

An update on the GMC's work to address the Francis Recommendations

In our [initial response](#) to the recommendations in the Francis Report, we committed to providing an update on our progress in six months.

In that time, the Government has commissioned six further reviews to inform its response to the Francis Report, some of which are due to be published later this year.

The Keogh Review into the quality of care and treatment provided by 14 hospitals with high mortality indicators, the Berwick Review into patient safety and Cavendish Review of the regulation of healthcare assistants have been published.

The delivery of many of these recommendations will require action from a number of organisations. We have been engaging with the Department of Health and other regulators to ensure we work closely to help deliver the changes suggested.

This update groups the recommendations across the six themes. In addition to explaining the work in relation to the specifics of these recommendations, we are also committed to tackling the wider issues highlighted by the Francis Report as a whole in particular playing our part in helping to promote a more open, patient-focused culture in health and regulation.

Themes:

- Education and training
 - Quality assurance visits
 - Education standards
 - Listening to medical students and trainees
- Patient insight
- Promoting professional practise
 - English language proficiency
 - Promoting professionalism
- Helping to ensure a safe practice environment
- Generic/systems concerns
- Joint working and information sharing

Education and training

Quality assurance visits

Francis
<p>155. The General Medical Council should set out a standard requirement for routine visits to each local education provider, and programme in accordance with the following principles:</p> <ul style="list-style-type: none">a. The Postgraduate Dean should be responsible for managing the process at the level of the Local Educational Training Board, as part of overall deanery functions.b. The Royal Colleges should be enlisted to support such visits and to provide the relevant specialist expertise where required.c. There should be lay or patient representation on visits to ensure that patient interests are maintained as the priority.d. Such visits should be informed by all other sources of information and, if relevant, coordinated with the work of the Care Quality Commission and other forms of review. <p>The Department of Health should provide appropriate resources to ensure that an effective programme of monitoring training by visits can be carried out.</p> <p>All healthcare organisations must be required to release healthcare professionals to support the visits programme. It should also be recognised that the benefits in professional development and dissemination of good practice are of significant value.</p>
<p>156. The system for approving and accrediting training placement providers and programmes should be configured to apply the principles set out above.</p>
<p>158. The General Medical Council should amend its standards for undergraduate medical education to include a requirement that providers actively seek feedback from students and tutors on compliance by placement providers with minimum standards of patient safety and quality of care, and should generally place the highest priority on the safety of patients.</p>
<p>161. Training visits should make an important contribution to the protection of patients:</p> <ul style="list-style-type: none">a. Obtaining information directly from trainees should remain a valuable source of information – but it should not be the only method used.b. Visits to, and observation of, the actual training environment would enable visitors to detect poor practice from which both patients and trainees should be sheltered.c. The opportunity can be taken to share and disseminate good practice with trainers and management. <p>Visits of this nature will encourage the transparency that is so vital to the preservation of minimum standards.</p>

We have been considering these recommendations as part of our review of quality assurance in education. Two papers, now available on our website and shared with key interests, have posed a number of proposals for discussion which are particularly relevant to Francis's recommendations: the first on the [merits of the GMC approving educational environments](#), published May 2013 and the second, on the future of [quality assurance visits/inspections](#), published July 2013.

We are now in the process of analysing the feedback we have received and are drawing up conclusions and proposals, which will be presented to our Council for consideration in December; we will be sharing our proposals in the first half of 2014.

Education standards

Francis

162. The General Medical Council should in the course of its review of its standards and regulatory process ensure that the system of medical training and education maintains as its first priority the safety of patients. It should also ensure that providers of clinical placements are unable to take on students or trainees in areas which do not comply with fundamental patient safety and quality standards. Regulators and deaneries should exercise their own independent judgement as to whether such standards have been achieved and if at any stage concerns relating to patient safety are raised to them, must take appropriate action to ensure these concerns are properly addressed.

163. The General Medical Council's system of reviewing the acceptability of the provision of training by healthcare providers must include a review of the sufficiency of the numbers and skills of available staff for the provision of training and to ensure patient safety in the course of training.

Berwick

5. Mastery of quality and patient safety sciences and practices should be part of initial preparation and lifelong education of all health care professionals, including managers and executives

Education regulators, providers and HEE:

Professional regulators (such as the GMC and NMC) should continue and build upon their good work to date with undergraduate and postgraduate education providers and Health Education England to ensure that medical and nursing undergraduates and postgraduates become thoroughly conversant with and skilful at approaches to patient safety and quality improvement.

As part of the [review of quality assurance of education](#) we are reviewing our standards for medical education as set out in [Tomorrow's Doctors](#) and [The Trainee Doctor](#) as highlighted in the above recommendations and the Berwick Review.

We have established an expert group, which, among other things is considering how we can improve the consistency and coherence of our standards across the continuum, and examining the case for developing a framework of core and developmental standards. The review is also considering how our standards can best reflect the characteristics of a good educational environment. We will consult on draft revised standards in 2014. We have continued our work to review the impact of the 2009 edition of [Tomorrow's Doctors](#), which sets out the knowledge skills and behaviours that medical students learn at medical school, to understand how prepared for practice graduates are as they go into their first year of foundation training. This review is set to report in mid 2014. We have published a [summary of interim findings](#).

Medical student, trainee and doctor voice recommendation

Francis

159. Surveys of medical students and trainees should be developed to optimise them as a source of feedback of perceptions of the standards of care provided to patients. The General Medical Council should consult the Care Quality Commission in developing the survey and routinely share information obtained with healthcare regulators.

The UK's 54,000 doctors in training are asked in our annual National Training Survey (NTS) to share their views about the quality of their training to help ensure we have high standards of medical education. Since 2012, we also ask doctors in training whether they have any concerns about patient safety, and we share these concerns with Postgraduate Deans so they can be investigated. The [National training survey 2013: key findings](#) have now been published. This year, 5.2% of doctors in training raised a patient safety concern, a similar proportion to 2012.

The NTS is an important tool in assuring the quality of training and enabling doctors in training to provide feedback to us and raise concerns about patient safety. We are developing a plan to enhance the survey over the next four years. This will include exploring whether we should survey other groups of doctors in addition to doctors in training, and survey medical students. We will also be piloting (in 2014) a new survey of postgraduate trainers.

Patient insight

Francis
233. While both the General Medical Council and the Nursing and Midwifery Council have highly informative internet sites, both need to ensure that patients and other service users are made aware at the point of service provision of their existence, their role and their contact details.
Berwick
<p>5. Mastery of quality and patient safety sciences and practices should be part of initial preparation and lifelong education of all health care professionals including managers and executives.</p> <p>6. The NHS should become a learning organisation. Its leaders should create and support the capability for learning, and therefore change, at scale, within the NHS.</p> <p>Education regulators, providers and HEE</p> <ul style="list-style-type: none"> Professional regulators (such as the GMC and NMC) should continue and build upon their good work to date with undergraduate and postgraduate education providers and Health Education England to ensure that medical and nursing undergraduates and postgraduates become thoroughly conversant with and skilful at approaches to patient safety and quality improvement.

The importance of giving patients and those making complaints support and practical ways to raise concerns and provide important insight to inform improvements in care is a prominent theme in the Francis Report and subsequent reviews. In the context of a doctor's practice, not only are patients key to raising concerns about care but also play an instrumental role in assisting doctors to improving their own practice through positive and critical feedback aiding in reflection.

We are working to ensuring that patients have access to the information they need about our work at the right time, are empowered to provide feedback (including concerns) and if a concern is raised with us they are supported through the process.

- We have begun a review of our digital strategy (including our website), which is considering the best ways to reach patients and others with an interest in our work through our own and other online channels, such as NHS choices, which we know many patients are already using.
- We have published for the first time [*Good medical practice: a guide for patients*](#) to make clear what patients should expect from their doctor.
- We have included patient feedback as a key part of the clinical governance supporting revalidation. As part of the evaluation of revalidation we will look at the role of patient feedback and how this can be further developed. The evaluation will include a longitudinal study beginning next year. All doctors registered with a licence to practise must participate in revalidation, including those involved in postgraduate education.

- We are currently reviewing our educational standards, which are set out in *Tomorrow's Doctors* and *The Trainee Doctor* and will consider the Berwick Review's recommendations as part of this review. The review will be complete in 2014.
- We know that raising a concern can be stressful and we will continue to develop our face to face meetings with complainants, which provide an opportunity to explain our progress and the outcome. This is a development of our already existing programme which provides emotional support to complainants throughout a case.

Promoting professional practice

English language proficiency

Francis

172. The Government should consider urgently the introduction of a common requirement of proficiency in communication in the English language with patients and other persons providing healthcare to the standard required for a registered medical practitioner to assume professional responsibility for medical treatment of an English-speaking patient

In September we launched a three month consultation to seek views on changes that will allow us to check the language skills of doctors from the European Economic Area (EEA) when a concern is raised during their registration process. This runs in line with the Department of Health's consultation on changes to the Medical Act to give us new powers, which are due to come into effect in 2014. This will mean that we can carry out further checks and investigation where we believe the safety of patients might be at risk because a doctor cannot speak English. Following calls from the GMC, the UK Government and others we are pleased that the new proposed European Directive on professional qualifications will provide further assurance that doctors and other healthcare professionals benefitting from the free movement of labour in the EU will have to demonstrate that they are competent in the language of the country where they intend to practice.

Promoting professionalism

Francis

160. Proactive steps need to be taken to encourage openness on the part of trainees and to protect them from any adverse consequences in relation to raising concerns

Berwick

4. Government, Health Education England and NHS England should assure that sufficient staff are available to meet the NHS's needs now and in the future. Healthcare organisations should ensure that staff are present in appropriate numbers to provide safe care at all times and are well-supported.

All leaders and managers of NHS-funded provider organisations:

- NHS organisations, working with professional regulators, should create systems for supportively assessing the performance of all clinical staff, building on the introduction of medical revalidation.

We establish the principles and values that must underpin a doctor's practice in our core guidance, *Good medical practice*. We want all doctors to be familiar with, and understand how to apply, these principles and values that enable high-quality care

that puts the patient first. We also want them to study, train and work in environments that encourage and support them to embody these values and principles. In support of these aims we continue to deliver a range of engagement activity with doctors and other key stakeholders.

- We produce [explanatory guidance and learning resources](#) that focus on key areas of GMP, such as [Raising and acting on concerns about patient safety](#). This type of guidance and supporting resources enables us to explore key issues in more detail and help doctors understand how to put our guidance into practise.
- Our [Regional Liaison Service \(RLS\)](#), as well as our teams in Scotland, Wales and Northern Ireland, engages directly with groups of doctors (including students and doctors in training) delivering workshops and presentations targeted on our guidance. Since January 2013 we have engaged with almost 13,000 doctors, 6,000 students and educators and 700 members of the public.
- We have a student engagement strategy where we seek to run 'professionalism' events at all medical schools every year and engage with each medical student three times over the course of their undergraduate study. About 15,000 students have signed up to our quarterly Student News bulletin. This raises our profile as a resource for advice and support in relation to good practice relevant to all doctors.
- Together with the Medical Schools Council we published guidance in July for medical schools to support students with mental health conditions. We view this as a contribution to fostering an environment at the outset of doctors' careers that encourages them to seek help, guidance and raise concerns while supporting their confidentiality and professional education.
- We are piloting our 'Welcome to UK Practice' work to test demand for, and the impact of, work to support doctors who are new to UK Practice to understand medical professionalism in the UK context. We are running pilot events in all four countries of the UK during November.
- We have introduced the use of a range of social media tools, including corporate twitter, facebook and LinkedIn accounts along with a new blog space that we are using to engage significant numbers of students, doctors, employers and patients in a sustained discussion about our professional standards.
- Our direct communications with doctors through our monthly eBulletin, GMC News, reaches over 200,000 doctors which together with other targeted mailings enables us to highlight key messages to the profession. From April this year we have covered the launch of our updated *Good medical practice*, continuing professional development for doctors, appropriate use of social media, and raising and acting on concerns.
- We continue to help with the delivery and development of revalidation – a key tool in supporting doctors' regular reflection on their practice and opportunities for professional improvement against the standards set in *Good medical practice*. About 21,000 doctors have now been revalidated.
- Our Employer Liaison Advisers (ELAs) continue to meet with Responsible Officers across the NHS and independent sector to support them with fitness to practise concerns and revalidation. These meetings, together with

revalidation, are helping to influence the environment in which doctors practise.

- In April we published our first [guide for patients](#) to the professional standards they can expect from their doctor and over the past six months have actively promoted this guide to patient groups across the UK. In September we held 'Making feedback count: Listening to, and learning from the patient voice', an event we jointly hosted with the Nursing and Midwifery Council and the Richmond Group (who represent 10 major health charities). The event was attended by representatives of regulators, health charities, patient advocacy groups, Department of Health, Health Education England and the Council of Deans. Once the report of the event is finalised we'll continue to work with stakeholders to identify opportunities to enhance the patient voice in promoting quality care.

Helping to ensuring a safe practice environment (Approved Practice Settings)

Francis
164. The Department of Health and the General Medical Council should review whether the resources available for regulating Approved Practice Setting are adequate and, if not, make arrangements for the provision of the same. Consideration should be given to empowering the General Medical Council to charge organisations a fee for approval.
165. The General Medical Council should immediately review its approved practice settings criteria with a view to recognition of the priority to be given to protecting patients and the public.
166. The General Medical Council should in consultation with patient interest groups and the public immediately review its procedures for assuring compliance with its approved practice settings criteria with a view in particular to provision for active exchange of relevant information with the healthcare systems regulator, coordination of monitoring processes with others required for medical education and training, and receipt of relevant information from registered practitioners of their current experience in approved practice settings approved establishments.
167. The Department of Health and the General Medical Council should review the powers available to the General Medical Council in support of assessment and monitoring of approved practice settings establishments with a view to ensuring that the General Medical Council (or if considered to be more appropriate, the healthcare systems regulator) has the power to inspect establishments, either itself or by an appointed entity on its behalf, and to require the production of relevant information.
168. The Department of Health and the General Medical Council should consider making the necessary statutory (and regulatory changes) to incorporate the approved practice settings scheme into the regulatory framework for post graduate training.

Approved Practice Settings (APS) were conceived and implemented before the merger of the Postgraduate Medical Education and Training Board (PMETB) with the GMC, which gave the GMC powers to quality assure the training environments for doctors engaged in postgraduate training. Subsequently the Medical Profession (Responsible Officer) Regulations 2010 and revalidation have together driven improvements in clinical governance bringing the vast majority of doctors into governed environments by virtue of prescribed connections. Furthermore, we now apply a test of fitness to practise at the point of registration which gives us some additional confidence about new registrants.

We have carefully considered the recommendations of the Francis Report through a fundamental review of Approved Practice Settings (APS), which has considered APS

in the context of all our functions and how they promote assurance and patient safety. The final recommendation of the fundamental review is that the provisions of section of the Medical Act 1983, which deals with APS, should be repealed through the next available legislative vehicle, which we anticipate will be the work of the Law Commission. In other words the APS scheme should be abolished.

We accept this will take time, and in the meantime we will place the scheme on a firmer footing by aligning our recognition requirements with the existing statutory duties for healthcare organisations, namely the RO Regulations. This would, in effect, prevent doctors newly registered or recently restored to the register from practising in circumstances where they do not have a prescribed connection to a designated body. We will also build on our relationships with systems regulators in each of the four countries – they have an important role in ensuring that organisations comply with the duties for designated bodies set out in the RO regulations.

We will now proceed to take forward the recommendations, the plans for which will be presented to our Council in December. We will consult on our proposals in 2014.

Generic/systems concerns

Francis
222. The General Medical Council should have a clear policy about the circumstances in which a generic complaint or report ought to be made to it, enabling a more proactive approach to monitoring fitness to practise.
225. The General Medical Council should have regard to the possibility of commissioning peer reviews pursuant to section 35 of the Medical Act 1983 where concerns are raised in a generic way, in order to be advised whether there are individual concerns. Such reviews could be jointly commissioned with the Care Quality Commission in appropriate cases.
Berwick
<p>Recommendation 10: We support response regulation of organisation, with a hierarchy of responses. Recourse to criminal sanctions should be extremely rare, and should function primarily as a deterrent to wilful or reckless neglect or mistreatment.</p> <p>NHS-funded provider organisations and professional regulators Employers need to improve their support of staff around implementing guidance on reporting of serious incidents and professional regulators should take appropriate action when required. Organisations should demonstrate that they have in place fully functional reporting systems for serious incidents, that staff know how to use them, that the systems are use, and that appropriate action is taken in response to incidents, including provision of appropriate support to the affected patients and their carers.</p>

We know that there are ways we can, and do, contribute to the identification and investigation of systemic or generic concerns. We already do this in the following ways.

- We sign post complainants to the appropriate regulator if their concerns are not for us. We also make referrals ourselves to systems or other professional regulators.
- We investigate concerns that are brought to our attention in the media, which may not specifically name a doctor.

- We share information with and participate in Regional Quality Surveillance Groups and Risk Summits.

We have started to look at ways we can improve how we deal with the generic concerns we identify in the course of a fitness to practise investigation or through our Liaison services. One of the most effective ways we can deal with concerns that do not fall within our regulatory remit, as a professional regulator, is through the improvements we are making in the way we use our data and share information with other regulators, for example through our information sharing protocol with the CQC, discussed in the following section.

The recommendation of the Berwick Review highlights the important role we are able to play in assisting employers with information to help them make the appropriate decisions about the types of concerns that should be referred to us for investigation. The [Employer Liaison Service](#) is a hands on way that we do this. We will be formally evaluating the work of this service in 2014.

We are willing to provide information and support for CQC in undertaking reviews of medical services, but we are clear that direct interventions by the GMC should be confined to matters within our statutory remit – that is around the quality of education and of individual practitioners. Where there are system issues, we should provide information and any other appropriate assistance to the relevant system regulator, but we should not blur lines of responsibility in this or other areas.

Information sharing and joint working

Francis
152. Any organisation which in the course of a review, inspection or other performance of its duties, identifies concerns potentially relevant to the acceptability of training provided by a healthcare provider, must be required to inform the relevant training regulator of those concerns.
153. The Secretary of State should by statutory instrument specify all medical education and training regulators as relevant bodies for the purpose of their statutory duty to cooperate. Information sharing between the deanery, commissioners, the General Medical Council, the Care Quality Commission and Monitor with regard to patient safety issues must be reviewed to ensure that each organisation is made aware of matters of concern relevant to their responsibilities.
223. If the General Medical Council is to be effective in looking into generic complaints and information it will probably need either greater resources, or better cooperation with the Care Quality Commission and other organisations such as the Royal Colleges to ensure that it is provided with the appropriate information.
224. Steps must be taken to systematise the exchange of information between the Royal Colleges and the General Medical Council, and to issue guidance for use by employers of doctors to the same effect.
234. Both the General Medical Council and Nursing and Midwifery Council must develop closer working relationships with the Care Quality Commission – in many cases there should be joint working to minimise the time taken to resolve issues and maximise the protection afforded to the public.
Berwick
7. Transparency should be complete, timely and unequivocal. All non-personal data on quality and safety, whether assembled by government, organisations, or professional societies, should be shared in a timely fashion with all parties who want it, including in accessible form, with the public.
8. All organisations should seek out the patient and carer voice as an essential asset in monitoring the safety and quality of care.
All healthcare system organisations

- Government, CQC, Monitor, TDA, HEE, NHS England, CCGs, professional regulators and all NHS Boards and chief executives should share all data on quality of care and patient safety that is collected with anyone who requests it, in a timely fashion, with due protection for individual patient confidentiality.
- Government, CQC, Monitor, TDA, HEE, NHS England, CCGs, professional regulators and all NHS Boards and Chief Executives should include patient voice as an essential resource for monitoring and improving the safety and quality of care.

9. Supervisory and regulatory systems should be simple and clear. They should avoid diffusion of responsibility. They should be respectful of the goodwill and sound intention of the vast majority of staff. All incentives should point in the same direction.

CQC, Monitor and the TDA

...It is imperative that CQC, Monitor and the TDA commit to seamless, full, unequivocal, visible and whole-hearted cooperation with each other and with all other organisational and professional regulators, agencies and commissioners.

Regulators, HEE, professional societies, commissioners

CQC, Monitor, TDA, professional regulators, HEE, professional societies, Royal Colleges, commissioners and others should streamline requests for information from providers so that they have to provide information only once and in unified formats. The same is true of inspections.

Keogh

Ambition 2: The boards and leadership of provider and commissioning organisations will be confidently and competently using data and other intelligence for the forensic pursuit of quality improvement. They along with patients and the public, will have rapid access to accurate, insightful and easy to use data about quality at service line level.

- All those who helped pull together the data packs produced for this review must continue this collaboration to produce a common, streamlined and easily accessible data set on quality which can then be used by provider, commissioners, regulators and members of the public in their respective roles. Healthwatch England will play a vital role in ensuring such information is accessible to local Healthwatch so that they and the consumers they serve can build a picture of how their local service providers are performing. The National Quality Board would be well placed to oversee this work.

Ambition 4: Patients and clinicians will have confidence in the quality assessments made by the Care Quality Commission, not least because they will have been active participants in inspections.

- In the new system, the place that data and soft intelligence comes together is in the recently formed network of Quality Surveillance Groups. These must be nurtured and support the Care Quality Commission in identifying areas of greatest risk

We are committed to finding better ways to work with other regulators. Building on a Memorandum of Understanding with the CQC, we have put in place practical arrangements to facilitate our commitments. This joint operational protocol was agreed in September and sets out key contacts at both organisations, when and how we will share and record information and how the teams at each organisation are involved.

We are sharing information with the CQC, such as our hearing decisions and national training data. Similarly, the CQC shares information with us that informs our approved practice settings process. We also work with each other at risk summits and regional quality surveillance groups.

Over the next few months there will be a series of training events for GMC and CQC staff who work in teams who will be using the protocol regularly. With the CQC we are developing a joint approach to the evaluation of the operating protocol, with an interim evaluation scheduled for September 2014 and a full evaluation in September 2015.

We are currently in the process of refreshing our Memoranda of Understanding with the Regulation and Quality Improvement Authority in Northern Ireland, Healthcare Improvement Scotland, and Healthcare Inspectorate Wales. As part of this process we will be exploring the creation of joint working protocols. Additionally, we are working with Monitor and the NHS Trust Development Authority to develop information sharing agreements and create accompanying practical arrangements.

Since April we have undertaken scoping work to understand how we can better use our data to support our work and that of others, including other professional regulators. The recommendations from this initial piece of work will be considered as we develop our Corporate Strategy for 2014 – 2017.

Joint proceedings

Francis
235. Joint proceedings The Professional Standards Authority for Health and Social Care (PSA) (formerly the Council for Healthcare Regulatory Excellence), together with the regulators under its supervision, should seek to devise procedures for dealing consistently and in the public interest with cases arising out of the same event or series of events but involving professionals regulated by more than one body. While it would require new regulations, consideration should be given to the possibility of moving towards a common independent tribunal to determine fitness to practise issues and sanctions across the healthcare professional field.

While this recommendation is relevant to the work of the Medical Practitioners Tribunal Service, the Professional Standards Authority (PSA) has responsibility for progressing this work. We are engaged in conversation with the PSA and remain interested in exploring the possibility of offering the services of the MPTS to other regulators in due course