To consider

Proposals for increased sharing of information with the Care Quality Commission

Issue
1. Proposals for increased sharing of information with the Care Quality Commission.

Recommendation
2. The Strategy and Policy Board is asked to approve the proposals jointly developed with the Care Quality Commission for increased information sharing.
Proposals for increased sharing of information with the Care Quality Commission

Issue

Information Sharing

3 The Care Quality Commission (CQC) is responsible for setting standards in the quality and safety of healthcare delivered by providers (including, hospitals, clinics, dentists, community care providers and General Practice surgeries, etc.) through monitoring, inspection and regulation.

4 We routinely share relevant information relating to individual concerns as they arise during the course of our investigations. However, the Public Inquiry into the failings of the Mid-Staffordshire NHS Foundation Trust, culminating in the Francis Report, identified the need for the different regulatory bodies to develop closer working relationships to reduce the risk of harm to patients*.

5 We proactively share information with the CQC which supports the CQC inspection programme and intelligence monitoring model. We do this in accordance with our powers under Section 35(B)(2)(b) of the Medical Act 1983 (the Act) and under paragraph 9, Schedule 1 of the Act, and this information exchange is supported by the Operational Protocol developed with the CQC.

6 The CQC shares information with the GMC where it identifies concerns about an individual doctor's fitness to practise during the course of its inspections. We have been working closely with the CQC to develop thresholds for information sharing as part of the Operational Protocol. This is to ensure that all relevant information is shared as soon as possible to enable us to investigate and take action when necessary.

Our current approach

7 Where we receive information that highlights a failure in a healthcare provider's systems, e.g. where a hospital is not managed properly or where measures in place to safeguard patients are not being adhered to, we share these concerns with the CQC immediately or as soon as it is possible.

8 The majority of information shared between us and the CQC relates to 'system concerns' or aggregate data, rather than personal information relating to doctors.

* recommendation 234 of The Mid Staffordshire NHS Foundation Trust Public Enquiry Report 2013
9 We are developing a closer working relationship with the CQC to maximise the protection afforded to the public receiving healthcare and to minimise the time taken to resolve issues identified at an early stage.

10 We have developed a framework to support that relationship with the CQC, which includes the appointment of an Information Sharing Officer within the GMC, regular meetings between both regulators, an Operational Protocol, and a Memorandum of Understanding (MoU) between the GMC and the CQC. A joint training programme has also been developed and will be launched on 1 December 2014 at both the GMC and CQC offices.

11 The Operational Protocol provides guidance and signposting for all Directorates to support the information sharing process. However the focus of the development work has initially been in relation to information held by the Fitness to Practise (FtP) directorate and the proposed approach below relates to FtP information. Further joint meetings have been scheduled for December 2014 and January 2015 to review the information sharing categories and processes for sharing concerns within the Education and Standards, and the Registration and Revalidation directorates.

Proposed approach

12 We propose to continue sharing information which supports the role of the CQC and in light of the Francis Report, to increase the amount of information we share. We will do this when we receive information that highlights a concern that does not pose an immediate risk to patients but the information could inform the CQC inspection programme and intelligence monitoring model. In these cases a high level summary report will be provided to the CQC on a monthly basis. Examples of the types of cases in this category include:

a Unhygienic ward as the floor wasn’t cleaned on one occasion.

b Equipment wasn’t working in a General Practice surgery so the patient had to move to another surgery.

c Patient stated that staff in a hospital showed no respect or failed to treat him/her with dignity when changing a dressing.

13 It should be noted where it is deemed that a concern could cause immediate or high risk to patients, these concerns will be shared with the CQC immediately or as soon as it is possible.

14 We will seek consent from a complainant in all cases where we intend to share patient identifiable data with the CQC.
If we do not have the complainants consent to share their information, all personal and irrelevant data will be redacted unless there is a risk of serious harm posed to patients in which case it may be in the public interest to share such information.1

Given that the information shared with the CQC relates to system concerns, rather than particular groups of doctors no equality and diversity issues have been identified.
Supporting information

How this issue relates to the corporate strategy and business plan

17 This issue relates to Strategic Aim 3 of the Corporate Strategy: to improve the level of engagement and efficiency in the handling of complaints and concerns about patient safety.

How the issues support the principles of better regulation

18 The Francis Report identified the need for the different regulatory bodies to develop closer working relationships with the Care Quality Commission. Our proposals will give a consistent approach to our working partnership with the CQC. We will continue to consult with the CQC for agreement on our protocol as part of the joint working framework. We aim to maximise the protection afforded to the public involved in the healthcare system and to minimise the time taken to resolve issues identified at an early stage with the development of a closer working framework.

How the action will be evaluated

19 The CQC has commenced an evaluation of the impact of our joint working relationship the results of which will be ready in the spring of 2015. We continue to monitor the statistics and provide status reports whilst considering workshops to support our joint working framework.

What engagement approach has been used to inform the work (and what further communication and engagement is needed)

20 We have engaged in Workshops with the CQC, Monthly Operational Meetings, and Quarterly Joint Working Groups. We have developed an internal user group to monitor our systems and policy on the increased sharing of information with the CQC. A joint training programme has been developed and will be launched on 1 December 2014 at both the GMC and CQC offices. Our approach to sharing information has been informed by advice from GMC Legal and other internal guidance documents on consent and disclosure.

How the issues differ across the four UK countries

21 It is anticipated that the approach being developed by the GMC with the CQC will be used as a template for the rest of the UK. A separate piece of work is taking place to develop MOUs and protocols for the devolved countries.

If you have any questions about this paper please contact: Joanna Farrell, Assistant Director of Investigations, JFarrell@gmc-uk.org, 0161 923 6507.

1 Section 35 (B) (2) (b) of the Medical Act (the Act) and under paragraph 9, Schedule 1.