Royal College of General Practitioners (RCGP) organisational response to the General Medical Council (GMC)'s Public consultation on guidance: *Leadership and management* and *Raising and acting on concerns about patient safety*

January 2026

About RCGP

We are the professional membership body for GPs in the UK. Our purpose is to encourage, foster and maintain the highest possible standards in general medical practice. We support GPs through all stages of their career, from medical students considering general practice, through to training, qualified years and retirement.

About this consultation

The GMC is updating its guidance on *Leadership and management* and *Raising and acting on concerns about patient safety*. It is carrying out an in-depth review to ensure that the guidance reflects developments across the UK's healthcare systems and wider social changes and remains clear, relevant and helpful.

The GMC is reviewing both pieces of guidance together because they are connected and share several key issues the GMC wants to explore.

This guidance review builds on the key principles in the recently updated version of *Good medical practice*, the GMC's core guidance on professional standards. This focuses on behaviours and values that foster fair, inclusive, and compassionate cultures where everyone feels empowered to speak up, share ideas, and ask questions.

The structure of *Leadership and management*

[GMC: In the *Leadership and management* guidance, most of the paragraphs apply to all our registrants. However, there are some paragraphs that apply only to those who have *extra responsibilities*. The term *extra responsibilities* refers to those with management or leadership responsibilities at a personal, team, organisation or policy level. This may include formal management roles, such as clinical or medical directors, or roles with responsibility for supervising and managing staff (including those from a different professional background), resources and services.]

1. **To what extent do you think the structure of the *Leadership and management* guidance makes it easy to use?**

Very easy	Easy	Neither easy nor difficult	Difficult	Very difficult	Don't know
			X		

If you'd like to, please explain your answer to question 1.

The current distinction between "all registrants" and those with "extra responsibilities" risks oversimplifying how leadership and management operate in practice. In reality, responsibility is often task-dependent, situational, and transient, rather than determined by formal title alone. The guidance would be clearer and more usable if it adopted a tiered or contextual approach, for example by framing expectations around when a registrant is supervising, chairing, investigating, allocating work, or responding to concerns, rather than relying on a binary categorisation. This would better reflect modern portfolio careers, rotational training, locum practice, and multidisciplinary working, and would reduce ambiguity about when enhanced responsibilities apply.

The title of *Raising and acting on concerns about patient safety*

[GMC: We have received feedback that the current title of this guidance could be acting as a barrier to doctors, PAs and AAs who want to raise concerns, but don't believe their concern is linked to patient safety. For example, their concern might be about the poor behaviour of a colleague, or the behaviour of another person such as a patient or patient's relative. It is important these concerns are raised. We want to encourage doctors, PAs and AAs to speak up when things aren't right.

We understand that there are many factors which can have a detrimental effect on patient experience, such as a poor working culture which focuses on blame rather than learning, and a lack of governance and accountability. These are some of the reasons we are thinking about updating the title of the guidance.]

2. **To what extent do you agree that the title should be updated to reflect concerns beyond patient safety?**

Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
	X			

If you'd like to, please explain your answer to question 2:

Concerns can exist about culture, behaviour, governance, and systems, alongside patient safety given. Unsafe care often emerges from unchallenged cultural and organisational problems.

If you have a suggestion for a new title, please share this in the box below

"Raising and acting on concerns"

3. **To what extent do you agree with the suggestion to combine *Leadership and management* and *Raising and acting on concerns about patient safety* into a single piece of guidance?**

Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
			X	

4. **Do you have any suggestions for guidance aimed at leaders and managers to help them foster inclusive, discrimination-free environments where all team members feel respected and valued?**

The guidance would benefit from explicitly addressing unconscious bias, affiliation bias, and power asymmetry, particularly in relation to decision-making, appraisal, disciplinary processes, and responses to concerns. Explicit reference to psychological safety as a leadership responsibility would help clarify expectations on leaders and managers to create environments where speaking up is not only permitted but realistically possible, especially for those from marginalised or less powerful groups.

The GMC may consider referencing evidence on Civility in healthcare – see, for example:

https://www.civilitysaveslives.com/theevidence
NHS Support our Staff – a toolkit to promote cultures of civility and respect
https://www.socialpartnershipforum.org/system/files/2021-10/NHSi-Civility-and-Respect-Toolkit-v9.pdf

5. **Do you have any suggestions about how our *Raising concerns* guidance can be improved to help to achieve this?**

The guidance should emphasise the relationship between workplace cultures and patient safety. It should also highlight that organisations and leaders need to provide staff/colleagues/employees/GP partners with an opportunity to criticise behaviours and/or the outcomes of behaviours. Regular colleague/staff surveys and 360-degree feedback can support this process. There should be no place for non-disclosure agreements (NDAs) in the NHS as a learning organisation. Colleagues leaving the NHS should have exit interviews and there needs to be an appropriate level of transparency around these. However, there should be consideration that if an exit interview is widely available that will likely reduce the sincerity of the testimony.

Terminology

[GMC: The current *Leadership and management* guidance does not define the terms leader/leadership and manager/management. In this guidance the words are used interchangeably. We recognise that leaders and managers are distinct roles. So, in the updated guidance we want to be clearer about our expectations of doctors, PAs and AAs who perform these roles. We want to get your views on how the new guidance should describe registrants who lead and/or manage others and what it means to lead and to manage

Defining a leader, leadership behaviours and leadership skills

While not all doctors, PAs and AAs will have the word 'leader' in their job title, many will be demonstrating leadership behaviours every day, maybe without realising. This could be taking a ward round or reporting a concern.

We want to encourage our registrants to recognise these everyday leadership behaviours and to consciously develop them. Demonstrating leadership behaviours can have a positive impact on a doctor's, PA's or AA's own practice, their interactions with their colleagues and teams and on patient care.
For doctors, PAs and AAs who want to gain a greater understanding of leadership as they progress in their career, we would encourage them to develop leadership skills. Like any skill, leadership can be studied, practised, and recognised through qualifications. We think our registrants demonstrate leadership when they do the following:

- **act with integrity**
- **show accountability when things go wrong**
- **role model professional and inclusive behaviours**
- **create compassionate, fair and psychologically safe environments**
- **act when negative behaviour undermines the inclusive environment**
- **motivate and inspire individuals and teams to perform at their best**

- **show respect for and sensitivity towards others' life experience, cultures and beliefs**
- **oversee clinical governance, risk management and audit processes**
- **set direction and have strategic vision for long term success**
- **drive positive change.**

This isn't a finalised definition of leadership; it's simply a starting point. We want to hear from you about how we should describe a leader in the updated guidance.]

6. **To what extent do you agree that the list above is a good starting point to describe the skills a doctor, PA or AA should have to be a leader?**

Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
		X		

7. **Do you have any further comments or suggestions around the definition of leadership?**

It may be helpful for the guidance to distinguish between:

• *clinical leadership* exercised in day-to-day patient care,
• *educational or supervisory leadership*, and
• *formal organisational leadership* with decision-making authority.

Without this clarification, there is a risk that aspirational leadership qualities are interpreted as enforceable expectations across all roles, regardless of seniority, authority, or working context.

It may be helpful to separate core behaviours expected of everyone e.g. integrity, accountability, compassion, respect and those that are more specific to leadership – for example, creating environments, inspiring individuals, setting direction and governance.

Given scope of practice, it is worth considering that some leadership capabilities may be more relevant to some regulated professions than others.

Defining a manager, management behaviours and management skills

[GMC: Some doctors, PAs and AAs will have the word 'manager' in their job title. However, just as with the term 'leader', some of our

registrants may be displaying management behaviours when carrying out their everyday tasks without holding a formal management title.

Some doctors, PAs and AAs may wish to develop their management skills and may opt for further study or training, so their skills are recognised through qualifications. Registrants who are managers may well act as leaders too.

As UK healthcare continues to evolve and technology continues to advance, we also recognise that some of those registered with us will perform non-traditional management roles, such as managing colleagues remotely, which can present both opportunities and challenges.

As a starting point we think a doctor, PA or AA who is a manager or who wants to display management skills will be demonstrating many of the skills we have listed for leadership, along with the ability to do the following:

- **plan, organise and oversee operational activities to achieve a desired outcome.**
- **empower and direct the people they manage by:**
- **setting clear goals**
- **providing constructive feedback**
- **supporting their health and wellbeing**
- **ensure polices are implemented, processes are followed and standards maintained**
- **manage resources efficiently and appropriately.]**

8. **To what extent do you agree that the list above is a good starting point to describe the skills a doctor, PA or AA should have to be a manager?**

Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
		X		

9. **Would you like to comment on how we have described managers/management behaviours and management skills? Do you have any suggestions for improvement?**

As per our response to Question 7, it is worth considering that some management capabilities may be more relevant to some regulated professions than others.

We also reiterate that organisations and leaders need to provide staff/colleagues/employees/GP partners with an opportunity to criticise behaviours and/or the outcomes of behaviours, and that regular colleague/staff surveys and 360-degree feedback can support this process. We would encourage consideration of:

- The introduction of independent whistleblowing contacts
- Public annual independent reporting on organisational culture from hospitals, ICBs, health boards etc.
- How the findings of multiple public enquiries can be considered together rather than in isolation.

10. To what extent do you agree that the current guidance supports safe and effective supervision?

Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know
		X			

11. Would you like to comment on how the guidance on supervision could be improved?

There needs to be consideration of the differences between independent and professionally regulated practitioners and those who are dependent and/or unregulated, and what this means in relation to supervision. With regards to doctors, the guidance appears to be written through the 'lens' of those who are employed rather than those with independent contractor status. Clarifying how supervision expectations apply across these different professional and contractual contexts would improve both fairness and practical usability. It is worth noting that the BMA's *Safe Scope of Practice for Medical Associate Professionals* (MAPs) guidance advises that MAPs must not supervise doctors or medical students. RCGP guidance on Physician Associates in General Practices advises limits around a PA's supervisory responsibilities in a general practice setting.

16. Is there anything else you wish to tell us about the *Leadership and management* guidance?

Asking the experience of colleagues who may have had multiple experiences in many and varied organisations decreases the value of the answer. The consultation questions would yield more meaningful data if respondents were asked to reflect on defined periods (e.g. early career, mid-career, current role) and/or specific

organisational contexts, rather than averaging across diverse and sometimes contradictory experiences.

For example, it may be better to break the question down into:

Thinking about an organisation where you worked 10 years ago…
Thinking about an organisation where you worked five years ago…
Thinking about where you work now, please answer for each organisation if you have multiple roles/locum in different organisations and answering for each, (i), (ii), (iii).

One RCGP respondent provided the following examples:

Thinking about an organisation I worked in 10 years ago, valid criticism of policies pursued by that organisation in a confidential professional forum could lead to summary dismissal. A bullying manager could manage someone out including GP partners. Organisations and leaders need to provide staff with an opportunity to criticise behaviours and or the outcomes of behaviours, including through regular staff surveys and 360-degree feedback.

Thinking about an organisation I worked in 5 years ago a manager could bully employees with no right to reply/defence. As above, organisations and leaders need to provide staff with an opportunity to criticise behaviours and or the outcomes of behaviours, including through regular staff surveys and 360 feedback. There should be no place for NDAs in the NHS as a learning organisation – colleagues leaving should have exit interviews and there needs to be an appropriate level of transparency.

Thinking about an organisation where I work now the best example of leadership has come from the leader/CEO not having their own office/desk but hotdesking and networking with colleagues. Colleagues is also an excellent term to replace 'staff.' Thinking about another organisation where I am currently there are leaders who belittle the use of the word 'culture' or changing 'Human Resources' to 'People, culture and development' or similar which focuses on the workplace culture and wellbeing rather than people as a simple resource.

17. To what extent do you agree with our suggested approach to doctors, PAs and AAs who are leaders or managers who fail to act when serious concerns have been raised with them?

Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree

	X			

18. Were you previously aware of the expectation on doctors, PAs and AAs who are leaders and mangers to act when they witness poor behaviour or are made aware of it? Do you have any comments?

Clear differentiation between failure to act despite authority and inability to act due to structural or organisational barriers would help ensure the guidance is applied fairly and consistently. Ability to act can be impaired due to systemic pressures, workplace culture issues, lack of psychological security and trust in being able to raise concerns.

We highlight the relevant section of our response to the GMC's 2022 *Good Medical Practice* consultation, which we consider:

"We suggest greater clarity about the level of responsibility a medical professional may hold in reference to not condoning 'such behaviour by others' and taking 'action…if you witness or are made aware of bullying…'. As mentioned previously, these paragraphs could be of concern to more junior medical professionals who may fear repercussions if challenging bullying behaviour from a more senior colleague. We also suggest clarification about what may be included in 'networking sites' and the level of responsibility a medical professional has to ensure they aren't seen to 'condone such behaviour by others'. Many medical professionals are, for example, included in Whatsapp and Facebook groups with a large number of colleagues. To what degree may they be expected to call out potential discriminatory behaviour in that context? Similarly, would a medical professional be expected to call out bad behaviour from anyone on social media sites like Twitter, where there are millions of users and posts every day? The level of responsibility a medical professional has in these settings needs to be clarified."

19. Do you have any suggestions on how we can reduce barriers for doctors, PAs and AAs to raise concerns?

The suspension of doctors by employers when they raise concerns creates a powerful disincentive for others to do so.

As per our response to Question 9, we would encourage consideration of:

- The introduction of independent whistleblowing contacts
- Public annual independent reporting on organisational culture from hospitals, ICBs, health boards etc.

• How the findings of multiple public enquiries can be considered together rather than in isolation.

21. To what extent do you agree that the existing guidance is sufficient to protect those who raise concerns from experiencing victimisation, including being blamed or threatened by doctors, PAs or AAs in leadership or management roles?

Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
				X

22. Do we need a new paragraph to explicitly prohibit our registrants from victimising those who raise concerns?

Yes, this would be an important addition. The paragraph should include clear statements that threatening regulatory referral, initiating disciplinary processes, or otherwise disadvantaging a colleague as a consequence of raising concerns is incompatible with professional standards and undermines patient safety.

23. Please provide your overall comments

There needs to be clear recognition that doctors are working in high-pressured, under-resourced environments. It also needs to be clear what the difference is between 'must' and 'should', who the guidance applies to (i.e. who counts as a leader or manager), and what happens if you don't follow the guidance exactly.
Without this clarity, there is a risk that guidance intended to promote safe systems is interpreted as placing disproportionate responsibility on individual registrants for failures that are fundamentally organisational or structural in nature. Explicit recognition of this risk would improve confidence, fairness, and trust in the guidance.