18 month update to our April 2013 response to the Francis Report

Issue

1  In our initial detailed response to the Francis Report, published on 16 April 2013, we promised to publish an update every six months on our progress against the 24 recommendations relating to the GMC. This is the third of these updates.

Recommendations

2  The Strategy and Policy Board is asked to agree that:

   a  Our October 2014 update on progress against the recommendations of the Francis report (at Annexes A and B) be published on 16 October 2014.

   b  This update will be the GMC’s final stand-alone published update on work to address the Francis recommendations.
18 month update to our April 2013 response to the Francis Report

Issue

3 We published a detailed consideration of the 24 recommendations with specific impact on our work on 16 April 2013. In that document, we committed to providing an update every six months on our progress against these recommendations. The third and final update is set out at Annex A.

4 As with our previous updates, the recommendations are grouped across six themes relevant to our work. This update is meant to stand alone as a final summation of our work related to the Francis Report’s recommendations, rather than simply focus on progress since April 2014.

5 When published on our website, there will be links to the earlier updates and to other parts of our website where relevant work has been published or developed, for example the review of standards of education and training, the development of the Regional Liaison Service and the National Training Survey results.

Consideration of additional reviews

6 Following the publication of the Francis Report, the government commissioned additional reviews to inform its line by line response to the Francis recommendations. In our 12 month update of 16 April 2014 we included consideration of the recommendations contained in the Berwick review of patient safety, the Keogh review of 14 trusts with high mortality and the Clwyd Hart review of the NHS complaints system.

7 This update provides further information on our progress in addressing the recommendations of each of these additional reviews.

Further updates

8 We have undertaken a significant amount of work to address the issues and recommendations in the Francis Report, as well as the subsequent Keogh, Berwick and Clwyd/Hart reviews. The table at Annex B details our work programmes, which are aimed at addressing each of the recommendations. We have been successful in addressing most of these recommendations and are on track to deliver those projects that are outstanding in 2015. Each of these outstanding projects is due to report, or to publish a separate update via our website, in 2015.

9 As work streams have developed, a number of the Francis recommendations have now become part of our business as usual activities. The core themes from Francis have been integrated into the GMC Corporate Strategy 2014-2017, such as increased transparency and making better use of intelligence about doctors and the healthcare
environment to ensure good standards and identify risks to patients. Therefore we suggest that this be our last stand-alone update on our work to address these recommendations.

10 We will continue to support the system wide commitment to promote a more open, honest and transparent culture in healthcare. We will also continue to provide updates to the Department of Health on the progress of those work streams which are scheduled to deliver in 2015, and we will provide updates on these individual work programmes via our website.

11 Our 18 month update will be published ahead of the Government’s one year on report of Hard Truths: The Journey to Putting Patients First, expected in November 2014.
Supporting information

How this issue relates to the corporate strategy and business plan

12 This work relates to strategic aim 5 of the 2014-2017 Corporate Strategy which is to work better together to improve our overall effectiveness, our responsiveness and the delivery of our regulatory functions.

Other relevant background information

13 The Board agreed the publication of the 16 April 2014 12 month update by circulation on 15 April 2014.

How the issues support the principles of better regulation

14 We are demonstrating leadership in relation to the Francis Report by proactively publishing updates on our progress against the recommendations. It is a continuation of the proactive approach we have taken to accountable and transparent regulation.

How the issues differ across the four UK countries

15 The Francis Report, being focused on a Trust in England, has only given consideration to the regulatory and healthcare systems in England. Given that we are a national regulator, we are taking account of the spirit and recommendations in Francis’ Report in our work in all four countries as demonstrated in our update on our progress on information sharing agreements and protocols with systems regulators.

What equality and diversity considerations relate to this issue

16 Equality and Diversity issues that arise out of the work associated with our response to the Francis report are considered in the management of each of those individual projects. We will continue to work with the Equality and Diversity team to ensure due consideration of these issues should any additional projects arise.

If you have any questions about this paper please contact: Thomas Jones, Regulation Policy Manager, TJones@gmc-uk.org, 0207 189 5370.
As the independent regulator of doctors in the UK, the General Medical Council (GMC) plays a role in helping to protect patients and improve the standards of medical practice throughout the UK. In short, our job is to make sure that patients can have confidence in doctors. We do this by:

- controlling entry to and maintaining the list of registered and licensed doctors
- setting standards for all stages of medical education and training and ensuring that those standards are met
- determining the principles and values that underpin Good Medical Practice
- taking firm but fair action against doctors’ registration where the standards we set have not been met.

In understanding our role, it is important to recognise that we are just one part of a much wider regulatory system, where a number of different agencies operate with complementary responsibilities. This requires clear lines of responsibility between system and professional regulators so that they know when to involve each other, and are able to contribute their expertise and exercise their powers and influences when it is appropriate to do so.

We’ve changed a lot since the organisation was established in 1858. We have evolved over time to remain relevant and adapt what we do and what we expect of doctors to ensure we fulfil our statutory purpose as set out in the Medical Act 1983, ‘to protect, promote and maintain the health and safety of the public’.

Regulation has an important part to play in reinforcing professional standards and providing leadership, with others, in helping to change attitudes and behaviours. Much of what needs to be done concerns the culture of organisations and empowering healthcare professionals to do the right thing in difficult circumstances.
While we have made significant progress in recent years, the Francis Report on the failings of Mid Staffordshire NHS Foundation Trust highlighted particular areas for us to reflect on how we deliver our functions and ensure we are making progress to develop.

5 In our first response to the Francis Report in April 2013 we identified 24 recommendations in the report with specific impact on our work and committed to providing further updates every six months (October 2013, April 2014). These specific recommendations, as well as the overarching themes of the Francis Report, have challenged us to consider the ways in which we are working to promote a more collaborative and patient-focused culture in healthcare regulation.

6 We are determined to play our part, while recognising that many of these issues go well beyond regulation. The reforms we have made and plan to make reflect our determination to be a more outward facing, proactive and responsive regulator. Our overarching plans and direction are captured in our Corporate Strategy 2014 - 2017, which explains how we intend to continue our development by seeking to engage more widely with the system and better understand risk.

7 In this final update on our progress related to the Francis recommendations, we have provided an overview of our priorities and work in the two years since we first responded to the Francis Report. The specifics of how we are addressing each of the 24 recommendations with specific bearing on our work are set out in the following table (Link to Annex B).

**Education and training**

8 We have a statutory responsibility for ensuring high standards of medical education and training. We do this by setting standards for education and training, and quality assuring the way it is managed and delivered. Ensuring that doctors are well trained to treat patients now and in the future is crucial in addressing the cultural issues that are highlighted throughout the Francis Report.

9 The 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 work to be done.

10 In 2012 we began a review of our quality assurance processes for medical education and training. The review, which reported in February 2014 made wide-ranging recommendations which are now being taken forward. These included enhancing the role of the medical royal colleges and faculties in supporting our quality assurance inspections; developing the appointment process for the medical specialists involved in inspections; restructuring the inspection cycle, and enhancing the transparency and accessibility of visit reports.
Additionally, where a training institution gives rise to concerns which relate to patient safety or quality of education, it may be subject to enhanced monitoring within our quality assurance process. To ensure transparency, details of those concerns are published on our website.

Linked to our review of quality assurance of education, we have also been reviewing our standards for medical education and training as set out in Tomorrow’s Doctors and The Trainee Doctor. One of the themes being considered by the review is the learning environment and culture within organisations which provide education and training. We need to ensure that educational environments are safe for patients and safe for leaners, recognising that learning is part of the culture of an organisation. The review is also considering the importance of student, trainee and trainer feedback on the training experience in identifying compliance with standards for patient safety.

By ensuring the quality of medical education and training we are better able to ensure that students leave medical school and subsequent training with the skills to be able to meet changing patient needs. This will help to achieve the sort of cultural changes called for by the Francis Report. This work also addresses recommendations from the Berwick Review around ensuring medical education and training focusses on patient safety and quality improvement. There have been a series of roundtable events this year with stakeholders to discuss each of the themes of the standards review and we aim to consult on a draft standards framework in January 2015.

Patient insight

Effective communication with patients is vital to effective medical regulation. We are committed to improving our communication channels with patients to ensure they have clear understanding of our regulatory responsibilities, what we do and how we can help patients. By enhancing communication with patients about our regulatory functions we aim to build confidence in the profession and the GMC.

In May 2014 we introduced a new Tracking Survey to look at perceptions of the GMC held by our stakeholders, including doctors, patients/public, educators, employers and parliamentarians. This work will enable us to understand how each of our key interest groups feel about us, and how this changes over time. It will help us meet our strategic aim to work more closely with doctors, medical students and patients, properly informed by their views so that we can regulate more effectively. Our new strapline Working with doctors Working for patients reflects the fundamental shift we have made as an organisation and emphasises our ultimate purpose, to protect patients.

We also sought to improve patient understanding of our Fitness to Practise (FtP) processes by piloting in 2012 a Patient Information Service. The aim of this service was to improve communications with members of the public who raise concerns about a doctor, in line with our pledge to the Clwyd Hart review to support patients.
through fitness to practise cases. 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.

17 A number of the Francis recommendations highlight the need to collect more useful data on the standards of care provided to patients, as well as the need to ensure patients can feel confident in their understanding of professional regulators. We have addressed this through a number of work streams. We have begun including more patient safety questions in our National Training Survey (NTS). 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.

Promoting professionalism

18 Our standards set out the principles and values on which good practice is founded. These principles describe medical professionalism in action. We undertake a broad range of work to raise awareness of our standards and encourage doctors to embody these principles and values in their work. Through this we seek to promote professionalism of doctors and foster good medical practice.

19 Effective regulation is, in part, about the influence we are able to exert 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 new liaison services that engage with health services, the profession and patients.

20 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, 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.

21 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.

22 We are also planning to run a series of standalone events on ‘Professionalism’ over the next 12 months across the UK. These will be targeted at doctors and we hope to create an event which facilitates a rich debate about the current challenges in medical professionalism and how we can support doctors, educators and employers to meet those challenges. The above areas of work also encompass recommendations from the Berwick Review concerning empowering staff to provide safe care and ensuring appropriate support is given when assessing performance.

23 We also seek to promote professionalism of doctors and foster good medical practice through the introduction of Revalidation. Introduced in 2012, 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.

24 We now have new powers to make sure all doctors are able to communicate in English well enough to treat patients safely. New language checks were introduced in June this year requiring doctors from other European countries to provide evidence of their English skills or, if the GMC has concerns about their ability to communicate effectively with their patients, undergo a language assessment. Our new powers also enable us to take action through our fitness to practise procedures. These checks ensure that all licensed doctors have the necessary knowledge of English to practise safely in the UK and will help to improve care provided to patients.

25 We strive to promote an open and transparent culture that puts patients first. 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 harm or distress. On the professional duty, the GMC and Nursing and Midwifery Council (NMC) are working with the other professional regulators to develop a consistent approach across the healthcare professions. To this end, we will also be consulting, together with the NMC, on new explanatory guidance on the professional duty of candour, which will be launched on 3 November 2014.

**Safe practice environment**

26 We believe 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. However, developments since the scheme was introduced meant a new approach was needed.
Following the five recommendations made about APS in the Francis Report, we committed to undertaking a fundamental review of the scheme in 2013. That review concluded that we should replace the APS arrangements with a new scheme which was aligned with the existing statutory duties for healthcare organisations, namely the Responsible Officer Regulations. In effect, this prevents doctors who are newly registered or recently restored to the register from practising in circumstances where they do not have what is called a 'prescribed connection to a designated body' – a prescribed connection means making sure that every licensed doctor is supported with revalidation and that they are always working in an environment that monitors and improves the quality of its services. The new arrangements were introduced on 2 June 2014.

Joint working/ information sharing

Collaboration with others in carrying out organisational functions was highlighted by the Francis Report as a fundamental aspect of ensuring efficient detection of patient safety concerns and that appropriate, prompt and effective action is taken to address those concerns. We remain committed to strengthening our relationships with other regulators and understand the importance of collaborative working and information sharing in identifying patient risks.

We have begun to address the need for greater collaboration with others through development of an Operational Protocol with the Care Quality Commission (CQC) to enable us to work more closely together and share information more efficiently. The Protocol also sets out how we plan to begin working with the CQC, including joint education inspections, holding local liaison meetings and sharing emerging concerns about GPs and healthcare providers. In addition to this we have developed a Memoranda of Understanding with Health Inspectorate Wales and progress is continuing on the development of refreshed or new Memoranda of Understanding with other organisations, including those in the devolved administrations, such as Regulation and Quality Improvement Authority and Monitor. We are also considering how to further enhance the current information sharing arrangements with Medical Royal Colleges.

Generic systems concerns

We need to ensure that appropriate action is taken when patient safety concerns come to our attention, whilst being careful not to overstep our regulatory functions and intervene where another organisation may be better placed to take action.

We are aware of the importance of using our data to better support our work and that of others. We have begun to develop a data strategy, which will allow us to adopt a more proactive and data driven approach to regulation based on a proper understanding of risk. It will also help us to connect information and insight more effectively across the organisation.
32 Linked to the work on the data strategy we have established a GMC Patient Safety Intelligence Forum (PSIF). The Forum is in the early stages of development but it aims to help us better co-ordinate information from across the GMC which may raise concerns about patient safety or medical practice so that we can target our regulatory actions more effectively.

33 The development of the data strategy and the establishment of PSIF also address the emphasis in the Keogh review for the need for better use of data between organisations, as a means of driving improvement.

**Holding doctors to account**

34 Ensuring that organisations are held to account when incidents of poor care occur is a key aspect of the Francis Report. There is a legitimate public expectation that those responsible for incidents of poor care are held to account and required to justify their actions or lack of action. Part of our regulatory function is to protect the public by dealing firmly, fairly and speedily with those doctors who fail to meet the standards expected of them.

35 In 2011, we made a commitment to reform our fitness to practise procedures by streamlining our adjudication processes and strengthening confidence in the independence of our adjudication function and in the process as a whole.

36 One of our most significant reforms has been the launch of the Medical Practitioner Tribunal Service (MPTS), an independent decision making body which was set up to provide clearer separation between the GMC’s complaints and investigation functions and adjudication on those complaints.

37 Changes have also been made to the way we deal with cases at the end of an investigation. In September 2012 we piloted meetings with doctors to test whether a meeting at the end of an investigation would deliver a quicker resolution to a case. The meetings allow us to speak with doctors at an earlier stage of the FtP process and encourage them to share information with us in order for us to better understand the concern which has been raised with their practice. By speaking with doctors at this stage we are able to decide earlier if a full hearing is necessary. These changes should help us deliver a quicker system for dealing with complaints which continues to put patient safety first.

38 We are conscious that there have been occasions when we have been prevented from taking action in serious cases because the doctor concerned has been able to show that they have subsequently improved their practice. We believe that doctors and patients want stronger action in these cases. Therefore, we are currently consulting on a wider range of proposals to update the guidance we give to MPTS panels about what action should be taken to deal with doctors who do not meet our professional standards. This guidance is similar to sentencing guidelines used by courts.
The sanctions imposed on doctors range in seriousness – from warnings and restrictions on their practice, through to temporary suspension and erasure from the medical register. In August 2014 we launched a consultation reviewing our indicative sanctions guidance, given to panels when deciding on what action to take where a doctor has failed to meet the professional standards required. We are also reviewing the role of apologies and warnings. This consultation is a chance to make sure that the action we take is fair to doctors while never losing our focus on protecting the public. The consultation will run until 14 November and we will publish the outcome in 2015.

The future

We are committed to developing our regulatory framework to ensure we maintain our relevance to doctors and patients, recognising the need to evolve as a regulator as the healthcare environment in which doctors work, evolves.

We anticipate that over the next few years our regulatory framework will continue to develop in line with the proposals from the Law Commission’s Regulation of Health and Social Care Professions Bill. The Bill proposes a legal framework which will support a more modern and efficient approach to regulation by creating a single, overarching, but more flexible, legal framework that will apply to the regulation of all the nine health and social care regulators. Although the Bill has not been bought forward in this parliamentary session, we continue to support the Department of Health in developing the Bill and will continue to emphasise the need for the fundamental and wide ranging regulatory reforms which the Bill would deliver.

Although this will be the last dedicated update on our work to address the Francis recommendations and associated Department of Health commissioned reviews, the themes identified by Francis will remain part of the ways in which we strive to be a better regulator, informing the activities we undertake. The individual programmes of work that will conclude in 2015 will be reported separately on our website. We will continue to support the system wide commitment to promote a more open, honest and transparent culture in healthcare, as well as striving to enhance patient care.
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.

Working with doctors Working for patients
- Generic/systems concerns.
- Joint working and information sharing.

**Education and training**

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<th>Francis</th>
<th>GMC work to address recommendation</th>
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<tr>
<td>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:</td>
<td>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:</td>
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<td>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.</td>
<td>- Scope and understand the current appointment processes and training required by other regulators, Royal Colleges, LETBs and Deaneries.</td>
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<td>b. The Royal Colleges should be enlisted to support such visits and to provide the relevant specialist expertise where required.</td>
<td>- Map the appointment processes and training undertaken and understand the similarities and differences.</td>
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<td>c. There should be lay or patient representation on visits to ensure that patient interests are maintained as the priority.</td>
<td>- 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 website.</td>
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<td>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.</td>
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<td>e. The Department of Health should provide appropriate resources to ensure that an effective programme of monitoring training by visits can be carried out.</td>
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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 education and training can be achieved.

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<tr>
<th>156. The system for approving and accrediting training placement providers and programmes should be configured to apply the principles set out above.</th>
<th>We are reviewing our standards of medical education and training, as set out in Tomorrow’s Doctors and The Trainee Doctor respectively. 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 leaners. 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. 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. We will consult on the new framework in early 2015.</th>
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<td>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</td>
<td>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</td>
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<td>non-compliance with standards.</td>
<td>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. 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.</td>
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<td>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. Our review of <em>Tomorrow’s Doctor</em> and <em>The Trainee Doctor</em>, 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.</td>
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<td>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 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</td>
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<td>information obtained with healthcare regulators.</td>
<td>positive feedback that NTS results are a useful and valuable source of data.</td>
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<td>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 were published this month (To be updated before publication to reflect any additional reports published before October 16).</td>
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<td>Our Trainer Survey is being piloted in three Local Education and Training Boards from this month (To be updated before publication). 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.</td>
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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.

**161.** Training visits should make an important contribution to the protection of patients:

- Obtaining information directly from trainees should remain a valuable source of information – but it should not be the only method used.
- 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.
- 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.

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.

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:

- 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 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.

The new standards framework we are developing through the review of Tomorrow’s Doctors and the Trainee Doctor will 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.

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.

We will consult on the new framework in early 2015.

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.

The new framework being developed as part of the review of Tomorrow’s Doctors and The Trainee Doctor contains requirements and exploratory questions which address this recommendation, including requirements about supervision and rotas.

We will consult on the new framework in early 2015.

### 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:

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.

### GMC work to address recommendation
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.

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<tr>
<th>Clwyd Hart Review</th>
<th>GMC work to address recommendation</th>
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<tr>
<td>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.</td>
<td>We continue to look at the preparedness for practice of new medical school graduates. 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 published the report in September 2014 (To be updated before publication).</td>
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**Patient insight**

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<th>GMC work to address recommendation</th>
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<td>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,</td>
<td>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</td>
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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.

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<th>Clwyd Hart Review</th>
<th>GMC work to address recommendation</th>
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<td><strong>Pledge 1.</strong> 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.</td>
<td>We have commissioned an evaluation of our revalidation 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.</td>
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<td>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</td>
<td>We are aware that the Department of Health (England) is undertaking a project to look at the impact of revalidation in</td>
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September 2014, a research partner will have been commissioned to undertake this work.

England and we are working with Department leads to share emerging findings and minimise burdens on systems where possible.

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.

See recommendation 233 above.

**Promoting professional practice**

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<td>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.</td>
<td>Our current review of standards of medical education and training, outlined above, has considered this recommendation, 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. 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</td>
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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.

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.

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.

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.
181. A statutory obligation should be imposed to observe a duty of candour:

- **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.

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.

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 harm or distress.

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 now been agreed by the Chief Executives of the eight professional regulators and will be published late this year. 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.

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.

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<td>4. Government, Health Education England and NHS England should assure that sufficient staff are available to meet the</td>
<td>Continuing to ensure that our standards and guidance remain clear, up to date and fit for purpose is a crucial part of our</td>
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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.

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 clinical staff, building on the introduction of medical revalidation.

role. We also work with doctors, employers, trainees and patients to promote and embed the principles and values of professional practice.

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, 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 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.

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.

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<td>Pledge 4. The GMC’s core guidance for all doctors, Good medical practice, sets out what is expected of doctors, including in</td>
<td>We are continuing to work to define generic professional capabilities in partnership with the Academy of Medical Royal</td>
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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 postgraduate 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.

Helping to ensure a safe practice environment

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<td>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.</td>
<td>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</td>
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<td>165. The General Medical Council should immediately review its</td>
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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.

discontinued.

New APS requirements were introduced on 2 June 2014. 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.

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 setting providing clarity for doctors and the organisations that employ or contract with them.
Generic systems/ concerns

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<td>222. The General Medical Council should have a clear policy about the</td>
<td>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.</td>
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<td>circumstances in which a generic complaint or report ought to be made</td>
<td>We contribute to the identification and investigation of systemic or generic concerns by: signposting 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.</td>
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<td>to it, enabling a more proactive approach to monitoring fitness to</td>
<td>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</td>
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<td>practise.</td>
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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.

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. 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 development of information sharing agreements with other systems regulators.

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<td>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</td>
<td>See recommendation 222 above.</td>
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mistreatment.

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 use, and that appropriate action is taken in response to incidents, including provision of appropriate support to the affected patients and their carers.

Information sharing and joint working

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<td>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.</td>
<td>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.</td>
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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.

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.

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<tr>
<th>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.</th>
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<td>See above, recommendation 152.</td>
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<th>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</th>
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<tr>
<td>See recommendation 152 above and 224 below.</td>
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<td>Information.</td>
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<td>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.</td>
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<td>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 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.</td>
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<td>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.</td>
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<tr>
<td>See recommendation 152 above outlining our work to strengthen relationships with CQC and others.</td>
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<td>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</td>
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<td>We remain interested in exploring the possibility of offering the services of the Medical Practitioner Tribunal Service (MPTS) to other regulators in due course. The publication on 2 April of the draft Law Commission Bill has been a stimulus for</td>
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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.

### 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

- 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, 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.

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<td>See recommendation 152 above outlining our work to strengthen relationships with the CQC and others.</td>
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<td>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</td>
<td>See recommendation 152 above outlining our work to strengthen relationships with CQC and others.</td>
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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.
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 proprieties 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.

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.