 7 to 10 in our *Guidance for Case Examiners on deciding on the outcome of a case where the doctor under investigation has raised concerns locally.*

What early warning signs does the GMC track, if any, to alert itself of poor employer practices with respect to GMC referrals?

85% of the referrals we received from ROs in 2022 met our test for an investigation. If a referral does not meet that test, our outreach team will scrutinise the referral to see what learning can be taken from it and feed this back to ROs through the mechanisms outlined above.

Has the GMC estimated at national level what proportion of GMC referrals annually by employers are inappropriate and/or could have been dealt with another means?

We don't report anything directly on this and 'inappropriate/dealt with by other means' referrals aren't something that we capture data on.

If so, please give the total percentage of GMC referrals annually which the GMC believes could have been avoided.

Please see response provided above.

What policies and strategies does the GMC have in place to address inappropriate referrals, and how does it measure the effectiveness of these policies and strategies?

We have a range of policies and strategies in place to support fair referrals. These have been outlined below.

1) **Fairer Employer Referrals (FER)**

In 2019 we published *Fair to refer?*, a review aimed at understanding more about why some groups of doctors are disproportionately referred by employers to the GMC. The findings pointed to workplace environments and cultures as causes of disproportionality in referrals to the GMC. We have committed to eliminating disproportionality in fitness to practise referrals from employers based on ethnicity and place of primary medical qualification by 2026. For more information on our targets and measures, please see our 2023 annual Equality Diversity and Inclusion progress report to Council.

Addressing this inequality is beyond the control of the GMC alone and, as well as making changes to our own procedures, we're working with our partners to create more inclusive, supportive and fair local environments.

We have completed **Phase 1** of our programme to support delivery of the target and our activity so far includes:

- We've had fairness conversations with all employers to emphasise their duty to provide supportive and inclusive working environments and to explore how they are implementing the findings of the *Fair to Refer?* research.
- We've made changes to our RO referral form, to include additional questions about how employers have considered systemic issues, the support they've provided locally, and the impartial checks that have been made to ensure the referral is fair and inclusive.
- We've developed new training for our staff on the specific risks of bias in employer referrals.
- We've developed and implemented a mechanism to provide feedback to employers about the outcome of concerns referred to us at the end of an investigation.
- We're developing a mechanism to provide feedback to employers about concerns that do not meet our threshold for investigation.
- We're supporting NHS Resolution's *Being Fair* programme which brings together a range of stakeholders to collaborate on ED&I matters, specifically supporting a just and learning culture for following incidents in the NHS.
- We're supporting the work of our partners to standardise local investigation processes and how these might address disproportionality at the early stages of a concern being raised, to avoid unnecessary GMC referrals. For example, we worked with HEE to introduce a standardised induction process for international medical graduates that was launched last year.

Plans for 2023:

Phase 2 of our action plan is currently underway and includes further work with ROs and system partners.

2) **Public Interest Concerns (PICs)**

Please see information relating to our public interest concerns process set out above.

3) Referral reforms

One recommendation from *Fair to Refer* led to 3 new questions being added to the referral form. These questions ask employers to confirm:

- action taken to assess any environmental pressures and systems issues, and action taken to improve them,
- for non-UK qualified doctors, training that has been provided to the doctor in relation to expectations relating to demonstrating insight when something goes wrong,
- checks carried out to ensure a GMC referral is appropriate.

A recent review of this form has been competed as part of the FER project and the recommendations from this review will be included in the next phase of the FER project. More information on these changes can be found here.

What quality indicators does GMC monitor, if any, on each employer's GMC referrals?

Each referral should be discussed with the ELA, which includes understanding the local context and investigation process before considering whether advice whether to make a referral. We monitor referrals from designated bodies to understand and feedback where ELA advice has not been sought. Feedback of any learning arising from our investigation process is shared with referrers through the feedback loops outlined above.

What comparative data does GMC collate centrally, if any, to track differences between employers' behaviour, in terms of quality and outcomes of GMC referrals?

For individual employers, we collate data about the cases they refer to us and their outcomes.

Can the GMC, based on its current systems and data collection, tell whether some employers are outliers in terms of higher rates of GMC referrals which end in no case to answer, no further action, or only advice given?

The data mentioned above would enable comparisons between employing organisations of their referrals by outcome.

Does the GMC collate central data on whether it raises concerns with individual employers about poor referral practice or gives formal warnings to individual employers and medical managers about poor practices such as vexatious GMC referrals or GMC referrals which are suspected to be vexatious?

Each referral is discussed with the RO and ELA, and advice is given on appropriateness and timing of referral if the ELA is satisfied that an FTP threshold may have been met. If those referrals do not pass our initial triage stage, we will look to understand the learning from them, and feedback to the RO if appropriate. More information on our FTP thresholds can be found here.

Has the GMC in the last five years disciplined any senior doctor for abusing power and vexatiously referring a doctor under their line management to the GMC, for example, by carelessly or knowingly making a false allegation?
If so, on how many occasions has this happened and what was the GMC sanction(s) applied, for example, undertakings, warning, suspension or erasure etc?

We have identified one instance where a senior doctor was given a warning for making a misleading referral which I think falls into the scope of the kind of case you are interested in.

If the GMC currently has no system for tracking poor GMC referral practice by individual employers, and for publishing such comparative data, will it give consideration to doing so in future?

Please see the information set out above regarding feedback loops on referrals. The *Fair to Refer?* research identified that the matters that lead to disproportionate referrals occur not just at the point of referral but throughout a doctor's career and employment with a referring body, including poor induction and ongoing support, isolated working and lack of consistent feedback. As part of our FER programme, we have established a target to eliminate differentials in employer referrals by the end of 2026 and we have a programme of work to support meeting that target. Regular monitoring will allow us to keep scrutinising this and review mechanisms to continue in the right direction. For more information on our targets, please see our regulatory equality, diversity and inclusion targets on Fairer employer referrals and Fair training cultures (pages 13-15). We will report on any future findings in relation to how we are meeting these targets.

If the GMC does currently track this data but does not publish it, will it give consideration to doing so in future?

Please see the response provided above.

Will it also consider a change to Good Medical Practice guidance to specifically make it a proscribed practice for doctors in leadership positions to carelessly or knowingly make unsubstantiated or false GMC referrals or PPA referrals on doctors whom they manage?

Good Medical Practice (GMP) and our other guidance on professional standards set clear expectations in terms of honesty and integrity when appraising or managing the performance of doctors. For example:

Good medical practice

> 41 You must be honest and objective when writing references, and when appraising or assessing the performance of colleagues, including locums and students. References must include all information relevant to your colleagues' competence, performance and conduct
>
> 68 You must be honest and trustworthy in all your communication with patients and colleagues. This means you must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate.
>
> 71 You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents. You must make sure that any documents you write or sign are not false or misleading.
>
> a You must take reasonable steps to check the information is correct.
>
> b You must not deliberately leave out relevant information

Leadership and management

> 34 You must be honest and objective and keep to the principles of equality and diversity when appraising or assessing colleagues' performance.

These principles will remain in the updated professional standards due to be published later this year.

Lastly, GMC previously kindly shared a status update on its Hooper implementation project. Could it do so again?

We completed our work relating to the recommendations identified in 2015 by Sir Anthony Hooper following his review of the way in which we handled cases involving individuals who regarded themselves as whistleblowers some years ago and the changes we made are now part of our usual practice. We have described the public interest concerns process above. We have since continued to identify and deliver improvements to employer referrals as part of our programme of work to support a profession under pressure which launched in 2018. Through this programme, we aim to help develop well led, inclusive and supportive healthcare environments across all four countries of the UK. Recommendations resulting from three independent reviews we'd commissioned in 2018 that fed into this were:

1. Independent review of gross negligence manslaughter and culpable homicide in medical practice, chaired by Leslie Hamilton.
2. Fair to refer? Reducing disproportionality in fitness to practise concerns reported to the GMC, by Dr Doyin Atewologun and Roger Kline.
3. Caring for doctors, caring for patients: How to transform UK healthcare environments to support doctors and medical students to care for patients, by Dame Denise Coia and Professor Michael West.

Please see our regulatory equality, diversity and inclusion targets for more information.