General Medical Council

Our work to address the recommendations of inquiries and reviews

1 We believe that professional regulation has an important part to play in helping protect patients from harm and raising the standards of medical education and practice. Inquiries and reviews help us reflect on our systems and practice, identifying lessons for us and the system as a whole.

2 Since the publication of Sir Robert Francis' 2013 report on the failings at Mid Staffordshire NHS Foundation Trust we have been publishing regular updates on our work to address the recommendations in the report. This update takes a broader view, incorporating our work related to the recommendations of other recent inquiries and reviews; notably the Vale of Leven, Morecambe Bay, Operation Jasmine and Sir Robert Francis' Freedom to speak up review, among others.

3 We have not attempted to describe our response to each individual recommendation in these reviews and inquiries here, but rather briefly address the broad themes that they have shared: designing and maintaining a health system centred on patients; fostering a more open and honest culture in healthcare, including encouragement and support for raising concerns; greater emphasis on professionalism; intelligent and collaborative regulatory systems.

Patients' insight

4 Our function, to help protect patients and improve medical education and practice, is set out in statute. Patients are at the heart of what we do and we strive to ensure that sufficient information is available to help patients and the public understand when and how we can help. However, the recommendations of inquiries and reviews have shown that there is scope to improve the ways we do this. The following are some examples of how we have responded:

- **Patient Information Service**: We have made significant progress in improving patient understanding of our Fitness to Practise (FtP) processes through our pilot face-to-face meetings with patients. The aim of the service was to improve communications with members of the public who raise concerns about a doctor. The independent evaluation of the pilot was published on our website in September 2014 and in January 2015 the pilot was rolled out to our GMC offices across the UK in Manchester, Cardiff, Edinburgh and Belfast. We will continue to

roll out the pilot to other regions across the UK and are now inviting patients from other areas including the East of England, South West, North East, Yorkshire and Humberside and the Midlands to take part in the pilot. By May 2016 we hope to be offering this service to all regions in the UK

- **Revalidation**: Revalidation is the process by which all licensed doctors are required to demonstrate on a regular basis, usually every five years, that they are up to date and fit to practise. Since the introduction of revalidation in 2012, over 123,400 doctors have been revalidated. We want to find out what impact revalidation has had so far, which is why we commissioned UMbRELLA (UK Medical Revalidation Evaluation Collaboration) to undertake a long term evaluation of revalidation, which is now well underway. Separately from the evaluation of revalidation, we are currently considering how we can improve understanding of the patient role in revalidation. To raise awareness, in late 2015 we will be publishing enhanced information on patient feedback focusing on the importance of doctors reflecting on patient feedback to improve their practice. We will consider the effectiveness of patient feedback as part of our long term evaluation of revalidation.

- **Communications** We are in the process of developing a new communications and engagement strategy, which draws heavily on independent research we commissioned in 2014 to help us understand how well each of our key audiences understand our role. Around 1500 members of the public completed the survey and 79% expressed confidence in the regulation of doctors. We will run this survey again in 2016.

Being open and honest

5 One of the key themes in the Mid Staffordshire and Morecambe Bay Inquiries, Berwick Review and Freedom to speak up, is the need to embed a culture of openness and honesty within healthcare, supporting staff to raise concerns and drive improvements in care.

Being open and honest

6 A common finding of recent inquiries and reviews has been a failure of doctors and other healthcare professionals to be open and honest about problems and mistakes. Francis recommended a statutory duty of candour for organisations and individual professionals; the government has only taken this forward in relation to organisations. To reinforce the importance of the professional duty on doctors, nurses and midwives to be open and honest when things go wrong, we have worked closely with the Nursing and Midwifery Council (NMC) to address this recommendation and on 29 June 2015 we launched new joint guidance *Openness and honesty when things go wrong: the professional duty of candour*.

7 The guidance builds on advice in *Good medical practice* and the NMC's Code which says that doctors, nurses and midwives have a professional duty to be open and honest with patients when things go wrong. It also says that they should always report when mistakes are made that have compromised - or could have compromised patient safety. To support the new joint guidance we have developed a number of interactive tools and useful resources. We continue to promote awareness of the guidance through our Liaison Advisers across the UK.

Raising concerns

8 Ensuring all levels of staff feel confident to raise concerns about patient safety and understand the importance of patient feedback in improving the quality of care, has been highlighted in a number of reviews. Part of being open and honest is speaking up when there may be cause for concern. We continue to promote our guidance *Raising and acting on concerns about patient safety*, to help doctors decide how best to raise their concerns and our regional liaison service continues to engage with doctors, students and educators through focussed workshops on raising and acting on concerns.

9 We have made it easier for doctors and doctors in training to raise concerns with us. In 2012 we established a confidential helpline and we have developed and expanded our National Training Survey (NTS) to ensure it is a reliable source for identifying concerns within education environments, including concerns about patient safety. Last year we published two reports following the key findings of the 2014 National Training Survey, *Concerns about patient safety*, which includes an analysis of the patient safety concerns raised, and *Undermining*, which covers bullying and undermining behaviour and our plans to work with others to combat this kind of behaviour in clinical environments. Starting next year we are also surveying trainers alongside the NTS. By running the two surveys at the same time every year, we hope to be able to provide a more comprehensive picture of training environments.

10 In 2014 we commissioned the Right Honourable Sir Anthony Hooper to undertake a review of how we deal with doctors who raise concerns in the public interest. Sir Anthony engaged with a number of doctors about their experience as whistle-blowers as well as a number of employers. Sir Anthony published his review in March 2015 and it included recommendations relating to our investigation processes, to make sure that such whistleblowers are treated fairly. Sir Anthony also identified there was a risk of organisations making complaints to the GMC about individual doctors who had raised legitimate concerns about patient safety. He recommended a number of steps we could take to help us identify such cases and we have now published our action plan to address the recommendations, which we aim to complete by mid-2016.

Professionalism

11 A number of inquiries highlighted areas where medical professionals seemed to lack sufficient awareness of our guidance, including conflicts of interest, consent, and

raising concerns. Instances have also been identified where ineffective implementation of our standards and guidance for doctors on these areas contributed to poor patient care.

Education and training

12 Doctors are professionals and there are fundamental values and modes of behaviour that are intrinsic to their status. Our standards define what makes a good doctor by setting out the professional values, knowledge, skills and behaviour required of all doctors working in the UK.

13 The foundations of professionalism are established in education. On 30 July we published our new standards for medical education and training *Promoting excellence: standards for medical education and training*. The standards state that patient safety is the first priority and we will make sure that education and training only takes place in settings where patients are safe, the care and experience of patients is good, and education and training are valued.

14 When the standards come into effect, at the start of 2016, for the first time there will be one set of standards covering undergraduate, foundation and postgraduate training in the UK.

15 Additionally, we are working with the Academy of Medical Royal Colleges to develop a framework – *Generic professional capabilities* - setting out the core professional values, knowledge, skills and behaviours which all doctors should be able to apply to a range of clinical and non-clinical contexts by the time they complete specialty training. This includes skills such as communication, teamwork and leadership. We will be developing this framework in line with comments received from our recent consultation.

Promoting professionalism

16 We continue to undertake a broad range of work to raise awareness of our standards and encourage doctors to embody these principles and values in their work. The following paragraphs highlight our recent work promoting professionalism, helping to ensure that fundamental values are embedded within the healthcare environment.

17 We continue to raise awareness of our range of guidance and actively promote it through our Regional Liaison Service (RLS) in England and Devolved Office teams in Northern Ireland, Scotland and Wales. Recent appointments in the Devolved Office teams mean that we now have capacity to engage with more of our stakeholders across the UK. Both teams meet regularly with doctors, medical students, employers and the public on a variety issues such as openness and raising and acting on concerns.

18 Additionally, on the 6 August 2015 we launched our first app 'My CPD' which is constructed around the domains of *Good Medical Practice* and allows doctors to record and reflect on their learning activities on the go and remain up to date with our most recently published guidance.

19 As part of our work to address specific Francis recommendations around promoting professionalism, we are continuing with our programme of UK-wide 'Medical Professionalism Matters' events during 2015 and 2016. These events explore some of the key challenges facing doctors including, collaboration and leadership, multi-disciplinary working, resilience, raising concerns, confidentiality, consent and compassion. These events are being run in partnership with the BMA, Medical Schools Council, NHS Employers and medical royal colleges. When the programme concludes we will publish a report reflecting the discussion, debate and experiences we have heard from frontline clinicians and what they have told us about the current and future state of medical professionalism.

20 Throughout 2013 and 2014 we began piloting a number of Welcome to UK practice events for doctors new to our register. The aim was to ensure doctors new to the register are aware of the ethical and professional standards expected of doctors practising in the UK and thereby help improve medical practice and the quality of care that patients receive. Following the success of these pilots we now hold regional events, working closely with employers and other organisations.

Collaboration and information sharing

21 The need for greater collaboration and co-ordination between regulators and other organisations has been highlighted in all recently published inquiries as being key to ensuring efficient detection of patient safety concerns.

22 In recent years our systems and processes have developed significantly to be more reliable and robust. But as a professional regulator we are just one part of a wider system of assurance. We must therefore continue to work closely with others to help us deliver our functions, to ensure our guidance is understood and acted upon by doctors, that concerns about patient safety are identified and intelligence is shared with others.

23 To these ends we have continued to strengthen our relationship with the Care Quality Commission (CQC) and in recent months have held a series of workshops with the CQC to further understand the types of information we should share so that together we can regulate more effectively. We now have Memoranda of Understanding with Health Improvement Scotland, Monitor, NHS Trust Development Authority and Health Inspectorate Wales. These agreements assist early identification of concerns and help to ensure that concerns are dealt with appropriately.

24 In order to address specific Francis recommendations on identifying generic complaints and system concerns, we are implementing a new approach to managing

data across the organisation through our Data Strategy. This will enable us to make links between information held in different parts of the business more quickly and help identify, analyse and understand trends and areas of risk. We recently launched a new internal reporting system which brings together data we hold on the medical profession and will launch this publicly in the first quarter of 2016. This system uses quantitative data collected through all of our functions and allows our policy and decision making teams to have a more coherent view of the environments and cohorts of doctors we regulate. We are also developing an intelligence model to use this system and gain greater insight around specific areas of risk. The model will facilitate the assessment and monitoring of specific risks and, where possible will forecast the likelihood of their occurrence.

25 Alongside our Data Strategy is the Patient Safety Intelligence Forum (PSIF) which was established in 2014 and continues to develop to ensure information is shared across our directorates about emerging risks to patient safety.

Looking forward

26 We remain committed to developing our approach to regulation to ensure we can meet the expectations of patients and needs of doctors in the future. Although we have been able to make progress over the last two years (some of this achieved through amendments to the Medical Act), further legislative changes will be required before we can fully achieve our aims.

27 We continue to work with the Department to Health to secure legislative change through the Professional Accountability Bill (formerly known as the Law Commissions' Bill). The Government has said that it is committed to legislative reform but has not yet found parliamentary time to take matters forward. We continue to urge that it does so at the earliest opportunity in order to support us in our efforts to protect the public.

28 We are determined to play our part in promoting patient safety, while recognising that many of the issues highlighted within recent inquiries and reviews go well beyond professional regulation. The reforms we have made and plan to make in response to recommendations from various inquiries and reviews reflect our determination to be a more outward facing, proactive and responsive regulator.

29 We will continue to provide updates on our work to address recommendations from all major inquiries and reviews on our website.