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Aims of the protocol?

This protocol is intended to support staff from the General Medical Council (GMC) and the Care Quality Commission (CQC) as they work together to help protect patients and promote high standards of medical practice.

This guidance builds on the memorandum of understanding to provide an operational model for staff of both organisations. In several areas of work in the GMC and the CQC, information gathered by one organisation can help the work of the other. The protocol is part of a suite of guidance and tools, called the joint working framework.

It outlines:

- key contacts in each organisation
- when and how CQC and GMC will share and record information, including categories, themes and examples of when and how information should be shared across all relevant directorates in both organisations.

The protocol is designed to work alongside existing processes in each organisation.

Key contacts at CQC and GMC

The CQC and the GMC have different structures. To make sure there is always a clear point of contact, each organisation has a single email address for sharing information. You should use these email addresses both to request information and to share concerns.

The CQC enquiries email ensures that queries are directed to the inspector via the customer relationship management system specific to a particular service, or the relevant member of CQC staff.

The GMC email account is checked regularly to ensure that requests and concerns are transferred to the appropriate part of the organisation as quickly as possible.

Staff will receive an acknowledgement for their email. Both organisations will monitor the exchange of information to enable us to evaluate outcomes.

If you think something is urgent and presents a risk to patient safety you should escalate the issue to the nominated contact in your own organisation and the counterpart organisation without delay. For details of escalation contacts see Annex 1. For information on urgent and emerging concerns, please see page 6.
<table>
<thead>
<tr>
<th>GMC staff approaching CQC</th>
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<tr>
<td>CQC staff approaching the GMC</td>
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<tr>
<td>In all cases, copy in the mailbox</td>
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</tbody>
</table>
When and how we share information

There are six planned ways that we share information:

- routine information sharing
- emerging and urgent concerns (non-routine)
- local liaison
- coordination of ongoing activities
- risk and quality summits
- strategic collaboration.

Routine information sharing

Routine information sharing is an important way of making sure that both the GMC and the CQC can fulfil their functions effectively. The GMC routinely shares published information about the fitness to practise of individual doctors with the CQC. Information about a doctor’s health is always kept confidential.

Examples of current routine information sharing between CQC and GMC include:

- information provided by the GMC for CQC inspection activity, including data from the GMC’s annual national training survey, primarily through provision of the Designated Body Dashboard
- the GMC shares its monthly summary on enhanced monitoring with the CQC. This lists all organisations delivering medical education or training where the GMC’s Education team has active concerns
- the CQC shares a weekly output covering the most recent judgements
- the GMC sends a monthly decision circular to CQC. This lists all sanctions (whether interim or substantive) and warnings brought against UK registered doctors in the previous month. It also lists those doctors who have taken voluntary erasure, or have been administratively erased, while in GMC fitness to practise processes.

The information can also be provided on request, and a doctor’s registration status can be checked by searching the List of Registered Medical Practitioners on the GMC’s website at: www.gmc-uk.org/doctors/register/LRMP.asp.

The GMC also tells the CQC about forthcoming fitness to practise panel hearings, which are held by the Medical Practitioners Tribunal Service (MPTS).
The MPTS interim orders tribunals can place conditions on a doctor’s registration, or suspend a doctor, when there are particularly serious allegations making it appropriate to restrict the doctor’s practice during investigation. These restrictions and suspensions are included in the decisions circular, but it is important to note that the allegations have not been fully investigated and may be unfounded.

**How the CQC uses information about individual doctors**

Under the *Health and Social Care Act 2008* the CQC has a statutory responsibility to register and regulate providers and registered managers of regulated activities. Regulated activities are defined in the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2010* (the Regulations). The provision of primary medical services is a regulated activity. This means that many GPs have applied to the CQC to register as individuals or as members of partnerships to carry on regulated activities.

An individual or partnership that provides regulated activities should be able to comply with the requirements of the Regulations, including the requirement to be fit to carry on the regulated activity. In regulation 4 of the Regulations, being fit means that an individual is of good character, is physically and mentally fit and has the necessary qualifications, skills and experience to carry on the activity. A partner in a partnership must be of good character, be physically and mentally fit and the partnership as a whole must have the necessary qualifications, skills and experience to carry on the activity.

Those GPs who are in the GMC fitness to practise processes, and are seeking CQC registration to carry out regulated activities, may tell CQC about their case and any restrictions, or existing sanctions or warnings. The CQC can confirm any information about restrictions, sanctions and warnings through the List of Registered Medical Practitioners, the decisions circular and notifications of MPTS hearings.

The GMC and the CQC are working together to protect the public by ensuring that we share information about individual doctors where the law and our statutory powers allow it.

**Emerging and urgent concerns (non-routine)**

Emerging or urgent concerns that may present risk of harm to patient safety need to be shared more quickly than through routine channels.

Urgent concerns regarding doctors, systems and environments where doctors are trained fall into the following categories:

- concerns about an individual doctor’s fitness to practise
- concerns about an individual’s doctors registration and revalidation
- concerns about the quality of education, systems or environment.

Emerging system concerns may affect one or more directorate within the GMC.

A system concern is about the systems that should be in place to safeguard patients. GMC staff should refer any system concerns which include to the following issues:

- staffing issues
- management/leadership issues
- equipment and premises
- patient safety.

Further details and examples of fitness to practise system concern categories can be found in Annex 2. Examples of information sharing with the CQC can be found in the following annexes:

- Annex 4: Fitness to practise examples
- Annex 6: Education examples
- Annex 8: Registration and Revalidation examples
- Annex 11: Regional Liaison Service examples

If you think that a concern relates to the other organisation’s regulatory remit but are uncertain whether to share this information, you should discuss with your manager or key escalation contact in Annex 1.
Information for CQC staff on sharing concerns with the GMC

When to share non-routine information

Referring a concern to the GMC is appropriate when the conduct, performance or health of a doctor raises potential issues about their fitness to practise. The GMC provides detailed guidance about raising a concern at:

www.gmc-uk.org/concerns/employers_information.asp

The thresholds for sharing non-routine information with the GMC are contained in the following document:

www.gmc-uk.org/Guidance_GMC_Thresholds.pdf

Referral to the GMC is also appropriate when serious concerns arise in an environment in which doctors are trained. Medical staffing and rota issues may mean that doctors in training are not getting the clinical supervision they require, which can put patients at risk.

Examples of when we share non-routine information are contained in Annexes 4, 6 and 8.

Where there are concerns about an individual doctor, in almost all cases, the responsible officer* (NHS England or Health Education England for doctors in training) should make the referral to GMC.

The purpose of liaising with the responsible officer is to ensure that:

- all the relevant information is available to the doctor’s responsible officer to allow them to fulfil their statutory role in the investigation of fitness to practise concerns
- appropriate support is available for the doctor
- appropriate support is available for relevant colleagues (such as doctors in training attached to the doctor)
- adequate resource is available for the investigation and remediation of concerns.

When communicating with the doctor’s responsible officer, the GMC’s local employer liaison adviser should be copied in to ensure that no delays occur that provide a risk to patient safety. If the responsible officer does then decide to make a formal referral to the GMC, then the CQC inspector should ensure they are copied in to provide assurance

* Responsible officers are nominated or appointed by designated bodies under the Medical Profession (Responsible Officers) Regulations 2010. The designated bodies are listed in the schedule.
that the referral has occurred. Relationships with responsible officers should be held at a local level and work within strategic agreements with NHS England and Health Education England.

Some issues involving doctors may be better addressed by the Trust or referral to the National Clinical Assessment Service if they include training or performance issues that do not directly place patients at risk. However, local action or an existing referral should not preclude either a CQC referral to the GMC, or contacting the GMC employer liaison adviser. There may also be times where a referral to the GMC is appropriate but where the responsible officer is reluctant to make the referral e.g. when doctors move between jobs frequently. In these cases, the CQC may still decide to proceed with a referral to the GMC itself.

If you think a concern relates to the other organisation’s remit, but are uncertain whether the concern is sufficiently serious to engage their processes, you should discuss with your manager and/or the key escalation contacts in Annex 1.

How to share non-routine information

After considering the issue and the action that has been taken, it may be that the CQC still wishes to make a referral to the GMC. In such instances there is a range of information that may be useful to include, such as:

- the doctor’s full name, or surname, initials and GMC reference number
- the name and address of the department, trust, hospital, care home or practice where they work
- a full account of the events or incidents that prompted the referral, with dates if possible, and a note of your concerns
- copies of any relevant papers and any other evidence you have
- details of any action you have taken already
- details of anyone else who can support the referral
- details of any investigation or action being taken by the CQC and the local contact at the CQC.

The GMC has a team of senior fitness to practise staff based in the regions of England called employer liaison advisers. Employer liaison advisers work with responsible officers and their teams in the NHS and the independent sector, advising on GMC fitness to practise procedures, thresholds for referral and revalidation.
The GMC also have a team of regional liaison advisers who work regularly in health care environments, meeting with groups of doctors, medical students and patients. This team links closely with the employer liaison service and regional education managers to share information and intelligence they are made aware of and patient safety concerns.

If the issue is related to clinical supervision or other serious concerns in environments where doctors are trained, details should also be shared as per agreed routes. The GMC has a team of regional education managers who oversee all education and training within their region, and provide advice to organisations and individuals who are involved in the training of doctors locally.

**You should refer your concern by emailing:**

- GMC email address the local GMC employer liaison adviser (Annex 1)
- the GMC regional education manager (Annex 1)
- the relevant CQC regional lead (Annex 1).

Once you have decided to refer information about a doctor or an organisation you should record information on the referral in the appropriate place (for example through the customer relationship management system).

Confidential personal information must only be shared under this protocol where the purpose of that disclosure provides a legal basis for doing so, determined by considering the CQC statutory Code of Practice on Confidential Personal Information and Sharing Information Guidance. The CQC will only share confidential information where it has considered the likely impact of making the disclosure, the implications of making the disclosure, and where we judge that the public interest to be served by sharing the information justifies doing so.

You can find the CQC Code of Practice on confidential personal information at [www.cqc.org.uk/content/confidentiality-and-sharing-information](http://www.cqc.org.uk/content/confidentiality-and-sharing-information)
Information for GMC staff on sharing concerns with the CQC

When to share non-routine information

When the GMC identifies system concerns it should consider whether to share this information with the CQC. When considering sharing information with the CQC, the GMC must also consider informing relevant bodies at a local level that may be able to provide immediate resolution. This can be discussed with the relevant employer liaison adviser, or if the information was received at a local event, such as a training session with junior doctors, then consideration should be given to raising the concern directly with the local body in the first instance.

In most cases, consent is not required for the GMC to share the information.

There may be instances where the GMC believes concerns are serious enough to share with the CQC but an individual has raised concerns about sharing information. Decisions as to whether to share system concerns when someone has raised concerns about our sharing their information will be taken within individual directorates. In the Fitness to Practise directorate the decision will be taken by the Assistant Director (Investigations).

When considering whether to share information with the CQC, consideration must be given to the data protection principles. This means you must share only relevant information and the minimum information necessary to achieve the objective.

You must discuss all instances of sharing information when an individual has raised concerns with your line manager/head of section, and get their authorisation before sharing. They may, if required, take advice from the Information Access team, or refer to the Emerging concerns protocol.

Examples of sharing non-routine information are contained in Annex 4, 6 and 8 and 11.

How to share non-routine information

After considering the issue and the action that has been taken, it may be that the GMC still wishes to share information with the CQC. In such instances there is a range of information that may be useful to include:

- the event or issue identified
- the risks to patients, service users or staff
- how the risk was identified and whether it was verified
- incident location
- incident date
system concern category

reasons for referral.

If sharing information that relates to an unproven allegation, we must make it clear that the allegation is unproven.

For clarification on whether to share information, you should seek advice from your line manager or from the relevant GMC contact for your directorate:

<table>
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<tr>
<th>Education and Standards</th>
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<tr>
<td>Fitness to Practise</td>
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<tr>
<td>Registration and Revalidation</td>
<td></td>
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<tr>
<td>Strategy &amp; Communications &amp; Engagement</td>
<td></td>
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</tbody>
</table>

You should refer your concern by emailing:

- GMC email address copy in
- the local GMC employer liaison adviser (Annex 1)
- the relevant CQC regional lead (Annex 1)
- the relevant GMC regional liaison adviser (Annex 1).

Requests from CQC for information that is not in the public domain must be reviewed in line with the Level 3 Access Policy and be approved by a manager. Please see annex 9 for further information on Level 3 access.
Local liaison meetings

Local liaison meetings provide a structured, scheduled way for the GMC and the CQC to share information at the local level.

Local liaison allows us to:

- provide updates on any local changes at each organisation
- carry out a local stocktake, whereby each regulator highlights key concerns and activities that the other should be aware of in the region
- consider actions that either regulator may need to take in response to these concerns and activities
- interrogate statistical data and analyse trends to develop a better understanding of each other's data and information
- build relationships between local teams across the two organisations
- review the effectiveness of communication and information-sharing channels.

Local liaison can be held as a meeting between just the GMC and the CQC or as part of a wider meeting with other stakeholders, for example through Local or Regional Quality Surveillance Group meetings.

As a minimum, it is expected that local teams will meet with their counterparts twice a year. Visibility of these meetings should be provided through regional heads, so that assurance can be provided to senior management that local liaison is occurring consistently at a national level.

This document does not set out to enforce strict rules of engagement – your working relationship with your counterpart needs to work best for you. Local relationships are integral to successful partnership working between both organisations.

Coordination of ongoing activities

The coordination of ongoing activities includes sharing information at a number of points in the CQC’s inspections and the GMC’s planned visiting processes. We can coordinate this in a range of ways, including but not limited to:

- using information from the other organisation as part of the evidence base to decide whether or not to undertake a coordinated activity and/or the selection of region or sites where an activity will take place
aligning dates of activity (either to coincide or to leave enough time between activities, which will reduce the burden on the provider and ensure the outcomes of earlier activity can be taken into account)

considering making a joint inspection or visit (likely to be in the event of a serious ongoing concern at a healthcare provider)

inviting a member of the other organisation to shadow an inspection

sharing information before an activity and any outcomes, ensuring that we give a consistent message to the organisation or, where that is not possible, that the reasons for the different perspectives of the regulators are clear

sharing early post-inspection correspondence with GMC sent by the CQC to providers highlighting concerns of interest to the GMC. This may include post inspection briefings dependent on the issues raised.

Coordinating activity has to allow for the differences between the two regulators. For example, visits by the GMC Education team are planned several months in advance, whereas CQC visits can be unannounced.

You can use the planning tool in Annex 10 to help you decide whether to undertake a coordinated joint planned inspection, and what form that inspection should take.

Risk and quality summits

Risk summits
Risk summits to review urgent concerns at a healthcare provider can be triggered by a range of organisations. This is not to be confused with a CQC quality summit, which occurs after a CQC inspection. When a risk summit is called, GMC and CQC staff who have been invited should check that the other organisation has also been invited.

Quality summits
The purpose of CQC quality summits is to develop a plan of action and recommendations based on the inspection team’s findings as set out in the hospital inspection report. This plan will be developed by partners from within the health economy and the local authority.

If the inspection raises concerns about a provider which may call into question its suitability as a learning and training environment, the CQC should ensure that the GMC is invited to the quality summit by inviting the relevant GMC employer liaison adviser and copying in the joint mailbox:
Strategic collaboration

Strategic collaboration includes longer term, higher level activity, such as national concerns, thematic reviews, and media and communications work. This will primarily be managed through the joint working group, to which both organisations will provide a regular update on strategy, policy and communication.

The chief executives and the CQC’s chief inspectors also meet on a regular basis to ensure each organisation is aware of arising issues and to raise any concerns.

Press and publications

The CQC and the GMC will endeavour to give each other adequate warning of, and sufficient information about, any planned public announcements on issues relevant to the other organisation. It is acknowledged that this may be challenging in some circumstances, such as where urgent enforcement is action required.

Each organisation will involve the other as early as possible in the development of planned announcements, including through sharing drafts of proposals and publications that may affect both regulators.

Each organisation will ensure wherever possible that the other receives:

- drafts of any planned publications with implications for specific healthcare providers approximately 48 hours before they are released to the media
- drafts of any press releases with implications for specific healthcare providers approximately 24 hours before they are released to the media.

The CQC and the GMC will respect the confidentiality of any documents shared in advance of publication and ensure that the content of those documents is not made public ahead of the planned publication date.

Evidence to parliamentary committees and central government

The CQC and the GMC will, where possible, share with each other details of evidence provided to any parliamentary committees in relation to the operation of the regulatory regime or the exercise of their functions. This should take place in line with standard rules on parliamentary hearings or engagements. As such, there may be occasions when one party is unable to share their evidence in advance of the hearing or engagement.
**Safeguarding**

Sometimes the CQC or the GMC receive complaints which indicate that abuse, harm or neglect has taken place. Any form of abuse, avoidable harm or neglect is unacceptable and should not be tolerated by a provider, its staff, the regulators, or by members of the public or professionals who may also become aware of such incidents.

It is essential that we follow the correct procedures when dealing with safeguarding issues. Both the CQC and the GMC have organisational processes in relation to safeguarding and whistleblowing, which are reviewed and updated regularly.

CQC staff can find safeguarding protocols on their website at [www.cqc.org.uk/content/safeguarding-people](http://www.cqc.org.uk/content/safeguarding-people).

The GMC protocol on sharing information with social services can be found [here](http://www.gmc-uk.org/about-gmc/our-work/protecting-public/whistleblowing/) and the GMC protocol for referring information to the Disclosure and Barring Service ('DBS') can be found [here](http://www.gmc-uk.org/about-gmc/our-work/protecting-public/whistleblowing/).

It is for the body who receives information giving rise to safeguarding concerns to escalate this as appropriate in line with the protocols outlined above. However in certain circumstances this information may also highlight wider concerns, e.g. about systems pressures or an individual doctor’s conduct. In these circumstances any decision to share information between the GMC and CQC will be taken in accordance with the procedure for ‘sharing of non-routine information’ outlined at pages 9 – 13 of this document.
Whistleblowing

The term whistleblowing can be defined as raising a concern by a current or ex-employee of an organisation who reports on problems about the safety and quality of care being provided.

The CQC and the GMC have joined with other regulators, professional bodies and trade unions to launch the Speaking Up Charter, a commitment to work together to support people who raise concerns in the public interest. Concerns identified from whistle-blowers to the CQC regarding the fitness to practise of doctors will be shared with the GMC, whilst concerns raised with the GMC regarding system concerns at health care providers will be shared with CQC.


Any information about concerns for the safety of patients or service users must be treated urgently and flagged as such. Neither of our organisations should suspend its own statutory enforcement responsibilities and processes pending the outcome of another process, without ensuring appropriate interim measures are put in place.

In response to concerns about the culture in the NHS, the Secretary of State for Health commissioned Sir Robert Francis to carry out an independent policy review ‘Freedom to Speak Up’. The review was asked to identify measures to foster a culture in the NHS in England where staff can feel safe to speak out about patient safety, as well as learning lessons by listening to those who have experiences to share both positive and negative. The review identified the need for a National Freedom to Speak Up Guardian.

(See Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS: Feb 2015)

The National Guardian’s office opened in April 2016

The National Guardian’s Office is hosted by the Care Quality Commission, which means it is a prescribed body for the purposes of the Employment Rights Act 1996. This legislation is commonly referred to as the Public Interest Disclosure Act 1988, or PIDA, which made the changes to the Employment Rights Act.

The Care Quality Commission, NHS England and NHS Improvement are all prescribed bodies. This means that where a worker makes a disclosure, which is a protected disclosure within the meaning of the legislation, they may be able to claim unfair dismissal at an Employment Tribunal if they are victimised or dismissed for doing so.

More detail can be found here:

http://www.cqc.org.uk/content/information-nhs-staff
Annexes

Annex 1: Escalation contacts

Escalation contacts at the GMC and CQC

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<th>GMC</th>
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<td>CQC</td>
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<td>Primary Care</td>
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<td>Hospitals</td>
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<tr>
<td>Strategic Lead</td>
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<tr>
<td>Hospitals</td>
<td>North West</td>
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<tr>
<td><strong>Primary Medical Service</strong></td>
<td>North</td>
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### GMC employer liaison advisers

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<th>Region</th>
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<tbody>
<tr>
<td>Merseyside and Cheshire</td>
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<td>North East, Lancs and Cumbria</td>
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<td>Greater Manchester</td>
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<td>East Yorkshire</td>
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<td>West and South Yorkshire</td>
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<td>North Midlands</td>
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<td>West Midlands</td>
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<td>Central Midlands</td>
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<td>South Midlands</td>
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<td>East of England</td>
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<td>London – South West</td>
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<td>London – North East</td>
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<td>London – North West</td>
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<tr>
<td>London – South East</td>
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<tr>
<td>South Central, Military and Channel Islands</td>
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<td>South West and Thames Valley</td>
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<tr>
<td>Wessex and South West Coast</td>
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<td>South East</td>
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<td>South Pennines</td>
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### GMC regional education managers

<table>
<thead>
<tr>
<th>Region</th>
<th>Contact Details</th>
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<td>North West, West Midlands</td>
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<td>North East, Yorkshire &amp; Humber</td>
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<td>East of England, East Midlands</td>
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<tr>
<td>Kent, Surrey and Sussex, London</td>
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<tr>
<td>South West, Thames Valley, Wessex</td>
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### GMC regional liaison advisers;

- **Head of the Regional Liaison Service (RLS) for England**
- **Principal RLA North of England**
- **Principal RLA South of England**
- **North East and Cumbria**
- **North West**
- **Yorkshire and Humber**
- **East Midlands**
- **West Midlands**
- **East of England**
- **London – North**
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<th>Region</th>
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<td>London - South</td>
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<td>West of England</td>
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<td>South West</td>
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<td>South East</td>
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## Annex 2: System concern categories to be shared with the CQC

<table>
<thead>
<tr>
<th>Category</th>
<th>Examples</th>
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<tbody>
<tr>
<td><strong>Premises</strong></td>
<td>- Insufficient or faulty equipment</td>
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<td></td>
<td>- Lack of appropriate facilities of equipment</td>
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<td></td>
<td>- Poor accessibility</td>
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<td></td>
<td>- Poor safety or hygiene</td>
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<tr>
<td><strong>Treatment</strong></td>
<td>- Ineffective referral process</td>
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<tr>
<td></td>
<td>- Avoidable death, injury or infection</td>
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<td></td>
<td>- Delays or cancellations of treatment</td>
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<tr>
<td></td>
<td>- Failure to provide mental health services</td>
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<td></td>
<td>- Misuse of mental health legislation</td>
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<td></td>
<td>- Use of restraint</td>
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<tr>
<td><strong>Staffing issues</strong></td>
<td>- Insufficient staffing</td>
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<td></td>
<td>- Undertrained staff</td>
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<td>- Commissioning or commercial decisions</td>
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<td>- Victimisation of staff</td>
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<td>- Pressurising staff to suppress concerns</td>
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<td>- Failures to follow procedures or guidelines</td>
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<td></td>
<td>- Failure to report incidents</td>
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<td>- Management or monitoring of medication</td>
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<td>- Staff not registered with the relevant regulators</td>
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<tr>
<td><strong>Patient experience</strong></td>
<td>- Delays in admission, transfer or discharge</td>
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<tr>
<td></td>
<td>- Early discharge</td>
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<td>- Lack of dignity or respect to patients</td>
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<td>- Lack of involvement in decisions</td>
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<td>- Poor communication</td>
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<td>- Poor nutrition</td>
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<td></td>
<td>- Lack of confidentiality eg patient records</td>
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<tr>
<td></td>
<td>- Discrimination (access to care)</td>
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<tr>
<td></td>
<td>- Security failings</td>
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<tr>
<td></td>
<td>- Failure to obtain informed consent</td>
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<tr>
<td></td>
<td>- Discrepancies on medical records or death certificates</td>
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<td></td>
<td>- Waiting times</td>
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<td></td>
<td>- Safeguarding concerns</td>
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</tbody>
</table>
## Annex 3: Examples of information raising fitness to practise concerns shared with the GMC

<table>
<thead>
<tr>
<th>Scenarios</th>
<th>Rationale</th>
<th>What will information be used for?</th>
</tr>
</thead>
</table>
| **1 Primary medical services (GPs)**<br>CQC contacted by NHS England regarding a single-handed GP practice. Concerns were sufficient to warrant a responsive inspection. Concerns include:  
- lack of confidentiality for patients  
- poor recruitment of staff  
- repeat prescriptions being written with no review  
- potential fraud. | This raises potential fitness to practise concerns regarding the doctor. | To inform the GMC investigation process. |
| **2 Primary medical services (GPs)**<br>CQC inspects a single-handed GP practice. It finds the provider is below the required standards in a number of areas and requires improvements. Warning notices are issued. Concerns include:  
- inadequate records  
- failure to refer when urgent referral was indicated  
- out of date vaccines  
- poor hygiene. | Possible referral as these issues may signify poor practice. | To inform the GMC investigation process and notify the local NHS area team. |
<p>| <strong>3 Hospital services</strong>&lt;br&gt;During the course of an inspection the team is told by several members of staff that one of the doctors is persistently very late for work, making weak excuses but expecting others to cover. They believe this is because she has a chaotic home life with no fixed child-minding arrangements. | This is unlikely to be a GMC referral issue as the doctor’s fitness to practise is not significantly impaired. Nevertheless some action should be taken as behaviour is disruptive to the department. The medical director should initiate appropriate action. | If initial action by medical director does not resolve issues, the concern could be referred to the GMC. |</p>
<table>
<thead>
<tr>
<th><strong>4 Hospital services</strong></th>
<th>After a focus group of doctors in training, one of them requests a 1–1 meeting. At this meeting he mentions his concerns about the performance of one of his consultants. He says that he has witnessed him operating in a way that he has never seen before, being aggressive with instruments and panicking at the resultant blood loss.</th>
<th>This requires urgent action by the trust medical director. Patient safety is at risk. If there is sufficient evidence to support the concern then an interview with the surgeon may result in suspension from operating pending further investigation. If he fails to engage then GMC referral may be needed.</th>
<th>If initial action does not resolve issues, this concern could be referred to the GMC.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>5 Hospital services</strong></td>
<td>During an interview a midwife says she has concerns about an obstetrician who is carrying out exposure prone procedures and whom she believes has a chronic viral infection that could be transmitted to patients. She is concerned that the obstetrician realises he has been recognised and he is looking to move on to another job elsewhere.</td>
<td>The medical director needs to interview the doctor to establish the facts. Did they make a false declaration on their occupational health questionnaire? The concern here is that if this doctor persistently moves on then they may present a risk to other patients.</td>
<td>In such cases, referral to the GMC should be considered to inform the investigation process.</td>
</tr>
<tr>
<td><strong>6 Mental health services</strong></td>
<td>An approved mental health practitioner (AMPH) raises a concern in a focus group relating to a section 12 doctor not employed by the trust who is repeatedly rude to both service users and other members of the assessing team. There have been several incidents when the doctor has shouted at the assessing AMPH if his clinical judgement is questioned or errors in his paperwork are pointed out.</td>
<td>This should initially be referred to the medical director of the trust for initial investigation and consideration of referral to the GMC. CQC does have a more direct role here however as it has a statutory role in the review of the performance of the Mental Health Act.</td>
<td>If there were sufficient concerns that weren’t being directly addressed by the trust medical director after referral then there is a need for CQC to share with the GMC.</td>
</tr>
</tbody>
</table>
# Annex 4: Examples of Fitness to Practise information shared with the CQC

<table>
<thead>
<tr>
<th>Scenarios</th>
<th>Rationale</th>
<th>What will information be used for?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff at the hospital failed to record fluid intake/output in a patient with recurrent vomiting. The evidence of dehydration was concealed from the medical records.</td>
<td>This represents a risk to patient safety as it shows potentially life threatening failures in monitoring a patient. If repeated this could also cause future harm to patients.</td>
<td>To trigger a responsive inspection.</td>
</tr>
<tr>
<td>A medical unit was run by bank and agency staff on one weekend. These staff did not have access to patient records and care ceased at the weekend as a result.</td>
<td>Without access to patient records there is a potential risk of future harm to patients.</td>
<td>To trigger responsive inspection.</td>
</tr>
<tr>
<td>Poor record keeping, inadequate staffing levels and poor systems identified for communicating abnormal results at a GP surgery.</td>
<td>Inadequate staffing levels, poor record keeping and inadequate ways of communicating abnormal results all indicate systems concerns and potential risk to patient safety.</td>
<td>To inform CQC inspection program.</td>
</tr>
<tr>
<td>Concerns raised about the poor cleanliness of the wards. The allegations are supported by other patients who were on the ward at the same time.</td>
<td>An unclean environment could lead to infection and therefore there is the potential for harm to patients.</td>
<td>To inform CQC inspection program.</td>
</tr>
</tbody>
</table>
### Annex 5: Education system concern categories

A number of issues may arise within a healthcare environment which have adverse effects on the education and training that takes place there. Some themes and examples are presented below:

<table>
<thead>
<tr>
<th>Categories</th>
<th>Examples</th>
</tr>
</thead>
</table>
| **Patient Safety**       | - Staffing issues: insufficient staffing, low levels of recruitment, high turnover, undertrained staff and frequent or inappropriately filled rota gaps  
                           - Significantly heavy or intense workload  
                           - Poor health of doctors in training e.g. adverse effects of sleep deprivation due to poor rota design  
                           - Doctors in training working hours which are contravening European Working Time Regulations  
                           - Ineffective or problematic care pathways  
                           - Procedure/protocol/safeguarding issues e.g. problems with handover or serious incident reporting or escalation procedures unclear  
                           - Lack of clinical supervision  
                           - Doctors in training expected to carry out tasks beyond their competency without appropriate support or supervision  
                           - Supervisors are not clearly identified, accessible and/or approachable  |
| **Environment**          | - Poor patient experience and/or poor service outcomes that may make the environment unsuitable for training                                                                                           |
| **Management/Leadership**| - Lack of visible/proactive management  
                           - Lack of engagement in identifying and resolving safety and education issues  
                           - Lack of a clear strategy for education and training and how it relates to service delivery  
                           - Lack of profile of education on board agendas  |
| **Undermining, Bullying or Harassment** | - Systemic problems with or culture of undermining, bullying or harassment  
                                                             - Undermining, bullying or harassment amongst  |
consultants or other healthcare professionals which is likely to negatively impact on education and training

- Equality and diversity: failure to comply with relevant legislation or policies
- Discrimination: failure to comply with relevant legislation or policies

**Other Education and Training Concerns**

- Education is not valued, evaluated, visible in management decision-making
- Lack of educational supervision
- Doctors in training unable to attend regular, relevant, timetabled, organised educational sessions
- Doctors in training regularly required to carry out inappropriate tasks which are of little or no educational value
- Doctors in training not getting appropriate access to educational opportunities, such as theatre experience or are not receiving regular feedback
- Evidence of falsifying training records
# Annex 6: Examples of information to be shared with CQC from GMC Education

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Rationale</th>
<th>What will information be used for?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 On a GMC visit, the team identify the following: The closure of the gynaecology ward at weekends means that patients are dispensed to a number of different outlying wards. The process by which patients are assigned to different wards is unclear, including the sign off process. Their care may be provided by the doctors in these departments who do not have any training or experience in obstetrics or gynaecology although they have been provided an induction to the specialty and treatment of its most common conditions.</td>
<td>This raises concerns as to whether the quality of care is: safe, effective, caring, responsive to people’s needs or well-led.</td>
<td>To inform intelligence monitoring and the CQC inspection programme.</td>
</tr>
<tr>
<td>2 A letter of complaint has been sent to the GMC from Core Medical Trainees at a hospital stating that: Doctors are moved around from ward to ward on a daily basis in order to cover gaps in the rota. This has led to poor continuity of care and absolutely no teaching or training value. When raised with medical staffing, these concerns have been ignored because service provision seems to remain a priority.</td>
<td>This raises concerns as to whether the quality of care is: safe, effective, caring, responsive to people’s needs or well-led.</td>
<td>To inform intelligence monitoring and the CQC inspection programme.</td>
</tr>
<tr>
<td>3 On a GMC visit, the team identify the following: there is a high volume of patients coming into the emergency department, the four hour target is being breached daily and trainees are unable to move patients into the appropriate specialty wards because there are no available beds. The staff in the emergency department report undermining behaviours in several receiving specialties and patient flow is not working as it should. There are reports of ambulances parked outside the emergency</td>
<td>This raises concerns as to whether the quality of care is: safe, effective, caring, responsive to people’s needs or well-led.</td>
<td>To inform intelligence monitoring and the CQC inspection programme.</td>
</tr>
</tbody>
</table>
department because paramedics are not able to hand over patients to the emergency department and provide them with a safe environment to await treatment.

4 On a GMC visit, the team identify the following: planned cancer surgeries are not happening because there are no post-operative beds available. This is due to long term boarding of medical patients who no longer need hospital care but cannot be discharged into the community because they do not have carers or community based healthcare professionals to provide after care. This raises concerns as to whether the quality of care is: safe, effective, caring, responsive to people’s needs or well-led. To inform intelligence monitoring and the CQC inspection programme

5 On a GMC visit, the team are told by one of the trainees that they are training at a single handed General Practice and that their trainer has been on long term sick leave requiring them to see patients on their own and without the opportunity for senior review or to discuss potential treatment or referrals. This raises concerns as to whether the quality of care is: safe, effective, caring, responsive to people’s needs or well-led. To inform intelligence monitoring and the CQC inspection programme
### Annex 7: Examples of information to be shared with GMC Education from the CQC

<table>
<thead>
<tr>
<th>Scenarios</th>
<th>Rationale</th>
<th>What will information be used for?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong> A GP practice has been put into special measures by the CQC after being rated as inadequate for 'being safe, effective, caring, responsive and well-led.' There may be medical students and doctors in training who are on placements at this practice.</td>
<td>This raises potential education and training concerns.</td>
<td>To help us work with the local education and training board (LETB) and the medical school to determine whether the practice remains an appropriate environment for education.</td>
</tr>
<tr>
<td><strong>2</strong> On a CQC visit, the inspectors identify the following: Foundation doctors in surgery described signing discharge letters that have been written by other doctors and relate to patients they have never examined. One foundation doctor has also prescribed antibiotics for a patient they have not examined because of pressure placed on them by a nurse.</td>
<td>This raises potential patient safety and undermining and bullying concerns.</td>
<td>To take immediate action to ensure Foundation doctors are not pressured to work beyond their competence.</td>
</tr>
<tr>
<td><strong>3</strong> On a CQC visit the inspectors identify that adequate checks to ensure staff are properly qualified and able to do their job are not being carried out before employing staff, including locum doctors who may have to fulfil a supervisory role for doctors in training.</td>
<td>This raises potential education and training concerns, including supervision and patient safety.</td>
<td>To take immediate action to ensure supervision of doctors in training is safe and effective.</td>
</tr>
<tr>
<td><strong>4</strong> On a CQC visit the inspectors identify the following: doctors in training are not being provided with learning opportunities that are required in order for them to progress. They are often charged with taking blood samples and catheterising patients because there is no phlebotomy service and nursing staff are not able to undertake basic clinical skills.</td>
<td>This raises potential concerns of trainee progression and patient safety concerns.</td>
<td>To work with the LETB to ensure that doctors in training are undertaking tasks with educational value.</td>
</tr>
</tbody>
</table>
# Annex 8: Registration and Revalidation categories

<table>
<thead>
<tr>
<th>Categories</th>
<th>Examples</th>
</tr>
</thead>
</table>
| Registration     | - Unregistered doctor working at a CQC-registered clinic  
|                  | - Unregistered doctor undertaking regulated activities at a clinic not registered with the CQC  
|                  | - Information of when conditions will affect a practice’s CQC registration (GP is also practice Manager for example—This would also be fitness to practise issue) |
| Revalidation     | - Lack of appropriate appraisals  
|                  | - Poor quality appraisals  
|                  | - Clinical governance process at NHS FT or Trust is not robust and there are concerns about revalidation recommendations  
|                  | - Evidence of inadequate resources to support revalidation  
|                  | - Evidence that an organisation should be a designated body and is not supporting doctors with revalidation  
|                  | - Evidence that designated body is falsifying training records  
|                  | - Process being managed in coercive way  
|                  | - Zero evidence of proper audit |
| Leadership       | - Allegations of manipulation of statistics  
|                  | - Low quality appraisals |
Annex 9: Summary of GMC Level 3 access policy

Level 3 information is not public domain information and must be protected from inappropriate disclosure. It includes:

- date of birth
- photograph
- passport details
- registered address
- registered email address
- if a doctor is subject to a fitness to practise investigation
- revalidation submission date.

It’s important to remember access to Level 3 information is not necessarily given due to the status of an organisation but for the purpose the information is requested.

The GMC discloses information if it’s requested under relevant legislation or the purpose aligns with its responsibilities under the Medical Act 1983 and its relevant disclosure policies. The types of organisation the GMC shares Level 3 information with are:

- **Regulatory bodies** – eg General Pharmaceutical Council and the Nursing and Midwifery Council
- **Judicial authorities and Public Prosecution Service** – eg Coroner’s Office, Ombudsmen, Criminal Cases Review Commission, Independent Police Complaints Commission, Scottish Children’s Reporter Administration (SCRA)
- **Government departments** – eg HM Revenue and Customs
- **Organisations it has an information sharing agreement with** – usually NHS Litigation services
- **Employers** (present or prospective) – including NHS bodies and Judicial Appointments Commissions (England and Wales, Northern Ireland, and Scotland). They can access level 3 information to update their records, eg the GP and Ophthalmic performers lists. Only one check per call. If there is an internal fitness to practise concern, only current employers may be given level 3 access.
- **Designated bodies (including responsible officers and their delegates)** – have level 3 access for revalidation purposes, eg they require the doctor’s
revalidation submission date or contact details to confirm a doctor’s correct designated body.

- **Past employers** – for NHS employers:
  - For medical negligence litigation where a patient is involved, the address can be provided to the medical staffing officer.
  - For witness statements, the address can be provided to the medical staffing officer.
  - For any type of debt recovery, the GMC cannot assist them.

- **Solicitors** – if they work on behalf of the NHS for litigation purposes, the rules are the same as past employers above. Also includes other litigation organisations not covered by sharing agreements, e.g., army medico-legal services (who deal with medical negligence claims against the army). If it is a private solicitor, not working on behalf of NHS, do not release the address – offer post box only.

- **International regulators and other organisations with legitimate access rights** – e.g., Jersey tax office. Treat the same as HM Revenue and Customs.
Annex 10: Considerations for joint planned inspections

- **How relevant is the inspection to the other regulator?**
- **Does the focus of the inspection overlap in any way with the regulatory remit of the other organisation?**
- **Dates of planned and unplanned inspections should be shared to avoid visit clashes.**
- **Is a joint visit required?**
  - Has the organisation being inspected been the subject of specific concerns relevant to the other regulator in the past?
  - Are there known issues that fall directly within the regulatory remit of the organisation?
- **What information is required?**
  - What additional information should be gathered before the inspection?
  - Which functions or teams will provide the information?
- **Who will attend and how will it be managed?**
  - Which function or team will attend the inspection?
  - How will internal and external briefing take place?
  - How will the respective roles of the two organisations be managed during the inspection?
- **How will findings be shared and followed up?**
  - How far will initial findings be shared between the two organisations?
  - How far will final draft reports be shared?
  - How will the inspected organisation receive initial feedback?
  - Will there be any joint follow-up?

- **If no, keep the other organisation informed of any relevant findings or outcomes.**
- **Are there any issues to raise at local liaison meetings?**
Annex 11: RLS system concern categories

A wide range of issues may come to the attention of a GMC regional liaison adviser during the course of their work. They may have disclosed to them or observe one or more of the following types of issue:

<table>
<thead>
<tr>
<th>Categories</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Safety</strong></td>
<td>▪ Staffing issues including insufficient staff numbers, low levels of recruitment, high turnover, undertrained / qualified staff and frequent or inappropriately filled rota gaps</td>
</tr>
<tr>
<td></td>
<td>▪ Significantly heavy or intense workload</td>
</tr>
<tr>
<td></td>
<td>▪ Poor health of doctors e.g. adverse effects of sleep deprivation due to poor rota design or lack of breaks over prolonged periods</td>
</tr>
<tr>
<td></td>
<td>▪ Doctors working hours which are contravening European Working Time Regulations</td>
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<tr>
<td></td>
<td>▪ Ineffective or problematic care pathways</td>
</tr>
<tr>
<td></td>
<td>▪ Inadequate or ineffective procedures / protocols to deal with safeguarding issues</td>
</tr>
<tr>
<td></td>
<td>▪ Poor procedures and processes in respect of raising patient safety concerns</td>
</tr>
<tr>
<td></td>
<td>▪ Lack of clinical / educational supervision</td>
</tr>
<tr>
<td></td>
<td>▪ Doctors expected to carry out tasks beyond their competency without appropriate support or supervision or training</td>
</tr>
<tr>
<td></td>
<td>▪ Supervisors are not clearly identified, accessible and / or approachable</td>
</tr>
<tr>
<td><strong>Environment &amp; Equipment</strong></td>
<td>▪ Poor patient experience / dignity and / or poor service outcomes that may make the environment unsuitable for the provision of patient care or training</td>
</tr>
<tr>
<td></td>
<td>▪ Lack of / insufficient equipment, supplies or medication</td>
</tr>
<tr>
<td></td>
<td>▪ Poor maintenance of equipment affecting patient safety, dignity or experience</td>
</tr>
<tr>
<td><strong>Management/Leadership</strong></td>
<td>▪ Lack of visible / proactive management</td>
</tr>
<tr>
<td></td>
<td>▪ Lack of engagement in identifying and resolving safety and education issues</td>
</tr>
<tr>
<td></td>
<td>▪ Issues of patient safety raised but not dealt with</td>
</tr>
</tbody>
</table>
### Undermining, Bullying or Harassment
- Systemic problems with a culture of undermining, bullying or harassment within or across teams / depts
- Undermining, bullying or harassment amongst consultants or other healthcare professionals which is likely to negatively impact on education, training or the quality of care to patients
- Equality and diversity: failure to comply with relevant legislation or policies
- Discrimination: failure to comply with relevant legislation or policies

### Other concerns
- Education is not valued, evaluated, visible in management decision-making
- Significant or prolonged vacancies in key educational posts ie DME /MEM
- Education poorly organised
- Mandatory training not facilitated
- Poor induction of new / agency staff
- Inadequate access to patient medical records
- Doctors in training / SAS doctors unable to attend regular, relevant, timetabled, organised educational / CPD sessions
- Doctors regularly required to carry out inappropriate tasks which are of little or no educational value
- Doctors in training not getting appropriate access to educational opportunities, such as theatre experience or are not receiving regular feedback
- Evidence of falsifying training or clinical records
- Double / triple booking of outpatient appointments
- Lack of availability of medical notes
### Annex 12: Examples of information to be shared with the CQC from the Regional Liaison Service (RLS)

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Rationale</th>
<th>What will information be used for?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  During a teaching session with staff grade doctors held by a regional liaison adviser (RLA) some of those present indicate that patient safety concerns are not being recorded at this organisation as to do so is frowned upon by particular senior staff.</td>
<td>This raises concerns as to whether the quality of care is: safe, effective, or well-led.</td>
<td>To inform intelligence monitoring and the CQC inspection programme.</td>
</tr>
<tr>
<td>2  An RLA is told by a group of trainee doctors they are moved around from ward to ward on a daily basis in order to cover gaps in the rota. This has led to poor continuity of care and absolutely no teaching or training value. When raised with medical staffing, these concerns have been ignored because service provision remains the priority.</td>
<td>This raises concerns as to whether the quality of care is: safe, effective, caring, responsive to people’s needs or well-led.</td>
<td>To inform intelligence monitoring and the CQC inspection programme.</td>
</tr>
<tr>
<td>3  The RLA is presenting to a mixed group of trainee and staff grade doctors working in the ED. The staff present tell them that there is a high volume of patients coming into the emergency department, the four hour target is being breached daily and trainees are unable to move patients into the appropriate specialty wards because there are no available beds. The staff in the emergency department report undermining behaviours in several receiving specialties and patient flow is not working as it should. They report ambulances parked outside the emergency department because paramedics are not able to hand over patients to the emergency department and provide them with a safe environment to await treatment.</td>
<td>This raises concerns as to whether the quality of care is: safe, effective, caring, responsive to people’s needs or well-led.</td>
<td>To inform intelligence monitoring and the CQC inspection programme.</td>
</tr>
</tbody>
</table>
4 The RLA is visiting the Chair of the CCG for a local Trust. The Chair indicates that patients are being triple booked into outpatient appointments and that many are being seen without notes as the admin system cannot cope. They state that they have advised local GPs not to refer to the Trust as patients have suffered actual harm.

This raises concerns as to whether the quality of care is: safe, effective, caring, responsive to people’s needs or well-led.

To inform intelligence monitoring and the CQC inspection programme

5 During a session on adult safeguarding with a group of out of hours and locum GPs the RLA is told by a group of doctors about poor standards of care at a named care home and that they have raised their concerns with the management of the home about breaches of DOLS legislation but they are continuing.

This raises concerns as to whether the quality of care is: safe, effective, caring, responsive to people’s needs or well-led.

To inform intelligence monitoring and the CQC inspection programme

6 An RLA is undertaking a training session with a group of GPVTS trainees when one of the group tell the RLA that a GP practice in the area which they name is using out of date vaccines to save money

This raises concerns as to whether the quality of care is: safe, effective, caring, responsive to people’s needs or well-led.

To inform intelligence monitoring and the CQC inspection programme

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We are very keen for this to be a live document that is updated regularly, so please do email us if you have any suggestions, queries or feedback.