

April 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 second 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 our October 2013 update, 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.

The successful delivery of many of these recommendations and the wider agenda as a whole depends on many organisations and continuing to work together to successfully deliver the changes suggested and meet the challenges highlighted.

Themes:

- Education and training
 - Quality assurance visits
 - Education standards
 - Listening to medical students and trainees
- Patient insight
- Promoting professional practise
 - English language proficiency

- Promoting professionalism
- Helping to ensure a safe practice environment
- Generic/systems concerns
- Joint working and information sharing

Education and training

Quality assurance visits

Francis
<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> <p>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.</p> <p>b. The Royal Colleges should be enlisted to support such visits and to provide the relevant specialist expertise where required.</p> <p>c. There should be lay or patient representation on visits to ensure that patient interests are maintained as the priority.</p> <p>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.</p> <p>The Department of Health should provide appropriate resources to ensure that an effective programme of monitoring training by visits can be carried out.</p> <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 development and dissemination of good practice are of significant value.</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>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>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>

We have considered these recommendations as part of our review of quality assurance in medical education, the report of which we published in February 2014.

The report specifically highlights the role of Medical Royal Colleges in supporting visits, including a recommendation for some specialists who participate in GMC Quality Assurance (QA) inspections to be jointly accredited by the GMC and Medical

Royal Colleges; in addition, the report recommends that those responsible for commissioning postgraduate education and training and the GMC and colleges should support the work now being led by the Academy of Medical Royal Colleges (AoMRC) to professionalise and clarify the role of external advisors in the quality management process. The report also identifies issues with how we report on QA activity, including a recommendation that reports should give greater attention to the transparency and accessibility of information for patients and the public, students and trainees. The report also highlights the need to refine a set of measurable and deliverable descriptors for educational environments, which we will be consulting on in 2015 as part of the review of standards for education and training. Some of the QA review's recommendations have already been taken forward, whilst others will require further development and public consultation.

The current review of standards of medical education and training, as set out in *Tomorrow's Doctors* and *The Trainee Doctor*, is supportive of defining measurable descriptors for appropriate educational environments and will be building this into the new standards framework on which we will consult in 2015. This review will also be considering the importance of student/Trainee and trainer feedback on compliance with standards.

At the end of March 2014, we began publishing on our website information about 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.

Education standards

Francis
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 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.
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.
Berwick
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
Education regulators, providers and HEE: Professional regulators (such as the GMC and NMC) should continue and build upon their good work to date with 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.

Clwyd Hart Review

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 Tomorrow's Doctors 2009, which sets out the outcomes and standards for undergraduate medical education.

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.

One of our strategic priorities for 2014 – 2017 is to:

Help raise standards in medical education and practice.

A key piece of work in delivering this priority is to improve the consistency and coherence of standards across the continuum of education and training through our current review of education standards (see also above).

With the advice of an Expert Advisory Group we are designing a framework for a new set of standards, possible themes which will replace the current domains and a sample of draft standards. We will consult on revised standards in 2015.

We continue to look at the preparedness for practice of new medical school graduates, as outlined in our pledge to the Clwyd Hart Review. The research we have commissioned into the impact of *Tomorrow's Doctors*, 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. We will receive the final report in May 2014 and will publish our conclusions by autumn 2014.

Medical student, trainee and doctor voice recommendation

Francis

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 launched the 2014 National Training survey on 26 March 2014. The annual survey asks the UK's 54,000 doctors in training to share their views about the quality of their training to help ensure we have high standards of medical education. It is the fifth year we have run the survey since PMETB was merged with the GMC in 2010.

This year the National Training survey included more information for participants about how we will address concerns raised in their comments, what information we want in the comments and the types of information that will allow us to identify why problems have not been reported locally. We have also improved the guidance given to trainees as well as the process of investigating issues raised.

This year we will also pilot a trainer survey, and subject to the outcome of the pilot, we will roll it out from 2015. It will then be possible to compare trainee and trainer perceptions of training quality and safety in the same environment, giving us richer, more reliable information. We continue to survey medical students at the schools we are about to visit as part of our QA activity. We will be evaluating the feasibility of a larger survey of medical students in 2015.

Patient insight

Francis
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.
Berwick
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. 6. The NHS should become a learning organisation. Its leaders should create and support the capability for learning, and therefore change, at scale, within the NHS.
Education regulators, providers and HEE <ul style="list-style-type: none"> Professional regulators (such as the GMC and NMC) should continue and build upon their good work to date with 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.
Clwyd Hart Review
Pledge 1. The GMC believes there will be increasing use of 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. 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.
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. 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.

Later this year we will commission an independent survey of key interests' perceptions and understanding of the role of the GMC. Among other things, the results will help us refine our communications with patients and other interest groups.

We will be gathering information around patients' confidence in the profession and the GMC, awareness of GMC functions and the effectiveness of current communication channels. We will be publishing a report of the results in late 2014 or early 2015.

We are also specifically considering how we reach patients and other interest groups through digital channels. We are working with experts in using digital media and will be seeking views from key stakeholder groups to inform how we will take forward changes to our website and digital presence. Our overall aim is to make our website easier to use, interactive, supportive and more informative for our stakeholders.

The importance of giving patients and those making complaints support and practical ways to raise concerns and provide important insight to inform improvements in care is a prominent theme in the Francis Report and subsequent reviews. In the context of a doctor's practice, not only are patients key to raising concerns about care but also play an instrumental role in assisting doctors to improve and reflect on their own practice through positive and critical feedback.

We are working to ensuring that patients have access to the information they need about our work at the right time, are empowered to provide feedback (including concerns) and if a concern is raised with us they are supported through the process.

Last year the Revalidation Implementation Advisory Board hosted a seminar on public and patient involvement in revalidation. Some of the themes identified included the need to reflect the real needs of the patient, patient feedback as a means of improving service delivery and the purpose and value of patient feedback for doctors.

In March this year we published a report commissioned from Plymouth University, Evaluating the strategic impact of medical revalidation: Building an evaluation framework. The evaluation framework highlights patient and public involvement in revalidation as a key work stream for the future evaluation project itself. We are currently in the process of tendering for the evaluation which will cover the first cycle of revalidation.

Our pilot of face to face meetings with patients who raised a complaint with the GMC, launched in 2012, continues to receive positive feedback. Over the past year and a half we have conducted 50 initial and 50 end stage meetings. Feedback received so far indicates that complainants find the meetings helpful in reducing their feelings of isolation, ensuring that they feel listened to within the fitness to practise process and helping them to understand our role and purpose, our investigation process and what to expect, thereby managing their expectations. We will continue to hold patient meetings until the report from the independent evaluators is received, which we expect to receive in April 2014. At that point we will make a decision about the future of the pilot.

Promoting professional practice

English language proficiency

Francis
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

The results of the consultation we ran between September and December 2013, demonstrate a strong support for legislative changes that will allow us to check the language skills of doctors from the European Economic Area (EEA) when a concern is raised during their GMC registration process. We expect that, subject to Parliamentary approval, the checks will come into force this summer.

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.

Promoting professionalism

Francis
160. Proactive steps need to be taken to encourage openness on the part of trainees and to protect them from any adverse consequences in relation to raising concerns
181. A statutory obligation should be imposed to observe a duty of candour: <ol 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 practicable of that fact and thereafter to provide such information and explanation as the patient reasonably may request; 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>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>
183. It should be made a criminal offence for any registered medical practitioner, or nurse, or allied health professional or director of an authorised or registered healthcare organisation: <ol style="list-style-type: none"> a) knowingly to obstruct another in the performance of these statutory duties; b) to provide information to a patient or nearest relative intending to mislead them about such an incident; c) dishonestly to make an untruthful statement to a commissioner or regulator knowing or believing that they are likely to rely on the statement in the performance of their duties.
Berwick
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>All leaders and managers of NHS-funded provider organisations:</p> <ul style="list-style-type: none"> • NHS organisations, working with professional regulators, should create systems for supportively assessing the performance of all clinical staff, building on the introduction of medical revalidation.

Clwyd Hart Review

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 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.

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 set the principles and values that must underpin a doctor's practice in our core guidance, *Good medical practice*, and we must ensure that these standards are clear, consistent and apparent in all areas of our work. We also must work with doctors, employers, trainees and patients to promote and embed the principles and values of professional practice.

We are continuing to work to define generic professional capabilities in partnership with AOMRC. This work will ensure that skills such as communication and leadership are better reflected in postgraduate training, as outlined in our pledge to the Clwyd Hart Review.

We are also considering the specific issue of candour. Our existing guidance requires doctors to be open and honest with patients when things go wrong. We see this as 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 harm or distress. On the professional duty, we are now working with the other professional regulators to develop a consistent approach across the medical professions. We will be working later this year to produce explanatory guidance on the issue of candour, which will include issues related to near misses and apology.

Our strategic priorities for 2014 – 2017 include the commitment to work more closely with doctors, medical students and patients on the frontline of care. While issuing guidance sets the expectations for doctors and trainees, we also want them to study, train and work in environments that encourage and support them to embody these values and principles. In support of this we continue to deliver and develop a range of engagement activities with doctors and other key stakeholders.

The new GMC Regional Liaison Service (RLS), which engages directly with groups of doctors (including students and doctors in training) and patients have now met with 16,500 doctors, 9,000 medical students and up to 1,000 patient and public representatives. RLS engagement has improved understanding of the GMC, changed perceptions of the GMC, allowed doctors to reflect on their practice and has been an effective tool in tackling concerns around certain aspects of *Good Medical Practice*, by clearly explaining our guidance in focussed sessions. It has also shown that

feedback we received from these guidance focused sessions indicates that 73% of doctors will change their practice to better meet our standards following these sessions.

We have now piloted our 'Welcome to UK Practice' programme to help doctors who are new to UK Practice to understand medical professionalism in the UK context. We have received positive feedback from each of the pilot events, with most doctors leaving with a greater awareness of the role the GMC plays in supporting doctors and the standards we expect from all registered doctors. More work is planned to deliver this programme to wider populations of doctors.

An evaluation of our Employer Liaison Service was completed in November 2013. All responses received were positive and encouraging about the impact of the ELS, Responsible Officers (RO's) felt that the introduction of the ELS has made the GMC a more approachable organisation and improved understanding of GMC procedures and thresholds.

Helping to ensuring a safe practice environment (Approved Practice Settings)

Francis
164. The Department 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.
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.
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.
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 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.

Our fundamental review of Approved Practice Settings (APS) was completed in September 2013.

We are now implementing the recommendations of the review and will be aligning the APS requirements with those of the Responsible Officer (RO) regulations and revalidation. From 30 April 2014, any organisation which is a designated body under the RO regulations will be recognised as an APS.

This will mean that doctors granted full registration in APS from 30 April may only practise medicine in the UK when they have a prescribed connection to a designated body. This restriction will apply until they revalidate for the first time. 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.

Generic/systems concerns

Francis
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.
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.
Berwick
<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 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 used, and that appropriate action is taken in response to incidents, including provision of appropriate support to the affected patients and their carers.</p>

We are continuing to consider the ways we can 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 and of individual practitioners.

We are beginning to develop a data strategy that will set out how we will develop and use data and will allow us to identify, analyse and understand areas of risk. Through better use of the data we will be able to improve our ability to understand the meaning and significance of the information we hold.

In previous years we have collected data which provides information on the complaints about doctors that we have received, from secondary care organisations and investigated each year between 2007 and 2012. We continued to collect this data in 2013 and will be publishing the results in the summer of 2014.

We have also established an internal Patient Safety Intelligence Forum to coordinate information across our functions relevant to operational or thematic risks. This Forum will continue to develop throughout 2014 parallel with the development of the data strategy.

Information sharing and joint working

Francis
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.
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.
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.
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.
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.
Berwick
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.
8. All organisations should seek out the patient and carer voice as an essential asset in monitoring the safety and quality of care.
All healthcare system organisations
<ul style="list-style-type: none"> • 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. • 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.
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 direction.
CQC, Monitor and the TDA ...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.
Regulators, HEE, professional societies, commissioners 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.
Keogh
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.

- 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 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.

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.

- 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

One of our strategic priorities for 2014 – 2017 is to:

Make the best use of intelligence about doctors and the healthcare environment to ensure good standards and identify risks for patients.

The data strategy, discussed in the previous section will be instrumental in delivering this aim. 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.

We are also seeking to improve the way we share information by strengthening our relationships and ways of working with 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 scheduled for September 2014 and a full evaluation in September 2015.

We are also continuing to make progress in refreshing our Memoranda of Understanding (MoU) with the Regulation and Quality Improvement Authority in Northern Ireland, Healthcare Improvement Scotland, and Healthcare Inspectorate Wales. We have worked closely with with NHS Trust Development Authority (NTDA) and Monitor to develop information sharing agreements, our agreement with NTDA is now in the final stages of review and we met with Monitor in February 2014 to discuss the development. Following agreement of these MoUs we will work to develop information sharing protocols to practically support the agreed principles. We will continue to develop ways of sharing our data with CQC and others, to ensure data is accessible and risks can be identified, as highlighted in the Keogh Review.

Francis

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.

We remain interested in exploring the possibility of offering the services of the MPTS to other regulators in due course. The publication on 2 April of the draft Law Commission Bill will be a stimulus for discussion of these issues. There is no question that the greater separation of investigation and adjudication functions achieved by the establishment of the MPTS has increased confidence in the independence of decisions by fitness to practise panels.