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## **Liberating the NHS: Developing the Healthcare Workforce: The GMC's Response to the Department of Health (England) Consultation**

### **Executive summary**

1. The General Medical Council (GMC) is the independent regulator for doctors in the UK. Our statutory purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. We welcome the opportunity set out in the proposals to place the provision of high-quality medical education and training at the forefront of the mission of NHS organisations in England.

#### *Professional regulation underpins high standards of medical education*

2. The role of professional regulation in ensuring high standards of medical education and training is an essential, but undeveloped, part of the proposals and, remarkably, the consultation document barely mentions professional regulation. There is little detail about how the proposed new bodies (Health Education England (HEE) and healthcare provider skills networks) will relate to the system of professional regulation and regulators such as the GMC. The role and responsibilities of HEE, particularly 'promoting high quality education and training', directly overlaps with the GMC's duties. Further work is needed to describe HEE's functions more precisely to avoid the risk of duplication especially in areas where the statutory functions lie with the GMC.

#### *Importance of the UK perspective*

3. The proposals will lead to further differences between England and the devolved administrations. Organisations with a UK remit, such as the GMC, will need to develop arrangements to work with a variety of bodies responsible for quality management and quality control of medical education and training. It will also be important that a strategy is agreed with equivalent bodies in the devolved administrations to make sure that questions of demand and supply can be addressed within a UK context.

#### *A greater role for employers: opportunities and risks*

4. We support the principle of giving employers greater professional ownership of education and training quality standards. However, trainees will still need to gain

experience in a variety of different organisations, which may result in mobility between healthcare providers and across the four UK nations. The proposals must be able to accommodate this flexibility.

5. There must be sufficient safeguards in the new arrangements to make sure employers are held to account for education quality, and meeting the standards set by the professional regulators, and that shorter-term, service driven considerations do not dwarf longer-term strategic priorities.

6. The accountabilities for quality improvement in medical education and training are well established and clearly understood in the current system. Should the changes go ahead, we will need to review and re-assign responsibilities. It is important that a focus is kept on efforts to improve quality control in local education providers. The performance management of healthcare providers, overseen by the Care Quality Commission, could be strengthened by taking into account how well healthcare education is delivered.

7. Local Skills Networks will have an opportunity to adopt a stronger multi-professional approach to deliver, where appropriate, common professional skills and knowledge to students and professionals alongside one another. However, they will need to take account of differences between the professions. There may be greater value in focussing on inter-professional (as distinct from multi-professional) education and training to enable different professionals to understand their own and colleagues' roles to improve team-working and the quality of patient care.

8. We welcome the clear statement that employers have responsibility for investing in CPD for their workforce but it is not clear what resources organisations will make available for CPD and how the investment will be monitored.

9. The partnership between the health service and universities, medical Royal Colleges and other education providers, needs more development to emphasise the continuum of education and training.

#### *Need to strengthen the governance and accountability of healthcare provider skills networks*

10. We have concerns about the functions and governance of the healthcare provider skills networks with regard both to the lack of clarity around line management and accountability and also to the potential loss of an independent voice for education. Possible solutions are outlined in our response, but we wish to emphasise the importance of this matter.

#### *Maintaining continuity in the delivery of postgraduate deanery functions*

11. It is vital that **all** the functions of postgraduate deaneries are clearly identified and carried over to the new arrangements. Among other things, the postgraduate deaneries perform an important independent quality management role, to champion educational standards and other important functions. Similarly, the functions carried out by the UK Foundation Programme Office and Foundation Schools need to be retained.

### *Supporting transparency in resource allocation*

12. We support the proposal that DH(E) continues to provide core investment in the training of the next generation of healthcare professionals. Funding for education and training should be transparent, should follow the trainee, and must be accompanied by robust and agreed measures of quality which link directly to the standards set, and data required, by the GMC. The financial incentives must also support provision of training for specialties with small numbers, and support the attainment of experience across healthcare providers if this is necessary for training.

13. Conflicts of interest could arise because healthcare providers will have a role in the commissioning of education and training as members of local skills networks, and will also be contracting to provide education and training. This risk will need to be managed through transparent and independent mechanisms.

14. If the MPET budget is replaced with a levy on providers in the future, it will be important that existing education and training programmes are not destabilised during the transition.

### *Managing the transition risks*

15. The transition period will be challenging and should be managed to avoid disruption to students and trainees, and make sure safe patient care continues to be delivered. The shadow HEE should be set up in 2011 to oversee the establishment of skills networks and coordination of the developing arrangements nationally.

## **Introduction**

16. The General Medical Council (GMC) is the independent regulator for doctors in the UK. Our statutory purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. Parliament has given us four main functions:

- a. Keeping up to date registers of qualified doctors.
- b. Fostering good medical practice.
- c. Promoting high standards of medical education.
- d. Dealing firmly and fairly with doctors whose fitness to practise is in doubt.

17. As the single regulator for all stages of medical education, training and continuing professional development across all four UK countries, we have statutory authority to set and secure the standards for:

- a. Undergraduate medical education and the knowledge, skills, attitudes and behaviours that medical students should learn.

b. The foundation years leading to the grant of full registration, and entry to specialty training.

c. Specialty, including GP training, leading to the award of a Certificate of Completion of Training.

18. We also have responsibility to set standards for continuing professional development (CPD) and, in the future, for ensuring, through revalidation, that doctors remain up to date and fit to practise.

19. As a UK regulator, we seek comparability between arrangements in each of the UK countries, and good links to enable us to perform our functions effectively, and to ensure consistently high standards.

20. The proposals set out in the consultation document *Liberating the NHS: Developing the Healthcare Workforce*, represent a major change to the system for planning, commissioning and delivering medical education and training in England. The following response to the consultation sets out the issues and questions that are of relevance to our role, grouped under broad headings and with reference to the questions.

### **The role of independent professional regulation (questions 13, 14, 15, 16)**

21. Independent, publicly accountable professional regulation makes a distinct and indispensable contribution to securing high standards of care for patients in the UK. As the Government's recent Command Paper *Enabling Excellence* put it:

'[the] current system of professional regulation helps [to put improved outcomes for service users at the heart of what the NHS does] by setting high standards of education, training, conduct and ethics and by taking action .....in the rare cases when things go wrong. Regulation of healthcare workers and social workers therefore makes an important contribution to safeguarding the public, including vulnerable children and adults.'

22. However, the consultation document barely mentions professional regulation and there is remarkably little about its role in ensuring high standards of medical education. There is very little detail about how the proposed new bodies (Health Education England and healthcare provider skills networks) will relate to the system of professional regulation and regulators such as the GMC. If the new arrangements are to command confidence from patients, the public, and doctors, the new architecture must take account of and value the contribution of statutory, professional regulation, and set out clearly where it sits within a new set of relationships and accountabilities in healthcare education. It must also be compatible with arrangements in the devolved administrations.

23. *Good Medical Practice* is the GMC's core guidance and underpins everything that we do. It sets out the principles and values on which good practice is founded; these principles together describe medical professionalism in action. The guidance is addressed to doctors, and applies to all doctors including those in training, but it is also intended to let the public know what they can expect from doctors. In

*Good Medical Practice*, we say:

'Good doctors make the care of their patients their first concern; they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity.'

24. These principles and values are reflected in our educational standards. The GMC sets standards for, and assures the quality of, undergraduate medical education, through *Tomorrow's Doctors*. We set standards and outcomes for, and assure the quality of, the Foundation Programme and speciality, including GP training, through *The Trainee Doctor*. Postgraduate deaneries are accountable to us for managing the quality of foundation and specialty including GP, training. The theme of modern medical professionalism is strongly embedded in the standards that we set. This reflects the fact that professional regulation in ensuring high standards of medical education and training goes well beyond our quality assurance functions, and includes our crucial role in fostering a culture of professionalism, recognition by doctors of the principles of patient-centred care and an ability to deal with patients' healthcare needs in partnership with them. The consultation proposals do not pay sufficient attention to making sure that these aspects of medical education and training are supported and enhanced.

25. In setting and securing the standards for specialty, including GP training, we approve curriculum and assessment systems; prospectively approve all training programmes, posts and GP trainers; quality assure and evaluate the management of the training; and deal promptly with concerns that have not been resolved locally.

26. The GMC has broad and flexible statutory powers (in the 1983 Medical Act) For example, we have the power to send in visitors to any organisation providing or about to provide postgraduate medical education or training. We also have the power to require information from any such body, including information about the standards and requirements which must be met. We believe our statutory powers are sufficiently flexible to enable us to regulate new arrangements without the need for legislative change.

27. The proposals will have implications for how we carry out our statutory functions. They will lead to further differences between England and the other parts of the UK, and we will have to work with a variety of bodies responsible for quality management and quality control of medical education and training. We currently carry out our quality assurance functions through thirteen postgraduate deaneries in England, and, for the Foundation Programme, with the twenty foundation schools (which are part of postgraduate deaneries in England). More variability, and the establishment of more organisations, could increase our costs, but of course that would depend on the detail of what was eventually agreed at local level.

### **Objectives and design principles (questions 1, 2)**

28. We strongly endorse the objective that the new framework needs to achieve high quality education and training that supports safe, high quality care and greater flexibility. The document states (para 1.6) 'it is time to give employers greater

professional ownership of education and training quality standards and content'. We particularly welcome the opportunities within the proposals to place the provision of high-quality medical education and training at the forefront of the mission of NHS organisations in England.

29. We recognise that, at times, some employers have felt they have been passive recipients of trainees rather than active participants in investing in the next generation of medical professionals. Similarly, some trainees have felt they do not fully belong to the organisations in which they have been training. There is an opportunity here to address this lack of ownership on the one hand, and lack of belonging on the other, and that is to be welcomed. At the same time we must recognise that most postgraduate medical training will still require trainees to gain experience in a number of different organisations to obtain the breadth and depth of experience required.

30. Healthcare provider skills networks will need to make sure that training opportunities reflect changes in the way services are provided. This would be consistent with the view expressed in the Collins report on the Foundation Programme that trainees' experience should more closely match current and future workforce requirements, for example, through community placements in paediatrics, general practice or psychiatry.

31. While the employer perspective is important, there must also be sufficient checks and balances in the new arrangements to make sure employers are held to account for educational quality and that shorter-term service-driven considerations do not dwarf longer-term strategic priorities. The objectives and design principles as they stand do not yet provide confidence that those checks and balances will be put in place.

### **Strengths and opportunities (questions 3, 4, 8)**

#### Quality improvement

32. One strength of the existing arrangements is that accountabilities and functions are clearly established and understood throughout the education and training system. Work to drive up standards has taken place within three activities: quality assurance (QA) by the GMC, quality management (QM) by medical schools, postgraduate deaneries and medical Royal Colleges and faculties and quality control (QC) by local education providers.

33. Since taking over responsibility for postgraduate education the GMC has developed a *Quality Improvement Framework* (QIF). This makes clear that medical schools and postgraduate deaneries are responsible for managing the quality of medical education and training, as well as maintaining and improving standards. It emphasises the importance of the independent, educationally-focused, role that quality managers have in making sure that training programmes and students/trainees meet the required standards and outcomes. Assuming the proposed changes in the consultation document are implemented, we will need to review and re-assign responsibilities. However, the framework is flexible enough to

adapt to future structures for delivering education and training.

34. The last cycles of our quality assurance programmes, for medical schools (Quality Assurance of Basic Medical Education), Foundation Programme (Quality Assurance of the Foundation Programme) and speciality including GP training (the Quality Framework) were completed in 2010 and show that quality management in deaneries and medical schools has matured. Quality control within Local Education Providers, however, is less developed. It is important that the gains made through increasingly close working with postgraduate deans and medical Royal Colleges and Faculties are not lost in the transition to the new arrangements, and that the drive to improve quality control in Local Education Providers continues.

Education and training duty on healthcare providers (question 8)

35. The consultation document proposes that NHS healthcare providers will have a duty to plan and develop the workforce. The proposals are intended to put education and training at the forefront of their 'mission', through a 'duty to cooperate in planning the healthcare workforce *and in the planning and provision of professional education and training*' (emphasis added). We support the introduction of this duty but it must also be clear that healthcare providers must meet the standards for training set by the GMC, and other professional regulators.

36. Monitoring this duty could be strengthened if the performance management of healthcare providers in England, overseen by the Care Quality Commission, took into account how well healthcare education is delivered in the assessments of organisations' performance. This could be drawn from a range of sources, including quality indicator data from commissioners, data about compliance provided by Local Education Providers to the GMC and other professional regulatory standards and data provided by the GMC and other regulators from their quality assurance processes.

37. While the planning of the medical workforce is not a matter for the GMC, data which we are in the process of collecting may be able to contribute to more effective planning in the future. During 2011, we will be collecting more information from licensed doctors about the nature of their practice. The aggregate data collected may well be of benefit to organisations with national or local workforce planning responsibilities, including Health Education England and the Centre for Workforce Intelligence.

Multi-professional workforce planning, education and training

38. The proposals place greater emphasis on multi-professional approaches to workforce planning, education and training. Healthcare provider skills networks, should they take on postgraduate deanery functions, will have an opportunity to adopt a stronger multi-professional approach to postgraduate education and training, to deliver, where appropriate, common professional skills and knowledge to students and professionals alongside one another. While supporting this approach it does need to take account of important differences between the education of the professions. There are for example major disparities in areas such as entry requirements, length and breadth of training and the extent to which trainees need

access to a varied and co-ordinated programme of clinical placements in different settings. In medicine the latter is a key requirement for undergraduate, foundation and speciality/ GP medical training. There may be greater value in focussing on inter-professional (as distinct from multi-professional) education and training, which can be very effective in enabling different professionals to understand both their own profession's role and those of their colleagues in other healthcare professions and thereby to improve team-working and the quality of care for patients.

39. The multi-professional emphasis does, however, provide an opportunity for us to explore how we could work more closely with other professional regulators, for example, to coordinate our quality assurance arrangements, processes and information sharing.

#### Continuing professional development

40. We welcome the clear statement that employers have responsibility for investing in CPD for their workforce to make sure specialist skills are retained and developed. We agree that such investment, if it is wisely deployed, is in the public interest and in the interests of healthcare providers. The proposed duty for healthcare providers to cooperate in this area could provide better assurance that clinical skills are being developed and maintained to support safe and effective practice.

41. However, it is less clear what resources organisations will make available for CPD and how this investment will be monitored. We believe that the CQC has an important role to play here. For our part, we are currently reviewing our role in regulating CPD (across the UK), and this consultation in England provides an opportunity to consider the implications for how we might take this forward.

#### Relationship between healthcare providers and education providers

42. The consultation document contains only a brief reference to the need for an effective partnership between the health service and universities, colleges and other education providers. It is not clear whether healthcare provider skills networks would include Higher Education Institutes (HEIs) (and therefore medical schools), beyond a 'partnership' relationship. There is an opportunity to emphasise the continuum of education and training by including HEIs.

#### **Health Education England and the 'educational governance' of healthcare provider skills networks (questions 9, 10, 13, 14, 15, 16)**

43. At this stage, the proposals lack detail about the precise role, governance, and executive powers of HEE. However, the description of its intended role - particularly 'promoting high quality education and training that is responsive to the changing needs of patients and local communities', and 'setting the framework for continuous quality improvement, assurance of the quality outcomes of education and training, and reviewing curricula to make sure they meet the needs of patients and the public' - directly overlaps with the role of professional regulation and with the GMC's duties under the Medical Act 1983. It will be important that the contribution of HEE is complementary to professional regulation. Further work is needed to describe

HEE's functions more precisely to avoid the risk of duplication especially in areas where the statutory functions lie with the GMC.

44. We expect that, should HEE be established, we will seek to develop a relationship, and possibly, a formal memorandum of understanding delineating clearly our respective areas of responsibility and setting out arrangements for joint working to make the most effective use of resources.

45. We support the proposed role for HEE to undertake national – ie within England - functions to support healthcare providers in their workforce planning, education and training activity locally. It will also be important that there is a strategy in place with equivalent bodies in the devolved administrations to make sure that questions of demand and supply can be addressed within a UK context. We have pointed out that data which we are in the process of collecting may be able to contribute in this area (paragraph 37).

46. We have real concerns about the functions and governance of the healthcare provider skills networks, as described in the proposals. It is unclear what the structure and size of the healthcare provider skills network will be and thus the resources and expertise to which they will have access. It is also not clear how healthcare provider skills networks, which it appears will undertake the quality management functions currently carried out by Postgraduate Deaneries, will be accountable to the GMC (and other professional regulators). This will need to be clarified if we are to carry out our overall quality assurance role. Even more fundamentally, there is a risk that the lack of specificity about the governance of the new networks could lead to the loss of an independent voice for education on their Boards, making them incapable of quality managing their constituent providers. This 'education governance' risk – and lack of clarity around line-management and accountability - urgently needs to be addressed.

47. There are a number of possible solutions to this risk. The 'insider/outsider' model, used in financial services and health and safety regulation would require each network to have a named individual with responsibility on its board with the duty of making sure the network held education providers to account. At the same time that individual would be accountable externally, to regulators for the effective discharge of that role. In the event that the Board member for educational quality management was not a doctor, we would suggest that each network was required to designate a senior doctor, registered with a licence to practise, to whom we would relate and whom we would hold to account. This approach would enable us to hold the doctor to account and help ensure credibility with trainee doctors.

48. In the event that this model is adopted, we would suggest that the governance arrangements for each network should be developed locally but should be subject to approval by HEE to ensure a comparable approach (in contrast to the suggestion in para 5.22 that the governance arrangements would be determined locally).

49. A second possible solution would be to create an additional tier sitting between HEE and the local networks which would hold the networks to account and carry out, for example, some Postgraduate Deanery functions. The 'intermediate tier' could be part of HEE, and would be accountable to the GMC in respect of its quality

management role in medical education.

50. The choice of solution may depend on a number of factors including:
- a. The number of local healthcare provider skills networks (the more there are, the greater the argument for an intermediate tier).
  - b. The NHS Commissioning Board structures and their relationships with HEE (an intermediate tier below the Commissioning Board might sit well with a comparable HEE tier in terms of policy, operations and use of resources).

#### Postgraduate Deanery functions

51. The functions of postgraduate deaneries are not specified in detail in the consultation. Given the importance we attach to the postgraduate deaneries carrying out functions under the current arrangements, we believe it is vital that all functions carried out by postgraduate deans are clearly identified and carried over to the new arrangements.

52. The quality management functions carried out by postgraduate deaneries are central to our *Quality Improvement Framework*. This requires postgraduate deaneries to maintain an independent focus on the provision of education and training at local level. Those responsible for the day-to-day management of the service face immediate service pressures. An independent quality management function, with a responsibility to champion educational standards, can be an effective voice for education and training, providing sensible and proportionate challenge. This helps to protect the quality of training, and therefore, in the longer term, standards of clinical care and patient safety.

53. Postgraduate deaneries perform other crucial functions. They ensure the orderly recruitment, rotation and progression of trainees through their programmes, often across a wide range of providers and units. This is essential to the smooth running of training programmes and, because of the interdependence of training with service, to the continuity of care for patients.

54. Postgraduate Deans, on behalf of medical schools, are also usually responsible for certifying that a provisionally registered doctor has met the educational outcomes that we set, to make them eligible to apply for full registration. In addition they play an important role in the remediation of trainees with fitness to practise problems, and have built up substantial expertise in this area, liaising closely with the GMC and other organisations.

55. There was agreement that Postgraduate Deans would act as the Responsible Officers for trainees, making sure that there was effective clinical governance and other arrangements to underpin the revalidation of trainees. While this model will remain viable in the three other UK countries, an alternative will be needed in England if the deaneries are abolished in the new arrangements.

56. As well as these local responsibilities, the Conference of Postgraduate Medical Deans of the UK (COPMeD) has developed 'lead' postgraduate deans for

each of the main specialties. This has provided a national focus for specialty training and strengthened links between the deaneries and the medical Royal Colleges and faculties.

57. We support the proposal that healthcare provider skills networks work in partnership with universities and other education providers. Some Deaneries currently have an academic link with a local HEI, and we believe those arrangements, where they exist, should be maintained and extended where they do not.

58. If healthcare providers are providing education and training, they should be expected to work within a local networking arrangement. Allowing an 'opt out' for healthcare providers could raise transaction costs, including for regulatory bodies, if it leads to a proliferation of small bodies providing education and training, and may risk divergence of meeting standards.

#### Foundation School functions

59. There is no mention of the UK Foundation Programme Office in the consultation. It has played a crucial role in co-ordinating the delivery of the programme across the UK but there is some uncertainty about its future after 2011/12, creating delivery risks for the programme at the same time that the recommendations from the Collins evaluation of the Foundation Programme are to be implemented. There is also no mention of Foundation Schools. Their role is to make sure that trainees have access to varied and broad based training under appropriate educational and clinical supervision. It will be important to continue this function under the new arrangements.

#### **Funding and incentives (questions 9, 28 – 39)**

60. We welcome the proposal that DH(E) will continue to provide core investment in the training the next generation of healthcare professionals. This will require both a long term and a national view – workforce mobility is such that providers may not get a local 'return on investment', and specialties with small numbers may need bespoke consideration to ensure investment takes place. It would be helpful to be clear that 'the next generation of healthcare professionals' includes postgraduate medical trainees who are already providing service, yet at the same time are in training programmes which may last several years or more.

61. We support the principle that the funding for education and training should be transparent and that funding should follow the student or trainee. However, this must be accompanied by robust and agreed measures of quality which link directly to the standards set, and data required, by the GMC.

62. We agree that healthcare providers should have a duty to cooperate on workforce planning, as well as planning and providing professional education and training. But we question whether these duties are enough in themselves to provide the incentive for providers to invest at the right level, given the mobility of medical trainees between providers and the time required to complete some training

programmes.

63. The proposals to align the decisions to invest in education and training with decisions affecting supply are important. Local healthcare skills networks will take on a number of functions that will affect funding, commissioning and contracting. These include:

- a. The allocation of and accountability for education and training funding from the national education and training levy.
- b. Contracting for the provision of education and training with education and healthcare providers.
- c. Responsibility for value for money throughout the commissioning of education and training.

64. It will be important to set up transparent and independent mechanisms to manage potential conflicts of interest in commissioning and make sure healthcare providers are accountable for spending – funds intended for education must be spent on education. Healthcare providers will be both part of a skills network (doing the commissioning) and also providers of education and training (being commissioned). There is a potential for a conflict of interest within the provider skills networks given their dual role of commissioner/funder and provider. We believe there is a need to explore how financial incentives and sanctions will be used to improve quality or penalise providers who fail to provide good training.

65. In the longer term, if the MPET budget is replaced with a levy on providers, it will be important that it does not destabilise existing education providers and adversely affect training programmes, and the pace of change must reflect this. The proposal is that those who train the future workforce will be rewarded for doing so, while those who undertake less training than they receive the benefit from will contribute to the training provided by others. Getting this balance right will be important to make sure that providers do not simply opt out of training having paid their levy. The levy should include all healthcare providers that deliver their services using staff trained by the public purse, including private providers which may provide a greater proportion of healthcare service under the proposed healthcare reforms than was the case until now.

### **Transition (questions 41, 42, 43)**

66. The transition period will be very challenging. The timescale for, and complexity of, the changes need careful thought and planning. If this is not done training programmes could be disrupted to the detriment of students and trainees, and the knowledge of staff, especially within deaneries, could be lost. Stability and continuity in the delivery of safe, patient care and training programmes needs to be a priority.

67. It is clear that HEE will have a role in the development of networks, once they are set up, but not for assuring the transition to the new arrangements. The networks will create a legal entity to enable them to enter into contracts, but will decide locally

what form this will take and how they will work together. We do not regard this as acceptable for the reasons set out above (paragraphs 32-35). In addition, though, we believe there is a need for national oversight of the establishment of skills networks in the transition period, probably by the shadow HEE, although existing SHAs should have an important role until their abolition.

68. During the transition, there will be a need for some coordination between developing arrangements across the country. This is especially important given the tension between the innovative and local nature of the networks, and the need to establish a level of consistency recognising the transaction cost for national regulatory bodies of working with diverse arrangements, and the need to maintain nationally consistent standards.

69. Given the importance of HEE during the transition, we support the proposal that it should be established in shadow form during 2011. The sooner HEE can be established the better the transition risks can be managed.

### **Equality and diversity (questions 45, 46)**

70. We strongly support the focus on widening access, participation and diversity to develop a more diverse workforce, and delivering excellence. Our standards for postgraduate training require that training must be fair and based on principles of equality

71. The provision of education and training, including CPD responsibilities on providers – must cover all doctors (staff and associate specialist, locum, temporary etc) and all healthcare providers.