

October 2014 update on the GMC's work to address the Francis Recommendations

In our initial response to the recommendations in the Francis Report, we committed to providing an update on our progress every six months; this is our third and final update.

This update includes further comment on our work relating to the recommendations of the Keogh Review into the quality of care and treatment provided by 14 hospitals with high mortality indicators, the Berwick Review into patient safety and the pledges we made to the Clwyd/Hart review of the NHS complaints system, all of which the Government commissioned to help inform its response to the Francis Report.

As with previous updates, the recommendations and pledges are grouped across six themes. We remain committed to tackling the wider issues highlighted by the Francis Report as a whole and in playing our part in helping promote a more open, patient-focused culture in health and regulation.

Themes:

- Education and training.
- Patient insight.
- Promoting professional practise.
- Helping to ensure a safe practice environment.

- Generic/systems concerns.
- Joint working and information sharing

Education and training

Francis	GMC work to address recommendation
<p>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:</p> <ol style="list-style-type: none"> 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. The Royal Colleges should be enlisted to support such visits and to provide the relevant specialist expertise where required. There should be lay or patient representation on visits to ensure that patient interests are maintained as the priority. 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. <p>All healthcare organisations must be required to release healthcare professionals to support the visits programme. It should also be recognised that the benefits in professional</p>	<p>We considered this recommendation as part of our Review of Quality Assurance of Medical Education and Training. The final report was published on our website in February 2014 and we have begun a project to address the findings of the review. The project will include different phases to:</p> <ul style="list-style-type: none"> ■ Scope and understand the current appointment processes and training required by other regulators, Royal Colleges, LETBs and Deaneries. ■ Map the appointment processes and training undertaken and understand the similarities and differences. ■ With other relevant parties, agree a new approach to minimise the requirement to repeat generic training and develop a mechanism for co-badging visitors and inspectors for the future. We anticipate that this would help the move towards a more 'collective' assurance process for regulation in the future. Updates on the progress of this project will be available on the GMC

<p>development and dissemination of good practice are of significant value.</p>	<p>website.</p>
<p>156. The system for approving and accrediting training placement providers and programmes should be configured to apply the principles set out above.</p>	<p>We are reviewing our standards of medical education and training, as set out in <i>Tomorrow's Doctors</i> and <i>The Trainee Doctor respectively</i>. The review will be developing themes which will replace the current domains outlined in the standards. One of the themes is 'learning environment and culture', and focuses on ensuring that educational environments are safe for patients and safe for learners. The theme encourages the notion that an effective learning environment should ensure that learning is part of the culture and that safe and effective care can be provided to patients.</p> <p>There have been a series of roundtable events this year with stakeholders to discuss each of these themes and there has been wide support for defining what a learning environment would look like. Evaluation of these workshops is on-going, with the aim of producing a final draft set of standards in December.</p> <p>We will consult on the new framework in early 2015.</p>
<p>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</p>	<p>We considered this recommendation as part of our Review of Quality Assurance of Medical Education and Training. The final report includes a recommendation that reports should give greater attention to the transparency and accessibility of information for patients and the public, students and trainees. We have worked with medical royal colleges to develop a new</p>

<p>non-compliance with standards.</p>	<p>approach to College Annual Specialty Reports (ASRs), which is highlighted in the report, as well as including a recommendation that we should work with the colleges to implement the new approach to ASRs by 2015.</p> <p>We continue to work with Deans and Local education and training boards (LETBs) to improve our reporting mechanisms and how we use the information requested. LETBs and Deaneries report to the GMC on a twice yearly basis in April and October. These reports detail progress against concerns, and patient safety and undermining comments. In March we began publishing these reports as enhanced monitoring profiles on our website; profiles include a status rating for serious concerns. Additionally, we are currently implementing an action plan for sharing good practice which includes the recruitment of a specific project manager to take this forward.</p>
<p>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.</p>	<p>Our review of <i>Tomorrow's Doctor</i> and <i>The Trainee Doctor</i>, as outlined at recommendation 157, includes consideration of the importance of student, trainee and trainer feedback on their training experience, including supervision, support and learning opportunities.</p>
<p>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</p>	<p>Our National Training Survey (NTS) is an important engagement tool that helps us understand the views of doctors in training and take action in response to their concerns. NTS results form part of the data packs we send to CQC to support their investigations and we have received</p>

information obtained with healthcare regulators.

positive feedback that NTS results are a useful and valuable source of data.

This year the NTS included more information for participants about how concerns raised in their responses to the survey will be addressed and how that information will allow local providers to identify patient safety problems that may not have been reported. Guidance given to trainees as well as the process of investigating issues raised has also been improved. The 2014 National Training Survey, now closed, achieved a response rate of over 98 per cent of trainees. Comments relating to patient safety and undermining have now been analysed and included in our monitoring processes with Deaneries/LETBs if appropriate. We published our key findings from the 2014 survey on our website in June. The results showed a rise in overall satisfaction levels from previous years, with overall scores for educational supervision, induction, handover and adequate experience improving. Additional reports will be published in Autumn 2014.

Our Trainer Survey is being piloted in three Local Education and Training Boards from this month. Subject to the outcome of the pilot, this survey will be administered more widely from 2015. It will then be possible to compare trainee and trainer perceptions of training quality and safety in the same environment, giving richer, more reliable information.

We also continue to survey medical students at the schools we are about to visit as part of our quality assurance activity. The

	feasibility of a larger survey of medical students will be evaluated in 2015.
<p>161. Training visits should make an important contribution to the protection of patients:</p> <p>a. Obtaining information directly from trainees should remain a valuable source of information – but it should not be the only method used.</p> <p>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.</p> <p>c. The opportunity can be taken to share and disseminate good practice with trainers and management.</p> <p>Visits of this nature will encourage the transparency that is so vital to the preservation of minimum standards.</p>	<p>At the end of March 2014, we began publishing information about validated education concerns that are subject to enhanced monitoring by the GMC. Cases subject to enhanced monitoring relate to patient safety or quality of education issues in a local education provider and can come from a variety of sources (visits, routine monitoring, Deanery Reports). The aim of publishing this information is to increase the transparency of our monitoring process. This information appears on our website and is published quarterly.</p> <p>This recommendation was also considered as part of our Review of Quality Assurance of Medical Education and Training. As part of the action plan to strengthen the role of visits we:</p> <ul style="list-style-type: none"> ■ Have introduced a document register section at the end of each visit report to detail what evidence has been used and how it has contributed to the findings. ■ Have developed a 5 year visits schedule. ■ Will pilot GMC inspection teams to observe the environment in which clinical teaching occurs.
162. The General Medical Council should in the course of its review of its standards and regulatory process ensure that the	The new standards framework we are developing through the review of <i>Tomorrow's Doctors</i> and the <i>Trainee Doctor</i> will

<p>system of medical training and education maintains as its first priority the safety of patients.</p> <p>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.</p>	<p>have an overarching patient safety statement making it clear that everything else in the standards is connected to patient safety. This has received wide support from stakeholders.</p> <p>There are also several requirements within each of the themes of the new framework, particularly under the 'Learning environment and culture' theme, which deal directly with ensuring patient safety.</p> <p>We will consult on the new framework in early 2015.</p>
<p>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 and skills of available staff for the provision of training and to ensure patient safety in the course of training.</p>	<p>The new framework being developed as part of the review of <i>Tomorrow's Doctors</i> and <i>The Trainee Doctor</i> contains requirements and exploratory questions which address this recommendation, including requirements about supervision and rotas.</p> <p>We will consult on the new framework in early 2015.</p>
<p>Berwick</p>	<p>GMC work to address recommendation</p>
<p>5. Mastery of quality and patient safety sciences and practices should be part of initial preparation and lifelong education of all health care professionals, including managers and executives</p> <p>Education regulators, providers and HEE:</p> <p>Professional regulators (such as the GMC and NMC) should continue and build upon their good work to date with</p>	<p>We are continuing to build on the work begun in this area and have identified raising standards in medical education and practice as a strategic priority in our 2014 – 2017 Corporate Strategy.</p> <p>A key piece of work in delivering this priority is to improve the consistency and coherence of standards across the continuum</p>

<p>undergraduate and postgraduate education providers and Health Education England to ensure that medical and nursing undergraduates and postgraduates become thoroughly conversant with and skilful at approaches to patient safety and quality improvement.</p>	<p>of education and training through our current review of <i>Tomorrow's Doctors and The Trainee Doctor</i> as outlined above.</p>
<p>Clwyd Hart Review</p>	<p>GMC work to address recommendation</p>
<p>Pledge 3. The GMC will look at how well prepared medical graduates feel to deal with patient concerns and complaints in a positive way. They will do so as part of their review of the impact of <i>Tomorrow's Doctors 2009</i>, which sets out the outcomes and standards for undergraduate medical education.</p> <p>This research will be received in the second half of 2014 and work will have begun to identify any changes that may need to be made.</p>	<p>We continue to look at the preparedness for practice of new medical school graduates. The research we have commissioned into the impact of <i>Tomorrow's Doctors</i>, which sets out the knowledge, skills and behaviours that medical students learn at medical school, considers all aspects of preparedness including how well prepared graduates feel to deal with patient concerns. Our report <i>Be prepared: are new doctors safe to practise?</i> published on 8 October 2014, summarises the conclusions of the research and other analysis undertaken by the GMC.</p>

Patient insight

<p>Francis</p>	<p>GMC work to address recommendation</p>
<p>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.</p>	<p>We are committed to ensuring patients and the public have a clear understanding of the role of the organisation. We have commissioned a report into the confidence and awareness of our functions and the effectiveness of current communication channels, including our website, which will be published by</p>

	<p>early 2015.</p> <p>In 2012 we piloted a Patient Information Service with the aim of improving communications with members of the public who raise concerns about a doctor. We held a total of 298 meetings with patients, both at the beginning and end of our FtP processes. An independent evaluation of the pilot found that meetings had mostly provided patients with a better understanding of the GMC's processes. They felt listened to and felt their complaint was being taken seriously. Meetings were also helpful in reducing their feelings of isolation. The evaluation report was published on our website in September and there are plans for the pilot to be rolled out to GMC offices across the UK, in Manchester and London, as well as Cardiff, Edinburgh and Belfast, with meetings being held from January 2015.</p> <p>Additionally our Regional Liaison Service (RLS) has significantly developed engagement with patients and the public, meeting 2000 in England this year, discussing our guide <i>What to Expect from Your Doctor</i> together with the GMC's general role and its role in the complaints environment. The feedback from these discussions has been used to inform our meetings with local Healthwatch organisations. To date the RLS has met with 112 of the 152 local Healthwatch organisations in England.</p>
Clwyd Hart Review	GMC work to address recommendation
Pledge 1. The GMC believes there will be increasing use of	We have commissioned an evaluation of our revalidation

<p>instant patient feedback and welcomes the greater transparency and patient involvement this brings. The GMC also believes patient feedback in general is vital for professional development and it has produced guidance for best practise for patient feedback as part of the revalidation process, which requires doctors to go through a series of annual checks.</p> <p>As part of the evaluation of revalidation, the GMC will look at the role of patient feedback and how it can be further developed. By September 2014, a research partner will have been commissioned to undertake this work.</p>	<p>framework. This will run for three years with a first interim report expected at the beginning of 2015 and a final report in 2017. The evaluation will look at the role of patient feedback, our current guidance about how we expect it to be delivered and more generally how the patient voice can be made stronger throughout the revalidation process as a whole.</p> <p>We are aware that the Department of Health (England) is undertaking a project to look at the impact of revalidation in England and we are working with Department leads to share emerging findings and minimise burdens on systems where possible.</p>
<p>Pledge 2. The GMC will act to support patients through fitness to practice cases, undertaking to take tailored face to face opportunities to explain the process and outcomes. Interim findings from the pilot programme have been positive and the GMC will receive the final evaluation at the end of 2013.</p> <p>Subject to favourable findings and agreement of the Council, the GMC expect to have established the essentials of this programme in all four countries by mid-2015.</p>	<p>See recommendation 233 above.</p>

Promoting professional practice

Francis	GMC work to address recommendation
160. Proactive steps need to be taken to encourage openness on the part of trainees and to protect them from any adverse	Our current review of standards of medical education and training, outlined above, has considered this recommendation,

consequences in relation to raising concerns.

by developing the draft standards in a way which emphasise the importance of ensuring that the learning environment has a process for raising concerns about the safety of patients or learners in confidence.

We currently have a number of tools on our website which provide support for those raising concerns. We published our guidance on [Raising and acting on concerns about patient safety](#) in 2012. The guidance sets out our expectation that all doctors will, whatever their role, take appropriate action to raise and act on concerns about patient care, dignity and safety. We also developed a decision making tool which is an interactive web tool bringing the principles in our guidance on raising concerns to life, helping doctors and others understand how the principles in the guidance may apply in situations doctors face.

Additionally, we have commissioned the Right Honourable Sir Anthony Hooper to undertake a review of how we deal with doctors who raise concerns in the public interest. The review is expected to make recommendations as to how our current guidance and processes might be adapted to reflect the needs of all doctors, including those in training, who raise concerns and to ensure that they are appropriately supported. The review will hear the views of those who may have suffered as a result of raising concerns, as well as the perspective and experience of employers, trade unions and professional leaders. The review is expected to complete by the end of the

	year and the findings will be published on our website.
<p>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.</p>	<p>In 2013 we consulted on the principle of ensuring that all licensed doctors have the necessary knowledge of English to practise safely in the UK. Following the consultation, which received strong support, new checks came into force on 25 June 2014. The changes require doctors from other European countries to provide evidence of their English skills or undergo a language assessment, if the GMC has concerns about their ability to communicate effectively with their patients.</p> <p>We also announced in February 2014 that we are raising the scores for overseas doctors who take the IELTS (International English Language Testing System) test to demonstrate their English language skills, in light of the results of some research we commissioned. From June 2014, doctors will need to achieve an overall score of 7.5 out of 9 rather than the current score of 7. This change will help to ensure that patients are treated by doctors who can speak and communicate in English to a sufficiently high standard. We will continue to keep the score we require under review.</p>
<p>181. A statutory obligation should be imposed to observe a duty of candour:</p> <ul style="list-style-type: none"> a On healthcare providers who believe or suspect that treatment or care provided by it to a patient has caused death or serious injury to a patient to inform that patient or other duly authorised person as soon as is 	<p>Our existing guidance requires doctors to be open and honest with patients when things go wrong. This is complementary to the new statutory organisational duty of candour recently announced by the Department of Health. The legal duty on organisations will require them to support professionals in being open and transparent where those in their care suffer</p>

<p>practicable of that fact and thereafter to provide such information and explanation as the patient reasonably may request.</p> <p>b On registered medical practitioners and registered nurses and other registered professionals who believe or suspect that treatment or care provided to a patient by or on behalf of any healthcare provider by which they are employed has caused death or serious injury to the patient to report their belief or suspicion to their employer as soon as is reasonably practicable.</p> <p>The provision of information in compliance with this requirement should not of itself be evidence or an admission of any civil or criminal liability, but non-compliance with the statutory duty should entitle the patient to a remedy.</p>	<p>harm or distress.</p> <p>We, together with the eight other statutory professional regulators, established a working group to develop a consistent approach to a professional duty of candour. A joint statement has been agreed by the Chief Executives of the eight professional regulators and has now been published. The inter-regulator working group on candour is continuing to meet to oversee the implementation of the joint statement and to discuss progress and challenges as each regulator embeds the joint statement in their own professional guidance.</p> <p>Together with the NMC we will be consulting on new supplementary guidance on the professional duty of candour, which will be launched on 03 November 2014.</p>
<p>Berwick</p>	<p>GMC work to address recommendation</p>
<p>4. Government, Health Education England and NHS England should assure that sufficient staff are available to meet the NHS's needs now and in the future. Healthcare organisations should ensure that staff are present in appropriate numbers to provide safe care at all times and are well-supported.</p> <p>All leaders and managers of NHS-funded provider organisations: NHS organisations, working with professional regulators, should create systems for supportively assessing the performance of all</p>	<p>Continuing to ensure that our standards and guidance remain clear, up to date and fit for purpose is a crucial part of our role. We also work with doctors, employers, trainees and patients to promote and embed the principles and values of professional practice.</p> <p>Our new Regional Liaison Service (RLS) engages directly with groups of doctors (including students and doctors in training) and patients. The RLS has now met with over 26,000 doctors,</p>

clinical staff, building on the introduction of medical revalidation.

over 14,000 medical students and over 3,000 patient and public representatives. RLS engagement has improved understanding of the GMC, changed perceptions of the GMC, helped doctors to reflect on their practice and has been an effective tool in tackling concerns around certain aspects of Good Medical Practice, by enabling further exploration of our guidance in focused sessions.

We also piloted our 'Welcome to UK Practice' programme in 2013 to help doctors who are new to UK Practice to understand medical professionalism in the UK context. We received positive feedback from each of the pilot events, with most doctors leaving with a greater awareness of the standards we expect from all registered doctors and the role we play in supporting doctors to meet those standards. We are very pleased with the response to this initiative and we hope to roll this out more widely – working with partners – in 2015.

Following the success of the pilot, the programme will be taken forward by our Regional Liaison Service in England and our Devolved Offices in Scotland, Wales and Northern Ireland. We are already showing the 'Welcome to UK Practice' film to newly registered doctors who attend ID checks at the GMC offices and throughout 2014 will also be conducting a number of further evaluative pilot events across the UK, as well as demand analysis to measure the potential uptake of the programme and how it might be progressed in the future.

In December 2012 the GMC introduced Revalidation for all

	<p>doctors. Revalidation allows us to strengthen the way we regulate doctors who practise in the UK. All licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise through annual appraisals. Doctors are also required to regularly seek feedback from patients about their practice. Over 52,700 doctors have now been revalidated. We have commissioned an independent evaluation of our revalidation framework, the evaluation will run for three years with a first interim report expected at the beginning of 2015 and a final report in 2017.</p> <p>We are aware that the Department of Health (England) is undertaking a project to look at the impact of revalidation in England and we are working with Department leads to share emerging findings and minimise burdens on systems where possible.</p>
<p>Clwyd Hart Review</p>	<p>GMC work to address recommendation</p>
<p>Pledge 4. The GMC's core guidance for all doctors, Good medical practice, sets out what is expected of doctors, including in communication and partnership working with patients. Its guidance emphasises the need to listen to patients, provide the information they need, be polite and considerate as well as treat patients fairly and with respect. The GMC is examining how these skills can be better reflected in postgraduate training and also promoted as part of continuing professional development</p>	<p>The focus of medical education and training should be on becoming a dedicated doctor who is able to respond to an increasing numbers of patients with complex health needs in different settings. In order to achieve this, we need to strengthen the professional, non-technical skills needed by doctors in postgraduate curricula.</p> <p>We are continuing to work with the Academy of Medical Royal Colleges to define generic professional capabilities within</p>

for all doctors.

The GMC plans to consult patients and others on this work early in 2014. Guided by the work of an independent review of post graduate medical education, jointly sponsored with the Academy of Medical Royal Colleges, by September 2014, the GMC will be working with the medical Royal Colleges and other key interest groups to embed the generic professional competences outlined in Good Medical Practice in postgraduate training.

medical education and training, as outlined in our pledge to the Clwyd Hart Review, particularly in areas which relate to human interaction and behaviour and the relationship to patient safety – for example, communication with patients and colleagues, shared decision making with patients and families, teamwork, and inter-professional learning. These skills are integral to and should underpin education which supports good clinical care across the board.

An informal discussion group was formed to begin developing a framework. This group consists of experts in the fields of curriculum assessment, leadership, GP and surgical curriculum, as well as representatives from the Academy, NHS England, Higher Education Academy, and patient representative bodies. The development of a draft generic professional capabilities framework is on-going.

We will be engaging with stakeholders on the draft framework in the first part of 2015.

Helping to ensure a safe practice environment

Francis	GMC work to address recommendation
<p>164. The Department of Health and the General Medical Council should review whether the resources available for regulating Approved Practice Settings 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.</p>	<p>We completed a fundamental review of Approved Practice Settings (APS) in September 2013. It concluded that the APS provisions added very little by way of assurance that doctors new to practice in the UK were practising safely in a supportive environment; additionally it concluded that the APS concept had become redundant since the introduction of Revalidation and the Responsible Officer (RO) role and thus APS should be discontinued.</p>
<p>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.</p>	<p>New APS requirements were introduced on 2 June 2014.</p>
<p>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.</p>	<p>These requirements align the APS regime with the Responsible Officer Regulations. In essence doctors subject to APS requirements must now hold a prescribed connection to a designated body in order to undertake UK practice. Designated bodies are, for the most part, organisations that employ or contract with licensed doctors. Designated bodies are under a statutory duty to have systems in place to support the continuous evaluation of all doctors with a connection to their organisation. They must have an appraisal system in place for these doctors and support them with their revalidation.</p>
<p>167. The Department of Health and the General Medical Council should review the powers available to the General Medical Council in support of assessment and monitoring of approved practice settings establishments with a view to ensuring that the</p>	<p>This ensures that these doctors are subject to the clinical governance arrangements required for revalidation, such as regular appraisals based on our core guidance for doctors. They are no longer restricted to practising in a specific physical</p>

<p>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.</p>	<p>setting providing clarity for doctors and the organisations that employ or contract with them.</p>
<p>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.</p>	

Generic systems/concerns

Francis	GMC work to address recommendation
<p>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.</p>	<p>We recognise the need to contribute to the identification and investigation of system or generic concerns, while remaining clear that direct interventions by the GMC should be confined to matters within our regulatory remit around the quality of education, revalidation systems concerns and the fitness to practise of individual practitioners.</p> <p>We contribute to the identification and investigation of systemic or generic concerns by: sign posting complainants to the appropriate regulator if their concerns are not for the GMC, making referrals to systems or other professional regulators, investigating concerns that are raised in the media and sharing information with and participating in Regional Quality Surveillance Groups and Risk Summits.</p>

	<p>We know that we collect a rich and unique data set that may yield intelligence about systems or generic concerns and have developed a data strategy setting out how we will develop and use data. This work will allow us to identify, analyse and understand trends and areas of risk. We will use this intelligence to develop the way we regulate and reflect it back to the medical profession and, importantly, the wider healthcare system. The first phase of this project focusses on two information priorities, Tracking the Doctors' Journey and Environment Maps. Phase 1 of the project is planned to complete by March 2015 and we will be provided an update on this work via our website.</p> <p>Additionally, we have established an internal Patient Safety Intelligence Forum to coordinate information that may demonstrate concerns about patient safety or medical practice and ensure the appropriate operational and policy response across our functions relevant to operational or thematic risk. This Forum will continue to develop throughout 2014 and 2015 in parallel with the development of the organisation's enhanced data strategy.</p>
<p>225. The General Medical 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.</p>	<p>We have been clear that we have a role to play in contributing to the identification and investigation of system or generic concerns, while remaining clear that direct interventions by the GMC should be confined to matters within our regulatory remit around the quality of education and of individual practitioners. We are effecting this commitment through our Operational Protocol with the Care Quality Commission (CQC) and the</p>

	development of information sharing agreements with other systems regulators.
Berwick	GMC work to address recommendation
<p>Recommendation 10: We support response regulation of organisation, with a hierarchy of responses. Recourse to criminal sanctions should be extremely rare, and should function primarily as a deterrent to wilful or reckless neglect or mistreatment.</p> <p>NHS-funded provider organisations and professional regulators</p> <p>Employers need to improve their support of staff around implementing guidance on reporting of serious incidents and professional regulators should take appropriate action when required. Organisations should demonstrate that they have in place fully functional reporting systems for serious incidents, that staff know how to use them, that the systems are use, and that appropriate action is taken in response to incidents, including provision of appropriate support to the affected patients and their carers.</p>	See recommendation 222 above.

Information sharing and joint working

Francis	GMC work to address recommendation
<p>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.</p>	<p>We have been strengthening our relationships and ways of working with CQC and other organisations. We have already developed an Operational Protocol with the CQC and are developing a joint approach to the evaluation of the operating protocol, with an interim evaluation report scheduled for publication in March 2015. We have held a joint workshop to identify thresholds for sharing information which has led to further opportunities to develop our information sharing protocol.</p> <p>In addition to this we are in the process of developing policy, guidance and training for staff on the information sharing process with the CQC. This will be rolled out later in this year.</p> <p>We have also developed Memoranda of Understanding with Health Inspectorate Wales and progress is continuing on the development of refreshed or new Memorandas of Understanding or information sharing agreements with the Regulation and Quality Improvement Authority in Northern Ireland, Healthcare Improvement Scotland, the NHS Trust Development Authority (NTDA) and Monitor. Operational protocols will be developed to practically support these Memoranda of Understanding and information sharing agreements.</p>

<p>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 aware of matters of concern relevant to their responsibilities.</p>	<p>See above, recommendation 152.</p>
<p>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.</p>	<p>See recommendation 152 above and 224 below.</p>
<p>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.</p>	<p>We believe the exchange of information with Royal Colleges is important to ours and the Royal Colleges' work and the recommendations of the Review of Quality Assuring Education and Training, discussed in greater detail at recommendations 155,157 and 161 confirmed this.</p> <p>One of the main issues highlighted in the review was the importance of effective information sharing between the GMC and the Royal Colleges. We are currently considering how to further enhance the current information sharing arrangements with Royal Colleges as part of the review's implementation plan, with the aim of developing formal agreements with Royal Colleges. There is also a working group set up to take forward</p>

	<p>work developing the College Annual Specialty Reports, which is also looking at the data that both the Royal Colleges and GMC hold and the best way to use and share this data.</p> <p>By the end of 2014 we will be providing a richer set of tailored, targeted data to the Royal Colleges and, in return, we are beginning to gather further information from the Royal Colleges to inform our programme of visits (as part of our programme of quality assurance).</p>
<p>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.</p>	<p>See recommendation 152 above outlining our work to strengthen relationships with CQC and others.</p>
<p>235. Joint proceedings 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.</p>	<p>The publication on 2 April of the draft Law Commission Bill has been a stimulus for discussion of these issues and the Medical Practitioner Tribunal Service (MPTS) has recently hosted a hearing by the General Osteopathic Council. We have also instigated the first joint Adjudication Forum of all regulators, with the next forum being hosted by General Dental Council.</p>

Berwick	GMC work to address recommendation
<p>7. Transparency should be complete, timely and unequivocal. All non-personal data on quality and safety, whether assembled by government, organisations, or professional societies, should be shared in a timely fashion with all parties who want it, including in accessible form, with the public.</p>	<p>See recommendation 152 above outlining our work to strengthen relationships with CQC and others.</p>
<p>8. All organisations should seek out the patient and carer voice as an essential asset in monitoring the safety and quality of care.</p> <p>All healthcare system organisations</p> <p>Government, CQC, Monitor, TDA, HEE, NHS England, CCGs, professional regulators and all NHS Boards and chief executives should share all data on quality of care and patient safety that is collected with anyone who requests it, in a timely fashion, with due protection for individual patient confidentiality.</p> <p>Government, CQC, Monitor, TDA, HEE, NHS England, CCGs, professional regulators and all NHS Boards and Chief Executives should include patient voice as an essential resource for monitoring and improving the safety and quality of care.</p>	<p>See recommendation 152 above, outlining our work to strengthen relationships with the CQC and others and 222 above outlining the establishment of our Patient Safety Intelligence Forum.</p>
<p>9. Supervisory and regulatory systems should be simple and clear. They should avoid diffusion of responsibility. They should be respectful of the goodwill and sound intention of the vast majority of staff. All incentives should point in the same</p>	<p>See recommendation 152 above outlining our work to strengthen relationships with CQC and others.</p>

<p>direction.</p> <p>CQC, Monitor and the TDA</p> <p>...It is imperative that CQC, Monitor and the TDA commit to seamless, full, unequivocal, visible and whole-hearted cooperation with each other and with all other organisational and professional regulators, agencies and commissioners.</p> <p>Regulators, HEE, professional societies, commissioners</p> <p>CQC, Monitor, TDA, professional regulators, HEE, professional societies, Royal Colleges, commissioners and others should streamline requests for information from providers so that they have to provide information only once and in unified formats. The same is true of inspections.</p>	
<p>Keogh</p>	<p>GMC work to address recommendation</p>
<p>Ambition 2: The boards and leadership of provider and commissioning organisations will be confidently and competently using data and other intelligence for the forensic pursuit of quality improvement. They along with patients and the public, will have rapid access to accurate, insightful and easy to use data about quality at service line level.</p> <p>All those who helped pull together the data packs produced for this review must continue this collaboration to produce a common, streamlined and easily accessible data set on quality which can then be used by provider, commissioners, regulators</p>	<p>See recommendation 152 above outlining our work to strengthen relationships with CQC and other and 222 outlining the development of a new strategy.</p>

<p>and members of the public in their respective roles. Healthwatch England will play a vital role in ensuring such information is accessible to local Healthwatch so that they and the consumers they serve can build a picture of how their local service providers are performing. The National Quality Board would be well placed to oversee this work.</p>	
<p>Ambition 4: Patients and clinicians will have confidence in the quality assessments made by the Care Quality Commission, not least because they will have been active participants in inspections.</p> <p>In the new system, the place that data and soft intelligence comes together is in the recently formed network of Quality Surveillance Groups. These must be nurtured and support the Care Quality Commission in identifying areas of greatest risk.</p>	<p>One of our strategic priorities for 2014 – 2017 is to:</p> <p><i>Make the best use of intelligence about doctors and the healthcare environment to ensure good standards and identify risks for patients.</i></p> <p>We are investing in our data systems and infrastructure to enable us to be a more proactive regulator, and use information more effectively to mitigate risks and promote quality in medical practice and education as outlined at recommendation 152.</p>