Operational protocol

A practical guide for staff – for external use

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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 CQC, information gathered by one organisation can help the work of the other. This applies to strategic and communications information as well as operational information. 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 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 and does not exclude working with other organisations.

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:

Key contacts at CQC and GMC

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 an immediate risk to patient safety, you should escalate the issue to the nominated contact in your own organisation and the counterpart organisation without delay, following the process under emerging and urgent concerns. For details of escalation contacts see Annex 1.

GMC staff approaching CQC	
CQC staff approaching the GMC	
In all cases, copy in the mailbox	

When and how we share information

There are six ways that we share information that are described in the following section:

1. Routine data sharing (digital sharing of data and intelligence)
2. Emerging and urgent concerns (non-routine / ad hoc bilateral sharing): Advice for CQC inspectors and GMC advisor
3. Local regulatory alignment (liaison)
4. Risk and quality summits (including JSOGS and risk and quality summits)
5. Strategic collaboration (including communications)

1. Routine data sharing: (digital sharing of data and intelligence)

Routine sharing of data and intelligence is an important way of making sure that both the GMC and CQC can fulfil their functions effectively. The GMC routinely shares published information about the fitness to practise of individual doctors with CQC, and data on the quality of medical education and training.

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 Regulator / Designated Body Dashboard.
- the GMC shares its monthly summary on enhanced monitoring with CQC. This lists all organisations delivering medical education or training where the GMC's Education team has active concerns, has set conditions on approval, or is preparing to remove approval from a training environment.
- 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. Information about a doctor's health is always kept confidential.

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 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.

2. Emerging and urgent concerns (non-routine / ad hoc bilateral sharing): Advice for CQC inspectors and GMC advisors

This protocol is designed to support bilateral sharing of concerns between CQC and the GMC. For sharing multilateral concerns, please refer to the Emerging Concerns protocol on the CQC web site.*

CQC inspectors and GMC advisers – when do you need to share concerns?

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 doctor's registration and revalidation
- concerns about the quality of education, systems or environment

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

- staffing issues
- management/leadership issues

* Emerging Concerns Protocol is available at https://www.cqc.org.uk/files/emerging-concerns-protocol

- equipment and premises
- patient safety.

Further details and examples of concerns to be shared with each organisation can be found in the annexes:

Annex 2 (information to be shared with GMC)

Annex 3 (information to be shared with CQC)

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 regarding individual doctors

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_48163325.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 2 and 3.

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:

* 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.

- 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 (see Annex 1). 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 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 provider or referral to the NHSR Professional Practitioner Advisory 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 local GMC team.

If you think a concern relates to the GMC'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 regarding doctors

After considering the issue and the action that has been taken, it may be that 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. Where applicable, and particularly where the prescriber is not the patient's usual GP in both remote and face to face contexts, this may include medical records relating to the episode of care (e.g. prescriptions, medical histories considered before issuing the prescription, and medical records documenting additional advice provided to the patient and/or communication with the patient's registered GP) and steps taken to verify information.
- details of any action you have taken already
- details of anyone else, or organisation, who can support the referral
- details of any investigation or action being taken by CQC and the local contact at CQC.

You should refer your concern by emailing:

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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. 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

How to share non-routine information regarding training environments

If CQC evidence points to serious concerns within healthcare environments that could impact on medical students or doctors in training undertaking placements, this should be shared so that the GMC could investigate further.

Details of the concerns and the provider, including the department and cohort of students or trainees affected, should be shared with the GMC outreach teams (see Annex 1).

These concerns should also be discussed with the local Health Education England office.

Information for GMC staff on sharing concerns with CQC

When to share non-routine information

When the GMC identifies system concerns it should consider whether to share this information with CQC. Before sharing information with 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 regional head (Annex 1), 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 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.

When sharing information with 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.

Examples of sharing non-routine information are contained in Annex 2 and 3.

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 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.

You should refer your concern by emailing:

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3. Local Regulatory Alignment (liaison)

Local liaison is an opportunity for the GMC and CQC to align activity and share information at the local level.

Local liaison can be held as a meeting between just the GMC and CQC or as part of a wider meeting with other stakeholders, for example through local or regional quality fora. Liaison could also include co-ordinating ongoing activity to help reduce regulatory burdens, attending joint meetings and/or regular or ad hoc conversations as required.

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

4. Risk and quality summits

Joint Strategic Oversight Groups (JSOGs) and Quality Surveillance Groups (QSGs)

Quality Surveillance Groups (QSGs) bring together different parts of the health and care system, to share intelligence about risks to quality. These groups are being embedded across the seven regions of NHSE/1 and they align to the Joint Strategic Oversight Groups.

This is not to be confused with a CQC quality summit, which occurs after a CQC inspection. When a QSG or JSOG takes place, 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, CQC should ensure that the GMC is invited to the quality summit by emailing the joint mailbox:

5. Strategic collaboration

Strategy and communications

This will be managed pragmatically through ongoing conversations between relevant CQC/GMC teams, and a regular update will be provided to the joint working group.

Press and publications

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.

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

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.

Annexes

Annex 1: Escalation contacts

Escalation contacts at the GMC and CQC

GMC	
Regional leads (GMC Outreach)	
CQC	
Primary Care	
Hospitals	
Strategic Lead	

Annex 2: Examples of information to be shared with the GMC

A number of issues may arise within a healthcare environment which indicate potential fitness to practise concerns or have adverse effects on the education and training that takes place there.

Some examples with outcomes intended as guidance are presented below. Professional judgment and consideration of the broader situation should be applied at all times:

Scenarios	Rationale	What will information be used for?
1 Primary medical services (GPs) CQC contacted by NHS England regarding a single-handed GP practice. Concerns in this case 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) 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.
3 Hospital services 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	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	If initial action by medical director does not resolve issues, the concern could be referred to the GMC.

chaotic home life with no fixed child-minding arrangements.	taken as behaviour is disruptive to the department. The medical director should initiate appropriate action.	
4 Hospital services 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.	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.	If initial action does not resolve issues, this concern could be referred to the GMC.
5 Hospital services 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.	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.	In such cases, referral to the GMC should be considered to inform the investigation process.
6 Mental health services 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	This should initially be referred to the medical director of the trust for initial investigation and consideration of referral to the GMC.	If there were sufficient concerns that weren't being directly addressed by the trust medical

incidents when the doctor has shouted at the assessing AMPH if his clinical judgement is questioned or errors in his paperwork are pointed out.	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*.	director after referral then there is a need for CQC to share with the GMC.
7 A GP practice has been put into special measures by 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.	This raises potential education and training concerns.	To help us work with the local education and training board (LETB) and the medical school to determine whether the practice remains an appropriate
8 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.	This raises potential patient safety and undermining and bullying concerns.	To take immediate action to ensure Foundation doctors are not pressured to work beyond their competence.
9 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.	This raises potential education and training concerns, including supervision and patient safety.	To take immediate action to ensure supervision of doctors in training is safe and effective.
10 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.	This raises potential concerns of trainee progression and patient safety concerns.	To work with HEE to ensure that doctors in training are undertaking tasks with educational value.

11 Online primary medical services CQC inspects an online primary care provider. It finds that standards are below the required standards in a number of areas. Concerns include: ▪ Lack of identity checks for patients ▪ No system or process to contact the patient's regular GP / Inadequate steps taken to seek consent to share information ▪ Inadequate steps for ensuring that patients understand and consent to their prescribing treatment / medical advice ▪ Inadequate steps for taking a patient's medical history to inform appropriate prescribing through their online questionnaire There is also limited evidence that large numbers of prescriptions are being processed in a short time, raising cause for concern.	The inspectors raise concerns about the fitness to practise of the GMC-registered doctors involved due to a pattern of prescribing opioids where they did not have sufficient verified information to do so safely.	The GMC will need the names of the GMC-registered doctors involved and medical records for each doctor and patient encounter of concern to inform its investigation process.
6 Independent sector example		

Annex 3: Examples of information to be shared with CQC

A number of issues may arise within a healthcare environment which indicate system concerns. Some examples are presented below:

Scenarios	Rationale	What will information be used for?
1 During a teaching session with trainees, the GMC adviser is told of a live internal investigation where 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. Two trainees state that they have heard of previous instances where medical records have been amended to conceal errors on the same ward, but staff have been too fearful to report this.	This represents a risk to patient safety as it shows potentially life-threatening failures in monitoring a patient and cultural issues about raising concerns. This could also cause future harm to patients.	To trigger a responsive inspection.
2 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.	Without access to patient records there is a potential risk of future harm to patients.	To trigger responsive inspection.
3 Poor record keeping, inadequate staffing levels and poor systems identified for communicating abnormal results at a GP surgery. The issue was raised to the GMC by a locum GP who has covered at the surgery on several occasions. They raised the issue locally 3 months ago, but after returning the previous week, there has been no change.	Inadequate staffing levels, poor record keeping and inadequate ways of communicating abnormal results all indicate systems concerns and potential risk to patient safety.	To inform the CQC inspection program.
4 On a GMC visit, the team identify the following: The closure of the gynaecology ward at weekends means that patients are dispersed to a number of different outlying wards. The process by which patients are	This raises concerns as to whether the quality of care is: safe, effective, caring, responsive to	To inform intelligence monitoring and the CQC

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.	people's needs or well-led.	inspection programme.
5 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.	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 During a GMC training session, doctors raise the following concerns: 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 department because paramedics are not able to hand over patients to the emergency department and provide them with a safe environment to await treatment. The issues have been raised locally, but there has been no change.	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.

7 GMC staff are informed that 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
8 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

Annex 4 Potential illegal practice scenarios to inform decision-making by GMC and CQC

Scenario	CQC action	GMC action
1 Unregistered doctor visiting the UK and undertaking private consultations with patients *A doctor who is registered overseas but not in the UK and who specialises in treating a particular medical condition is visiting the UK to provide consultations to patients affected by the condition. These are at a hotel or in someone's home rather than in a clinical setting (if consultations are within a clinical setting see scenario 3 or 4)*	Refer information to GMC Registration Information team to investigate. A breach of the legislation relating to illegal practice may have taken place Also, assess information to determine whether there is any action for CQC registration team to take	Investigate to determine whether a breach of the legislation in relation to illegal practice has taken place, and if so, take appropriate action in line with procedure Refer information to CQC for intelligence-gathering purposes
2 Unregistered doctor has written a prescription *It is discovered that an unregistered doctor employed by a CQC-registered clinic has written a prescription*	Refer information to GMC Registration Information team to investigate whether the prescription has been written by an unregistered doctor If it has, investigate provider with reference to Regulation 19 and take appropriate action If prescription fraud has occurred, review to determine whether further investigation of the clinic is necessary	Investigate to determine whether the actual doctor has written the prescription, or the 'patient' did, and report findings to CQC If the doctor wrote the prescription take action in line with illegal practice procedure If a third party (including the 'patient') wrote the prescription take action in line with doctor impersonation procedure

3 Unregistered doctor potentially undertaking illegal practice at a CQC-registered clinic *A member of the public reports that they have been treated by an unregistered doctor at a clinic registered with CQC, or had a consultation with someone claiming they are registered/licensed when they are not*	Investigate provider with reference to Regulation 19 and take appropriate action Share information with Registration Information team so they can consider what action should be taken against the unregistered doctor If action is indicated by both CQC and GMC, arrange discussion to agree action plan	Share information with CQC so they can consider action against the provider Investigate to determine whether a breach of the legislation in relation to illegal practice has taken place, and if so, take appropriate action in line with procedure If action is indicated by both CQC and GMC, arrange discussion to agree action plan
4 Unregistered doctor potentially undertaking illegal practice at a clinic that is not CQC-registered *A member of the public reports that they have been treated by an unregistered doctor at a clinic that is not registered with CQC, or had a consultation with someone claiming they are registered/licensed when they are not*	Refer information to GMC Registration Information team to investigate. A breach of the legislation relating to illegal practice may have taken place Also, assess information to determine whether there is any action for CQC registration team to take	Investigate to determine whether a breach of the legislation in relation to illegal practice has taken place, and if so, take appropriate action in line with procedure If regulated activities appear to be taking place, refer information to CQC for intelligence-gathering purposes
5 Unregistered doctor providing medical advice to patients via remote consultation *A doctor who is not registered in the UK and based overseas (registered or not) is undertaking consultations with*	Refer information to GMC Registration Information team to investigate. A breach of the legislation relating to illegal	Investigate to determine whether a breach of the legislation in relation to illegal practice has taken place, and if so,

patients based in the UK via Skype or telephone	practice may have taken place If there is evidence of prescribing medication which is to be dispensed in UK, and company is based in UK, CQC to investigate	take appropriate action in line with procedure If there is evidence of prescribing medication which is to be dispensed in UK, and company is based in UK refer information to CQC

Overarching principles to be followed:

- If clinic is not CQC-registered, GMC to lead on what action to take against the individual. If there is evidence of regulated activities taking place, GMC to refer information to CQC for intelligence purposes
- If clinic is CQC-registered, CQC to lead on what action to take against the provider. CQC to refer details to GMC to consider whether action should be taken against the individual undertaking illegal practice
- If clinic is CQC-registered **and** there is evidence of illegal practice by an individual, GMC and CQC to agree action plan so as to avoid duplication of effort (eg in referring to the police), as provider may also want to take action
- CQC to report illegal practice to the GMC's Registration Information team by emailing
  GMC to report illegal practice to CQC by emailing the CQC escalation contacts in Annex 1.