Council, 10 May 2012

Annotation of the Register – qualifications in podiatric surgery

Executive summary and recommendations

Introduction

We have powers to annotate the Register. These are discretionary powers and it is for the Council and the Education and Training Committee to decide whether to exercise those powers.

We consulted between 1 November 2010 and 1 February 2011 on our proposals related to post-registration qualifications and annotation of the Register. The consultation sought stakeholder's views on two different areas:

- the criteria that we will use to make decisions about whether to annotate a post-registration qualification on the Register; and
- whether we should consider annotating qualifications in podiatric surgery and neuropsychology on the Register.

The Committee and Council have now agreed a policy statement setting out the principles that we will adopt in deciding whether or not we annotate a qualification on the Register. Now that we have agreed those principles, we must consider how those principles apply to the specific qualifications identified in the consultation.

This paper focuses on the qualifications in podiatric surgery. It provides information about podiatry practice and then looks at the evidence gathered by the Executive for and against annotation of the Register.

The Education and Training Committee considered the attached paper at its meeting in March 2012. The Committee recommended to Council that we should annotate the qualification in podiatric surgery on our Register. The Council is invited to discuss and consider this recommendation.

Decision

The Council's decision is set out in section five of the paper.

Background information

The Council considered the outcomes of the consultation and the policy statement on annotation of the Register at its meeting on 6 December 2011: http://www.hpc-uk.org/assets/documents/100037DFEnclosure05-consultationonpost-regquals.pdf

Resource implications

Depending upon the decisions by Council, there may be further resource implications for 2012-2013, when the policy on annotation of the Register is implemented. These would be incorporated within the relevant workplan for 2012-2013.

Financial implications

Depending upon the decisions by Council, there may be further financial implications for 2012-2013, when the policy on annotation of the Register is implemented. These would be incorporated within the relevant budgets for 2012-2013.

Appendices

- Appendix one – policy statement on annotation of the Register
- Appendix two – supporting information
- Appendix three – right touch regulation

Date of paper

27 April 2012

Annotation of the Register – qualifications linked to practice in podiatric surgery[1]

1. Introduction

1.1 At their meetings in November and December 2011 respectively, the Education and Training Committee and Council agreed a policy statement setting out the principles that we will adopt in deciding whether or not we annotate a qualification on the Register (see appendix one). We would consider annotating the Register where:

- there is a clear risk to the public if the Register is not annotated and the risk could not be mitigated through other systems;
- annotation is a proportionate and cost-effective response to the risks posed;
- the qualification annotated on the Register is necessary in order to carry out a particular role or function safely and effectively; and
- preferably there is a link between the qualification and a particular title or function which is protected by law.

1.2 Now that we have agreed the principles which underpin our approach to annotation, we must consider whether we should annotate the qualifications in podiatric surgery and neuropsychology we identified in our 2010 consultation.

1.3 It is important to note that we only have powers to annotate the Register. Decisions about whether the annotation is linked to a protected title or function are ones for government.

About this paper

1.4 In our 2010 consultation, we sought views on whether we should annotate qualifications in podiatric surgery and neuropsychology on the Register. This paper focusses on podiatric surgery and the Executive will present a separate paper on neuropsychology at a future meeting. It is important that the Council considers the qualifications separately as decisions about annotation must be made on a case by case basis.

1.5 Annotation of the Register is a complex area. The Council's previous discussions have covered both the general principles around annotation of the Register and the appropriateness of annotating specific qualifications.

[1] This paper uses the title 'podiatric surgeon' as that is the title used within the qualification. It is recognised that there are ongoing discussions about the title but the issue of the title is one that would be considered when making decisions about implementing a decision to annotate the Register with the qualification and does not specifically affect decisions made in principle.

This paper focusses on making an in principle decision on annotation of the Register and does not make recommendations about implementing those decisions (which would be explored separately).

1.6 This paper looks at the evidence in support of, and against, annotating qualifications in podiatric surgery on the Register. This draws on information from the consultation, from fitness to practise and from other sources.

1.7 The information presented in this paper is the information gathered to date, which is limited. The Executive is therefore seeking clear direction from the Council on the evidence base and whether additional information is required before the Council can make a decision.

1.8 This paper is divided into five sections:

- Section one introduces the paper.
- Section two explores different approaches to assessing risk.
- Section three provides information about the qualifications in podiatric surgery.
- Section four considers the qualification against the principles we have set for making decisions about annotating the Register.
- Section five sets out the Council's discussion and decision.

1.9 This paper has three appendices:

- Appendix one sets out the agreed policy statement on annotation of the Register.
- Appendix two gives some supporting evidence.
- Appendix three explores CHRE's right-touch regulation methodology in more detail.

2. Approaches to assessing risk

2.1 Annotation of the Register only applies to already regulated individuals. The risks we mitigate through annotation are the risks of practising in an area significantly beyond a registrant's normal scope of practice where existing standards and governance arrangements are insufficient. In these cases, it may be appropriate to develop a system of annotations and set standards linked to those annotations.

2.2 We have based our approach to annotation of the Register on the principle that generally, we will only annotate the Register where we are legally required to do so or in exceptional circumstances where we have evidence that there is a clear risk to the public if we do not annotate.

2.3 Our approach to risk should be flexible and take account of a variety of factors and different approaches. The information in the following paragraphs briefly sets out different approaches to assessing risk and considers the types of evidence that the Council could use to make a decision on annotation of the Register.

Enabling Excellence

2.4 In February 2011, the Government published 'Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers'.[2] The paper sets out government policy in relation to the regulation of healthcare workers, social workers and social care workers.

2.5 The government argue that professional regulation should be proportionate and effective, imposing the least cost and complexity whilst securing safety and confidence in the professions. The government emphasises that regulators should only take on new responsibilities or roles, including developing advance practice registers, where there is '…robust evidence of significant additional protection or benefits to the public' (page 11, paragraph 2.8).

Extending professional and occupational regulation

2.6 The Department of Health Extending Professional and Occupational Regulation working group was set up in 2008, to look at recommendations on extending the scope of professional and occupational regulation. The working group's report focuses on extending regulation to new groups but makes some more general statements relevant to assessing risk.[3] The report identified key factors that could be used to assess risk. These include:

[2] 'Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers', Department of Health 2011, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124359

[3] Extending professional and occupational regulation: the report of the Working Group on Extending Professional Regulation (July 2009) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_102824

- the type of intervention;
- where the intervention takes place;
- the level of supervision;
- the quality of education, training and appraisal of individuals; and
- the level of experience of the individual carrying out the intervention.[4]

Right-touch regulation

2.7 In August 2010, the CHRE published 'Right-touch regulation'.[5] The CHRE define right-touch regulation as being '…based on a proper evaluation of risk, is proportionate and outcome focussed; it creates a framework in which professionalism can flourish and organisations can be excellent' (page 8, 3.1).

2.8 The concept of 'right-touch regulation' focuses on evaluation of risk. Regulation should not act in response to every concern or question of safety; instead, all parties should take responsibility for managing risk.[6] Decisions about risks posed should take account of the broader context within which the practice takes place. This includes looking at the other systems (such as clinical governance arrangements) that manage risks linked to practice.[7]

2.9 The CHRE propose an eight-step methodology for ensuring that regulation is 'right-touch'.[8] By following this methodology, regulators can ensure that the costs of regulation are worth the benefits that regulation can bring. We have explored this methodology in more detail in appendix three.

Evidence of risk

2.10 Members of the Education and Training Committee have previously argued that we should assess risk based on evidence of harm, or evidence that the standards did not adequately protect the public, rather than on hypothetical risk.

2.11 The evidence base for annotation is therefore the evidence that existing systems do not sufficiently manage the risks posed by a particular area of practice **and** that the risks could be managed through annotation. We could use a variety of evidence to assess risk. Some of these are set out below, although the list is not exhaustive and not all evidence will be available for every area:

- outcomes of fitness to practise cases;
- evidence that improperly qualified individuals are practising in a particular area;

[4] Extending professional and occupational regulation, page 8 and chapter 2
[5] 'Right-touch regulation', CHRE 2010, http://www.chre.org.uk/_img/pics/library/100809_RTR_FINAL.pdf
[6] 'Right-touch regulation', page 9, paragraph 3.7
[7] Right-touch regulation', page 8, paragraph 2.14 – 2.17
[8] 'Right-touch regulation', pages 10-12, paragraphs 4.1 – 4.8

- evidence that existing governance systems are not sufficiently managing the risk;
- evidence of adverse outcomes;
- litigation data and insurance claims;
- evidence from professional bodies; and
- information from the consultation responses.

2.11 There is no one formula for making decisions about regulation based on the risks posed by practice in a particular area. Nor is there one kind of evidence that would clearly show that the existing systems do not manage risks effectively. Instead, decisions about risk must reflect all the evidence, be reasonable and be appropriate.

3. About podiatric surgery

Route to training

3.1 The training in podiatric surgery has developed over the last 30 years. Some podiatric surgeons were members of The Podiatry Association and qualified under the auspices of that body which, as part of the Camden Accord, became part of the Society of Chiropodists and Podiatrists, which also had its own podiatrists carrying out podiatric surgery.

3.2 Nowadays, a person normally qualifies as podiatric surgeon by undertaking the following training:

- HPC approved pre-registration bachelors degree leading to HPC registration as a chiropodist / podiatrist.
- A masters level programme in the theory of podiatric surgery.
- A minimum of two years surgery training following completion of the masters level programme in the theory of podiatric surgery.

3.3 The masters level programme in the theory of podiatric surgery is currently delivered at three education providers. These are Brighton University, Huddersfield University, and a joint programme between Glasgow Caledonian University and Queen Margaret University. The universities above validate their MSc programmes and the Society of Chiropodists and Podiatrists accredits them. Additionally, the two Royal Medical Colleges in Scotland accredit the joint qualification between Glasgow Caledonian and Queen Margaret. Courses include modules in anatomy, physiology, medicine and pathology, podiatric biomechanics and diagnostic imaging.

3.4 Once the masters level qualification has been completed, the individual then completes a programme of surgery training. The training post involves the candidate rotating through NHS podiatric surgery departments supervised by a consultant podiatric surgeon.

3.5 Successful completion of the training leads to fellowship of the Society of Chiropodists and Podiatrists Faculty of Podiatric Surgery. Employers usually require this qualification for employment in positions as a podiatric surgeon. In the NHS, they would be employed as specialist registrars in podiatric surgery. These posts usually last for three years and allow the podiatric surgeon to develop their skills and experience.

3.6 At the end of the 3 years, the podiatric surgeon submits information to the Faculty of Podiatric surgery for the award of the Certificate of Completion in Podiatric Surgical Training (CCPST). Completion of the qualification means that the podiatric surgeon can apply for consultant posts (although some consultant podiatric surgeons will not have this qualification). If we did decide to annotate the Register with qualifications in podiatric surgery, it is likely that we would annotate the Register with this qualification.

3.7 Further training therefore is required in order to be eligible for consultant podiatric surgeon posts (the title consultant podiatrist is also used). There is

therefore a distinction between completion of the qualification conferring fellowship of the Society and becoming a consultant podiatric surgeon.

3.8 NHS Education for Scotland has established a project board looking to develop podiatric surgery education within Scotland. The Executive are members of the project board so that we can take account of developments in Scotland appropriately.

Podiatric surgery practice

3.9 Podiatric surgery is the surgical management of the bones, joints and soft tissues of the foot and its associated structures. Normally, surgery is performed as a day case procedure and often but not always under local anaesthetic.

3.10 Surgical treatment is considered when other approaches have not succeeded. It is often employed to manage persistently painful conditions or where the foot is being affected by deformity. This could include problems caused by bunions, foot arthritis, toe deformities and inflammation of the tissues of the foot.

3.11 Podiatrists completing pre-registration education programmes are taught about carrying out surgical procedures for skin and nail conditions. However, this surgery is the only invasive procedure that a podiatrist would carry out when treating patients. Training in podiatric surgery equips podiatric surgeons with the skills to carry out a number of different invasive procedures on a patient's foot.

3.12 The training in podiatric surgery therefore significantly extends the podiatrist's scope of practice beyond that of most clinically practising podiatrists. Once the podiatrist has completed their training, they usually practise only as a podiatric surgeon. The podiatrist does not therefore incorporate podiatric surgery within their scope of practice, podiatric surgery becomes their scope of practice. Podiatric surgery is therefore different from other situations (such as physiotherapists carrying out acupuncture) where specialised practice is incorporated within a registrant's scope of practice.

3.13 Podiatric surgery also represents part of the scope of practice of an orthopaedic surgeon. Doctors who take up posts as consultant orthopaedic surgeons should be registered on the General Medical Council's Specialist Register.

4. Annotating the qualifications in podiatric surgery

4.1 This section looks at the qualifications in podiatric surgery against the principles that we have set to make decisions about annotation.

Risk to the public

Principle: There is a clear risk to the public if the Register is not annotated and the risk could not be mitigated through other systems.

4.2 We have drawn together information from various different sources to consider the risks posed to the public by practice in podiatric surgery. Any assessment of risk needs to be holistic, rather than simply statistical, taking into account all of the factors and evidence considered below.

What do we know about risks?

4.3 We can consider risk in a number of different ways:

- risks stemming from practice in podiatric surgery (adverse outcomes and fitness to practise cases);
- risks linked to a lack of quality assurance of the training programmes by an independent regulator;
- reputational risks for ourselves if we are not perceived to be taking action in this area; and
- risks stemming from a lack of publicly available information about the qualifications of individual podiatric surgeons.

4.4 The Executive have provided some supporting information about evidence of risk in appendix two of this paper.

Adverse outcomes

4.5 Podiatric surgery is a surgical intervention carried out on the foot and associated structures (see paragraphs 3.9 – 3.10 above). The Society of Chiropodists and Podiatrists have produced a leaflet for patients about podiatric surgery. This leaflet says that, on average, 80-90 per cent of patients are pleased with the outcomes of the surgery.

4.6 As with any surgical intervention, there is a potential for an adverse outcome. The adverse outcomes of the surgery can include a reaction to medication, infection, swelling, thrombosis and sensory loss. Information collected by the Society of Chiropodists and Podiatrists about the outcomes of surgery suggests that adverse outcomes, although sometimes serious, are rare occurrences. For example, the post-surgery calculated risk of thrombosis is 0.5%, whilst 5-10% of patients experience prolonged swelling after surgery.

4.7 Membership of the Society of Chiropodists and Podiatrists includes professional indemnity insurance to provide cover to members in the event of a patient making a claim against them. Membership for podiatrists

currently costs £355 per year and the cost of membership increases as individuals progress through their podiatric surgery training (so that a Consultant Fellow in private practice pays £1,860 per year).

Fitness to practise cases

4.8 We regulate chiropodists/podiatrists and can therefore consider concerns raised about the practice of podiatric surgeons. A small number of fitness to practise concerns have been raised with us about the practice of podiatric surgeons. Where stakeholders have raised fitness to practise concerns, we have considered those concerns against our existing standards.

4.9 We have provided a brief outline of several sample cases in appendix two. Although we have only identified a small number of fitness to practise cases, the number of cases itself is not a direct indicator of level of risk.

Reputational risk and public perception

4.10 Journalists and stakeholders occasionally contact us about the training for podiatric surgeons, their practice and the use of the title 'podiatric surgeon'. Some stakeholders perceive a lack in public protection as we do not independently assure the quality of the training or have our own standards for practice. They argue that we need to do more to manage the risks of practice. We therefore face a potential reputational risk if we do not annotate the Register.

4.11 There is also limited information available publicly about the registration and qualifications of podiatric surgeons. This means that whilst members of the public can check that the podiatric surgeon is HPC registered, they cannot check whether the podiatric surgeon is or is not appropriately qualified.

How are the risks of practice currently managed?

4.12 The risks of practice are currently managed in several different ways:

- We regulate podiatric surgeons, meaning that they must meet our standards (including the requirement to practise within their scope of practice).
- We can consider concerns raised about the practice of podiatric surgeons.
- Podiatric surgeons working in the NHS must adhere to the NHS's standards and clinical governance frameworks.
- Podiatric surgeons working in private practice in England may be required to register their premises with the Care Quality Commission (the employer's registration would cover those working in the NHS). As a result, they would have to meet CQC's standards which focus on the environment of practice and service delivery and are not about the individual practitioner.

How might annotation improve the way in which risks are managed?

4.13 Annotation would improve the way in which risks are managed because:

- It allows us to set standards above the threshold level for specific areas of practice.
- We can approve the education programmes linked to the annotation, thereby providing external quality assurance of training.
- Annotation provides information to members of the public, supporting choice.
- We can consider cases about a registrant's fitness to practise in the area annotated with reference to standards we have set for that area of practice.

Annotation is proportionate and cost-effective

Principle: Annotation is a proportionate and cost-effective response to the risks posed.

4.14 The Council has already agreed that we will only annotate the Register in exceptional circumstances and that the decision to annotate must be proportionate and cost-effective.

4.15 This paper does not look specifically at the costs associated with deciding to annotate the Register. However, the costs would include those linked to setting standards and approving education programmes. The route to training is set out in paragraphs 3.1 – 3.8 above. There would be a low number of programmes to approve, reducing the cost implications of the decision to annotate the Register.

4.16 One way of deciding whether annotation is proportionate and cost-effective is to follow the CHRE 'Right touch regulation model' (see paragraphs 2.7 – 2.9 above). We have explored this model in appendix three of this paper.

The qualification is necessary for practice

Principle: The qualification annotated on the Register is necessary in order to carry out a particular role or function safely and effectively.

4.17 As set out above, the training in podiatric surgery covers a wide range of subjects and individuals who successfully complete the training are able to carry out invasive surgery on the foot and associated structures.

4.18 We are aware that a small number of individuals are practising as podiatric surgeons without completing the qualifications offered by the Society of Chiropodists and Podiatrists. However, most employers now require completion of the qualifications in podiatric surgery before offering employment as a Consultant Podiatric Surgeon. The qualification is therefore necessary for safe and effective practice in podiatric surgery.

The qualification is linked to a function or title

Principle: Preferably there is a link between the qualification and a particular title or function which is protected by law.

4.19 As set out above, we are able to annotate the Register but do not have powers ourselves to protect a title or function linked to that annotation. Decisions about protected titles are ones for government. These decisions also relate to implementation, rather than the in principle decision about annotation. As a result, this paper has not specifically considered this principle.

4.20 Most individuals working under the title 'Consultant Podiatric Surgeon' have completed the training set out in paragraphs 3.1 – 3.8 above. There is therefore a link between completion of the qualification and a title that employers use and recognise.

5. Discussion

5.1 The Council is invited to discuss the information above.

5.2 In particular, the Council is invited to consider whether the information provided above in section four is sufficient to make decisions about whether or not to annotate the qualification in podiatric surgery on the Register.

5.3 The Executive has worked with the relevant professional body to draw together salient information on this issue. However, if the Council feels that the information is insufficient, the Executive seeks the Council's clear direction on what additional information the Executive could supply to support the Council's decision making.

Appendix one - policy statement on annotation of the Register

1.1 We are the Health Professions Council (the HPC). This policy statement sets out our broad approach to annotation of our Register. We have written this policy statement drawing on information we gathered following a public consultation.

1.2 In general, we will only annotate the Register where we are legally required to do so or in exceptional circumstances where we have evidence that annotation is necessary to protect the public and where we believe that annotating the Register is the only mechanism that could improve public protection.

1.3 This statement does not apply to situations where we are legally required to annotate the Register.

1.4 We have discretionary powers to annotate the Register. This statement does not limit our discretion to annotate the Register. Instead, we will have regard to the principles set out in this statement when making decisions about whether or not we annotate our Register.

1.5 Please contact the Policy and Standards Department (policy@hpc-uk.org) if you have any questions about this statement.

About annotation of the Register

1.6 We have powers to annotate our Register.[1] We annotate our Register to indicate where a registrant (someone on our Register) has undertaken additional training around medicines and has obtained entitlements to supply, administer or prescribe these medicines. We are required to do this by legislation called 'The Prescriptions Only Medicines (Human Use) Order 1997'. We therefore only currently annotate the Register where there is a legal requirement to do so.

1.7 In each of these cases, individuals can only practice in a particular area if they have the annotation on our Register. For example, a physiotherapist can only act as a supplementary prescriber if they have completed the appropriate training and have their entry on our Register annotated.

1.8 We annotate qualifications on the Register. The term 'qualifications' does not only mean those formal qualifications delivered by higher education institutions, but instead means any type of learning which has an

[1] These powers are set out in the Health Professions Order 2001 ('the Order') and in the Health Professions Council (Parts and Entries in the Register) Order of Council 2003 www.hpc-uk.org/publications/ruleslegislation/.

assessment process at the end. The assessment process means that the provider can check that the registrant has the necessary skills and we can be confident that the individual has successfully attained a package of skills and knowledge meaning that we can annotate their entry in the Register.

Broad principles on annotation of the Register

2.1 We believe that in most cases, existing systems, including our standards and processes, manage the risks posed by our registrants' practice. We do not therefore need to take additional action to manage those risks.

2.2 In general, we will only annotate the Register where we are legally required to do so or in exceptional circumstances where there is evidence that we can improve public protection in a specific area by annotating a qualification.

2.3 Annotating the Register means that we can set standards for a particular area of practice and approve the education programmes delivering training linked to that area of practice. We would consider annotating the Register where:

- there is a clear risk to the public if the Register is not annotated and the risk could not be mitigated through other systems;
- annotation is a proportionate and cost-effective response to the risks posed;
- the qualification annotated on the Register is necessary in order to carry out a particular role or function safely and effectively; and
- preferably there is a link between the qualification and a particular title or function which is protected by law.

2.4 Protection of titles and functions is a matter for government and where we consider that it is appropriate, we may proceed with annotation and then seek government approval for the protection of the associated title or function.

2.5 Our rationale for setting out these broad principles is set out below.

Annotation only in exceptional circumstances

2.6 We believe that the role of the regulator is to set standards for practice and identify discrete areas where additional standards may be necessary. It is not our role to provide a list of all post-registration qualifications or training which a registrant may have completed.

2.7 We will therefore only annotate the Register **in exceptional circumstances**.

Proportionality and cost-effectiveness

2.8 Annotation, as a mark on our Register, only applies to professionals already registered and subject to our standards. Any decision to annotate the

Register should be a proportionate and cost-effective action, to minimise the burden on registrants.

Annotation and risk

2.9 We will only annotate a qualification on the Register where there is a clear risk to the public if we did not annotate and if we could mitigate the risk through annotation and not through other processes.

2.10 We recognise that decisions about risk can be subjective and that it can sometimes be difficult to make decisions about the levels of risk posed. There is no one formula for making decisions about regulation based on the risks posed by practice in a particular area. Decisions made about risk should be reasonable, appropriate and informed by best practice but there is no absolute way of defining these decisions.

2.11 However, assessments of risk can draw on a number of factors including:

- the nature of the intervention;
- the environment within which the intervention is carried out; and
- existing mechanisms for managing the risks posed by the intervention.

The link between annotation and an area of practice

2.12 Annotations show where a registrant has completed specific qualification and where the registrant is therefore able to practise in a particular area. Therefore, there needs to be a clear link between the qualification and either a particular function or role. It should only be possible to undertake that function or role after completing the qualification that we annotate on the Register.

2.13 Some qualifications, whilst necessary for a particular role and required by an employer, are not necessarily relevant to public safety. In those cases, there is a distinction to be drawn between our requirements as a regulator setting national standards for practice in a profession and the requirements made by an employer for a particular role.

2.14 Normally, we would prefer to exercise our powers to annotate the Register only where there is a defined title or function that could be protected by law, so that only those who meet the necessary standards are able to practise in a particular area.

2.15 Protection of a title or function requires a change in the law and such decisions are a matter for government and not for us. We can make decisions about which qualifications to annotate but can only recommend to government that a particular title or function associated with that qualification is protected by law.

Appendix two – supporting information

1.1 This appendix gives more information about evidence of risk in relation to practice in podiatric surgery (see paragraphs 4.2 – 4.13 of the main paper). It covers the following areas:

- fitness to practise cases;
- press coverage; and
- information from the consultation.

1.2 The information in this paper is not designed to be exhaustive, but to provide additional information to support the Committee's decision making.

Fitness to practise decisions

1.3 In 2010 – 2011, complaints were made against 0.61% of chiropodists/podiatrists on the Register. However, it is important to remember that a significant number of cases do not reach final hearing stage as it is decided that there is no case to answer. It is not possible to identify the number of cases raised each year specifically against podiatric surgeons because cases are not systematically recorded in this way.

1.4 However, we have provided a summary of several fitness to practise cases considered about individuals practising as podiatric surgeons. We have considered cases around the conduct of podiatric surgeons (including allegations of plagiarism and theft) but we have focussed on issues related to competence.

Case one

1.5 Concerns were raised about the registrant's conduct in relation to two areas:

- practising minimal invasive surgery without the appropriate surgical knowledge to perform the surgery safely and effectively; and
- statements around the registrant's involvement in the establishment of a podiatric surgery regulator.

1.6 The registrant had completed part of the qualification in podiatric surgery offered by the Society of Chiropodists and Podiatrists but had not then undertaken the period of supervised practice as a surgical trainee. Instead, the registrant sought training overseas.

1.7 The panel decided that the facts were proven in both cases. The panel found that as the registrant had not undertaken the period of supervised practice they lacked the necessary knowledge to carry out surgical practice safely and effectively.

1.8 The panel imposed a conditions of practice order requiring the registrant not to perform any type of podiatric surgery (although the registrant could still perform nail resection and removal).

Case two

1.9 Concerns were raised about the registrant carrying out inappropriate and sub-standard surgery on the patient.

1.10 The panel found that the surgery was inappropriate at that stage in the patient's recovery but that the registrant carried it out to a reasonable standard.

1.11 The panel concluded that the registrant showed a lack of competence but that the decision to carry out the surgery was an isolated error with little chance of repetition. The panel decided that the registrant's fitness to practise was not currently impaired.

Case three

1.12 Concerns were raised that the registrant had failed to give correct advice and support to a patient both before and after the surgery.

1.13 The panel found that there was insufficient evidence to prove the allegations made about the registrant's competence. The panel dismissed the allegation.

Press interest

2.1 In the past, there has been some press interest in podiatric surgery. This has included articles in the Telegraph in 2008 and an item on the BBC London news and supporting article in 2009.[1]

2.2 The Telegraph article focuses on the use of the title 'podiatric surgeon' and concerns that members of the public are confused about a podiatric surgeon's qualifications.

2.3 Whilst the BBC article does cover this issue, it also looks at the training for podiatric surgery and comments on the absence of independent accreditation of the training.

2.4 Journalists continue to contact us occasionally on this issue.

[1] The Telegraph article can be found here:
http://www.telegraph.co.uk/health/3086093/Podiatrists-confuse-patients-by-calling-themselves-surgeons.html
The article to support the BBC London programme can be found here:
http://news.bbc.co.uk/local/london/hi/tv_and_radio/newsid_8400000/8400189.stm

Information from the consultation

3.1 We did not specifically ask respondents to our consultation on annotation of the Register to identify the risks posed by practice in podiatric surgery. However, respondents made arguments for and against annotating the podiatric surgery qualification on our Register based on risk.

3.2 Respondents to the consultation argued that we should annotate the qualification in podiatric surgery on the Register because podiatric surgery was a significant extension of a podiatrist's practice. Annotation would mean the regulator could manage the risks of practice by setting standards, approving education programmes and ensuring that only appropriately trained individuals carried out podiatric surgery.

3.3 Most respondents to the consultation who argued against annotating podiatric surgery did so because they were concerned about public confusion over the use of the title 'podiatric surgeon'. Respondents were worried that if we annotated the Register with the qualification, or protected the title, this would give undue credibility to podiatric surgeons and would not provide clear information for members of the public.

Appendix 3 – Right-touch regulation

1.1 This appendix explores CHRE's Right-touch regulation methodology as a way of exploring whether the decision to annotate the Register is appropriate and proportionate (see paragraphs 2.7 – 2.9 of the main paper).

1.2 CHRE have identified eight elements that support right-touch regulation in practice. We have set these out below and briefly explored these in relation to annotation of the Register. The information in this paper is not designed to be exhaustive, but to provide additional information to support the Committee's decision-making.

1) Identify the problem to be resolved before identifying the solution.

1.3 Podiatric surgeons are HPC registered podiatrists who significantly extend their scope of practice (see paragraphs 3.9 – 3.13 of the main paper) to be able to carry out invasive surgery on the foot. Currently, we do not approve the training in podiatric surgery and do not set specific standards for practice.

1.4 Stakeholders have raised concerns with us about whether existing mechanisms to regulate podiatric surgery are sufficient or whether we need to do more to protect the public.

2) Quantify the risks associated with the problem.

1.5 Decisions about risk are subjective and it is not always possible to quantify risk in a statistical way.

1.6 We have provided information on the risks associated with practice in paragraphs 4.2 – 4.13 of the main paper and in appendix two.

3) Get as close to the problem as possible.

1.7 This element focuses on identifying the context of the problem. This includes looking at the different levers and tools that may tackle particular issues (for example, regulatory or governance structures).

1.8 All podiatric surgeons are HPC registered and many (though not all) work within the NHS and its clinical governance systems. In addition, podiatric surgeons may be registered with the Care Quality Commission.

1.9 As a regulator, we can consider concerns raised about the practice of podiatric surgeons and can take appropriate action to protect the public.

However, we do not approve the education programmes which deliver podiatric surgery training, nor do we set standards for practice. Concerns have been expressed about the perceived absence of external quality assurance.

4) Focus on the outcome – improving public protection.
5) Use regulation only when necessary.

1.10 In our policy statement setting out our approach to annotation, we say that:

> 'In general, we will only annotate the Register where we are legally required to do so or in exceptional circumstances where there is evidence that we can improve public protection in a specific area by annotating a qualification.' (paragraph 2.2).

1.11 These principles underpin our approach to annotation and help us to make sure that we focus on the outcome and only annotate where necessary.

6) Keep the solution simple so that stakeholders can understand it.

1.12 Annotating the Register is a reasonably simple solution. Members of the public would be able to check easily that their podiatric surgeon was both HPC registered and had the appropriate annotation.

1.13 Stakeholders would also be able to see that there were externally agreed standards for practice, the training had been independently assured and that the qualification had been annotated appropriately.

7) Check the impact of the solution, including whether it will have unforeseen consequences.

1.14 We asked respondents to the consultation to comment on the feasibility of annotating qualifications in podiatric surgery.

1.15 Some respondents expressed concerns about annotating podiatric surgery because they were worried about the use of the title and because it might give credibility to practice. Alternatively, one respondent argued that annotation would limit practice because individuals who did not have the qualification offered by the Society (but had been practising as a podiatric surgeon) would not be annotated on the Register.

1.16 We would need to consider further the impact of any decision to annotate the Register, as part of our process to implement that decision.

8) Review the solution and revise where appropriate.

1.17 It is only possible to follow this step once a decision has been made to annotate the Register.