"Do no harm"
how do professional regulators help to avoid it?

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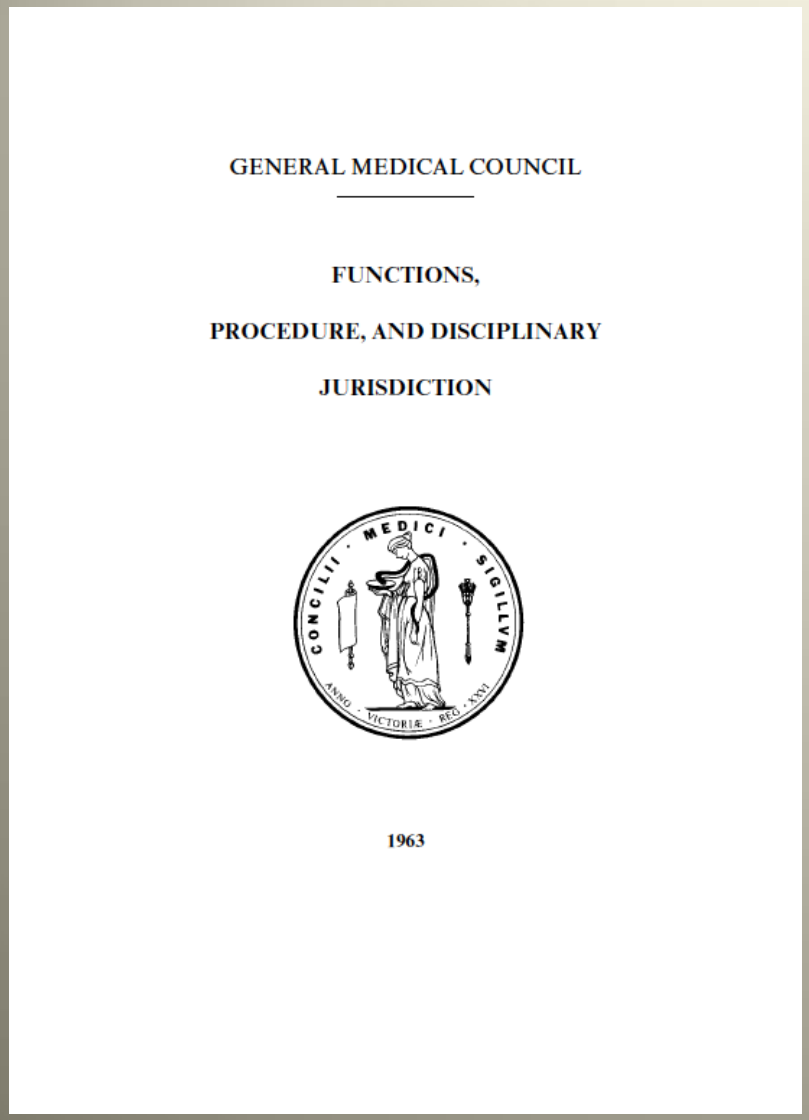
The old days…

Fitness to practise committee sitting days

Year	Number of sitting days					
	PPC	***PCC***	***IOC*** *(from Aug 2000)*	***Health Committee***	***CPP***	***ARC***
1998	7	91	-	16	1	-
1999	15	129	-	27	7	-
2000	30.5	242	16	38	25	12
2001	35	479	95	52	86	11
2002	41	651 (430 Lon; 221 Man)	97	56	123 (121 Lon; 2 Man)	29

GMC Annual Report and Accounts 2002

The Blue Book



GENERAL MEDICAL COUNCIL

FUNCTIONS,

PROCEDURE, AND DISCIPLINARY

JURISDICTION

1963

1963: 17 pages
Procedure and common issues
In detail:

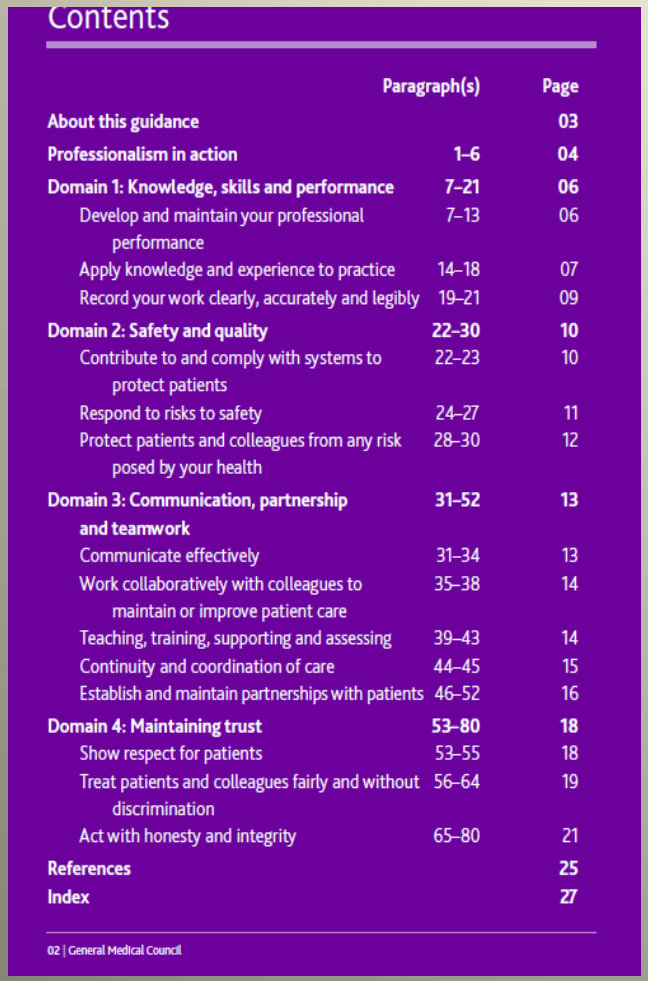
- Abortion
- Gross neglect in diagnosis/treatment
- Offences re abuse of alcohol
- Drug addiction
- Untrue/misleading certificates
- Covering unregistered persons
- Canvassing/advertising
- Depreciation of other doctors
- Improper financial transactions

How the mighty are fallen…

Downloaded 24/10/16 from http://www.venuesearchlondon.com/venues/699-the-hallam-cavendish-venues-council-chamber

The GMC today

Good medical practice



Contents

- 36 pages [but many supplementary guides
- 4 domains
  - Knowledge skills & performance
  - Safety & quality
  - Communication, partnership & teamwork
  - Maintaining Trust

Some figures

	2015	%	2010	
FTP complaints received	**8.269**			
closed immediately	**5,419**	**65**		
referred to employer	**562**	**7**		
referred for investigation	**2,240**	**27**		
FTP investigations concluded	**2,808**	**%**	**1,856**	**%**
· ***Interim orders restricting practice***		**20**		
· ***Closed with no further action***	**1,943**	**69**	**884**	**48**
· ***Closed with advice***	**383**	**14**	**460**	**25**
· ***Sanction or warning***	**482**	**17**	**512**	**28**
· **Warning**	**127**	**5**	**184**	**10**
· **Conditions/undertaking**	**164**	**6**	**132**	**7**
· **Suspension/erasure**	**191**	**7**	**196**	**5**

The state of medical education and practice in the UK report: 2016, gmc-uk.org
27 October 2016

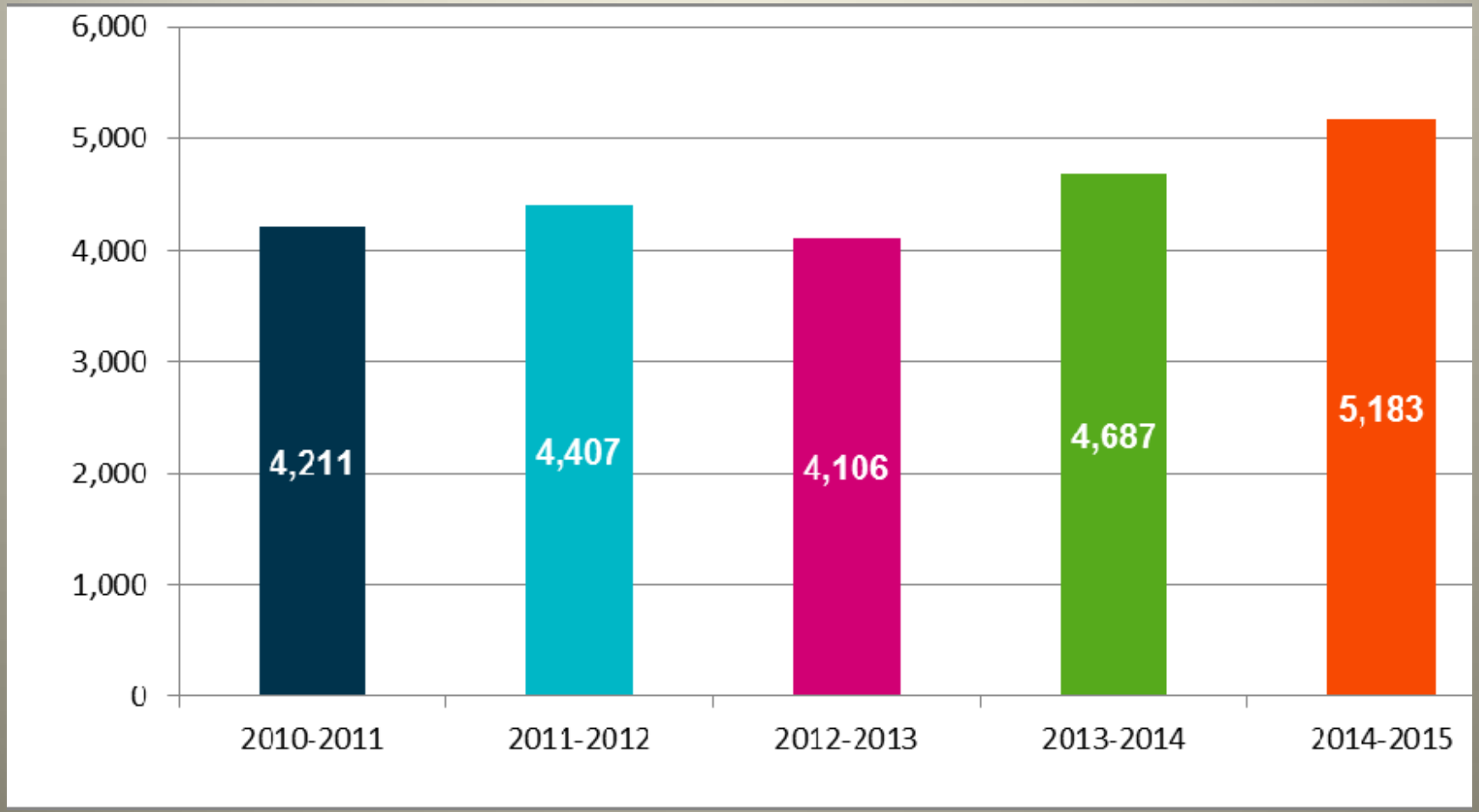
Investigations NOT resulting in a sanction or warning

- Allegations re clinical competence from:
  - Public 92%
  - Doctors/employers 71%
  - Others 70%
- Allegations from public about:
  - Professional performance 85%
  - Communication 93%
  - dishonesty/fairness 89%

Working with doctors Working for patients

The state of medical education and practice in the UK report: 2015, gmc-uk.org [2014 figures]

NMC – new referrals 2010-2015



Annual Fitness to Practice Report 2014-2015, NMC Oct 2015

NMC – referrals by country of registrant

Country	Percentage of register	Number of referrals	Percentage of referrals
England	79%	3,465	80%
Scotland	10%	412	10%
Wales	5%	246	6%
Northern Ireland	3%	112	3%
Overseas (including EU)	3%	67	1%
Total	**100%**	**4,302**	**100%**
Unidentified referrals		881	
		5,183	

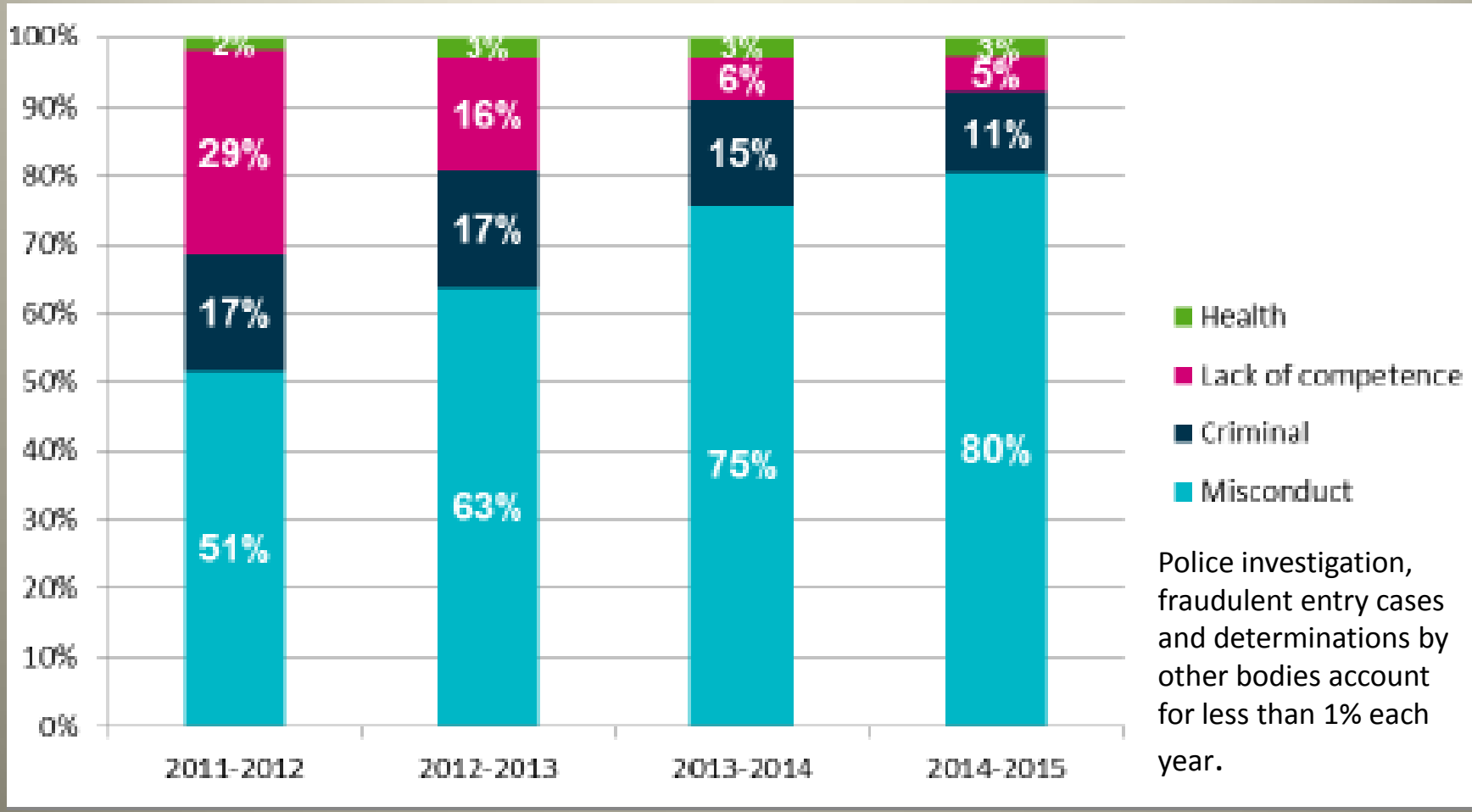
Annual Fitness to Practice Report 2014-2015, NMC Oct 2015

NMC - type of allegation – 2014-15

Type of allegation	Percentage of allegations
Misconduct	80%
Criminal	11%
Lack of competence	5%
Health	3%
Fraudulent/incorrect entry to NMC register	Less than 1%
Determination by another body	Less than 1%
Total	**100%**

Annual Fitness to Practice Report 2014-2015, NMC Oct 2015

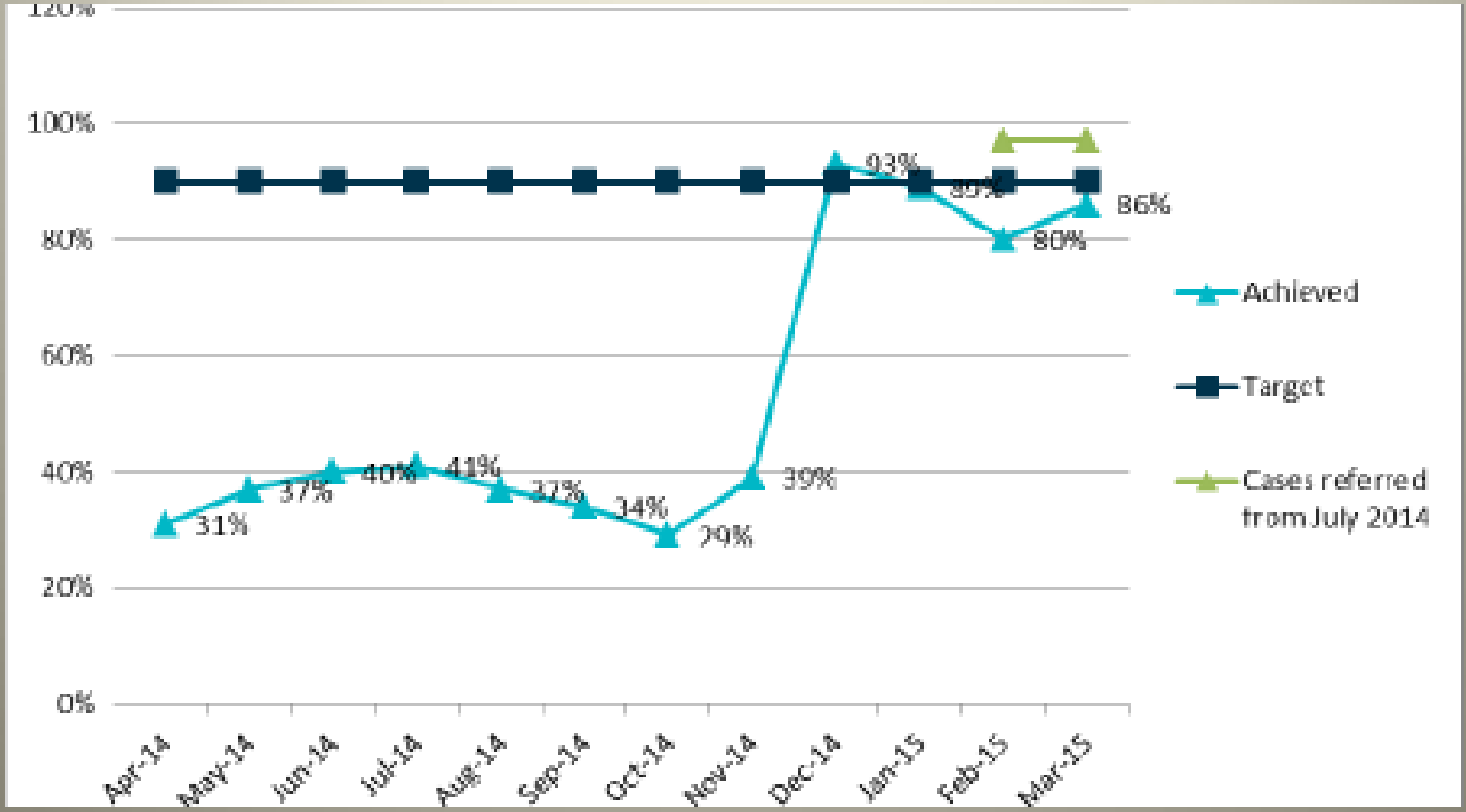
NMC – type of allegation 2010-2015



Police investigation, fraudulent entry cases and determinations by other bodies account for less than 1% each year.

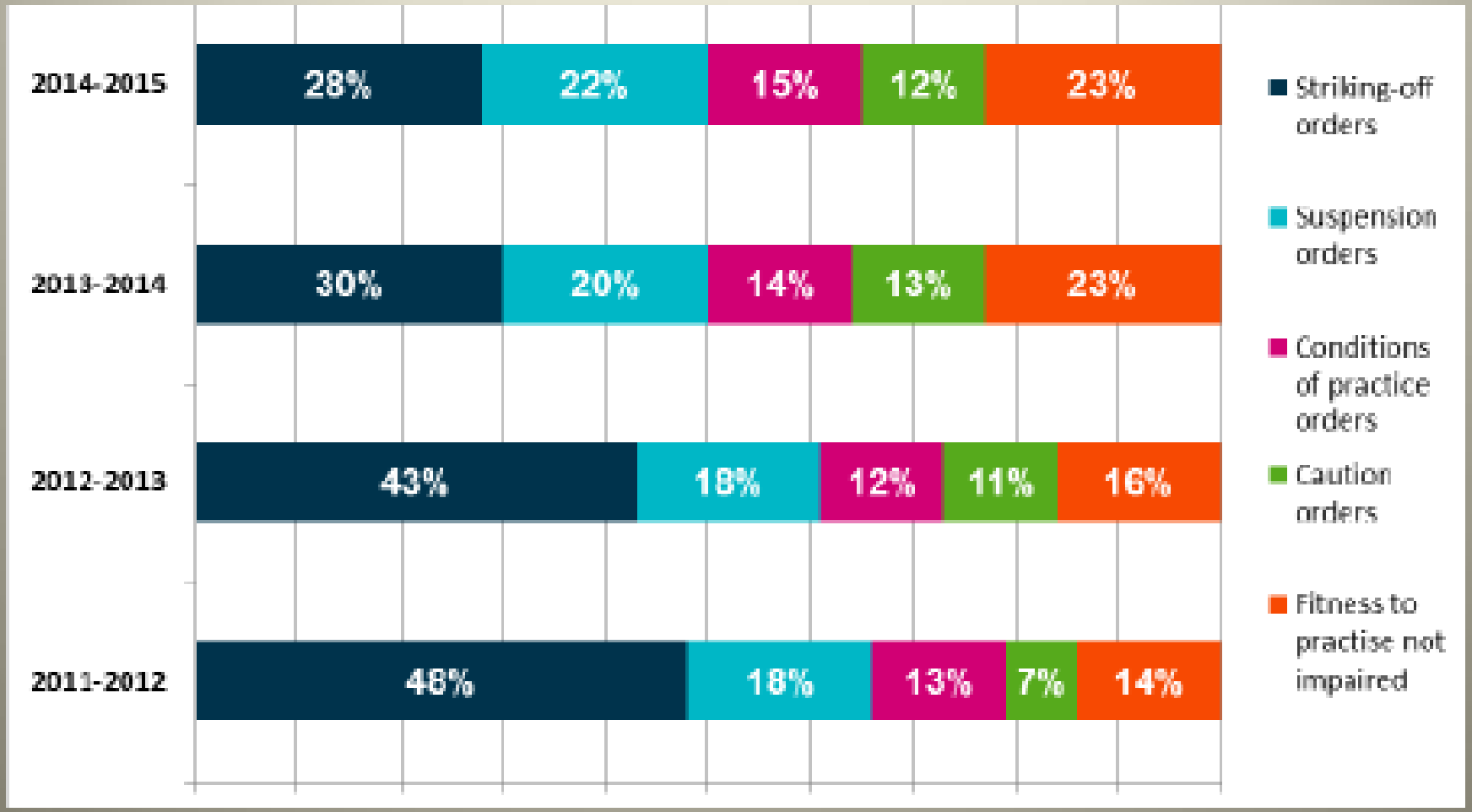
Annual Fitness to Practice Report 2014-2015, NMC Oct 2015

NMC – hearings within 6 months



Annual Fitness to Practice Report 2014-2015, NMC Oct 2015

NMC – outcomes 2014-15



Financial cost of FTP regulation

- NMC 2014 - 2015
  - Fee income £69,921,000
  - FTP cost £57,333,000

- GMC 2015
  - Registration income £92,832,000
  - FTP cost £49,901,000
  - MPTS cost £13,333,000
  - Total FTP £63,233,000
- Other regulators [HPC, GDC, GPhC, GOC etc]
- Other stakeholders [NHS, MDOs, unions, registrants, witnesses, complainants]

Other relevant work of regulators

- Registration
- Revalidation
- Professional standards/guidance
- Education standards/oversight
- Strategic relationships
- Support for staff who speak up?

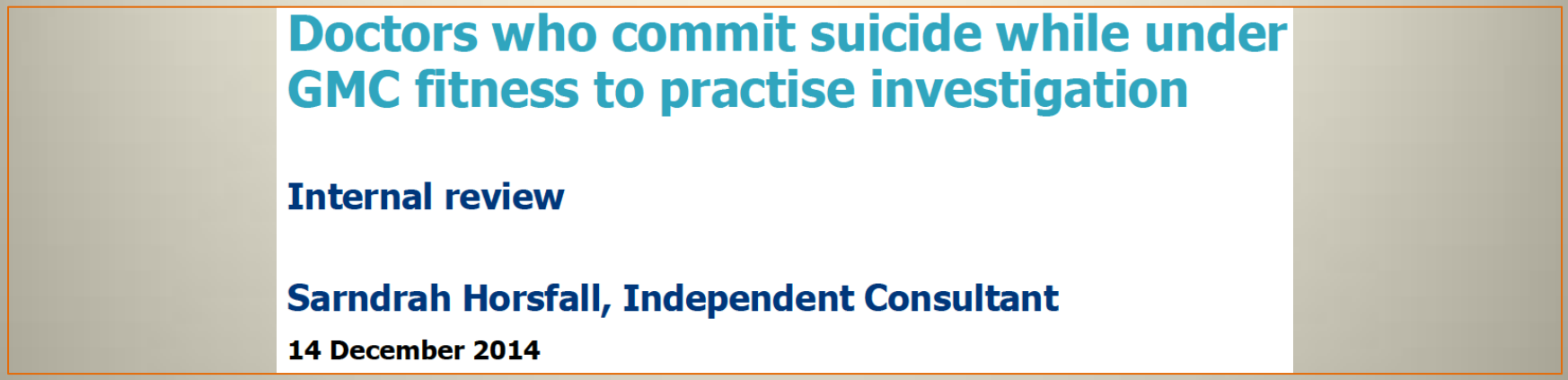
The purpose of professional regulation

*… **orders made by the tribunal are not primarily punitive**, it follows that considerations which would ordinarily weigh in mitigation of punishment have less effect on the exercise of this jurisdiction than on the ordinary run of sentences imposed in criminal cases….*

*… **The reputation of the profession is more important than the fortunes of any individual member. Membership of a profession brings many benefits, but that is a part of the price.***

Sir Thomas Bingham MR, *Bolton v Law Society [1994] 1 WLR 512*

Human cost of professional regulation



Stressors include

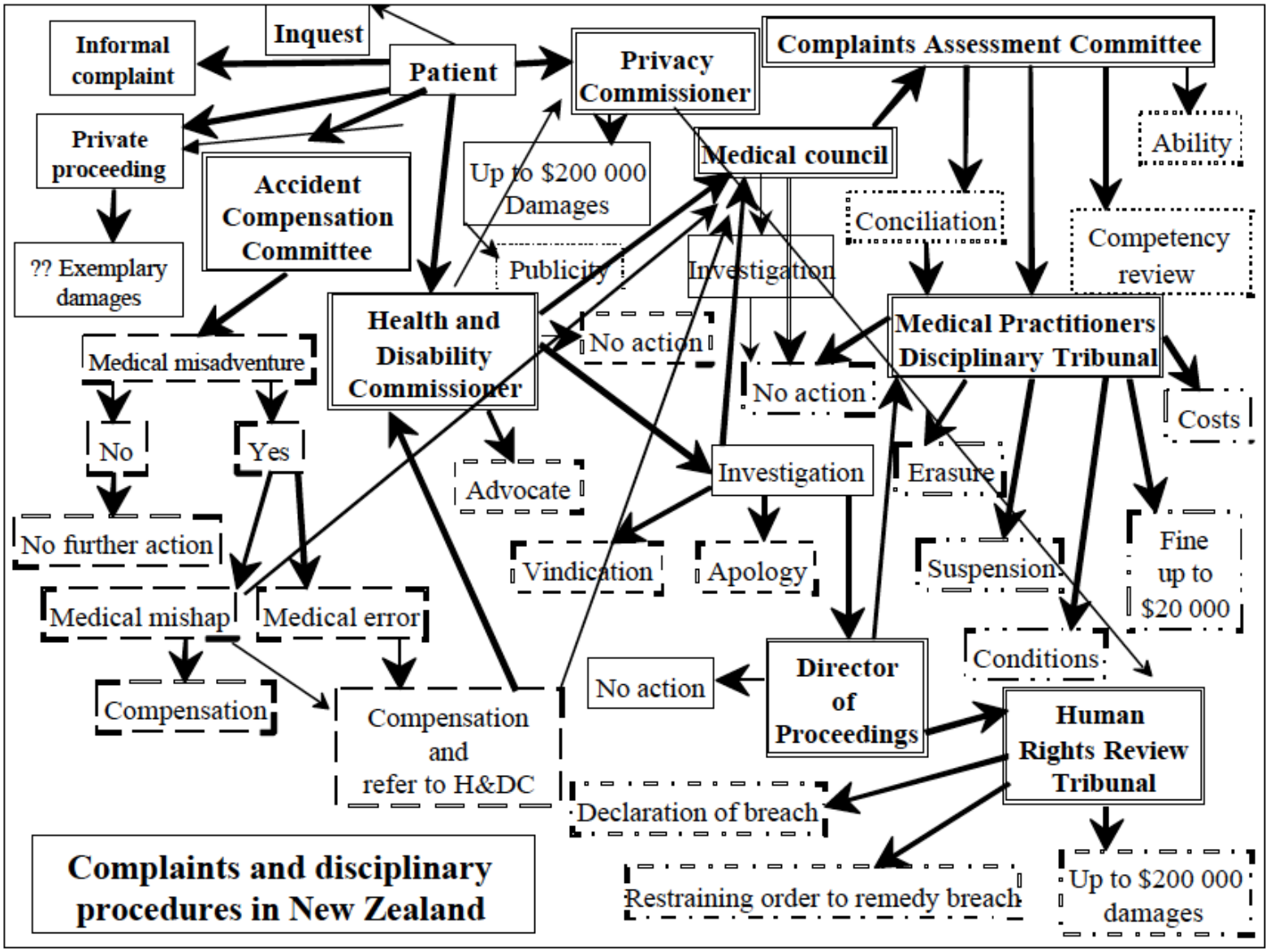
- Exclusion from work
- Investigations
- Complaints
- Court processes
- Multiple jeopardy:
  employers. regulators, police, commissioners,, courts, complaints processes

2005-13: 28 suicides/suspected suicides of doctors under investigation

Human cost of a healthcare profession

- Suicide rates:
  - US
    - Doctors: 28-49/100,00
    - General population 12.3/100,000
  - England and Wales:
    - 2001-2005: have highest suicide risk of any group PMRs"; men 164 (133-201; women 232 (167-315)
- Other risk factors
  - Unwillingness to seek timely help
  - Access to drugs; skills to self medicate
  - Poor support networks
  - Depression
  - Domestic issues
  - Personality factors: isolation

Figure 1. Death by 1000 arrows: the multiple pathways of the current complaints system in New Zealand



Cunningham, *The medical complaints and disciplinary process in New Zealand: doctors' suggestions for change*, NZMJ 23 July 2004, Vol 117 No 1198

When is FTP intervention actually needed?

The safety challenge
the demand for accountability

Bristol

Mid-Staffs

Morecambe Bay

The demand has not gone away

FOR HEALTHCARE LEADERS
HSJ

University Hospitals Bristol Foundation Trust

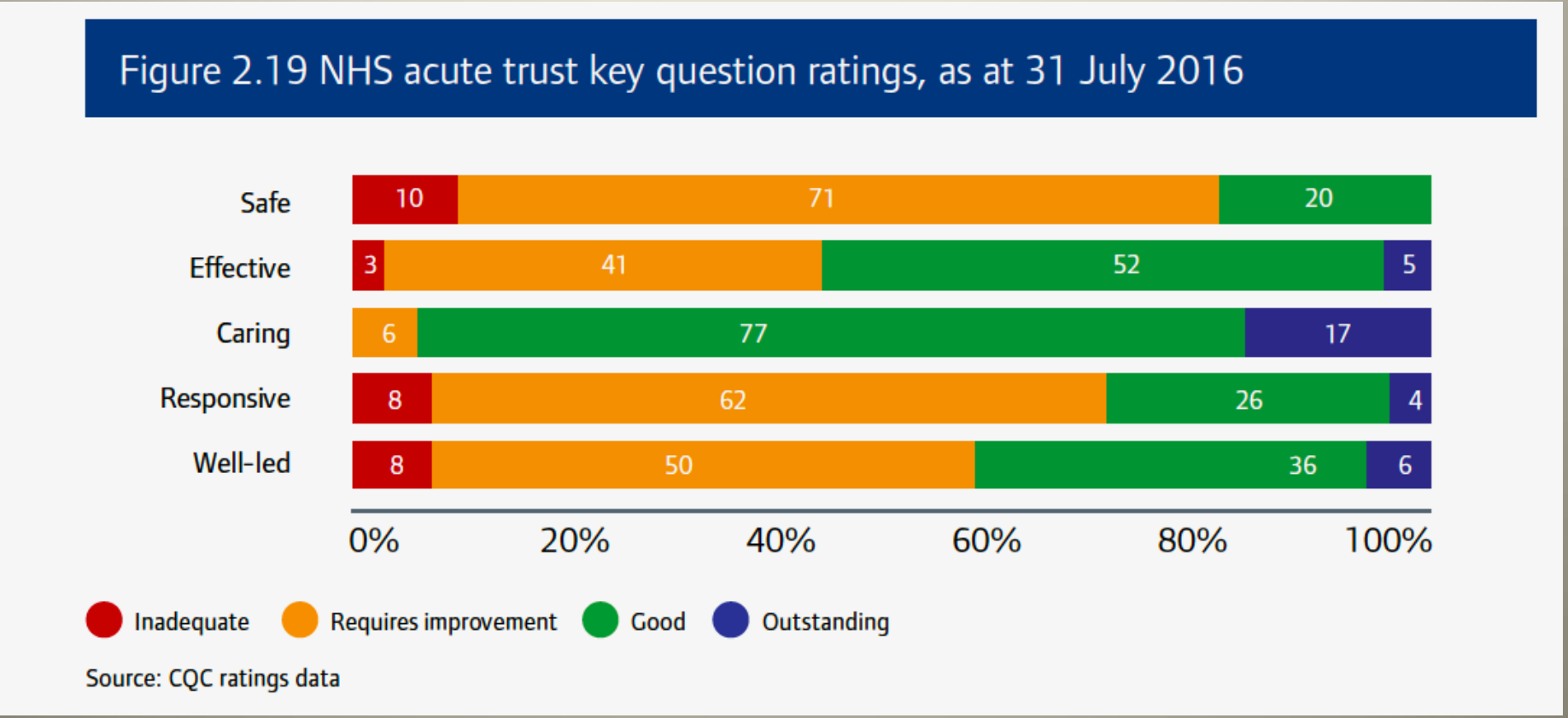
Exclusive: Trust guilty of serious service failure over child's death

27 October, 2016 **By Shaun Lintern**

- New report exposes systemic failings in care of four year old boy at Bristol Royal Hospital for Children
- Sean Turner was denied the best possible chance of survival because of failings by doctors and nurses in 2012
- Ombudsman report contradicts findings by earlier NHS England commissioned review

Sean's parents, Steve and Yolanda Turner, believe the NHS England review did not properly investigate the clinical care of their son and made judgements that amounted to a "whitewash"

Safety is a problem



Error is endemic

- Medical error may be the third leading cause of death in the US

  [Makarey & Daniel, *BMJ 2016; 353:i2139 – 3 May 2016]*

  – Suggests 254,454 deaths a year, but cf Gorski*, Are medical errors really the most common cause of death in the US?*, https://www.sciencebasedmedicine.org/are-medical-errors-really-the-third-most-common-cause-of-death-in-the-u-s/
- One in 20 NHS (England) hospital deaths may be preventable
  – = 11,858 deaths a year
  – *Lower* than previous estimates
  – Poor clinical monitoring
  – Diagnostic errors
  – Inadequate drug or fluid management
  – More common among surgical admissions
  – Study does not capture non fatal harm?

[Hogan et al, *Preventable deaths due to problems in English acute hospitals: a retrospective case record review study*, BMJ Qual Saf (2012 doc 10.11.1136/ bmjqs-2012-001 159[

Staff experience at work

- 58% staff report they often or always look forward to going to work
- 40% staff do not work unpaid overtime
- 37% staff report work related stress and pressure
- 15% staff report experience of physical violence from patients, relatives, or public in previous 12 months
- 13% staff report being bullied/harassed by manager at least once [18% by colleague]
- 41% had reported most recent incident of bullying

2015 NHS Staff Survey, March 2016

It may be worse for junior doctors

*Most responded that they **did not feel valued** by managers (83%), by the chief executive and the organisation (both 77%), and by the NHS (79%).But the profession itself has nothing to be complacent about – nearly 60% did not feel valued by their consultants.*

*While most appear positive about their experiences, the survey does reveal areas of real concern, not least the fact that between **50 and 60% of the doctors in training reported working beyond their allocated hours** every week and more important that up to **25% found their working patterns left them sleep deprived** on a weekly basis.*

GMC Annual survey 2016

View from the front line

- 2015 NHS Staff Survey
  - 25% staff had witnessed an incident which could have harmed service users
  - 89% of such staff said incident was reported
  - 43% staff thought employer treated near misses, errors and incidents fairly
  - 68% felt secure in raising concerns
- PHSO review into quality of complaints investigations [2016]
  - 40% investigations inadequate to find out what happened
  - 91% managers confident an investigation could find out
  - 8/28 serious incidents identified as such
- RCOG –Every Baby Counts [2016]
  - 48% of 599cases locally reviewed not reviewed with recognized method
  - In 25% cases parents not told of review
  - 27% of 204 local reviews obtained insufficient information to determine whether different care would have made a difference to the outcome

Solutions being offered

- Duty of candour
- Freedom to Speak Up
- Independent Patient Safety investigation Service
- “Safe space”

A safe space for safety's sake

We need to create the right conditions to enable staff to learn from their experiences, including their mistakes. All too often, they tell us that there is a culture of blaming, not learning. That is why the Government want to change the atmosphere in which NHS staff work…

There is a strong connection between 'psychological safety' and a culture of learning within an organisation…

That is why we are proposing to create a "safe space"—a statutory requirement that information generated as part of a safety investigation will be kept confidential and will not be shared outside the investigation's boundaries, except in a number of limited circumstances.

Secretary of State for Health, Written Statement 17 Oct 2016, Hansard Vol 615

But will the fear remain?

"But should the investigation uncover evidence of immediate risks to patient safety, criminal activity, serious misconduct or seriously deficient performance then the police or relevant professional regulator will be informed and will take the appropriate immediate action."

Secretary of State for Health, Written Statement 17 Oct 2016, Hansard Vol 615

Can we do better?

- **Improve the complaints system**
  - Involve complainants
  - Effective investigation and resolution techniques
  - Demonstrable learning
  - Appropriate redress

- **Protection from regulator if full cooperation with investigation unless**
  - Criminal conduct
  - Gross neglect not caused by systemic defect
  - Repeated error
  - Failure to acknowledge and address deficiencies

- **Regulate [senior] healthcare managers as a profession**

- **Professional regulators to focus on**
  - Promotion of learning,
  - Ensuring protection of the public by best available means
  - Bringing patients and professionals together when things go wrong
  - Regarding convectional FTP process as last resort
  - Supporting those who raise concerns

GMC view of the present

… how we understand our role in protecting the public must be shaped by the expectations of the society on whose behalf we regulate, while at the same time retaining the consent of the doctors who fund us.

GMC The state of medical education and practice 2016 p 97

GMC view of its challenges

"Regulation must also understand the complex interplay between the practice of individual professionals and the wider systemic pressures of the healthcare environment. Our job is to regulate individual doctors, but we can only do that in a way that is relevant and effective by recognising the effect of the system upon individual practice."

GMC view for shaping the future

“If our job is to protect patients from harm, then it does not make sense to devote 60% of our resources to dealing with fitness to practise issues where some form of harm has already happened. Not only does this model fail to prevent harm, it may even contribute to it”

THANK YOU

SIR ROBERT FRANCIS QC

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