

Update on the GMC's work to address the Francis recommendations, October 2014

- 1 As the independent regulator of doctors in the UK, the General Medical Council (GMC) plays a role in helping to protect patients and improve the standards of medical practice throughout the UK. In short, our job is to make sure that patients can have confidence in doctors. We do this by:

 - controlling entry to and maintaining the list of registered and licensed doctors
 - setting standards for all stages of medical education and training and ensuring that those standards are met
 - determining the principles and values that underpin *Good Medical Practice*
 - taking firm but fair action against doctors' registration where the standards we set have not been met.
- 2 Regulation has an important part to play in reinforcing professional standards and providing leadership, with others, in helping to change attitudes and behaviours. Much of what needs to be done concerns the culture of organisations and empowering healthcare professionals to do the right thing in difficult circumstances. While we have made significant progress in recent years, the Francis Report on the failings of Mid Staffordshire NHS Foundation Trust highlighted particular areas for us to reflect on how we deliver our functions and ensure we are making progress to develop.
- 3 In [our first response](#) to the Francis Report in April 2013 we identified 24 recommendations in the report with specific impact on our work and committed to providing further updates every six months ([October 2013](#), [April 2014](#)). These specific recommendations, as well as the overarching themes of the Francis Report, have challenged us to consider the ways in which we are working to promote a more collaborative and patient-focused culture in healthcare regulation.

- 4 We are determined to play our part, while recognising that many of these issues go well beyond regulation. The reforms we have made and plan to make reflect our determination to be a more outward facing, proactive and responsive regulator. Our overarching plans and direction are captured in our [Corporate Strategy 2014 - 2017](#), which explains how we intend to continue our development by seeking to engage more widely with the system and, through making the best use of intelligence about doctors and healthcare standards, ensure good standards and identify risks to patients.
- 5 This update consolidates our previous responses (April 2013, October 2013 and April 2014) to provide a comprehensive summary of how we are responding to the core themes and recommendations from the Francis Inquiry. In addition, our summary describes how we have responded, and are continuing to respond, to related reviews, for example, the Berwick Review into patient safety, the Clwyd Hart Review of the NHS complaints system and the Keogh Review of quality of care and treatment provided by 14 hospitals with high mortality indicators. The specifics of how we are addressing each of the 24 Francis recommendations with specific bearing on our work are set out in [Annex A](#).

Education and training

- 6 We have a statutory responsibility for ensuring high standards of medical education and training. We do this by setting standards for education and training, and quality assuring the way it is managed and delivered. Ensuring that doctors are well trained to treat patients now and in the future is crucial in addressing the cultural issues that are highlighted throughout the Francis Report.
- 7 The Report identified several areas of concern about the education and training of doctors and we are mindful that, while improvements have been made since the events at Stafford Hospital, there is still work to be done.
- 8 In 2012 we began a [review of our quality assurance](#) processes for medical education and training. The review, which reported in February 2014, made wide-ranging recommendations which are now being taken forward. These included enhancing the role of the Medical Royal Colleges and Faculties in supporting our quality assurance inspections; developing the appointment process for the medical specialists involved in inspections; restructuring the inspection cycle, and enhancing the transparency and accessibility of visit reports.
- 9 Additionally, where a training institution gives rise to concerns which relate to patient safety or quality of education, it may be subject to enhanced monitoring within our quality assurance process. To ensure transparency, details of these concerns are published on our website.
- 10 This year, we have begun including more patient safety questions in our [National Training Survey](#) (NTS). The NTS included more information for participants about

how concerns raised in their responses to the survey will be addressed and how that information will allow local providers to identify patient safety problems that may not have been reported. All the concerns raised with us are brought to the attention of local education and training boards (LETBs), deaneries and local education providers to investigate further and take action where needed. The changes made are then reported back to us. In this context, the survey provides a powerful lever to improve patient safety rather than just report on it.

- 11 Linked to our review of quality assurance of education, we have also been [reviewing our standards for medical education and training](#) as set out in *Tomorrow's Doctors* and *The Trainee Doctor*. One of the themes being considered by the review is the learning environment and culture within organisations which provide education and training. We need to ensure that educational environments are safe for patients and safe for learners, recognising that learning is part of the culture of an organisation. The review is also considering the importance of student, trainee and trainer feedback on the training experience in identifying compliance with standards for patient safety.
- 12 In addition, patient safety will continue to be a central feature of the new education standards, which will cover all stages of education and training, and will be introduced next year.
- 13 By ensuring the quality of medical education and training we are better able to ensure that students leave medical school and subsequent training with the skills to be able to meet changing patient needs. This will help to achieve the sort of cultural changes called for by the Francis Report. This work also addresses recommendations from the Berwick Review around ensuing medical education and training focusses on patient safety and quality improvement. There have been a series of roundtable events this year with stakeholders to discuss each of the themes of the standards review and we aim to consult on a draft standards framework in January 2015.

Patient insight

- 14 Effective communication with patients is vital to effective medical regulation. We are committed to improving our communication channels with patients to ensure they have a clear understanding of our regulatory responsibilities, what we do and how we can help patients. By enhancing communication with patients about our regulatory functions we aim to build confidence in the profession and the GMC.
- 15 In May 2014 we introduced a new Tracking Survey to look at perceptions of the GMC held by our stakeholders, including doctors, patients/public, educators, employers and parliamentarians. This work will enable us to understand how each of our key interest groups feel about us, and how this changes over time. It will help us meet our strategic aim to work more closely with doctors, medical students and patients, ensuring we are properly informed by their views so that we can regulate more effectively. Our new strapline *Working with doctors Working for patients* reflects the

fundamental shift we have made as an organisation and emphasises our ultimate purpose, to protect patients.

- 16 We also sought to improve patient understanding of our Fitness to Practise (FtP) processes by piloting in 2012 a Patient Information Service. The aim of this service was to improve communications with members of the public who raise concerns about a doctor, in line with our pledge to the Clwyd Hart review to support patients through fitness to practise cases. We held a total of 298 meetings with patients, both at the beginning and end of our FtP processes. An independent evaluation of the pilot found that meetings had mostly provided patients with a better understanding of the GMC's processes. They felt listened to and felt their complaint was being taken seriously. Meetings were also helpful in reducing their feelings of isolation. The evaluation report was published on our website in September and there are plans for the pilot to be rolled out to GMC offices across the UK, in Manchester and London, as well as Cardiff, Edinburgh and Belfast with meetings to be held from January 2015.

Promoting professionalism

- 17 Our standards set out the principles and values on which good practice is founded. These principles describe medical professionalism in action. We undertake a broad range of work to raise awareness of our standards and encourage doctors to embody these principles and values in their work. Through this we seek to promote professionalism of doctors and foster good medical practice.
- 18 Effective regulation is, in part, about the influence we are able to exert on the professionals we regulate. This requires direct regular contact and dialogue with patients, employers, and doctors. In the last two years we have developed a much stronger local presence by setting up new liaison services that engage with health services, the profession and patients.
- 19 Our new [Regional Liaison Service](#) (RLS) engages directly with groups of doctors (including students and doctors in training) and patients. The RLS has now met with over 26,000 doctors, over 14,000 medical students and over 3,000 patient and public representatives. RLS engagement has improved understanding of the GMC, changed perceptions of the GMC, helped doctors to reflect on their practice and has been an effective tool in tackling concerns around certain aspects of *Good Medical Practice*, by enabling further exploration of our guidance in focused sessions. In Northern Ireland, Wales and Scotland, our devolved offices continue to provide a similar service.
- 20 We also piloted our '[Welcome to UK Practice](#)' programme in 2013 to help doctors who are new to UK Practice to understand medical professionalism in the UK context. We received positive feedback from each of the pilot events, with most doctors leaving with a greater awareness of the standards we expect from all registered doctors and the role we play in supporting doctors to meet those standards. We are very pleased with the response to this initiative and we plan to roll this out more widely – working with partners – in 2015.

- 21** Earlier this year we launched the Better care for older people campaign. Drawing on the key challenges faced by doctors and older patients, including communication, dignity, respect and compassionate care, we developed a collection of online resources including guidance, case studies, tools and opinion pieces to support doctors in the care they provide. We launched the campaign with three themes – Basic Care, Families and Carers and Access to services and we will continue with the roll out of further themes, drawing on feedback from doctors and patients to ensure this online content is both useful and relevant.
- 22** We are also planning to run a series of standalone events on ‘Professionalism’ over the next 12 months across the UK. These will be targeted at doctors and we hope to create an event which facilitates a rich debate about the current challenges in medical professionalism and how we can support doctors, educators and employers to meet those challenges.
- 23** We also seek to promote professionalism of doctors and foster good medical practice through the introduction of [revalidation](#). Introduced in 2012, revalidation allows us to strengthen the way we regulate doctors who practise in the UK. All licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise through annual appraisals. Doctors are also required to regularly seek feedback from patients about their practice. Over 52,700 doctors have now been revalidated.
- 24** We now have new powers to make sure all doctors are able to communicate in English well enough to treat patients safely. New language checks were introduced in June this year requiring doctors from other European countries to provide evidence of their English skills or, if the GMC has concerns about their ability to communicate effectively with their patients, undergo a language assessment. Our new powers also enable us to take action through our fitness to practise procedures. These checks ensure that all licensed doctors have the necessary knowledge of English to practise safely in the UK and will help to improve care provided to patients.
- 25** We strive to promote an open and transparent culture that puts patients first. Our existing guidance requires doctors to be open and honest with patients when things go wrong. This is complementary to the new statutory organisational duty of candour recently announced by the Department of Health. The legal duty on organisations will require them to support professionals in being open and transparent where those in their care suffer harm or distress.
- 26** On the professional duty, we, together with the Nursing and Midwifery Council (NMC) have worked with all the professional regulators to develop a consistent approach to candour. A joint statement on the professional duty of candour, agreed by the Chief Executives of eight of the professional regulators, was published on the 13 October.
- 27** With the NMC, we will shortly be consulting, on new explanatory guidance, *Openness and honesty when things go wrong: the professional duty of candour*. This will

expand on the advice we give in our core guidance documents, including enhanced content on near misses and apologies, as well as explaining the context of the new organisational duty of candour.

- 28** In addition to our work on candour, we have distributed guidance on Raising and acting on concerns about patient safety to all doctors on our register and developed an interactive decision making tool to help doctors decide how best to raise their concerns. Over the last 18 months, our Regional Liaison Service has held around 150 workshops on raising concerns, attended by 4,500 doctors and 1,000 students and educators. Furthermore, our guidance on [*Leadership and management for all doctors*](#) also helps to encourage doctors to speak up and be open about concerns through setting out the wider management and leadership responsibilities of all doctors in the workplace, including their duty to raise and act on concerns about patient safety.

Safe practice environment

- 29** We believe it is important to ensure that doctors who are newly registered or unfamiliar with the UK practice are given appropriate support and oversight. The Approved Practice Setting (APS) scheme was designed to achieve this. However, developments since the scheme was introduced meant a new approach was needed.
- 30** Following the five recommendations made about APS in the Francis Report, we committed to undertaking a fundamental review of the scheme in 2013. That review concluded that we should replace the APS arrangements with a new scheme which was aligned with the existing statutory duties for healthcare organisations, namely the Responsible Officer Regulations. In effect, this prevents doctors who are newly registered or recently restored to the register from practising in circumstances where they do not have what is called a 'prescribed connection to a designated body' – a prescribed connection means making sure that every licensed doctor is supported with revalidation and that they are always working in an environment that monitors and improves the quality of its services. The new arrangements were introduced on 2 June 2104.

Information sharing and joint working

- 31** We continue to strengthen our relationships with other regulators and understand the importance of collaborative working and information sharing to improve our collective ability to identify and act on risks to patient safety. Collaboration with others in carrying out organisational functions was also highlighted by the Francis Report as a fundamental aspect of ensuring efficient detection of patient safety concerns and that appropriate, prompt and effective action is taken to address those concerns.
- 32** We began to address the need for greater collaboration with others through development of an Operational Protocol with the Care Quality Commission (CQC), to enable us to work more closely together and share information more efficiently. The Protocol also sets out how we will work with the CQC, including joint education

inspections where appropriate, holding local liaison meetings and sharing emerging concerns about GPs and healthcare providers. In addition, and to help embed the protocol, we will shortly introduce guidance and training for staff on the information sharing process with the CQC. In addition to this we have agreed a Memoranda of Understanding with Health Inspectorate Wales and are in the process of defining a joint working protocol. Progress is continuing on the development of refreshed or new Memoranda of Understanding with other organisations, including Monitor and those in the devolved administrations, such as Regulation and Quality Improvement Authority, Health Improvement Scotland and NHS Education Scotland.

- 33** We are also considering how to further enhance the current information sharing arrangements with Medical Royal Colleges. Earlier this year, we established a working group to look at the data on examination outcomes held by the Royal Colleges and the GMC and to explore the best way to use and share this. By the end of 2014 we will be providing a richer set of tailored, targeted data to the Royal Colleges and, in return, we are beginning to gather further information from the Royal Colleges to inform our programme of visits (as part of our programme of quality assurance).

Generic systems concerns

- 34** We need to ensure that appropriate action is taken when patient safety concerns come to our attention, whilst being careful not to overstep our regulatory functions and intervene where another organisation may be better placed to take action.
- 35** We are aware of the importance of using our data to better support our work and that of others. We have begun to develop a data strategy, which will allow us to adopt a more proactive and data driven approach to regulation based on a proper understanding of risk. It will also help us to connect information and insight more effectively across the organisation.
- 36** Linked to the work on the data strategy we have established a GMC Patient Safety Intelligence Forum (PSIF). The Forum is in the early stages of development but it aims to help us better co-ordinate information from across the GMC which may raise concerns about patient safety or medical practice so that we can target our regulatory actions more effectively.
- 37** The development of the data strategy and the establishment of PSIF also address the emphasis in the Keogh review for the need for better use of data between organisations, as a means of driving improvement.

Holding doctors to account

- 38** Ensuring that organisations are held to account when incidents of poor care occur is a key aspect of the Francis Report. There is a legitimate public expectation that those responsible for incidents of poor care are held to account and required to justify their actions or lack of action. Part of our regulatory function is to protect the public by

dealing firmly, fairly and speedily with those doctors who fail to meet the standards expected of them.

- 39 In 2011, we made a commitment to reform our fitness to practise procedures by streamlining our adjudication processes and strengthening confidence in the independence of our adjudication function and in the process as a whole.
- 40 One of our most significant reforms has been the launch of the [Medical Practitioner Tribunal Service](#) (MPTS), an independent decision making body which was set up to provide clearer separation between the GMC's complaints and investigation functions and adjudication on those complaints.
- 41 Changes have also been made to the way we deal with cases at the end of an investigation. In September 2012 we piloted meetings with doctors to test whether a meeting at the end of an investigation would deliver a quicker resolution to a case. The meetings allow us to speak with doctors at an earlier stage of the FtP process and encourage them to share information with us in order for us to better understand the concern which has been raised with their practice. By speaking with doctors at this stage we are able to decide earlier if a full hearing is necessary. These changes should help us deliver a quicker system for dealing with complaints which continues to put patient safety first.
- 42 We are conscious that there have been occasions when we have been prevented from taking action in serious cases because the doctor concerned has been able to show that they have subsequently improved their practice. We believe that doctors and patients want stronger action in these cases. Therefore, we are currently consulting on a wider range of proposals to update the guidance we give to MPTS panels about what action should be taken to deal with doctors who do not meet our professional standards. This guidance is similar to sentencing guidelines used by courts.
- 43 The sanctions imposed on doctors range in seriousness – from warnings and restrictions on their practice, through to temporary suspension and erasure from the medical register. In August 2014 we launched a consultation reviewing our indicative sanctions guidance, given to panels when deciding on what action to take where a doctor has failed to meet the professional standards required. We are also reviewing the role of apologies and warnings. This consultation is a chance to make sure that the action we take is fair to doctors while never losing our focus on protecting the public. The consultation will run until 14 November and we will publish the outcome in 2015.
- 44 *Good medical practice* says doctors 'must be open and honest with patients when things go wrong and offer an apology when a patient under their care suffers harm or distress.' However, we do not currently have a sanction that can require a doctor to apologise. We are consulting on whether panels should require doctors to apologise where patients have been harmed. This would help us to hold doctors to account for

their actions, for example where a serious clinical error has adversely affected a patient's life expectancy or quality of life. If there is support for this in principle, we will do further work to develop proposals for how this might work in practice. Any proposals to add to the range of sanctions available to panels will require further consultation prior to legislative change.

- 45** We are also consulting on proposals to strengthen our guidance for panels on how to assess whether a doctor has insight, and the extent to which an apology is evidence of insight. In principle, we believe that where a patient has been harmed as a result of a doctor's actions or omissions, a doctor's failure to apologise is evidence that they lack insight. Subject to the outcome of the public consultation, these changes would allow MPTS panels to hold doctors to account where they fail to apologise for harm caused to a patient, and increase consistency in our decision making when considering the role of insight.

The future

- 46** We are committed to developing our regulatory framework to ensure we maintain our relevance to doctors and patients, recognising the need to evolve as a regulator as the healthcare environment in which doctors work, evolves.
- 47** We anticipate that over the next few years our regulatory framework will continue to develop in line with the proposals from the Law Commission's Regulation of Health and Social Care Professions Bill. The Bill proposes a legal framework which will support a more modern and efficient approach to regulation by creating a single, overarching, but more flexible, legal framework that will apply to the regulation of all the nine health and social care regulators.
- 48** Although the Bill has not been brought forward in this parliamentary session, the Government has brought forward legislation to introduce a limited number of the most pressing reforms contained within the Bill. These 'Section 60 Orders' provide us with new powers to appeal decisions of fitness to practise panels where we feel those decisions are insufficient for the protection of the public.
- 49** We continue to support the Department of Health in developing the Bill and will continue to emphasise the need for the fundamental and wide ranging regulatory reforms which the Bill would deliver.
- 50** The themes identified by Francis will remain part of the ways in which we strive to be a better regulator, informing the activities we undertake. The individual programmes of work that will conclude in 2015 will be reported separately on our website. We will continue to support the system wide commitment to promote a more open, honest and transparent culture in healthcare, as well as striving to enhance patient care.