General Medical Council

Regulating doctors
Ensuring good medical practice

The General Medical Council response to the report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry

Patients and their families were badly let down by the failures of care at Mid-Staffordshire NHS Trust. We are determined to play our part by helping to raise standards to try to ensure this never happens again.

As the Francis Report recognised, we have already taken some important steps to help create a safer health service for patients, particularly with the roll out of regular checks for doctors with the introduction of revalidation, the setting up of local GMC teams to work with the NHS, doctors and patients, and through the major reforms of our fitness to practise procedures which are designed to speed up and improve what we do.

We have made progress, but we know there is more to do. If we are to help prevent another tragedy and improve care for patients we, along with everyone else in the healthcare system, need to work together.

The reforms we have underway reflect our determination to be a more outward facing, proactive and responsive regulator. In this initial report we have responded to each of Robert Francis' recommendations and provided further detail of what we are attempting to do.

We will continue to keep this information updated as we work with others to help create a safer, more compassionate and more effective healthcare system for patients.

Niall Dickson
Chief Executive
General Medical Council

The Recommendations

We have identified 24 recommendations with specific impact on our work, 17 of which name us directly. We have set out our initial response to these recommendations under the themes identified in the Report.

For each theme we have set out some of the work we are already undertaking and provided a table with the relevant recommendations and our initial responses, including how we will take forward the recommendations in the context of our ongoing programme of reform.

We will be reporting on progress every six months on a section of our website dedicated to the Francis Report.

Medical training and education

Medical training

Education is one of our core statutory functions. High quality medical education and training is essential for patients now and in the future. The Francis Report identified several areas of concern about the education and training of doctors and we are mindful, that while improvements have been made since the events at Stafford Hospital, there is still a great deal of work to be done.

Last year we began a comprehensive review of our approach to assuring the quality of all stages of medical education and training in the UK. This will report towards the end of 2013 (the education QA review).

In 2010, the GMC took over responsibility for postgraduate education from the Postgraduate Medical Education and Training Board (PMETB). This gave us responsibility for regulating all stages of medical education and training in the UK. As a result we decided to undertake a major review to develop a more consistent approach to how we assure the quality of education at all stages in a medical career. The review was also prompted by changes to NHS education structures in England and failures within some hospitals which deliver training (including Mid Staffordshire).

The review will report by the end of 2013. It is exploring a range of issues, including: our standards for medical education and training; the approach to visits and inspections; how we measure and report performance (including the transparency of such reporting); whether there is a case for approving educational environments; responding to concerns; the role of medical Royal Colleges; and ensuring consistency in the way we approve against standards.

While regulation is often about powers directly exercised by regulators, it is also crucially about the influence they can bring. Regulators should be an authoritative voice, supporting professionals, promoting professionalism and promoting and protecting standards. For regulators such as the GMC who have a critical role in

education, this supportive role for those involved in providing and receiving education and training is vital. We recognise too that education, training and continued professional development will play an important role in addressing the cultural issues that Robert Francis highlights throughout his report. We know students, trainees and doctors are aware of our guidance, but we also know it needs to be useful, relevant and accessible to them in their front line care. We are therefore planning a major programme of work to engage doctors and medical students in discussions about professional standards and to do everything we can to ensure our guidance is firmly embedded in everyday clinical practice. We have undertaken further research to support this, including examining barriers and incentives in the workplace and factors that encourage good practice.

Recommendation	GMC Initial Response
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.	We agree. We work with many other organisations, including other regulators and bodies representing patients and doctors, such as the CQC, in order to share information. We recognise too that as a professional regulator we must be part of a wider system committed to improving the quality and safety of care. We are determined to strengthen our information sharing relationships and are currently building a new operational model for sharing information with CQC. We will also continue to work with other regulators and organisations such as the medical Royal Colleges to improve how we share information so that everyone is assured that concerns will be raised with the appropriate organisation and action taken when required.
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	We agree. These duties must be reciprocal and in consultation with the devolved administrations we would wish them to apply across the UK.

aware of matters of concern relevant to their responsibilities.	
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: **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.** **The Department of Health should provide appropriate resources to ensure that an effective programme of monitoring training by visits can be carried out.** **All healthcare organisations must be required to release healthcare professionals to support the visits programme. It should also be recognised that the**	We are committed to a thorough and consistent inspection regime and we are addressing all of the issues raised in points a-d of this recommendation in our review of quality assurance in education. On the final point, we would fully support a requirement on healthcare organisations to release healthcare professionals to support statutory inspections and visits and we agree that it is a benefit to professional development. In February 2012, our Chair, Professor Sir Peter Rubin, and the four UK Chief Medical Officers wrote a joint letter to NHS organisations setting out the importance of releasing clinical staff to perform roles that improve the overall quality of patient care, medical education and the effective running of the health service.

benefits in professional development and dissemination of good practice are of significant value.	
156. The system for approving and accrediting training placement providers and programmes should be configured to apply the principles set out above.	We will consider this in our education QA review.

Matters to be reported to the General Medical Council; Training and training establishments as a source of safety and information

To be an effective regulator we need high quality information. This includes both information from other organisations and feedback directly from students, trainers, other doctors and patients. As discussed below in relation to recommendations 224 and 233-234 we are working with other regulators, Health Education England, deaneries, Medical Schools, and Royal Colleges to ensure we are sharing information effectively.

In 2012, for the first time, we introduced a specific patient safety question in our annual survey of doctors in training. Of the 51,000 doctors in training who completed the survey (a 95% response rate), approximately 2,400 (4.7%) reported a patient safety concern and 23% of the concerns had not previously been reported locally. This has enabled us to identify and follow up risks to patient safety about which neither we, nor the deaneries, were previously aware. We have included patient safety questions in the 2013 survey, released in March and will again follow up every concern and publish the results.

Last year, we launched a confidential helpline for doctors concerned about patient safety. It is aimed at those who want advice and support about our guidance or who feel they cannot raise a concern locally. We have also produced an online tool to guide them through the process of raising concerns and produced new guidance on *Raising and acting on concerns about patient safety* which we have sent to every doctor in the UK. This guidance includes advice on when it would be appropriate to involve a regulator, what protections are offered by law for individuals and how to make public interest disclosures.

We know that culture is an important part of ensuring we receive information about concerns and as discussed in the previous section we are planning a major programme of work to engage doctors and students in discussion about professional standards and our guidance. We are working with other health professions regulators to support the NHS Employers Whistleblowing Charter and we expect that employers throughout the NHS and beyond will seek to implement the steps in the statement.

Recommendation	GMC Initial Response
157. The General Medical Council should set out a clear statement of what matters deaneries are required to report to the General Medical Council either routinely or as they arise. Reports should include a description of all relevant activity and findings and not be limited to exceptional matters of perceived non-compliance with standards.	Deaneries are required to submit an annual report to us. This is based on a template we provide setting out what must be included - for example information about concerns and good practice. They are also required to produce action plans which we publish on our website. In the light of this recommendation we will consider how we can improve the value of deanery reports and this will be included in our review of quality assurance in education.
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.	Feedback from students and tutors is a key component of quality education and patient safety - we will consider this recommendation as part of our education QA review.
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.	We agree that surveys of medical students and doctors in training are vital in assessing the quality of education and can be an important tool in evaluating the standards of care provided to patients. We are now including questions about the quality of care provided to patients in the National Training Survey. We survey medical students ahead of formal visits to their medical schools, and we are committed to consider whether we should survey all medical students on an annual basis, as we do with doctors in training. We will take forward the issues raised in this recommendation as we develop our survey work.
160. Proactive steps need to be taken to encourage	We believe some good progress has been made in this area, including through the inclusion of a

openness on the part of trainees and to protect them from any adverse consequences in relation to raising concerns.	patient safety question in the National Training Survey, the development of new guidance on raising concerns and the introduction of our new confidential helpline for doctors. But we also accept that more needs to be done to raise awareness and encourage openness. We will include this in our planned programme to engage with students and doctors in training in discussions about professional standards (see above, page 3).
161. Training visits should make an important contribution to the protection of patients: **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.** **Visits of this nature will encourage the transparency that is so vital to the preservation of minimum standards.**	We agree that visits/inspections are an important tool for assuring high quality training and protection of patients, and they form a major part of our existing quality assurance programme. The education QA review is looking at how we can strengthen the role of visits/inspections and at how we report on them. In the meantime, from the summer of 2013, where we have validated any concern about an educational setting we will publish that information on our website.
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	We agree that this is a fundamentally important principle. We give it prominence in our guidance for doctors, *Good medical practice*. Patient Safety is the first domain in our standards for education. The question of how we can be assured of the adequacy and appropriateness of the training environment is a key consideration of our

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.	education QA review.

Safe staff numbers and skills

Our role in education is to decide whether undergraduate schools are entitled to issue medical degrees; approve curricula, assessment systems and training programmes, posts and trainers for postgraduate medical education; and publish guidance on the principles for continued professional development. We do this by setting standards for entry into education and training, curricula and outcomes, and methods of assessment.

On 1 April 2013, significant changes were made to the structure of the NHS in England, including changes to the national leadership for professional education, training, and workforce development. These changes established a new agency, Health Education England (HEE), and have changed the relationships of various organisations, including Local Education Training Boards and deaneries and the role of these organisations in the oversight of medical education and training. We decide whether or not to approve curricula and assessment systems, training programmes, GP trainers and training posts. We can withdraw approval or make approval subject to conditions as we see fit.

Recommendation	GMC Initial Response
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	We agree. Domain 8 of our standards for training deals with educational resources and capacity and provides, among other things, that there must be a suitable ratio of trainers to trainees. What this will mean in any given situation will depend on a range of factors best determined by those responsible for delivering the educational

and skills of available staff for the provision of training and to ensure patient safety in the course of training.	programme. We are looking at our standards for delivery of education and training within the QA review, and will consider whether the standard should be more specific while allowing necessary scope for local flexibility.

Approved Practice Settings

We agree that it is important to ensure that doctors who are newly registered or unfamiliar with the UK practice are given appropriate support and oversight. The Approved Practice Setting (APS) scheme was designed to achieve this, although its impact has been minimal.

We believe that APS needs to be reviewed in the light of the launch of revalidation in December 2012. This has had a significant impact on the way all licensed doctors are supervised and evaluated, including those who are new to practice.

Under revalidation all licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise. In effect they must all be part of a governed system.

The Responsible Officer Regulations, introduced by the UK Government in January 2011, provided a statutory framework for connecting every licensed doctor with a 'designated body' and a Responsible Officer. Every NHS organisation is a designated body and now has a statutory duty to evaluate the fitness to practise of those licensed doctors with whom it has a connection. Responsible Officers are senior licensed doctors in each designated body who have a responsibility for ensuring that there are processes in place to evaluate their doctors (through a system of annual appraisal and clinical governance) and for making periodic recommendations to the GMC on their revalidation. They are also responsible for dealing with practice concerns as they arise and for referring doctors to the GMC where those concerns are significant.

Given this significant change, we need to consider whether APS continues to provide any additional assurance in relation to doctors who are new to UK practice. In December 2011, the GMC's Council took the view that the APS system would no longer be of value once the RO regulations and revalidation were embedded in healthcare organisations but we will consider this position in light of the recommendations in the Francis Report.

In the meantime, we are required to operate the APS scheme and we want to do that in the most effective way possible. Accordingly, we have begun a review of APS to evaluate our current approach. The review will consider the legislative framework, the current powers that we have, the criteria we apply and the processes we have in place to ensure compliance. The review will report in late summer 2013.

Recommendation	GMC Initial Response
164. The Department of	We are undertaking a fundamental review 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.	APS. The review will consider whether APS continues to add value, in the light of developments since its introduction, and whether any change to the legislation is necessary.
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.	We are undertaking a fundamental review of APS. The review will consider the issue of resources and whether any change is needed to the criteria.
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.	The review of APS will look at the procedures for assuring compliance. We are also reviewing our data strategy and pursuing closer cooperation and information sharing with a variety of organisations, discussed in greater detail below at recommendations 224 and 233–234.
167. The Department of Health and the General Medical Council should review the powers available	We will include these issues in the scope of the fundamental review of APS and then discuss next steps with the Department of Health.

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.	Both the review of APS and the education QA review will address this issue. We will ensure that the reviews work together to consider this.

Proficiency in the English language

We have made considerable progress working with the Department of Health towards ensuring that doctors working in the UK can speak English proficiently. Our ability to assess doctors' English language skills is covered by both domestic and European legislation. At present, we can test the language skill of doctors who have qualified outside Europe before we register them, but we cannot do the same for doctors who qualified within the European Union.

On 25 February 2013, the Health Minister announced the Government's plans to give us new powers to check the language skills of doctors who qualified in Europe. We are working closely with Department of Health to ensure that the necessary legislative changes can be introduced as quickly as possible. In the meantime, the Department of Health has taken steps to strengthen measures to protect patients in England by placing a mandatory duty on responsible officers to ensure that the doctors they recruit and appoint are able to communicate effectively before taking up a post. We are working with NHS Employers and others to ensure responsible officers are clear about these responsibilities. We have also discussed these additional responsibilities with officials in Scotland, Wales and Northern Ireland to explore the best way of achieving the same level of assurance for the public in these

jurisdictions, while recognising that the response of the health systems to this issue is a matter for the devolved administrations.

We have also been engaging with the UK Government, European Union institutions and other UK and European regulators on the current review of the Recognition of Professional Qualifications Directive. Our aim has been to ensure that the revised Directive will enhance patient safety and clarify that healthcare professional regulators can check the language skills of migrating professionals.

Recommendation	GMC Initial Response
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.	We agree that this is an urgent issue and have been clear about our position – that patients must be confident that the doctor who treats them has the right communication skills to do the job. At present, we can test the language skill of doctors who have qualified outside Europe before we register them but we cannot do the same for doctors who qualified within the European Union. On 25 February 2013, the Health Minister's announced the Government's plans to give us new powers to check the language skills of doctors who qualified in Europe. We are working closely with Department of Health to ensure that the necessary changes legislative changes can be introduced as quickly as possible.

Professional regulation of fitness to practise

Systemic investigation where needed; Enhanced resources; Peer review

The Francis Report rightly identifies the problem of 'generic concerns' that can arise when a department or team is performing badly but where no one individual has been singled out. This is certainly an area we wish to explore. We recognise that there is a need for all regulators - ourselves included - to help identify problems before they have an impact on patient care. At the same time we must ensure there are clear lines of responsibility between system and professional regulators, that they know when to involve the other, and that they are able to contribute their expertise and exercise their powers and influence when it is appropriate to do so. While accepting that there is a need for a better set of mechanisms for dealing with generic concerns we wish to discuss this recommendation with CQC and the Department of Health to ensure we find the best way forward.

Effective regulation is not only about our powers, but also the influence we are able to exercise on the professionals we regulate. This requires direct regular contact and dialogue with patients, employers, and doctors. In the last two years we have developed a much stronger local presence by setting up two new liaison services that engage with health services, the profession and patients. The Employer Liaison Advisers and the Regional Liaison Advisers work with patients and those who oversee and deliver frontline healthcare and medical education. This is a key part of our strategy to be more outward facing and engaged.

Employer Liaison Advisers (ELAs) have face-to-face contact with every Medical Director/Responsible Officer in the country, supporting and advising them as they manage their list of doctors. In this way the advisors help to ensure that employers identify fitness to practise concerns about doctors at an early stage, and deal with them in a way that protects patients.

The Regional Liaison Advisers (RLAs) in England work with patient groups, individual doctors, including doctors in training and medical students, medical schools and local medical organisations. Their role is to understand the needs of these groups at local level, gather intelligence, and promote our work, and especially the professional standards we require doctors to meet. They will also work with local staff from system regulators, sharing intelligence and making sure our activities are coordinated.

These teams are in the early days of operation, but we believe they are already helping to give us a better understanding of what is happening at the clinical frontline and in strengthening our local relationships. We will review the effectiveness of both services as they develop, and reflect on any lessons from the Francis Report to consider what more we can do.

While the future does lie in more ‘active’ regulation, we believe that should mean working collaboratively and proactively with those who deliver care and the organisations in which they work. We need to use data and intelligence to help identify areas of risk – the answer may lie in smarter rather than more regulation. An important aspect of this will be cooperation with other organisations, which is discussed in more detail in our consideration of recommendations 224 and 233-234. In circumstances of generic concerns, there may be failure among one professional group, but often it will involve more than one, and it will be linked to the context of the organisation and its systems of management and governance. This is a good example of where it is important to understand the boundaries of professional regulation and the relationships of regulators and organisations.

The task of identifying generic concerns that would trigger action is itself quite challenging. It would involve identifying mechanisms by which a generic concern may be raised, such as through direct report, or through our own analysis of data (death rates, training survey, volumes of patient complaints - including complaints that do not meet thresholds, and if a Trust has settled a class action).

We regularly audit our actions and the outcomes of fitness to practise cases to ensure we are handling complaints correctly and that we learn from each case.

Alongside this, we have commissioned an independent review by a leading QC of our actions and the outcomes of the 64 cases involving Mid-Staffordshire NHS Foundation Trust doctors. We will consider whether there are any lessons for us and others regarding these individual cases and their relevance to the systemic failures at that hospital.

In addition to reviewing our own information, we believe that analysing and sharing the information we hold is another way in which we can be more proactive by finding ways to support and improve good medical practice rather than waiting for things to go wrong. In September 2011, we published our first report on the state of medical education and practice in the UK. The report drew on our own and others' data to provide a picture of the medical profession and to highlight some of the on-going challenges that we and others need to address. It was widely welcomed, and in 2012 we published a second report that developed these insights to identify what we know to be the barriers and enablers to good medical practice. This work continues to help inform our future external engagement and we are committed to building upon it in our 2013 report to build a better understanding of what our data tells us and others about the risks in the healthcare environment.

Recommendation	GMC Initial Response
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.	We recognise the need for us to contribute to the identification and in some cases the investigation of generic concerns. We would like to explore with the Department of Health and others how best this could be achieved. We have made significant progress in recent years to become a more proactive and collaborative regulator. We are continuing that work, for example, through further development of the liaison services, carefully considering our data strategy and regulatory collaboration.
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.	As outlined in our response to recommendations 224 and 233-234 we are determined to improve the way we share information and work with other regulators and organisations such as the medical Royal Colleges.
225. The General Medical	As detailed in our discussion of

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.	recommendations 222-223, we will consider how we can contribute to helping identify generic concerns. The key issue from our perspective is how to use the available data to identify unacceptable patient care and the joint approach necessary by national bodies in order to respond to this. We recognise and agree with the benefits of peer-review as outlined in the Report. However, we do not believe that we should take forward such an initiative in isolation. We would be happy to discuss with others (eg CQC/NMC) the extent to which a triggered response to identified risk should be jointly owned.

Information sharing; For joint action with the NMC – cooperation with the Care Quality Commission

We support the call for closer collaboration between professional regulators and other organisations. It is also clear that we must be more engaged locally and put in place measures that enable us to be more effective at spotting problems earlier. We have started to do this with the liaison services, participation in the Quality Surveillance Groups recently established in England, increased publication of our data, as well as meetings with doctors and patients, but there is more to do.

In addition to these initiatives, we continue to work with many other organisations, including other regulators and organisations representing patients and doctors, to share information, ideas, promote good medical practice and support health professionals. A key part of this is using our data and insights to strengthen how we can work better together to enhance patient safety. We are committed to turning data into intelligence to help identify areas of risk where we and others can take action to ensure regulation is proportionate and more targeted than in the past. As part of this commitment we are reviewing our data strategy and pursuing closer cooperation and information sharing with a variety of organisations.

In particular, we have been building on our Memorandum of Understanding with CQC, to deliver an operational model that supports effective partnership working. We have systems for sharing information with the CQC at different levels within the two organisations and on high risk sites employing doctors in training. We now also work with the NMC and CQC to respond to emerging high risk situations.

In addition, we are represented on the National Quality Board and work with the new Quality Surveillance Groups to share intelligence and agree how we can best work together where we believe patient safety may be at risk.

Recommendation	GMC Initial Response
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.	We agree that the exchange of information with Royal Colleges should be further systematised. We are considering how this can best be achieved through our education QA review.
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.	We agree that it is important to ensure that patients have access to the appropriate information. Our website is an important source of information for patients and the 'for patients' section of our site receives 5000 hits every month. We are conducting a review of our website in 2013 and that will include improved accessibility and information for patients. This year we are going to review what each group with a key interest in our work need to know, as well as when and how we communicate that information with them. This will include consideration as to whether patients need information about the GMC when they visit hospitals and GP surgeries.
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.	As outlined above, we have been working closely with the CQC to build on our Memorandum of Understanding. The emphasis is on joint working to address emerging issues, on systematically sharing information and on coordinating activity where possible.

Joint proceedings

We are engaged in a major programme to reform our fitness to practise processes. We are determined to speed up our investigations work, modernise and streamline our adjudication procedures and strengthen confidence in the independence of our adjudication function and in the process as a whole.

One of our most significant reforms has been the launch of the Medical Practitioners Tribunal Service (MPTS) in June 2012, which created a clear separation between our role as investigator and presenter of cases from the adjudication of those cases. The MPTS is an impartial adjudication service which has taken over all interim orders and fitness to practise cases. The service is led by an independent Chair, who is a former Deputy High Court Judge and is responsible for appointing, training, appraising and mentoring MPTS panellists and legal assessors. Based in a dedicated centre in Manchester, the MPTS is part of the GMC but operationally separate from our complaint handling, investigation and case presentation functions and has its own identity, logo, website and branding.

A number of these reforms will however require amendments to our legislation. We are working with the Department of Health to make the necessary changes and, given the importance of these reforms to protecting patients, we believe it is vital that we secure the necessary changes separately and before the completion of the Law Commission's review.

Recommendation	GMC Initial Response
235. 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.	The MPTS is less than one year into operation and as outlined above, a number of legislative reforms still need to be made. We are focused on achieving these necessary changes and continuing to develop and embed the service. We are however interested in exploring opportunities to work with other regulators and will discuss this with the PSA and Department of Health.