General
Medical
Council

GMC submission to CQC consultation on sector-specific frameworks

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 we stated in our response to your previous consultation on improving how the CQC assesses and rates providers, it's more important than ever that there is synergy between the expectations of professional and system regulators. This is especially true as healthcare delivery becomes increasingly integrated – at the level of both professionals and organisations.

While providers will be better placed to respond to sector-specific elements of the consultation, we nevertheless have an interest in the content of assessments. In this submission, we highlight the aspects of the proposed frameworks that we welcome, particularly where they support clearer expectations, stronger alignment across regulation, and a focus on culture and safety. We also identify the areas where we think further attention is needed, including where the frameworks would benefit from greater specificity, stronger expectations, or clearer evidence requirements.

The key points in our submission are that:

- safe staffing is not limited to alignment with standards but extends to safe delegation, handover, revalidation and assessments, and training and learning
- the frameworks align well with GMC professional standards
- assessment of staff use of AI as a clinical tool needs to be expanded upon
- culture is central to care but assessment parameters need specificity, evaluating aspects like team working, speaking up, and training – which link with safe cultures
- clinical governance and local investigations require clearer assessment parameters around local and disciplinary governance processes, as well as examination of internal investigations policies and leadership/management training, safeguarding and accountability culture, and prevention

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* 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.

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You are welcome to contact us in Welsh. We will respond in Welsh, without this causing additional delay.

- workforce equality and equity require understanding that unequal experiences impact care, and effective governance requires an inclusion lens
- embedding sustainability in strategic decision-making is necessary to achieve outcomes in the longer term.

Overall feedback on the draft frameworks

The revised frameworks are welcomed. They are clear and set out the general expectations for each Key Line of Enquiry (KLOE) and how to achieve specific ratings.

We have previously encouraged alignment with GMC professional standards (Good medical practice) and related guidance and, overall, we feel the frameworks and standards align well. In particular we welcome the alignment with our standards on dignity, respect, fair treatment, communication, consent, and involving patients in decisions about their care.

Key question: Is the service safe?

Safe staffing: support, revalidation and broader alignment

It is positive to see there is a focus on workforce and the impacts this can have if it's not at the right level, including to patient safety and increased pressure on other staff.

While the scope of this KLOE is broadly welcome, we think it could go further in several respects.

Beyond *levels* of staff, the CQC should assess the robustness of inductions and ongoing support. It could explore whether staff (including locum staff) brought into an organisation are adequately supported through structured induction periods and ongoing mentorship. The assessment parameters should also look at how staff are integrated and retained. Assessing the presence of tailored induction programmes and culturally-safe onboarding is vital for both retention and patient safety and aligns with our own organisational messaging in 'The state of medical education and practice in the UK' reports.

Revalidation and/or periodic assessment coverage is also limited. Frameworks include "skills and qualifications and revalidation" under safe staffing, but the descriptors at every rating level don't engage with what revalidation requires or how it connects to assuring safe clinical practice. Clear alignment with our revalidation standards (and those of other regulators) could strengthen both documents.

Finally, it will also be important for the frameworks to align with the staffing standards that are being developed by NHS England (NHSE). If the staffing standards are to become a reality they must be embedded in how provider performance is measured and evaluated.

Safe staffing: learning, development and competence

Overall, from an education and training standpoint, the GMC are supportive of the updated sector-specific assessment frameworks. However, there are some areas where we think greater clarification would be beneficial.

Patient-centred care is a core principle which will inform the design of our education framework. When patient experience is prioritised, it leads to better outcomes. There is also a clear link between patient safety and professional development. All staff – not just those in formal training – should have the support and training needed to carry out their roles safely.

We therefore welcome the recognition of staff knowledge, skills, and experience development, which aligns with our project on the future of education and career development (FutureEd) and the wider importance of investing in learning to support safe, high-quality care.

Wellbeing and psychological safety are also essential to effective learning, and it is positive that the frameworks place responsibility on organisations to create supportive learning environments and give educators the time and support they need.

It would be valuable to see more detail on expectations for supporting supervisors, educators, and assessors, and the governance expectations on organisations and how they are held accountable for prioritising the provision of education and learning. The GMC regularly observes concerns about these issues within our Quality Assurance, Monitoring, and Improvement (QAMI) work.

Supervision and assessment receive minimal mention and there are no specifics on how supervisors can be supported by organisations to ensure they have the time and resources to effectively carry out their role and responsibilities – which are vital to patient safety. Additionally, we would also want to see greater emphasis on the importance of learning environments with stronger expectations on organisations to provide time and resource for education and learning.

Doctors, PAs, and AAs in training, and medical students, are also absent as the frameworks don't acknowledge the learning environment as a patient safety variable. Educational governance, supervision quality, training post capacity, and the wellbeing of trainers and learners within and across professional groups are safety issues – their omission is a notable gap from an education standards stance. The GMC's delivery standards for the providers of medical education and training may be helpful in this regard, specifically.

- The requirements that apply to the organisational culture within CQC-accredited environments: R1.1, R1.2, R1.3 and R1.4 (Page 10), R1.7 (page 11)
- The requirements that apply to the processes that CQC-accredited environments have that ensure safe supervision and learning: R2.11 (page 20), R2.16 and R2.17 (page 21)
- The requirements that apply to the experience of learners in CQC-accredited environments: R3.13 (page 26), R3.14 (page 27)
- The requirements that apply to educators teaching and supervising in CQC-accredited environments: R4.1 and R4.2 (page 30).

Safe environments and infection prevention and control

There could be greater detail on what is meant by 'fit for purpose' AI technology. AI is treated as part of healthcare infrastructure rather than a clinical competency issue with no consideration to how staff can use or critically evaluate AI tools, the governance of AI-assisted clinical decision-making, or accountability when AI is in a care pathway. This is a gap that we would encourage CQC to address more substantively across the rating levels.

Key question: Is the service well-led?

Workforce equity and culture: support, speaking up and staff safety

The emphasis on open and supportive workplace cultures, leadership, speaking up, and just culture is welcome and aligns with the GMC's approach to safe, inclusive care.

While we support the overarching outcomes outlined in the staff and culture sections of the proposed KLOEs, we are concerned that they remain too abstract to ensure consistent inspection or meaningful provider accountability. There needs to be specificity in evaluation, as high-level metrics risk missing systemic cultural issues if they lack detail on *how* they will be evaluated.

Culture links to - and directly impacts - teamworking and service effectiveness. Assessments should consider collaboration, respect, and behaviours across teams, not only operational coordination, because these factors influence safety and outcomes. These aspects are emphasised in Good medical practice, which promotes respectful, inclusive, and compassionate working environments, marked by effective teamworking, communication, continuous learning, and accountability.

For a specific example, the inclusion of sexual safety as a measure is welcome, but the framework currently lacks detail on how this will be assessed. To drive real improvement, the CQC should cite specific, concrete operational benchmarks within the framework. Inspections should actively evaluate, for instance, whether Trusts have embedded specialist investigators for sexual misconduct and whether clear pathways exist to support victims.

In terms of speaking up and culture, it would be good for the CQC to measure this from a medical workforce perspective, triangulating across to National Training Surveys, and other sources of workforce data.

We also suggest the framework explicitly looks at whether postgraduate medical education and training are actively prioritised and protected by leadership, as high-quality training environments directly correlate with safer patient care. A positive learning culture also relies on supportive team working within multidisciplinary teams (MDTs).

Workforce equity and culture: diversity and equitable treatment of staff

Our research indicates that there is rising workforce diversity, but unequal experiences remain: disadvantage continues to correlate with protected characteristics, including ethnicity and disability.

There are also nuances regarding experiences. Different patterns exist for ethnic minority doctors and international medical graduates (IMGs) and there are variations in reported experience and support, including perceptions of bias and lack of trust – which can contribute to stress and burnout. Disabled doctors in particular report worse outcomes on key measures, including disproportionate difficulty with workload and workplace adjustments. And more needs to be done to prevent sexism and sexual misconduct, and to support those impacted.

These issues are not ancillary to quality: they are integral to safe care, retention, wellbeing and public confidence. Quality assessment should therefore include whether providers identify and address discrimination and differential experience. 'Good' must also reflect current expectations.

Rating characteristics and thresholds for workforce equality, diversity and inclusion (ED&I) need to keep pace with raised baseline expectations and changing employer duties, including preventing and responding to harassment.

Clinical governance must also be viewed through an inclusion lens. The framework should look for active evidence of compassionate leadership that listens to and tackles concerns fairly, backed by robust, proactive policies designed to eliminate discrimination against minority or international staff groups.

The GMC encourages CQC to work with professional regulators to develop and apply robust workforce ED&I prompts, guidance and evidence expectations, drawing on existing work on fair training, and fair referrals.

Governance

It is positive to see that organisations will be assessed on the clarity and effectiveness of their governance structures, and how efficiently they enable decision making.

The CQC could also include clear assessment parameters around local disciplinary and clinical governance processes. The assessment needs to be able to reliably identify cultural and governance drivers of safety and quality, including freedom to speak up and inclusive leadership. Leadership is a recurring driver of safety and quality failures, as inquiry findings and staff feedback have repeatedly pointed to organisational leadership as a barrier to delivering good care.

Inspections should evaluate whether an organisation's internal investigation policies are fair, compassionate, and proportionate – rather than punitive. There should be some assessment of how well organisations listen to patients, families, and staff when things go wrong, with an organisational response of openness, learning, and candour.

One aspect of this is CQC's assessment of whether the staff responsible for executing local investigations are adequately trained in their proper, unbiased use. The frameworks also need to set out clear expectations that organisations will have systems to monitor the conduct and performance of clinical staff and to identify, investigate and manage concerns early.

Safeguarding responsibilities must be assessed consistently and remain visible in expectations about safety. Board accountability and 'line of sight' on culture also needs to be a considered. Boards should review meaningful data on culture, inclusion, speaking up, and team functioning – and act on it.

Strategic direction: environmental sustainability

Delivering healthcare with due consideration for environmental sustainability is also increasingly important. How that is embedded into standards for organisations and expected outcomes for learners will be a key consideration in the development of the GMC's new education frameworks. As such, we are encouraged to see the assessment frameworks include environmental sustainability and how it is embedded at a strategic decision-making level.