GMC submission to the CQC consultation on improving how it assesses and rates providers

The General Medical Council (GMC) regulates doctors, physician associates (PAs) and anaesthesia associates (AAs)[*] in the UK. We work with patients, the professionals we regulate, and other stakeholders to support good, safe patient care. This involves working in partnership with others to promote greater alignment between regulators at both a professional and system level.

As healthcare delivery becomes increasingly integrated – at the level of both professionals and organisations – it's more important than ever that there is a synergy between the expectations of professional and system regulators.

While providers will be better placed to respond to the majority of the questions you've posed, we have a keen interest in the content of your single assessment framework (SAF) and, more broadly, issues relating to equality, diversity and inclusion. Our submission will therefore focus on questions 3a and 8.

Drawing on our data and insights

Each year we publish four reports which provide analysis on the state of medical education and practice in the UK. These reports provide a unique, evidence-based perspective on the professionals we regulate and their workplace experiences. Our response to your consultation will draw partly on the data and insights[†] contained in the following:

- Our Workforce report presents findings from our analysis of trends in the number, demographics, and place of primary medical qualification of doctors holding a licence to practise in the UK.
- Our Workplace experiences report explores how doctors' experiences impact their practice and the care they provide to patients.
- Our Barometer survey is a tracking survey that we run every year to find out how doctors' experiences of practising in the UK are changing over time.
- Our National training survey asks trainees and trainers about their postgraduate medical education environment and experiences.

Consultation question 3a: Do you have any comments on the content of our current single assessment framework?

Key question 1 of the single assessment framework - Safe

Safeguarding

We set the values, knowledge, skills and behaviours expected of all doctors, PAs and AAs working in the UK. Our core guidance, *Good medical practice* (GMP), and the more detailed guidance which supports it, is an ethical framework which supports our registrants to deliver safe care to a good standard in the interests of patients. It applies to all our registrants - regardless of their

[*] We are aware that changes to these titles have been proposed in the Leng Review and the UK government is considering implementation. In the meantime, to make sure our regulatory processes and documentation remain clear and consistent, we are continuing to use the titles for our registered professionals that are currently set out in law.

[†] The data cited in this submission will be UK-wide unless otherwise stated.

specialty, grade, and area of work. It is therefore necessarily high level, in order to be widely applicable.

Your current quality statement in relation to safeguarding includes a requirement that 'There is a strong understanding of safeguarding and how to take appropriate action'. We suggest retaining this criterion. If you are considering changes to this, or if you develop rating characteristics and new supporting questions to help stakeholders understand the key areas you would be likely to assess, we would encourage you to ensure alignment with our own standards - we believe that alignment between the expectations of both professional and system regulators is vital for providing consistency for patients.

GMP provides guidance on safeguarding children and adults who are at risk of harm (at *paragraphs 41 and 42*) and we go further in our more detailed guidance *Protecting children and young people* and *0-18 years*.

We also provide advice on how our professional standards can be applied in the area of adult safeguarding, and signpost to relevant resources in our ethical hub topic.

Learning culture

We think this quality statement should better assess the complaint process and patient experience of raising concerns. And your statements should reflect that people feel listened to and that organisations are open and honest with them.

Key question 2 of the single assessment framework - Effective

How staff, teams and services work together

Your current quality statement in relation to how staff, teams and services work together includes a requirement that 'Information is shared between teams and services to ensure continuity of care, for example when clinical tasks are delegated or when people are referred between services.' We suggest retaining this criterion. If you are considering changes to this, or if you develop rating characteristics and new supporting questions, we would encourage you to ensure alignment with our own standards.

GMP provides guidance on delegating safely and appropriately (at *paragraphs 66 to 68*) and we also provide more detailed *guidance*. This is aligned with our guidance on *Decision making and consent*.

This quality statement also rightly focuses on joined-up care. But it should have a further assessment of team and organisational culture in order to reinforce that people must treat colleagues with respect, collaborate in the best interest of patients, and work together to solve problems.

Key question 3 of the single assessment framework - Caring

Kindness, compassion and dignity

Your current quality statement in relation to kindness, compassion and dignity includes a requirement that 'People feel they are treated with kindness, compassion and dignity in their day-to-day care and support'. Again, we suggest retaining this criterion. If you are considering changes to this, or if you develop rating characteristics and new supporting questions, we would encourage you to ensure alignment with our own standards.

GMP provides guidance on *Treating patients with kindness, courtesy and respect* (at *paragraph 23*).

Workforce wellbeing and enablement

There is strong evidence that healthcare environments that prioritise the health and wellbeing of their staff deliver better care. Staff wellbeing is linked to increased productivity and improved experiences for people using services - and the willingness of staff to continue working in challenging and complex environments. The workforce wellbeing and enablement element of the quality statement should therefore be retained.

Our workplace experiences reports have, for several years, highlighted a continuing cycle of workload pressures, low satisfaction and risk of burnout among doctors. Doctors' workplace experiences deteriorated sharply following the pandemic. Risk of burnout grew notably, while levels of job satisfaction declined. A build-up of pressures – including the pandemic but also longer-term challenges – has led to an increasingly fatigued and burnt-out profession.

Burnout and workload pressures adversely affect capacity and productivity. They also pose risks to retention and patient care. It is therefore vital that effective strategies to improve the wellbeing and retention of professionals are in place. Ensuring greater accountability for providers on this issue is an important part of this - retaining a focus on workforce wellbeing and enablement in the SAF is one way of achieving this.

Key question 4 of the single assessment framework - Responsive

Person centred care

Your current quality statement in relation to person-centred care sets the following expectation:

'We make sure people are at the centre of their care and treatment choices and we decide, in partnership with them, how to respond to any relevant changes in their needs'.

We suggest retaining this criterion. If you are considering changes to this, or if you develop rating characteristics and new supporting questions, we would encourage you to ensure alignment with our own standards.

GMP provides guidance on the sharing of information with patients (at *paragraphs 28 to 36*) which is central to good decision making. More detail about this is given in our guidance on *Decision making and consent*.

We also provide guidance on continuity of care in GMP (at *paragraph 65*) where we say that continuity of care is important for all patients, but especially those who may struggle to navigate their healthcare journey or advocate for themselves. Continuity is particularly important when care is shared between teams, between different members of the same team, or when patients are transferred between care providers.

Key question 5 of the single assessment framework – Well-led

Capable, compassionate and inclusive leaders

We work with partners across the UK health services to improve working cultures and environments to make them fair, supportive and inclusive for our registrants. So we have a strong interest in this aspect of the SAF.

There is robust evidence that healthcare environments that prioritise the health and wellbeing of their staff deliver better care. Capable, compassionate and inclusive leadership is integral to this. Yet 45% of doctors in the UK identify poor organisational leadership as a barrier to providing good patient care. And failures in leadership remain one of the most frequent factors cited in inquiries and reviews into patient safety failings.

We would therefore encourage you to retain this criterion. It is essential that leadership is more sharply focused on creating inclusive and supportive environments for healthcare professionals: prioritising staff wellbeing and leadership leads to higher quality patient care, higher levels of patient satisfaction, and the improved ability to retain talented professionals.

But we think there is an opportunity to go further in describing what's required to achieve the expectation set out in this quality statement. We would encourage you to strengthen your assessment criteria by requiring providers to:

- start and implement programmes of compassionate leadership and obtain feedback from healthcare professionals to evaluate its effectiveness – this should include mechanisms to ensure clinical leads and other leaders at all levels in the healthcare system are recruited, selected, developed, assessed and supported to model compassionate and collective leadership
- promote, enhance and drive improved leadership by ensuring equal access to leadership opportunities in order to create a leadership cadre that reflects the professions they represent and the communities they serve
- support the development of leadership at every level
- ensure meaningful buy-in from boards by requiring that they review data on leadership, team working and other indicators of culture and inclusion with a view to assessing performance and identifying areas for improvement (eg establishing a key performance indicator for voice and influence - and reviewing feedback to assess performance)
- introduce a key performance indicator for compassionate leadership and review feedback from healthcare staff to assess if leadership is compassionate and collective

- promote psychological safety by supporting staff to speak up about unprofessional behaviours
- ensure boards have an appropriate mix of skills and experience to ensure there is relevant understanding of the working environments in which staff are operating and the factors that hinder creating and maintaining supportive and inclusive working environments
- address issues of qualifications needed for board membership in order to to achieve a diversity of skills and experience at board level.

Freedom to speak up

Your current quality statement in relation to freedom to speak up sets the following expectation:

'There is a culture of speaking up where staff actively raise concerns and those who do (including external whistleblowers) are supported, without fear of detriment. When concerns are raised, leaders investigate sensitively and confidentially, and lessons are shared and acted on'.

We suggest retaining this criterion. If you are considering changes to this, or if you develop rating characteristics and new supporting questions, we would encourage you to ensure alignment with our own standards. At paragraph 58 of GMP we set out our expectations regarding witnessing unprofessional behaviours.

Your current quality statement in relation to freedom to speak up also sets the following expectation:

'When something goes wrong, people receive a sincere and timely apology and are told about any actions being taken to prevent the same happening again.'

We suggest retaining this. If you are considering changes, or if you develop rating characteristics and new supporting questions, we would encourage you to ensure alignment with our own standards.

Being open if things go wrong *(paragraph 45 of GMP)* is the professional duty to be open and honest with patients if things go wrong, and we provide *more detailed guidance* which supports what we say in GMP.

We also provide guidance on demonstrating leadership behaviours (at *paragraphs 60 to 64 of Good medical practice*) and go further in our more detailed guidance *Leadership and management*.

We provide advice and tools on how to follow the processes set out in our guidance around speaking up, whistleblowing and raising concerns in our ethical hub topic *Speaking up*.

Workforce equality, diversity and inclusion

More must also be done to tackle discrimination and improve workplace cultures.

The medical workforce is increasingly diverse. Doctors from an ethnic minority made up the majority of the medical workforce for the first time in 2024, and there were more female than male doctors on the UK register for the first time. Despite this increased diversity, protected characteristics are associated with disadvantage - particularly ethnicity and disability.

While joiners from abroad tend to report relatively positive experiences, they are less likely to report feeling supported in the workplace than UK graduates. Furthermore, ethnic minority UK graduates are at a higher risk of burnout than their white counterparts. And disabled doctors do not fare as well as their non-disabled colleagues on multiple measures. 38% of disabled doctors say they struggle with workload, and only 34% of ethnic minority UK graduates feel able to progress their careers in the way they'd like.

Ethnic minority UK graduates and non-UK graduates also report experiences of unfavourable bias and a lack of trust from senior doctors, leading to heightened anxiety and burnout.

We would therefore encourage you to retain this criterion.

Governance, management and sustainability

The assessment framework should take into account whether boards have clear sight - and open, proactive discussion - of risks to patent safety. Governance processes should be clear and followed in practice. And performance concerns should be escalated through a governance framework that is applied consistently and fairly across an organisation.

Consultation question 8: Do you think our proposals will affect some groups of people more than others?

Equality, diversity and inclusion

Our reflections on your Equality Impact Assessment (EqIA)

Our primary reflection is that this is brief but positive. It commits to engagement, co-production, and consultation – all of which we welcome. We are also pleased to see reference to equity-focused quality statements (ie equity in access; equity in experience and outcomes; workforce equality, diversity and inclusion; listening and involving people; providing information) and that these remain as priority topics in the assessment of services in all sectors.

We also note your commitment to ensure that evidence in the People's experience and Observation evidence categories continues to have balanced weighting in the assessment and scoring of relevant quality statements, including those that are equity-focused and those that are likely to identify human rights abuses (Assessing needs, Person-centred care, and Independence, choice and control).

Taken together, we are encouraged by this approach.

Our broader reflections on improving equality and human rights in your proposals

More generally we are supportive of your emphasis on promoting equality, diversity and inclusion (ED&I) and evidence-based decisions.

There are ED&I considerations present throughout all aspects of leadership, culture, and wellbeing. We also know that some groups experience differential treatment more than others in the workplace, and that this can impact on patient safety. It is therefore important to consider how organisational culture affects healthcare professionals and staff - and the resulting impact on patient safety. We suggest that organisations should be assessed on how they are meeting the needs of a diverse workforce and how they are demonstrating that they address the areas of their organisation where there are risks of bias.

It is also good to see the CQC has embedded the need to reduce health inequalities and associated opportunities, the balance of local collaboration and national coalitions, and commitments to collaborate on reducing inequalities through data sharing.

Taking this work forward

Broadly we think there is a good opportunity for the CQC to work closely with professional regulators as this work progresses - in particular as you develop your rating characteristics and new supporting questions relating to workforce ED&I. Our work on fairer employer referrals (FER) and fair training cultures (FTC) has provided strong evidence in this area which we think could help to inform your more detailed rating statements.

There will need to be some consideration of where thresholds for rating statements lie – and relating to ED&I, that a lot has changed and continues to change. The expectations of a high performing organisation a few years ago, may now reflect the minimum on ED&I. Organisations will also have new duties – like preventing sexual harassment – which they will need to consider when deciding where thresholds lie. This something that CQC will need to be open to collaborating with professional regulators on – as it relates to workforce ED&I.

The consultation indicates a move towards re-introducing more detailed rating characteristics. There needs to be an update from the previous versions and there is an opportunity here on what these ratings descriptors say in terms of ED&I. This would be a good opportunity for CQC to work with professional regulators to consult on the new descriptors relating to workforce ED&I – assuming that they existed in the well led domain. The GMC understands from the consultation that CQC intend to publish more detailed guide. If CQC are intending to write guidance on workforce ED&I standards and evidence, we would advise that CQC draw from professional regulators in this regard.

Finally, there are additional and more specific considerations, such as digital exclusion. New and innovative types of service have started up using digital channels and the growth of artificial intelligence and advances in data analytics. Inevitably these positives have a flipside – and it would be helpful to understand the risks associated with differences in digital accessibility; and how to ensure a representative and diverse set of perspectives.