

Council, 25 September 2014

Professional Standards Authority for Health and Social Care
Performance Review Report 2013/14

Executive summary and recommendations

Introduction

In June 2014, the Professional Standards Authority for Health and Social Care (PSA) published its annual performance review of the regulatory bodies for the year 2013/14, including its performance assessment of the HCPC.

The attached paper provides a summary of this year's report; discusses the PSA's assessment of the HCPC's performance; and highlights other areas of interest, including good practice from other regulators. In keeping with the format of previous papers, the performance review content around fitness to practise is set out separate appendices.

Decision

The Council is invited to discuss the attached paper.

Background information

None

Resource implications

None

Financial implications

None

Appendices

- Appendix 1: The Professional Standards Authority for Health and Social Care performance review 2013/14: Fitness to practise
- Appendix 2: Fitness to Practise – Timeliness
- Appendix 3: The Professional Standards Authority for Health and Social Care Performance Review Report 2013/14 (full report)

Date of paper

11 September 2014

Professional Standards Authority for Health and Social Care Performance Review Report 2013/14

1. Introduction

- 1.1 In June 2014, the Professional Standards Authority for Health and Social Care (PSA) published its annual performance review of the HCPC for the year 2013/14. A full copy of the report is appended to this paper.
- 1.2 The Council has considered papers on each year's performance review in the past.¹ The PSA has recommended that each regulator should ensure that their respective Councils review and discuss the performance review report and that, in reviewing the report each regulator should consider whether they can learn and improve from the practice of other regulators and how to address any areas of concern highlighted.
- 1.3 This paper provides an overview of the PSA's performance review for the HCPC, as well as the Executive's comments on a number of the topics and activities discussed. It also identifies examples of good practice from the other regulators relevant to our work and outlines areas to be included in our submission for next year's performance review.
- 1.4 In keeping with the format of papers in previous years, the performance review content around fitness to practise is set out in separate appendices. Appendix 1 discusses the findings of the PSA in respect of fitness to practise in a thematic way. Appendix 2 provides further detail about timeliness in progressing cases through the fitness to practise process.

About the performance review process

- 1.5 The PSA oversees the nine regulators of health and social care professionals in the UK and is accountable to Parliament. The PSA is required by law to assess the performance of each of the regulators and to publish a report of its findings each year. The process seeks to check how effective the regulators have been in protecting the public and promoting confidence in health and care professionals; and to identify strengths and areas of concern in order to enable improvement. The findings are reported each year to Parliament and to the devolved administrations.
- 1.6 The annual review process is based on a self-assessment carried out by each regulator against the PSA's Standards of Good Regulation. These standards

¹ Last year's paper on the PSA performance review report for 2012-13 was considered by the Council on 18 September 2013 and can be found here: <http://www.hcpc-uk.org/assets/documents/100041FCEnc05-ProfessionalStandardsAuthorityforHealthandSocialCareperformancereview.pdf>

are grouped under the four regulatory functions: guidance and standards; education and training; registration; and fitness to practise. A regulator meets a standard when it provides sufficient evidence of good performance against it which is in line with the evidence framework.

- 1.7 The PSA usually sends the self-assessment template to the regulators to complete in September or October of each year and regulators submit a completed template in early December that year. Key departments across the organisation collate the written response to the review, drawing on Council or Committee papers as well as management information to respond. The PSA also contacts a range of professional, patient and public organisations and invites members of the public to give feedback on the regulators.
- 1.8 The PSA then assesses the material provided and if needed requests further information or clarification of a particular area of a response, before meeting with each regulator to discuss its findings. The HCPC has the opportunity to comment at each stage of the process in addition to commenting on drafts of the performance review before it is finalised.

2. Overview of HCPC performance review 2013-2014

- 2.1 This section provides an overview of the PSA's assessment of the HCPC's performance for 2013/14 (which is contained in section 16 of the report). It also identifies key pieces of work that are on-going into 2014/15 or provides commentary on particular pieces of work where we have considered it would be helpful to the Council's discussions.
- 2.2 On the whole, the HCPC received a positive performance report this year. The PSA stated that the HCPC had 'maintained its performance as an effective regulator across most of its regulatory functions and continued to meet all of the Standards of Good Regulation'.
- 2.3 However, the PSA concluded that the HCPC's performance had declined against the fourth and sixth standards for fitness to practice and that it had performed inconsistently against the tenth standard for fitness to practise. These assessments are further discussed in Appendices 1 and 2.
- 2.4 Apart from these three areas, the PSA commended our performance in relation to the involvement of service users and carers in our work, as well as our success in managing the transition to statutory regulation of social workers in England. These areas are explained further below.

Guidance and standards

- 2.5 The HCPC continued to meet the Standards of Good Regulation for guidance and standards in 2013/14.
- 2.6 The PSA made special mention of the breadth of methods used in the on-going review of the standards of conduct, performance and ethics and the inclusion of a number of different stakeholder groups and organisations,

noting that this was an example of good practice (see paragraphs 7.18 and 16.8 in the report).

Area of work	HPCPC comments
Review of the standards of proficiency (paragraph 16.8)	This work is on-going. Revised standards for 12 professions have been published, and, pending approval by the Council, the Executive expects to publish revised standards for biomedical scientists and clinical scientists in December 2014. Draft standards for practitioner psychologists are currently out for public consultation. The standards of proficiency for social workers in England will be reviewed beginning in 2015, after all relevant education and training programme approval visits have been completed.
Review of the guidance 'A disabled person's guide to becoming a health professional' (paragraph 16.8)	The revised guidance, entitled 'Health, disability and becoming an HPCPC registered professional', has been recommended to Council for public consultation by ETC. The consultation would run from 1 October 2014 to 16 January 2015 (subject to approval by the Council).

Education and training

- 2.7 The HPCPC also continued to meet all the Standards of Good Regulation for education and training.
- 2.8 The report noted that two projects aimed at incorporating the views and perspectives of patients and service users in the quality assurance process for education and training programmes – which the PSA has encouraged since the 2009/10 performance review – were completed during the year.

Area of work	HPCPC comments
Service user and carer involvement in the design and delivery of education and training programmes (paragraph 16.13)	A new standard of education and training was agreed in July 2013 and published in August 2014. It will be phased in from the 2014/15 academic year.
Service users and carers on visitor panels (paragraph 16.14)	Redefined 'lay visitors' now include service users and carers, who will become part of the visitor panels from the start of the 2014/15 academic year.

<p>Review of the standards of education and training (paragraph 7.32)</p>	<p>The review is in its early stages with completion planned in 2017. It will include ensuring the applicability of the standards to education and training in the professions which have come under regulation by the HCPC since the standards were last published (including social workers).</p>
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- 2.9 Additionally, the PSA noted our work to approve all social work education programmes and maintain a social work student suitability scheme. It commended the HCPC's 'evidence-based approach to implementing a mechanism for approving all social work education programmes that both provides adequate public protection and aligns with its approach to the approval of other education programmes' (see paragraphs 16.16-16.19 in the report).
- 2.10 The report also discussed the two independent reviews of social work education by Martin Narey and David Croisdale-Appleby, commissioned respectively by the Secretary of State for Education and by the Minister of State for Health.² The PSA noted that both reports were critical of the HCPC's standards of proficiency for social workers and standards of education and training, as well as our processes for approving education and training programmes. However, the PSA asserted that it had no evidence to suggest that our approach to regulation of social work education was inappropriate (see 7.30-7.33 in the report).
- 2.11 In relation to this, the PSA made the following assessments:
- The standards of proficiency for social workers were developed via an appropriate process, i.e. a Professional Liaison Group which included a variety of stakeholders, and they were subject to public consultation. The PSA was supportive of the HCPC's plans to review the standards of proficiency for social workers once all social work education and training programme approval visits have been completed.
 - The standards of education and training are focused appropriately on outcomes and on ensuring that students are fit to practise at the point of entry to the register.
 - The HCPC quality assurance process and standards of education and training appeared to be sufficiently robust, as no social work programmes were approved without conditions attached.
 - Our approach to quality assurance of education and training programmes is in line with what is expected of the health and care regulators, in that it is based on consideration of documentation and a visit to the programme (which includes speaking to students, staff,

² A paper discussing these reports and setting out our response to the conclusions and recommendations made in the reports was presented to the Council earlier this year, see: Council meeting, 27 March 2014. Reviews of social work education in England. <http://www.hpc-uk.org/assets/documents/1000452AEnc01-ReviewsofsocialworkeducationinEngland.pdf>

service users, and carers), and takes account of any concerns raised by third parties about the programme.

- Although the education of social workers should be improved, further disruption so soon after the transfer of regulation from the General Social Care Council (GSCC) to the HCPC would not be in the interests of professionals or service users.

Registration

2.12 The HCPC met all of the Standards of Good Regulation for registration in 2013/14. In particular, the PSA commended the HCPC's use of social media in hosting its first 'tweet chat' in October 2013. It also noted our prompt response to changes in legislation which broadened the category of convictions and cautions that do not need to be declared to a professional regulator³, which required an amendment to application forms for registration and renewal (see paragraph 16.24 in the report).

Area of work	HCPC comments
Professional indemnity arrangements as a condition of registration (paragraph 16.24)	The Health and Care and Associated Professions (Indemnity Arrangements) Order 2013 went live in July 2014. Guidance has been published and a public consultation on a rules change to enable implementation of this requirement is due to run from 26 September to 31 October 2014 (subject to approval by the Council).
Validation of international qualifications (paragraph 16.24)	NHS Protect has been commissioned to validate the qualifications of all international route registrants who applied between June and August 2011. This work is on-going and the Registration Department continues to receive periodic updates.

Continuing professional development

2.13 The PSA outlined the work undertaken by the HCPC to assess our continuing professional development (CPD) standards and processes and noted that further work on this was commenced in 2013/14. It commended the HCPC for 'obtaining an evidence base' before deciding what model is most appropriate as a way forward in ensuring that registrants are up to date and competent (see paragraphs 16.20-16.23 in the report).

2.14 However, the report also emphasised the PSA's reservations about our current CPD systems, stating that it did not consider evidence of CPD activity

³ Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975 (Amendment) (England and Wales) Order 2013

in itself to sufficiently demonstrate continuing fitness to practise of a registrant (see paragraph 7.28 in the report). The PSA advocated development of a system that is more outcomes-focused in order to be able to demonstrate what impact an activity has had on a registrant's performance.⁴

Area of work	HCPC comments
Perceptions and experiences of the HCPC's approach to CPD standards and audits (paragraph 16.22)	<p>We are commissioning this research as part of a review of our existing CPD standards and audit. Feedback gathered from registrants and other stakeholders may inform any future changes to the CPD standards, audit process, and/or supporting communications materials.</p> <p>The call for research proposals closed in August 2014, and we anticipate appointing a researcher/research team in October 2014.</p>
Examination of the costs and benefits of a regulatory approach to the assessment of continuing fitness to practise of health and care professionals (paragraph 16.22)	<p>The Department of Health is commissioning research to analyse data from the HCPC's audit of CPD records in order to gather evidence on the costs, perceived benefits and regulatory impact of the system on professionals.</p> <p>The call for research proposals closed in July 2014, and a researcher/research team will be appointed by December 2014.</p>

Fitness to practise

2.15 Comments on the fitness to practise sections of the performance review are discussed in Appendices 1 and 2.

3. Good practice amongst regulators

3.1 This section summarises areas of good practice which were identified in section 7 of the PSA performance review report and are considered to be of relevance to work we are undertaking.

⁴ The Council for Healthcare Regulatory Excellence (CHRE) – former name of the PSA – published guidance in 2012 about the role of professional regulation in supporting registrants to demonstrate their continuing fitness to practise. See CHRE (2012), 'An approach to assuring continuing fitness to practise based on right-touch regulation principles' <http://www.professionalstandards.org.uk/docs/psa-library/november-2012---right-touch-continuing-fitness-to-practise.pdf>. In May 2013, the Executive produced a paper for the Council summarising and discussing the main points of the guidance. See HCPC Council meeting, 9 May 2013, Revalidation – 'Update and PSA report' <http://www.hpc-uk.org/assets/documents/10003FDDenc06-updateontherevalidationresearchprogramme.pdf>.

Guidance and standards

- 3.2 The General Medical Council (GMC) has produced a guide for patients entitled 'What to Expect from Your Doctor', working with several patient support organisations to promote and distribute it (see paragraph 7.15 in the report). This type of resource could be a useful way for HCPC to provide information to service users and the public about our core standards and expectations of the professionals we regulate.

Education and training

- 3.3 The GMC published new guidance to assist medical schools in supporting students experiencing mental health conditions. This included steps medical schools could take to encourage students with mental health conditions to seek help; suggestions about the types of support they might offer students; and guidance on the relationship between student health and fitness to practise (see paragraph 7.36 in the report). The Executive has taken into account this guidance and that of other professional regulators in making revisions to the guidance 'A disabled person's guide to becoming a health professional'. A public consultation on the revised guidance – now entitled 'Health, disability and becoming a health and care professional' – will run from 1 October 2014 to 16 January 2015 (subject to the agreement of the Council).

Fitness to practise

- 3.4 The areas of good practice relating to fitness to practise are included in Appendix 1.

4. 2014/15 performance review

- 4.1 The PSA identified several areas of work they would like us to cover in our submission for 2014/15. This section provides a summary of those areas and updates the Council on our progress, where relevant. Any on-going areas of work for the Fitness to Practise Department are addressed in Appendix 1.

Area of work	HCPC comments
Review of performance management information for Council (paragraph 7.67)	<p>The PSA has recommended that each regulator's Executive and Council undertake a joint review of the performance management information that is routinely presented to Council.</p> <p>A workshop on governance matters will form part of the Council's away day in October 2014.</p>
Mapping of UK-wide advocacy and patient groups	We engaged an external agency to undertake an initial stakeholder mapping

(paragraph 16.10)	exercise, informed by workshops with employees which they facilitated. We are now building on that work internally to produce a stakeholder mapping document which will meet our business needs, including setting out our engagement with UK-wide patient and service user advocacy groups.
Professionalism study (paragraph 16.21)	The Executive and the Chair have held recent meetings with the research team at Durham University as this research nears its completion. A progress report is being finalised and will be presented at a future meeting of the Council. We expect the final report from the research to be completed in May 2015.
Review of the standards of conduct, performance and ethics (paragraph 16.10)	<p>This review is on track to be completed in 2016. A Professional Liaison Group is currently considering amendments to the standards, in light of the results of the wide range of research and stakeholder engagement activities which took place during the first phase of the review.</p> <p>A public consultation on revised standards is expected to run between April and June 2015, with publication in January 2016.</p>

Appendix 1: The Professional Standards Authority Performance Review 2013-14 – Fitness to Practise

1. Introduction

- 1.1 This paper outlines the findings of the Professional Standards Authority for Health and Social Care (PSA), as set out in its 2013-14 annual performance review report, in relation to fitness to practise. The report provides a summary of how the nine UK health care regulators are meeting (or not meeting) the Standards Good Regulation in relation to fitness to practise at paragraphs 7.51 – 7.61.
- 1.2 The paper takes a thematic view of the risks and good practice identified by the PSA and sets out the HCPC's current practice together with ways the HCPC is planning to develop its processes in future. It then sets out the areas of work where the PSA expects to see improvement in the HCPC's 2014-15 performance review.
- 1.3 Reference to 'we' are references to the Fitness to Practise Department.

2. Performance Review Themes

Theme	PSA assessment of the current situation across the regulators	HCPC current practice	HCPC developments
<p>Accuracy of registers</p>	<p>The register-checking exercise undertaken by the PSA revealed errors in the registers of three regulators (including the HCPC – however only one error was identified and the PSA recognised that we took effective remedial and preventative action).</p> <p>Reference 7.42</p>	<p>To ensure the accuracy of the Register, managers in the Adjudication team conduct daily checks relating to concluded hearings from the previous day. Any actions taken are recorded on an internal database.</p> <p>The application of relevant sanctions to the Register are monitored through the use of ‘actions’ on the FTP case management system, with details of the sanction that needs to be applied, the expiry date and a code to link the registrant’s online entry to the full decision on the website. This is in line with the FTP case management system business rules.</p> <p>This process is completed by the Hearing Officer in attendance at the hearing and a checklist is populated and signed to demonstrate that all required actions have been undertaken. The action generates a notification to Hearings Team Managers on the date that the Register is due to be updated with details of the sanction that needs to be</p>	<p>The Assurance and Development team review and perform user acceptance testing as each new version of the existing Registration system is rolled out. This ensures that the link to the FTP case management system functions.</p> <p>The team has also contributed to the major project review registration systems and processes. The team will continue to contribute in 2015-16.</p>

		<p>applied.</p> <p>On a weekly basis, all hearing follow up is reviewed by a Hearings Team Manager to ensure all required actions have been completed for each concluded hearing. Reporting tools are also used to ensure that all pending notifications for the following week are active on the FTP case management system.</p> <p>The Quality Compliance team perform a monthly check to ensure all status changes in the previous month match between the Register and the FTP case management system. There have been no discrepancies on the public facing register in the last 12 months.</p> <p>The Assurance and Development team also report monthly to the Registration and Finance teams to ensure any registration status changes (such as cases where the registrant is no longer under investigation) are also updated to maintain the accuracy of the Register.</p> <p>The Quality Compliance Manager meets with peers from FTP teams to report on results of standard audits,</p>	
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		such as closed cases, ICP decisions, review of Not Well Founded cases, and identifies common issues that may affect training or process developments.	
Processes to manage risk in fitness to practise cases	<p>Three regulators were not able to demonstrate that they are meeting the 4th Standard of Good Regulation for fitness to practise: <i>All fitness to practise complaints are reviewed on receipt and serious cases are prioritised and where appropriate referred to an interim orders panel.</i> Concern was also noted about the performance against this standard of three other regulators (including the HCPC).</p> <p>Reference 7.51</p>	<p>The median time taken from initial receipt of complaint to interim order decision has remained stable at 15 weeks for the last two years. The time from receipt of new information to interim order decision has also remained stable at 18 days.</p> <p>Initial risk profiling is undertaken when a case is first received. This assessment includes identifying whether an interim order may be required.</p> <p>The presence of risk assessments on case files is checked as part of the regular case file audits. A report of risk assessments which have not been completed by their due dates is run each week. Where the completion of risk assessments is overdue, Case Team Managers will follow this up with the Case Manager to ensure that risk assessments are being completed in a timely manner.</p>	<p>In April 2014, following a review of the PSA's audit of the Nursing and Midwifery Council's initial stages fitness to practise process, additional audit activities have been introduced to monitor the interim order applications and interim order reviews to monitor:</p> <ul style="list-style-type: none"> • Time taken from the receipt of the concern to the IO hearing • Time taken to schedule the hearing • Length of time between issuing the Notice of Hearing and the IO hearing taking place • Level of reasoning provided in the IO Approval Form • Completeness of the decision-making audit trail, including completion of the risk assessment.

		<p>The file audit process monitors whether risk assessments have been completed. In addition, small samples of risk assessments are reviewed on a monthly basis to monitor the content and reasoning provided by case managers. Learning from this review is fed back to individual Case Mangers and captured as part of on-going training.</p> <p>Refresher training on Risk Profiling and interim order applications was provided to case managers and case team managers in March 2014.</p> <p>Our operational guidance on risk profiling and interim orders was reviewed and updated in June 2014. Amendments included: a specific timescale for completion of an initial risk assessment, i.e. to be completed by the case manager within five working days of receipt by HCPC of the fitness to practise concern (fresh risk assessments are also now required to be completed within five working days of receipt of new information); and the amount of detail that is required to be included in the risk assessment and guidance on assessing whether the registrant may</p>	<p>These additional audits will continue, with a particular focus on the length of time it takes for a case to be listed once approval to apply for an interim order has been given.</p> <p>Additional focussed audits of risk assessments are planned to evaluate the impact of the refresher training provided for case managers.</p>
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		<p>be vulnerable, e.g. mental health issues/suicide risk. The interim order approval form has been amended to formally capture whether a registrant is considered vulnerable and to alert the Hearings team whether any special measures or considerations need to be implemented to ensure any risks are mitigated.</p> <p>Cases subject to an interim order are prioritised for scheduling in order to ensure the case is listed as quickly as possible following investigation by our solicitors.</p> <p>Monthly meetings are held with managers from the Case Management and Adjudication teams to review all cases subject to an interim order which are due to expire in the next 6 months. A monthly interim order report is completed by the Case Advancement Team Manager who has responsibility for overseeing the interim order checks on a monthly basis. The meetings alert the group to cases that require an application to be made to the High Court for an extension of the interim order. This ensures that applications are made in a timely manner.</p>	
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		<p>The progression of cases which have an interim order in place is also closely scrutinised through the monthly Case Progression Conference and weekly teleconference which takes place between HCPC and its instructed solicitors for cases in the post ICP stage. This includes the progression of cases that have an existing interim order and assists in ensuring the number of cases requiring an extension from the High Court is kept to a minimum. Cases are assigned a red, amber or green priority rating to ensure their risk and urgency of case progression is clear to all.</p>	
<p>Voluntary removal/erasures</p>	<p>The regulators' voluntary removal/erasure processes must require decision makers to consider whether the public interest in the fitness to practise case going ahead means that the application should be refused. Also in order to maintain public confidence, regulators must put enough information in the public domain about the reasons why a voluntary removal/erasure has been granted, so that members of the public and other registrants can understand the decision.</p>	<p>The Health and Social Work Professions Order 2001 does not explicitly provide for consent arrangements to be put in place. However, the Council has approved consent arrangements as a means of allowing registrants, in suitable cases, to be removed from the Register, or to dispose of a case without the expense and time that a full hearing can require.</p> <p>The HCPC's approach to the disposal of cases by consent is outlined in a Practice Note and associated</p>	<p>We will take the PSA's comments into account when the Practice Note is reviewed in November 2014.</p> <p>A pilot audit of voluntary removal cases was completed in July 2014. The purpose of this audit was to provide assurance that the proscribed processes were being correctly followed and that only suitable cases which matched the criteria were being considered. Following</p>

	<p>Reference 7.53 and 7.54</p>	<p>operational guidance. The operational guidance was reviewed in March 2013 and the Practice Note is due to be reviewed in November 2014.</p> <p>Both pre- and post-final hearing consent applications are considered by a panel of the relevant practice committee, and the outcome is recorded in the Panel's Notice of Decision.</p> <p>All voluntary removal decisions are published on our website, in line with the publication of our final hearing decisions. All voluntary removal decisions contain a brief background to the case and outline the Panel's reasons for agreeing to the voluntary removal.</p>	<p>the completion of the pilot, VRA cases will continue to be audited on a quarterly basis.</p> <p>We will review whether any changes are needed to the HCPC publications policy to explicitly mention the publication of decisions relating to voluntary removal.</p>
<p>Timeliness</p>	<p>Four regulators were not able to demonstrate that they are meeting the 6th Standard of Good Regulation for fitness to practise: <i>Fitness to practise cases are dealt with as quickly as possible</i>. Concern was also noted about the performance of the HCPC against this standard and comment was made about the GMC's performance.</p>	<p>Please see appendix 2.</p>	<p>Please see appendix 2.</p>

	In response some of the regulators commented that they had either experienced a rise in the number of complaints received or that the complexity of cases had increased.		
Customer service	<p>Two regulators were not able to demonstrate that they provide a good quality customer service. Concern was also raised about one other regulator's performance against this standard.</p> <p>The main issues raised were failing to keep registrants and complainants up to date on the progress of an investigation and failing to promptly inform all interested parties of decisions.</p> <p>Other regulators were recognised for the feedback mechanisms they have in place.</p> <p>Reference 7.51</p>	<p>Our service standards are publicised on the HCPC website and our staff are trained in what is expected in terms of response times and updating registrants and complainants. We reviewed our service standards in January 2014 and reissued them to all staff.</p> <p>Our case management system is designed to remind case managers and other staff if an action, including updates to registrants and complainants, is outstanding. We monitor outstanding actions via a weekly report. We also report on cases that have no live actions to prevent them lying dormant.</p> <p>We have case closure checklists which must be completed upon closure of a case. These checklists provide that all interested parties must be informed of the decision.</p> <p>We have a process in place to deal</p>	<p>We are currently working on a project to develop our feedback mechanisms for registrants and complainants, in that we will seek feedback rather than waiting to receive it.</p> <p>We are currently working on a project to review our standard letter templates (within which we are also incorporating a 'tone of voice' review) to ensure our letters reflect our current processes. Further, to ensure the language used is clear and usable.</p> <p>We have recently worked with the Patients Association on a peer review of our fitness to practise processes from the perspective of a service user complainant. We will incorporate the learning from the peer review into our</p>

		<p>with any feedback we receive about FTP (be it about our service, a decision, a process or a supplier). We also have a feedback form and a specific feedback email address for witnesses and specific feedback email addresses for employers and representatives.</p> <p>The Adjudication team aim to notify registrants of panel decisions within three working days in line with our service standards. This is monitored through the use of the internal reporting tools.</p> <p>Calls to HCPC witnesses are made in advance of the hearing to ensure any queries or concerns are addressed prior to commencement of proceedings.</p> <p>Where appropriate we will also conduct witness de-brief calls, for example, if the witness was vulnerable or it was noted that the witness found the process of giving evidence particularly stressful. We feel this is particularly important to ensure the emotional well-being of witnesses.</p>	<p>current and future workplans.</p>
Reasonable and	The number of court referrals made	The FTP department undertake four	We have recently completed a

<p>well-reasoned decisions</p>	<p>by the PSA doubled in 2013-14 compared to 2012-13. It also provided feedback to regulators in 25% of the final hearing cases it reviewed and found evidence of poorly reasoned decisions during some of the regulators initial stages audits.</p> <p>Reference 7.51</p>	<p>strands of review on an on-going basis in order to monitor the standard of decision making at hearings (in addition to the review undertaken by the policy team). These are as follows:</p> <ol style="list-style-type: none"> a) Post-hearing decision reviews are conducted immediately after the event by Hearing Team Managers to ensure process has been followed b) Feedback from hearing participants is collected and studied in order that concerns can be addressed and trends analysed. c) Analysis of PSA feedback points are conducted on a monthly basis and formal responses are provided. Where concerns are recognised this information is communicated to the panel members concerned and fed into the development of guidance material. d) Individual studies of hearing activities (in particular papers on adjournment, not well found outcomes and preliminary activity) are drafted on a quarterly basis. 	<p>comprehensive review of the Investigating Panel Process and as a result of that review have developed a work plan focusing on further enhancements and developments to that process.</p> <p>The work plan also includes success indicators which will help us to assess whether the changes to the process had the anticipated effect. That work plan includes:</p> <ul style="list-style-type: none"> • revising the Case Investigation Report; • reintroduction of peer review approach for considering complex allegations prior to Case Team Manager approval; • review of operating guidance on investigations and information gathering; • evaluation of the benefits of using Case Examiners/Screeners; and • looking at the increased use of preliminary
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		<p>Through each of these reviews a body of information is collected, which is analysed by a Decision Review Group consisting of managers from each area of the Fitness to Practise Department, on a quarterly basis.</p> <p>Recommendations are made at each meeting for revisions to guidance or policy documents, the development of content for staff and panel member training and the management of any performance issues identified.</p> <p>A timetable of reporting activities is also delivered at each Decision Review Group meeting, which includes discussion of a number of reports drafted on a scheduled basis as highlighted at d) above.</p> <p>Panel members continue to receive comprehensive induction and refresher training on an on-going basis.</p> <p>Common issues around hearings and panel decisions are also highlighted in our quarterly Partner newsletter.</p> <p>The Quality Compliance team conduct a monthly audit of cases closed at ICP to ensure that the quality of decisions</p>	<p>hearings to ensure the smooth running of final hearings.</p> <p>We are planning to conduct an audit of ICP decisions later this year and will report the results to Council.</p>
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		remains consistent, and that any emerging trends are fed into Partner Training. Feedback is also given on a monthly basis to both the Case Management and Adjudication teams, to ensure consistency in the application of FTP processes and guidance is maintained. A particular focus is on periods of activity where there are changes in team members.	
Maintaining information security	<p>The PSA considers regulators should:</p> <ul style="list-style-type: none"> • have comprehensive information security policies and procedures in place; • ensure staff are trained in those policies and contractors are aware of their obligations; • ensure compliance with the policies is regularly monitored; and • have in place a formal log of data breach incidents. <p>Reference 7.55</p>	<p>We have undertaken a range of activities which are designed to minimise the risk of information security issues that can have an impact on public confidence. A comprehensive review of data security and information management arrangements was completed last year. The purpose of this review was to scrutinise the FTP processes and procedures to identify possible risk areas, and to identify possible changes to systems, processes and training that would mitigate the risk.</p> <p>The activities that have been completed as a result of the review include:</p> <ul style="list-style-type: none"> • updated operational guidance on Confidentiality and Information Security; 	<p>Confidentiality and information security refresher training for all FTP staff is scheduled for January 2015.</p> <p>We are considering the possibility of scoping a pilot looking at the use of electronic bundles in the next financial year however this is dependent on resources.</p>

		<ul style="list-style-type: none"> • information management and data security training for all FTP staff; • enhancement to case logging processes to verify the identity of registrants who are the subject of FTP complaints; • guidance and online information security training for Panel members; and • guidance on redaction for our instructed solicitors. <p>Data security is a standing item on the agenda of weekly FTP management meetings. This ensures there is a continued focus on assessing and mitigating the risks associated with information security whilst balancing this against the need to maintain operational effectiveness.</p> <p>A log of issues and actions is maintained by the Quality Compliance Manager and is used to identify trends that may affect induction or training of team members, enhancement to core business systems or areas to focus on in compliance audits.</p>	
Accessibility	The fitness to practise process should be readily accessible to	Our brochures are certified with a 'Plain English' Crystal Mark.	We have a current work stream which focuses on the

	<p>potential complainants and any barriers to raising concerns should be removed.</p> <p>Regulators were recognised for introducing online complaints forms and having complaints brochures certified with a 'Plain English' Crystal Mark.</p> <p>Reference 7.60</p>	<p>In 2014 we reviewed the FTP webpages of the HCPC website to ensure that the information contained therein is up to date; clear and usable. Whilst this is an on-going project, some changes have already been made, for example, improving the visibility of our Standard of Acceptance Policy and our brochures.</p> <p>We have processes in place to meet with complainants who have accessibility issues.</p>	<p>support provided to complainants. As part of this work stream we are reviewing our Standard of Acceptance Policy with a view to developing a complainant focused version. We are also developing a feedback mechanism and will be reviewing our complaints form.</p>
<p>Sharing information with other regulators and/or organisations</p>	<p>Sharing of information about the performance of both individuals and organisations should enable prompt and effective regulatory action to be taken (in the UK and around the world).</p> <p>Reference 7.60</p>	<p>We are about to sign a Memorandum of Understanding and a Joint Operating Protocol with the CQC. We have also recently signed a Memorandum of Understanding with the Data and Barring Service.</p> <p>We share information with the other UK countries' Care Councils on the outcomes of fitness to practise hearings on a monthly basis.</p> <p>We have processes governing the referral of individuals to the Disclosure and Barring Service (DBS) under the Vetting and Barring Scheme. Cases are referred for possible referral: on</p>	<p>We are currently working on a Memorandum of Understanding with NHS Protect.</p> <p>We will consider the possibility of sharing the outcomes of fitness to practise hearings with the NHS Area Teams.</p>

		receipt of a new case; as part of the on-going risk assessment of cases; following an FTP panel decision and where a decision is made to refuse an individual entry to the register. For the period 1 April 2013 to 31 March 2014, we made 17 DBS referrals.	
Learning from fitness to practise cases	<p>Two regulators have used the information they hold to categorise their fitness to practise cases to identify areas of practice which are more likely to be problematic and where additional guidance to registrants may be appropriate.</p> <p>Reference 7.13</p>	<p>We use information about fitness to practise cases, and identify trends and case studies, for our FTP annual report.</p> <p>Learning from FTP cases has been taken into account as part of the review of the SCPE.</p>	<p>We will review how we may enhance our use of information about fitness to practise cases to:</p> <ul style="list-style-type: none"> • link with the development of enhanced guidance to registrants, complainants and other stakeholders; and • to support registrants in terms of learning points or case studies. <p>As part of a project looking at disengagement, the researchers have analysed 30 fitness to practise cases.</p>
Professional indemnity arrangements	Requiring registrants to have professional indemnity arrangements in place ensures that patients can secure compensation when they suffer harm through	Once the necessary amendments to our Rules have been made to enact the relevant legislation, we will be asking registrants to confirm they meet the requirement to have a professional	Once the necessary amendments to our Rules have been made to enact the relevant legislation, we will remind our Case Management

	<p>negligence. The PSA hopes the new requirement will lead the regulators' fitness to practise panels to treat failure to have professional indemnity arrangements in place more seriously.</p> <p>Reference 7.43 and 7.44</p>	<p>indemnity arrangement in place by completing a declaration when renewing or registering with us.</p>	<p>team that any suggestion that a registrant may not have professional indemnity arrangements in place should be thoroughly investigated and acted upon appropriately. We will also inform our panel members of the legislative requirement and the purpose behind it.</p>
Governance	<p>Performance management information presented to the regulators' Councils should focus on meaningful and useful data; provide informative comparisons and trends; and be proportionate to the purpose for which it is collected.</p> <p>Reference 7.66 and 7.67</p>	<p>The FTP management pack has core information that is used to manage the budget and activity, and is reviewed on a quarterly basis. Information is also used at EMT and Council. It contains quantitative data for the previous five years, and also commentary for the preceding quarter. It is used to identify emerging trends in activity and the impact on the forecast/budget.</p> <p>We have recently applied the international data modelling standard (FAST) to this budget planner and reporting tool, to better model the impact of cases that do not meet the service standards (either in relation to closure times, case to answer rate, investigation time, cases that require further information, time to schedule, adjournment or part-heard rate, or</p>	

		duration of final hearing). We will be developing this model in the next year, but it is currently used to support the HCPC five-year business planning, as well as FTP activity monitoring.	
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3. PSA review of the HCPC

3.1 The PSA's assessments of the HCPC's performance in relation to fitness to practise are on pages 129-133 of the report. The PSA has said that it expects to see improvement in the following areas in the 2014-15 performance review.

3.2 The outcome of the mediation pilot study once it is complete.

- The mediation pilot went live in September 2013. Although potentially suitable cases have been identified, to date, no cases have successfully completed the mediation process. To maintain awareness of the pilot, and to assist case managers and panel members to identify potentially suitable cases, refresher training for case managers was held in July 2014 and a briefing video is shown at the beginning of all ICP meetings.

3.3 The completion of risk assessments at all required stages in the process.

- On-going audit activity is undertaken by the Case Management Team and the Assurance and Development Team to ensure risk assessments are completed at all required stages in the process in a timely manner. Further, to monitor the content and reasoning of risk assessments.
- Refresher training on risk profiling was provided to the Case Management team in March 2014.
- Our operational guidance on risk profiling was reviewed and updated in June 2014.

3.4 The median time taken from receipt of a complaint to a decision being made on application for an interim order.

- Additional audit activity has been introduced to monitor the time taken from the receipt of concern to interim order hearing and the time taken to schedule an interim order hearing. Any trends from this audit activity will be analysed and any learning will be implemented into the process.
- Refresher training on interim orders was provided to the Case Management Team in March 2014.
- Our operational guidance on interim orders was reviewed and updated in June 2014.

3.5 The median time taken to progress cases to a final hearing.

- Please see appendix 2.

Appendix 2: Fitness to practise – Timeliness

Table of contents

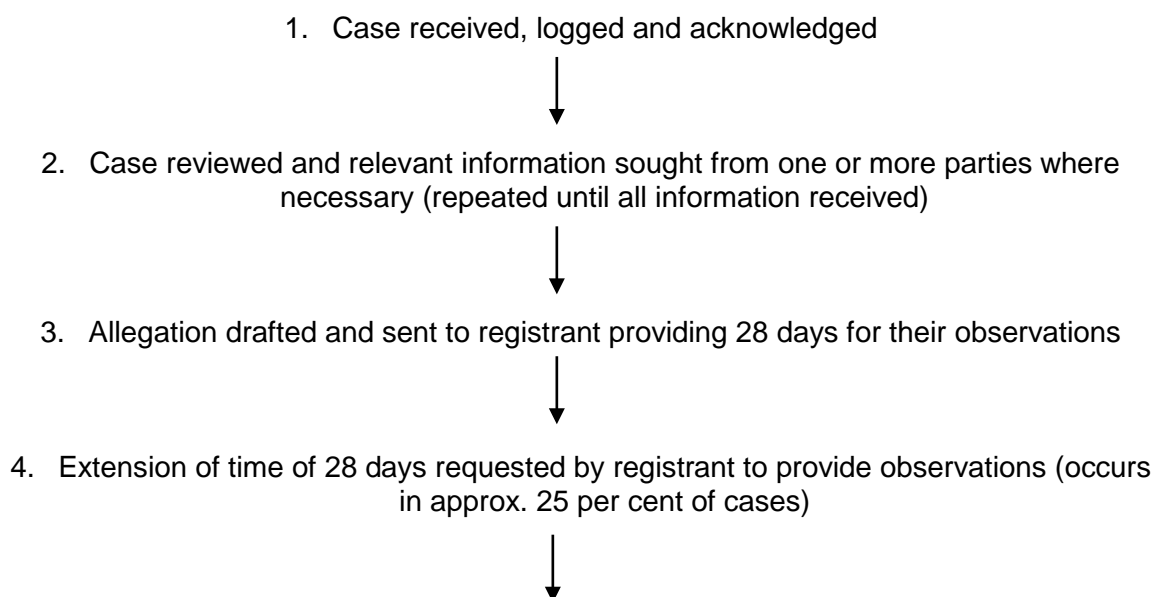
1. Introduction	2
2. Summary of the Investigation Process	2
3. Receipt of a Case	3
4. Cases that do not meet the Standard of Acceptance for Allegations	6
5. Case Review	7
6. Registrant observations	8
7. Consideration by an Investigating Committee	10
8. Length of time to conclude cases at Investigating Committee	12
9. Process developments.....	16
10. Preparing for the final hearing	17
11. Preliminary Hearings.....	18
12. Discontinuance	19
13. Fixing the Hearing.....	19
14. Scheduling Other Hearings	20
15. Changes to the Scheduling Process	22
16. Management of the hearing	22
17. Adjournment/Postponement and Part Heard Cases.....	23
18. Judicial Review	23
19. Ensuring the progression of final hearings	24
20. Final Hearing Length of time Statistics	24
21. Open Final Hearing Cases.....	26
22. Final Hearing Outcomes	27
23. Length of time by source of complaint.....	28
24. Length of time by Representation	29
25. Length of time – All cases	30
26. Transfer vs. Non Transfer Cases Length of time	32
27. Decision Review Group.....	32
28. Feedback Mechanisms	33
29. Future Developments.....	34
30. Conclusions	34

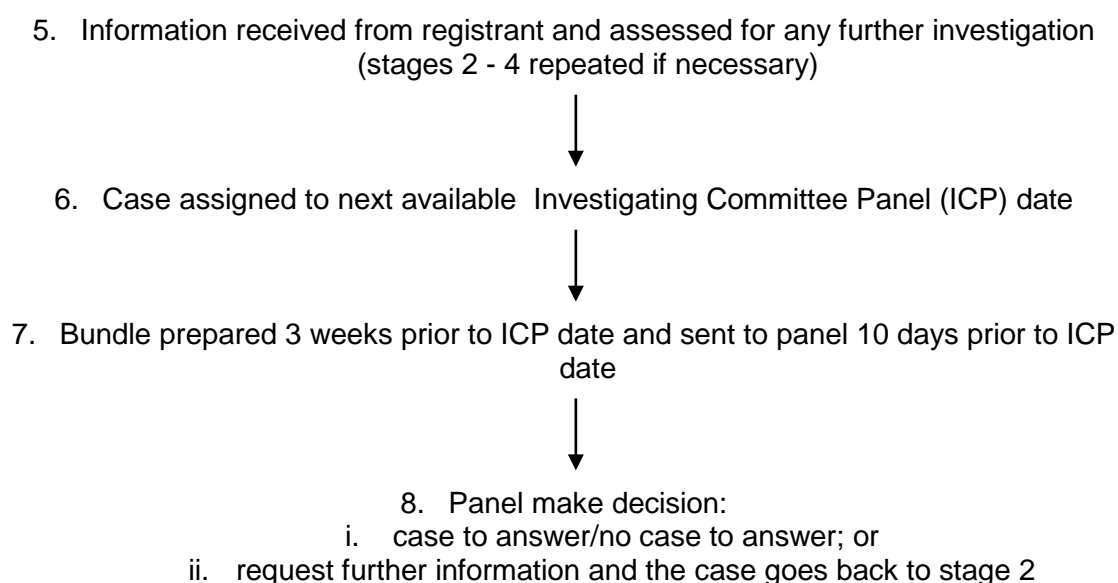
1. Introduction

- 1.1 In its 2013-14 performance review, the Professional Standards Authority for Health and Social Care (PSA) commented that the Health and Care Professions Council's (HCPC) performance against the sixth Standard of Good Regulation for fitness to practise had increased by seven weeks compared to the previous rate. The PSA commented that *'although the median time taken remains reasonable despite that increase, we are concerned to note the downturn in efficiency, which will have affected complainants, witnesses and registrants involved in fitness to practise cases'*.
- 1.2 As the Council will be aware, the HCPC takes a case-by-case approach to the investigation and management of fitness to practise cases. This means that every case has to be judged, assessed and investigated on its merits. This is based on the general principles of fairness and proportionality and recognises that we operate a fitness to practise process that differs from any criminal justice or disciplinary process. There are a range of practice notes in places to provide information to those who appear at or before fitness to practise panels. Those practice notes can be found at <http://www.hcpc-uk.org/publications/practicenotes>. We also have in place a range of Fitness to Practise Operating Guidance for use by the fitness to practise directorate in the course of their work.
- 1.3 This paper provides further information on the management of fitness to practise cases, the length of time it takes to manage cases and the work that the Executive is undertaking to ensure the expeditious management of cases. The data and commentary provided does not refer to General Social Care Council (GSCC) cases unless specifically stated.

2. Summary of the Investigation Process

- 2.1 The process flow below provides an overview of the investigation process. More detail is provided on that process in this paper.





3. Receipt of a Case

- 3.1 When a case is received, it is logged and assessed by a Case Team Manager and assigned to a Case Manager. Before setting up the case as a Fitness to Practise case in the case management system, the Case Team Manager is required to ensure that we have three pieces of personal data about the registrant contained within the complaint. This information is cross-checked against the registration system to ensure that a case is raised against the correct registrant. If this information is not contained within the complaint, the Case Manager is required to request further information to verify the identity of the registrant. Once this is done, the Case Team Manager undertakes an initial risk assessment before allocating the case to a Case Manager.
- 3.2 On allocation, the Case Manager will review the case to determine whether further information is required in order for the case to meet HCPC's Standard of Acceptance for Allegations. The Standard of Acceptance sets the minimum threshold which fitness to practise allegations must normally meet before they will be investigated by the HCPC. A fitness to practise allegation meets the Standard of Acceptance if it is provided in the appropriate form, i.e. it sufficiently identifies the registrant against whom the allegation is made and sets out the events and circumstances giving rise to it in sufficient detail for the registrant to be able to understand and respond and provides credible evidence which suggests that the registrant's fitness to practise is impaired. The time it takes to determine whether the case meets the Standard of Acceptance is dependent on a number of factors which include the nature and complexity of the complaint as well as who is making the complaint. For example, Case Managers may need to spend more time explaining the fitness to practise process and clarifying the nature of the concerns being raised when the complainant is a member of the public as opposed to an employer who may be making a referral having completed a disciplinary investigation.
- 3.3 In 2013-14 it took on mean average three months and a median of three months for a case to reach to Standard of Acceptance after the receipt of the

initial concern. In that period, there were 765 cases that met the Standard of Acceptance.

Table 1 – Time from receipt of complaint to Standard of Acceptance, 2013-14

Age from receipt to SOA	Number	%	Cumulative %
0 to 2 months	378	49	49
3 to 4 months	174	23	72
5 to 8 months	150	20	92
9 to 12 months	40	5	97
13 to 15 months	13	2	99
16 to 20 months	8	1	100
21 to 24 months	0	0	100
>24 months	2	0.3	100
Mean Months	3		
Median Months	3		
Total Cases	765		

- 3.4 At the end of July 2014 there were 271 cases which had met the Standard of Acceptance. The mean and median average age of those cases is four and three months respectively. A detailed breakdown of these cases is provided in the tables below.

Table 2 – Age of Cases, Open Standard of Acceptance cases, end of July 2014

Age from receipt to SOA	Number	%	Cumulative %
0 to 2 months	129	48	48
3 to 4 months	54	20	68
5 to 8 months	49	18	86
9 to 12 months	23	8	94
13 to 15 months	13	5	99
16 to 20 months	1	0.3	99.3
21 to 24 months	1	0.3	99.6
>24 months	1	0.3	100
Mean Months	4		
Median Months	3		
Total Open Cases	271		

- 3.5 At the end of July 2014 there were a further 963 cases which had been logged as an enquiry because they had not yet met the Standard of Acceptance. The mean and median average age of those cases is five and three months respectively. The table below provides more detail on the age of the cases that are currently open but have not yet met the Standard of Acceptance.

Table 3 – Age of Cases, Open Enquiry Cases, end of July 2014

Age from receipt	Number	%	Cumulative %
0 to 2 months	419	44	44
3 to 4 months	172	18	62
5 to 8 months	223	23	84
9 to 12 months	90	9	95
13 to 15 months	30	3	97
16 to 20 months	13	1	98
21 to 24 months	10	1	99
>24 months	6	1	100
Mean Months	5		
Median Months	3		
Total Open Cases	963		

- 3.6 In some cases, it will be possible to formulate an allegation solely on the basis of the initial information that has been received from the complainant. In many cases a more detailed investigation will need to be carried out. In gathering further information for this purpose, Case Managers may exercise the powers under Article 25(1) of the Health and Social Work Professions Order 2001 (the Order) to compel disclosure. This power cannot be used to compel the registrant concerned to provide information or to take part in an interview.
- 3.7 We are often informed of possible fitness to practise concerns at the early stages of a police investigation or employer disciplinary process. In such circumstances we will normally wait for the police or employer to complete their investigations before proceeding with any fitness to practise allegations. This ensures we have the most complete evidence available when considering allegations and that we do not prejudice any criminal or employment related proceedings. Notwithstanding this, we undertake an initial risk assessment when the case is initially received, as well as on-going risk assessments when new information is received, to determine whether any interim measures need to be put in place to protect the public. Article 31 of the Order enables HCPC Practice Committee Panels to impose interim suspension or conditions of practice orders on registrants who are subject of an allegation. We can apply for an interim order if we believe it is necessary for the protection of members of the public, is in the public interest, or is in the interests of the registrant concerned.
- 3.8 The types of cases where we may apply for an interim order include cases where, if the allegation is well founded, there is an on-going risk to service users from the registrant's serious lack of professional knowledge or skills:
- Cases which may not be directly related to practice but where the registrant may pose a risk to service users, e.g. allegations of indecent assault or where it appears a registrant with serious health problems is practising whilst unfit to do so
 - Cases where the allegations are so serious that public confidence in the regulatory process would be seriously harmed if the registrant was

allowed to remain in practice on an unrestricted basis, e.g. allegations of murder, rape or the sexual abuse of children.

3.9 In some cases it may also be necessary to seek advice from an expert in a particular field. The advice sought may relate to profession specific issues that arise in the complaint where clarification or explanation is required

4. Cases that do not meet the Standard of Acceptance for Allegations

4.1 Not all cases that are received will meet the Standard of Acceptance for Allegations. A decision to close a case either prior to it becoming a fitness to practise allegation, on the basis that it does not meet the Standard of Acceptance, or prior to it being put to an ICP, is only to be taken after consideration of all the available information. At this stage in the process, any doubts should be resolved in favour of public protection, by allowing the allegation to proceed.

4.2 Where a case has been identified as being potentially suitable for closure, a case closure form must be completed by the Case Manager in the Case Management System and submitted to their Case Team Manager for approval. It is important that clear reasons for the case closure decision are recorded, including express reference to why the Standard of Acceptance is not met. Where appropriate, legal advice may be obtained before closure but this is not routinely sought in every case. Case Team Managers are also required to approve closure letters.

4.3 In 2013-14, 1080 cases were closed without consideration by an ICP. Between April 2014 and July 2014, 304 cases have been closed. The mean and median length of time from receipt to closure of these cases is five and four months in 2013-14 and with no change in the period April to July 2014. The table below provides more detail on the length of time taken for those cases to be closed.

Table 4 – Cases closed pre-ICP, 2013-14

Age of Case	Number of cases closed	Cumulative number of cases	% of cases	Cumulative % of cases
0 to 4 months	601	601	56	56
5 to 8 months	359	960	33	89
9 to 12 months	89	1049	8.2	97.2
13 to 16 months	17	1066	1.6	98.8
17 to 20 months	7	1073	0.6	99.4
> 20 months	7	1080	0.6	100
Mean Months	5			
Median Months	4			
Total Cases Closed	1080			

Table 5 – Cases closed pre-ICP, April to July 2014

Age of Case	Number of cases	Cumulative number of cases	% of cases	Cumulative % of cases
0 to 4	170	170	56	56
5 to 8	91	261	30	86
9 to 12	30	291	10	96
13 to 16	4	295	1	97
17 to 20	7	302	2	99
> 20	2	304	1	100
Mean Months	5			
Median Months	4			
Total Cases Closed	304			

5. Case Review

- 5.1 We have a number of mechanisms and safeguards in place to ensure the progression of cases in the enquiry and pre-ICP stages are closely monitored review. Case review meetings are held at least once per month at which Case Managers discuss cases with their Case Team Manager and questions can be asked of the Case Manager about the investigation and approach taken.
- 5.2 Our Case Management System allows weekly generation of actions that have not been completed. This report is circulated to the management team and a process exists through line management and performance management systems to ensure that actions are completed, or are updated once an assessment of any delays has been made, with reasons recorded appropriately.
- 5.3 A Case Progression Conference is held each month. The case progression conference considers cases which have been under investigation for four months or more and where the Case Manager may have experienced difficulties in progressing the case. The purpose of the meeting is to examine the management of cases to date and explore ways in which the case can be progressed. Last year we extended the scope of the case progression conference to include cases that had been referred to a final hearing but had not been listed as ready to fix.
- 5.4 We have a Case Advancement Team which was created to provide a dedicated resource for the investigation and progression of the more complex cases. The Case Advancement Team uses a number of methods to support the progression of cases including a monthly case handling strategy meeting which provides an opportunity to consider cases where there are barriers to progression and to explore the use of different case management techniques.
- 5.5 We review data from our case management system to ensure that cases in any of the FTP stages continue to progress according to our service standard timescales, whilst recognising that the complexity of the complaints or the

information required to meet the Standard of Acceptance can be demanding and not met in every case, depending on the circumstances.

- 5.6 We have a mechanism to review cases that fall outside of our service standard times. These cases are assigned an escalation plan, and have a rating of red, amber or green depending on the combination of age and delay. Red cases are considered to need immediate action to progress, amber cases may be outside of the standards but have an action plan to progress, and green cases are progressing normally following intervention. Case progression data is reviewed weekly by the FTP Management team.
- 5.7 The length of time it can take to progress a case is affected by a range of external variables which include identifying and obtaining relevant information, the cooperation of the complainant and third parties e.g. Police and employers as well as the engagement of the registrant once allegations are formulated. There are also internal factors which impact how quickly FTP cases can be progressed. In particular we have to balance the resource demands of managing the FTP caseload with our responsibility for managing health and character declarations and investigating complaints about the misuse of protected titles. Furthermore, interim order applications and reviews, as well as reviews of orders by the Health Committee and Conduct and Competence Committee, as required by Article 30 of the Order, are presented in-house by Case Managers. This reduces the costs associated with instructing external solicitors.
- 5.8 An additional case team was created in 2013 to provide additional flexibility to manage health and character and protection of title cases as well as FTP cases. We have also undertaken resilience planning to ensure we maintain sufficient staff resources, taking into account staff turnover and sickness absence as well as seasonal peaks. An example of this is that we have employed a temporary case manager to help manage the seasonal increase in health and character declaration cases.
- 5.9 To maintain the optimum use of the available employee resources it is often necessary for cases to be reallocated between case managers, in particular when case managers leave or are on long-term sick leave. The transfer of cases between case managers has been identified as being a potential risk area which could impact on the timely progression of cases. Transfers of cases between case managers can add on average two months to the lifetime of a case as the details of the case are absorbed by the new owner, actions are completed, or contact is made with existing parties to the case. This is also dependant on the existing workload of the case manager who receives the cases. In response we have formalised the case handover process, which includes an approval stage before the case is transferred.

6. Registrant observations

- 6.1 All registrants subject to a fitness to practise investigation must be notified in writing of the allegations against them prior to the consideration of the case by an ICP.

- 6.2 The registrant must be provided with the particularised allegations and a copy of all the documents that the Panel will consider. The Case Manager is also required to review and redact case information that is sent to the registrant to ensure that the HCPC is protecting the privacy of complainants is compliant with data protection principles. All complainant personal details relating to members of the public are redacted to ensure the privacy of the complainant. Other than in exceptional circumstances, the name of the complainant is disclosed to the registrant in order for them to have the opportunity to fully respond to the allegations. The registrant must be provided with 28 days in which to respond to the allegations made. The allegation which is first put to the registrant is also be the allegation on which the ICP is asked to reach a case to answer decision and, assuming there is a case to answer, must be materially the same allegation which is considered at the subsequent hearing.
- 6.3 Careful consideration needs to be given to the formulation of allegations at the very outset of an investigation. The detail of an allegation may be amended, in the sense of providing more detail to help the parties understand or answer points raised by that allegation. However, an allegation cannot be extended or varied to any material degree without either the consent of the registrant or the additional elements being subjected to the investigative process outlined above, so that the registrant has the opportunity to make representations which can be considered by an ICP.
- 6.4 The requirement not to vary an allegation during the fitness to practise process is a facet of the common law rules of natural justice, which set the minimum standards of fair decision-making. An implied obligation to observe the principles of natural justice – essentially the right to a fair hearing free of bias – arises in respect of anybody determining questions of law or fact in circumstances where its decisions will have a direct impact on someone’s rights or legitimate expectations.
- 6.5 The right to a fair hearing requires that a person is given adequate prior notice of the allegations against him or her, and of the procedure for determining those allegations, so that he or she has a fair opportunity to:
- answer the case against him or her; and
 - present his or her own case, including;
 - presenting his or her version of the facts;
 - making submissions on principles of law or any applicable legislation, guidance or codes of conduct etc.
- 6.6 The right to a fair hearing is also protected by the Human Rights Act 1998 in consequence of Article 6 of the European Convention on Human Rights. In Convention jurisprudence, the concept of what amounts to a fair hearing is a flexible one and the essential requirements reflect the common law duty to apply the principles of natural justice and otherwise to act fairly.

- 6.7 Upon receipt of a response from a registrant to an allegation, Case Managers review the content of the response in order to identify any issues that may need clarification from the complainant. The HCPC does not provide the complainant with a copy of the registrant's response to the allegation. However, it may be necessary for the Case Manager to seek further clarification from the complainant in relation to aspects of the allegation following receipt of the registrant's response. Seeking such clarification prior to an Investigating Committee Panel can assist the Panel in their consideration of the case. If further information is sought at this stage, the case will be reviewed and the registrant provided with a further 28 days to respond to the new material that has been obtained.
- 6.8 A registrant may also request an extension of time in which to provide their observations, and one 28-day extension can be granted administratively by the Case Manager. Further requests of time must be considered by a Panel of the Investigating Committee. Requests for an extension of time are made in about seven per cent of cases (or 165 of the new cases received in 2013-14).
- 6.9 In 2013-14, a further 18 registrants sought a further extension by a Panel. In each of the above time periods, this can add four to eight weeks to the length of time a case takes to reach an Investigating Committee Panel.

7. Consideration by an Investigating Committee

- 7.1 As part of the preparing the case for consideration by an ICP, the Case Manager will prepare a case investigation report. This report:
- summarises the background to, and source of, the allegation;
 - sets out the allegation in the form that it was provided to the registrant;
 - provides a synopsis of the investigation which has been carried out; and
 - identifies all of the documents and other material received by the HCPC (full copies are attached to the report itself).
- 7.2 The case is then assigned to an ICP for the specific profession. It is forecasted that one ICP can consider up to nine cases per session. Panels also sit as Registration Panels to consider health and character declarations to ensure such declarations are dealt with swiftly. We hold between nine and 12 ICPs per month. Panels are scheduled three and six months in advance and the professions about which we receive the most allegations have up to five sessions per month. We also arrange for panel members from smaller professions to attend via telephone conference given the number of cases that will considered will be lower than for the larger professions.
- 7.3 Working with a Hearings Team Manager, a Case Team Manager is responsible for the allocation of cases to an ICP. They are responsible for ensuring the even flow of cases to ICP and that the cases allocated do not exceed the cap of nine cases to be considered on any particular day. This involves considering the nature and complexity of cases due to be considered to ensure there is sufficient time for decisions to be completed in the time

allotted, and identifying where ICP days can be consolidated when only a few cases are listed on a particular day. They also ensure that cases which have been re-listed (see paragraphs 7.7 and 7.8), or have an interim order in place, are prioritised.

- 7.4 A Hearings Team Manager acting as a co-ordinator, attends ICP. Their role is to ensure the smooth running of the Investigating Committee Panel meetings and to ensure that Panels are consistently applying the correct case to answer test. They will also provide advice to Panels and Case Managers on the amendment of allegations and use of learning points. The case manager for the case being considered will also attend. Case Managers do not participate in the decision making process but assist the panel in recording their decision using a standard template. They also direct the panel to the relevant parts of the Order and Rules, as well as practice notes. The Case Manager is also responsible for ensuring that the correct actions are taken following the ICP.
- 7.5 A case cannot generally be assigned to a date less than two weeks in advance due the administrative work that needs to be undertaken. The Administration Team goes through a process which involves arranging the copying of the bundles (some of which may be substantial) via an external supplier for all the cases due to be considered by a panel on a particular day and then collating and sending the bundles to the panel members in advance of the meeting date.
- 7.6 The bundle is sent to the panel 10 days in advance of the meeting in order to provide them with sufficient time to read the information. If a case misses the deadline for an ICP by only a couple of days it can add six weeks to the length of the case depending on when the next panel is scheduled to take place.
- 7.7 There are occasions when cases have to be moved to alternative date as the Panel has run out of time to consider the matter. This can mean that an additional six to eight-week delay is added to the process.
- 7.8 A panel can ask for further information if they consider that more detail is required before making their decision. This occurred on 25 occasions in 2013-14 and on 13 occasions between April and July 2014. Of the cases that were considered in 2013-14 this added an average of three months to the conclusion of the case by an Investigating Committee Panel. The minimum time to return to ICP was one month, and the maximum eight months, with two cases having no future ICP date yet.
- 7.9 If a case progresses with no need to request further information and no extensions of time and no other issues, the minimum amount of time it would take for a case to reach an ICP is 14 weeks (or three and a half months). The tables in section 8 set out the length of time from receipt to conclusion at an ICP.

8. Length of time to conclude cases at Investigating Committee

- 8.1 The mean and median length of time from receipt of complaint and from the date the Standard of Acceptance was met to conclude a 'no case to answer' decision was seven and six months at ICP in 2013-2014, and four and three months between April and July 2014.
- 8.2 The table below shows the length of time from receipt of complaint and from the date the Standard of Acceptance was met to conclude 'no case to answer' decisions in 2013-14 and between April and July 2014. It also provides the cumulative percentages to close those cases.

Table 6 – Length of time from receipt of complaint and from date SOA was met to conclude no case to answer decisions, 2013-14

Number of Months	Receipt to NCTA			SOA to NCTA		
	Number	%	Cumulative %	Number	%	Cumulative %
1-4	77	24	24	239	74	74
5-8	156	48	72	60	19	93
9-12	61	19	91	14	4	97
13-16	18	6	97	5	2	99
17-20	4	1	98	1	0	99
21-24	5	2	100	2	1	100
25-28	1	0	100	1	0	100
29-32	0	0	100	0	0	100
33-36	0	0	100	0	0	100
> 36	0	0	100	0	0	100
Mean Months	7			4		
Median Months	6			3		
Total	322			322		

Table 7 – Length of time from receipt of complaint and from date SOA was met to conclude no case to answer decisions, April to July 2014

Number of Months	Receipt to NCTA			SOA to NCTA		
	Number	%	Cumulative %	Number	%	Cumulative %
1-4	16	12	12	90	69	69
5-8	74	57	69	28	22	91
9-12	20	15	85	12	9	100
13-16	16	12	97	0	0	100
17-20	3	2	99	0	0	100
21-24	0	0	99	0	0	100
25-28	0	0	99	0	0	100
29-32	1	1	100	0	0	100
33-36	0	0	100	0	0	100

>36	0	0	100	0	0	100
Mean Months	8			4		
Median Months	7			3		
Total	130			130		

8.3 The mean and median length of time from receipt of complaint and from the date the Standard of Acceptance was met to conclude 'no case to answer' decisions in 2013-2014 and between April and July 2014 is demonstrated in the table below.

Table 8 – Mean and Median Length of time by complainant type, No Case to Answer Decisions, 2013-14

Source of complaint	Receipt to NCTA		SOA to NCTA	
	Mean months	Median months	Mean months	Median months
Article 22(6)/Anon	12	9	4	3
Employer	7	6	4	3
Other	7	8	4	4
Other Registrant	6	7	4	3
Police	5	5	4	4
Professional Body	3	3	2	2
Public	8	7	5	4
Self-Referral	7	6	3	3

Table 9 – Mean and Median Length of time by complainant type, No Case to Answer Decisions, April to July 2014

Source of complaint	Receipt to NCTA		SOA to NCTA	
	Mean months	Median months	Mean months	Median months
Article 22(6)/Anon	8	8	5	5
Employer	7	7	4	4
Other	7	6	4	3
Other Registrant	21	21	4	4
Police	6	5	5	3
Professional Body	n/a	n/a	n/a	n/a
Public	11	9	5	4
Self-Referral	7	7	3	3

8.4 The tables below shows the length of time from receipt of complaint and from the date the Standard of Acceptance was met to conclude case to answer decisions in 2013-14 and between April and July 2014. It also provides the cumulative percentage to consider those cases.

Table 10 – Length of time from receipt of complaint and from date SOA was met to conclude Case to Answer Decisions, 2013-14

Number of Months	Receipt to CTA			SOA to CTA		
	Number	%	Cumulative %	Number	%	Cumulative %
1-4	94	26	26	235	65	65
5-8	156	43	69	82	23	88
9-12	66	18	88	20	6	94
13-16	22	6	94	7	2	96
17-20	12	3	97	7	2	98
21-24	5	1	99	4	1	99
25-28	3	1	99	3	1	99
29-32	0	0	99	0	0	99
33-36	1	0	100	1	0	100
>36	1	0	100	1	0	100
Mean months	8			5		
Median months	6			3		
Total number of Cases	360			360		

Table 11 – Length of time from receipt of complaint and from date SOA was met to conclude, Case to Answer Decisions, April to July 2014

Number of Months	Receipt to CTA			SOA to CTA		
	Number	%	Cumulative %	Number	%	Cumulative %
1-4	25	16	16	102	66	66
5-8	66	43	59	37	24	90
9-12	38	25	83	9	6	95
13-16	11	7	90	4	3	98
17-20	13	8	99	3	2	100
21-24	1	1	99	0	0	100
25-28	0	0	99	0	0	100
29-32	1	1	100	0	0	100
33-36	0	0	100	0	0	100
> 36	0	0	100	0	0	100
Mean months	8			4		
Median months	7			3		
Total number of Cases	155			155		

8.5 The tables below show the mean and median length of time by complainant type for case to answer decisions in 2013-14 and between April and July 2014.

Table 12 – Mean and Median Length of time by complainant type, Case to Answer Decisions, 2013-2014

Source of complaint	Receipt to CTA		SOA to CTA	
	Mean months	Median months	Mean months	Median months
Article 22(6)/Anon	7	5	5	3
Employer	8	6	5	4
Other	6	6	3	3
Other Registrant	13	9	19	6
Police	9	5	8	5
Professional Body	6	6	4	3
Public	8	7	4	3
Self-Referral	8	6	4	3

Table 13 – Mean and Median Length of time by complainant type, Case to Answer Decisions, April to July 2014

Source of complaint	Receipt to CTA		SOA to CTA	
	Mean months	Median months	Mean months	Median months
Article 22(6)/Anon	20	24	4	3
Employer	9	7	5	3
Other	7	7	5	5
Other Registrant	9	9	4	3
Police	7	6	6	6
Professional Body	n/a	n/a	n/a	n/a
Public	7	5	4	3
Self-Referral	8	8	4	3

8.6 The tables below shows the length of time from receipt of complaint and from the date the Standard of Acceptance was met for both case to answer and no case to answer decisions.

Table 14 – Closure times, all concluded ICPs, 2013-14

Number of Months	Receipt to Conclusion at ICP			SOA to Conclusion at ICP		
	Number	%	Cumulative %	Number	%	Cumulative %
1-4	171	25	25	476	70	70
5-8	312	46	71	142	21	90
9-12	126	19	89	33	5	95
13-16	40	6	95	12	2	97
17-20	16	2	98	8	1	98
21-24	10	1	99	6	1	99

25-28	4	1	100	3	0	100
29-32	0	0	100	0	0	100
33-36	2	0	100	1	0	100
>36	1	0	100	1	0	100
Mean Months	7			5		
Median Months	6			3		
Total Cases	682			682		

Table 15 – Closure times, all concluded ICPs, April to July 2014

Number of Months	Receipt to Conclusion at ICP			SOA to Conclusion at ICP		
	Number	%	Cumulative %	Number	%	Cumulative %
1-4	41	14	14	192	67	67
5-8	140	49	64	65	23	90
9-12	58	20	84	21	7	98
13-16	27	9	93	4	1	99
17-20	16	6	99	3	1	100
21-24	1	0	99	0	0	100
25-28	0	0	99	0	0	100
29-32	2	1	100	0	0	100
33-36	0	0	100	0	0	100
> 36	0	0	100	0	0	100
Mean months	8			4		
Median months	7			3		
Total cases	285	100		285		

9. Process developments

9.1 We have a range of activities in our current work plan which is intended to improve the understanding of our processes by external stakeholders – including complainants and registrants – as well as improving quality and consistency of decision making. These activities include:

- Reviewing the Standard of Acceptance policy with a particular focus on where complaints can be resolved locally;
- Implementing actions from the recent review of the Investigating Committee process including:
 - revision of the Case Investigation Report;
 - re-introduction of peer review approach for considering complex allegations prior to Case Team Manager approval;
 - review of operating guidance on investigations and information gathering;
 - evaluation of the benefits of using Case Examiners/Screeners;

- looking at the increased use of preliminary hearings to ensure the smooth running of final hearings.
- Reviewing the approach taken to case allocation and the mix of cases allocated to case managers. This involves analysing the number of transactions involved in managing different case types and enhancing the management information that is available to inform the allocation of cases to ensure caseloads remain manageable.
- Reviewing the responsibilities of the case management and administration teams, for example evaluating whether there is value in separating the initial logging and assessment of cases in the Enquiry stage.

10. Preparing for the final hearing

- 10.1 When a case to answer decision is reached, our solicitors are formally instructed to prepare the case for final hearing. This preparation will include the taking of formal witness statements and instructing experts where necessary. To enable our solicitors to identify witnesses and prepare cases in line with agreed service standards, un-redacted copies of documentation have to be obtained. This can cause delays as third parties are sometimes reluctant to release un-redacted versions of documents due to data protection concerns. This often requires the Case Manager having to explain our power to order disclosure of information under Article 25 of the Order before documents are released. Similarly, delays can be encountered in obtaining specific service user records in cases where the allegations relate to a report written by the registrant; supervision records/meeting notes in competency cases; and obtaining consent from registrants for their medical records to be released in health cases.
- 10.2 There is a service level agreement in place between HCPC and our solicitors which sets out the requirements and timescales for delivery of key investigation elements. These include the initial case plan, the provision of witness details, notification of the case being ready to fix, the production and serving of the bundles of evidence to key parties, and practical arrangements for the presentation of the final hearing. Monthly service level agreement meetings are held, to review performance against the levels set out in the contract. These include volumes and quality of investigations and hearings, complaints against the provider, developments and improvements in the provider's service, and utilisation of hours to carry out investigations.
- 10.3 In some instances further concerns may be raised by witnesses during the course of interviews which raise new allegations against the registrant. To ensure that the process is fair and transparent, where new information comes to light it is not simply added to the existing case but the registrant must be given the opportunity to respond to the new allegations. In these circumstances, the case may be delayed while the additional allegations are considered by an ICP Panel and a case to answer decision reached. The allegations can then be joined and heard together in accordance with the Joinder practice notes. Applications for joinder were made in 5 cases in 2013-14 and in 4 cases between April and July 2014. This can add up to 12 months

to the time before the case is concluded at final hearing, with an average of eight months for cases where joinders were granted in 2013-14.

- 10.4 Once instructed, our solicitors obtain statements from the identified witnesses as soon as possible. Sometimes witnesses will be reluctant to engage in the process or difficult to contact which can cause delays. Our solicitors employ a range of measures to ensure that witness contact details are up to date and that witness interviews are conducted in a timely manner. Delays can occur if it is identified that expert evidence is required especially if it relates to a niche area of practice. In health cases, the HCPC asks the registrant concerned to consent to a health assessment by an expert appointed by the HCPC. Delays can occur if a registrant fails to consent to such an assessment or misses agreed appointments.
- 10.5 Sometimes the complexity of the case means that additional time is required for our solicitors to fully prepare the matter for final hearing, this could be because additional documentation is required or they are encountering difficulties in obtaining documents from third parties. In such instances, the HCPC will send correspondence requesting disclosure under Article 25 of the Order. Once all further investigations have been concluded, our solicitors will notify us that the case is ready to schedule.
- 10.6 There are a number of default directions that are in place to manage cases in advance of a final hearing. These directions provide for the exchange of documents between the HCPC and the registrant, service of notice to admit facts, documents and witness statements and the withdrawal of admissions. We aim to ensure that registrants and their representatives are provided with witness statements in advance of this and as soon as the individual witness statement is available. One of the common issues that come up during the preparation of witness statements is a reluctance to engage in the process. This may be due to anxiety about giving evidence before the Panel or concerns about the practical arrangements of attending HCPC in person. To deal with such concerns, we have a well-established witness support program in place that is designed to support witnesses before, during and after a hearing. Such support measures are essential in ensuring continued engagement by HCPC witnesses.

11. Preliminary Hearings

- 11.1 In cases where there are complex issues to resolve before the final hearing, a preliminary hearing may be required. The Preliminary Hearings practice note sets out the process which is followed. The types of issues and applications considered at preliminary hearing include:
- witness summons;
 - complex legal argument;
 - joinder applications;
 - discontinuance applications;
 - vulnerable witness applications;

- disclosure of information; and
- location of a hearing.

11.2 It is sometimes the case that dates for a final hearing cannot be listed until after a preliminary hearing has taken place. Decisions made at the meeting often influence the number of days allocated or venue for a hearing. Although a preliminary hearing can mean delay in the listing of a case, the types of issues that are resolved often mean that the final hearing itself runs more smoothly. In 2013-14, 34 preliminary hearings concerning 32 cases were held. Between April 2014 and July 2014, this number was 13.

11.3 Of the 34 cases where a preliminary hearing was held in 2013-14, 17 cases have now concluded. In 3 per cent of cases, adjournment/part heard decisions were made (compared with an overall percentage of 8 per cent. Those cases took a mean and median average of 30 and 26 months to conclude from the receipt of complaint; 27 and 25 months to conclude from the date the Standard of Acceptance was met; and 18 and 15 months to conclude from referral by the Investigating Committee.

12. Discontinuance

12.1 One of the issues that may be considered by a preliminary meeting is an application for discontinuance of all or part of the allegation. Occasionally, after a case has been referred for a final hearing, objective appraisal of the detailed evidence which has been gathered since the case to answer decision was made may reveal that it is insufficient to sustain a realistic prospect of proving the whole or part of the allegation. This may include instances where expert evidence has been sought which disproves the factual elements of the allegation or where it is clear that the HCPC would be unable to prove the allegation. The discontinuance process ensures that valuable resources are not exhausted on cases where there is insufficient evidence to sustain a realistic prospect of proving the whole or part of the allegation. It also helps to maintain the HCPC's reputation as a fair, responsive and transparent regulator.

12.2 In 2013-14, 12 applications for discontinuance of part of the allegation were made in advance of the final hearing.

13. Fixing the Hearing

13.1 Once our solicitors have completed the activity required to prepare the case for hearing they will notify the Scheduling team that the case is ready to fix. At this point they will also notify us how many days they estimate the hearing will take to conclude. The Scheduling team will then send a pre-hearing questionnaire to the registrant. The purpose of this questionnaire is to ascertain whether the registrant intends to appear before the panel, whether they intend to call any witnesses and whether they have any other special requirements that may affect the length of the hearing. The number of days required for a hearing may change following return of the questionnaire.

- 13.2 The Scheduling team will then contact the witnesses and representative (if any) to obtain their availability either by e-mail or post in the first instance. Once all dates have been received, a Scheduling Officer will use the information provided to find a suitable date for the hearing. Once a full panel, transcriber and venue (if applicable) have been found, the Scheduling Officer will notify the registrant of the hearing date by letter and e-mail to all known correspondence addresses. There is a statutory obligation to provide registrants with at least 28 days' notice of their hearing date, however most cases are fixed 3 months in advance, except for re-scheduled hearings (previously adjourned matters) or cases that require expediting, for example, those subject to an interim order. The scheduling process takes a median average of 4 months (from when the case is notified as ready to fix). In cases involving complex issues and/or a large number of witnesses the time taken to schedule the hearing can be longer.
- 13.3 For the hearings that were concluded in 2013-14, the average days per concluded case was 2.7 days. This includes days where the hearing was adjourned or part heard on a previous occasion. For the hearings that were concluded between April and July 2014 the average number of days was 2.9 days.
- 13.4 In the same period, the highest number of days required to conclude a hearing was 20 days in 2013-14 and eight days between April and July 2014.
- 13.5 The number of final hearings that can be scheduled is restricted by resource venue space and availability of the parties concerned. As part of the forecast, we will account for a percentage of external hearing activity, for example, in cases involving a large number of witnesses or where special requirements mean that the hearing needs to be held outside of London.
- 13.6 If a case was to progress and conclude at final hearing without any issues it should take 6 months. This means that from receipt of a complaint to final hearing, a case which were to run perfectly, with all necessary information available and no delay in the scheduling of the hearing (including all parties being available) could take 10 months.

14. Scheduling Other Hearings

- 14.1 HCPC's scheduling team also list the following types of hearings:
- final substantive hearings
 - Investigating Committee and registration panels
 - Interim order applications and reviews
 - substantive reviews, including reviews of striking off orders
 - preliminary hearings and discontinuances in part
 - consent hearings (including VRA)
 - application for restoration

- registration appeals.

14.2 The table below sets out the other type of activity that is listed by the scheduling team. It also includes the number of GSCC transfer cases listed.

Table 16 List of All Hearings listed by the Scheduling Team

Type of Hearing	Number of hearings 2013-2014	Percentage of Hearings Listed	Number of hearings April 2014-July 2014	Percentage of Hearings Listed
Investigating Committee Panel (also considering GSCC transfer cases and health and character declarations)	108	9.6%	44	10.5%
Interim orders Applications and Review Hearings	265	23.5%	112	26.7%
Preliminary Hearings	34	3%	17	4%
Final Hearings	311	27.6%	142	33.9%
Substantive reviews	159	14.1%	58	13.8%
Applications for Restoration	4	0.3%	5	0.95%
Registration Appeals	53	4.7%	12	2.8%
Total (non GSCC transfer)	934	83%	390	93%
GSCC transfer Interim order applications and review	60	5.3%	2	0.47%
GSCC transfer Preliminary Hearings	0	0	0	0
GSCC transfer Final Hearings	119	10.5	10	2.3%
GSCC transfer Substantive Reviews	13	1.1%	16	3.8%
GSCC transfer Applications for Restoration	0	0	1	0.23%
Total GSCC transfer cases	192	17%	29	7%
Total all Hearing Types	1126	100%	419	100%

14.3 In 2013-14, hearings took place over 1,554 days. In 2014-15 it is currently forecasted that hearings will take place over 1,588 days. The Scheduling Team is made up of 10 and the Hearings Team of 10. Hearings Officers are required to attend all hearings to ensure their smooth running (including the management of witnesses).

14.4 The Scheduling team prioritise the scheduling of final hearing cases that are subject to an interim order. Interim orders are only granted in cases where there is an immediate risk of harm to the wider public and such a step restricts

a registrant's ability to practise. Therefore, we have a duty to ensure that the case is concluded as quickly as possible so that a final determination can be reached. In addition, we have a statutory duty to review such cases after six months (from imposition of the order) and every three months thereafter. Each interim order review hearing requires a full panel, legal assessor and transcriber as well as resources to present, clerk and fix the hearing. As such, we aim to conclude cases subject to an interim order as quickly as possible so that we are not incurring the costs of continued review hearings.

15. Changes to the Scheduling Process

- 15.1 We are currently working on changes to the scheduling process that aims to reduce the length of time it takes to schedule a hearing and improve the process. The first change will be a nine-month pilot for the use of pre-hearing teleconferences, where an informal agreement would be made by all parties on topics such as the date and duration of the final hearing, the witnesses both parties intend to call and the identification of preliminary issues that will need to be resolved prior to the final hearing date. Contact will also be made with the registrant by the scheduling team at a much earlier stage and a 'target' month for hearing is likely to be provided which will improve communication with registrants. Currently, witness availability is obtained by the Scheduling team at the point at which the case is notified as ready to fix by our solicitors. We propose to make changes to this process by asking our solicitors to canvas witness availability at the point at which they obtain witness statements. This will provide us with availability at a much earlier stage and it is anticipated that this should reduce the length of time taken to schedule a hearing by at least 2 months.

16. Management of the hearing

- 16.1 Panel chairs are expected to proactively manage all hearings to ensure that they conclude within the allocated timeframe. This includes setting an agenda at the start of each day and encouraging flexible working where appropriate to meet agreed targets.
- 16.2 In order to facilitate this, a preparation meeting is conducted between Panel Chairs and Hearing Officers at the start of each hearing in order to establish a planned agenda for each day. This enables the HCPC to address any concerns about potential problems with the case at an early stage and guard against unnecessary delays. Hearings Officers assist in the management of an agreed agenda by supporting witnesses, maintaining communication with the panel and all other parties during adjournments and assisting with the management of exhibits and the production of the determination.
- 16.3 Where cases fail to conclude in the scheduled time period both the Hearing Officer and Panel Chair are asked to produce an exception report for the Adjudications Manager. Learning points arising from this are reported at management meetings and are used to influence further process development.

17. Adjournment/Postponement and Part Heard Cases

- 17.1 There are occasions when a hearing does not conclude as expected. Fitness to practise proceedings can be adjourned or postponed for a number of reasons. There is a distinction between a postponement and an adjournment. A postponement is an administrative action which may be taken at any time up to 14 days before the date on which a hearing is due to begin. An adjournment is a decision for the Panel or the Panel Chair, taken at any time after that 14 day limit has passed or once the proceedings have begun or are part heard. Part heard cases are those where proceedings have commenced and evidence has been heard but which cannot conclude within the allocated number of days.
- 17.2 We aim to ensure that adjourned/ postponed and part heard cases are kept to a minimum as there can be cost implications. Wherever possible, when a case has been adjourned or postponed we will re-use the allocated days for other types of hearings such as reviews or disposal via consent, as in general no witnesses are called in these types of hearings. The use of managed agendas for Panel Chairs assists with keeping the hearing on track and preventing the case from going part heard. The Hearings Officer also plays an important role in liaising with the Panel Chair regarding any issues and helping to keep the case on track. For more complex or lengthy cases, a preliminary hearing will be held to ensure any issues are dealt with in advance of the substantive hearing. If a case is part heard we will aim to re-schedule the matter as soon as possible (depending on the availability of the parties).
- 17.3 In 2013-14, 25 cases were adjourned/ postponed/cancelled and 15 cases were part heard. Of these cases, 23 have subsequently concluded at final hearing. Both the mean and median time from the adjournment or going part heard to the conclusion is three months. Overall, from receipt of complaint to the final hearing after resuming, the mean and median times were 21 and 22 months. For the 17 adjourned or part heard cases that are yet to conclude, the mean and median time from the adjournment or part heard event is 17 and 10 months respectively.
- 17.4 Between April and July 2014, 11 cases were adjourned, postponed or cancelled, and a further 12 went part heard. Of these cases, five have subsequently concluded at final hearings, taking a mean and median of two months. Overall, from receipt of complaint to the conclusion of the final hearing, the mean and median times are 23 and 22 months respectively. Of the 23 cases yet to conclude, the mean and median times from the adjournment or part heard event is two and one month respectively.

18. Judicial Review

- 18.1 There are occasions once a case has been referred for final hearing where a registrant or their representative acting on their behalf will seek to challenge a decision that has been made in relation to the case.

19. Ensuring the progression of final hearings

19.1 In the last year, we have been further analysing the length of time cases take to conclude. We have:

- developed a risk-based reporting system to identify red, amber, green cases (where red cases require immediate, high level action; amber cases have an acceptable action plan but fall outside of our service standards; and green cases are progressing without concern);
- assigned case escalation actions and dedicated owners for these cases to ensure that they continue to progress through the process;
- conducted weekly reporting and monitoring of trends in these cases;
- redirected existing case progression meetings to review and manage cases that are not progressing; and
- commissioned external review and analysis of our oldest cases to identify any learning that can be applied to future cases.

19.2 We can now identify a number of triggers early in the stages of the case that can be used to predict the impact on the lifetime of the single case, and also the overall system. We have modelled a number of scenarios based on this data, and are currently looking at how this can be developed further.

19.3 We also hold a weekly teleconference with our legal services provider to ensure that any instructions are sought and given, and that actions are escalated for cases that are not progressing. This teleconference is attended by the Heads of Case Management, Adjudication and Assurance and Development.

20. Final Hearing Length of time Statistics

20.1 The tables below shows the length of time from receipt of complaint and from the date the Standard of Acceptance was met for a final hearing to conclude in 2013-14 and between April and July 2014. It also provides the cumulative percentages to close those cases.

Table 17 – Total length of time to conclude cases from receipt and date Standard of Acceptance was met to final hearing, 2013-14

Age since receipt	Number	%	Cumulative %	Age since SOA	Number	%	Cumulative %
0 to 5 months	1	0.4	0.4	0 to 5 months	2	0.7	0.7
6 to 7 months	6	2	3	6 to 7 months	12	5	5
8 to 12 months	74	28	30	8 to 12 months	103	38	44
13 to 15 months	49	18	48	13 to 15 months	36	13	57

16 to 20 months	53	20	68	16 to 20 months	39	14	71
21 to 24 months	29	11	79	21 to 24 months	26	10	81
>24 months	55	21	100	>24 months	49	19	100
Mean Average	18				17		
Median Average	17				14		
Total Number of Cases	267				267		

Table 18 – Total length of time to conclude cases from receipt and date Standard of Acceptance was met to final hearing, April to July 2014

Age since receipt	Number	%	Cumulative %	Age since SOA	Number	%	Cumulative %
0 to 5 months	0	0	0	0 to 5 months	0	0	0
6 to 7 months	0	0	0	6 to 7 months	2	2	2
8 to 12 months	29	25	25	8 to 12 months	54	46	48
13 to 15 months	27	23	48	13 to 15 months	19	16	64
16 to 20 months	27	23	71	16 to 20 months	24	20	84
21 to 24 months	14	12	83	21 to 24 months	4	3	87
>24 months	21	17	100	>24 months	15	13	100
Mean Average	18				16		
Median Average	16				13		
Total Number of Cases	118				118		

20.2 The table below shows the length of time from the date of the Investigating Committee for a final hearing to conclude in 2013-14 and between April and July 2014. It also provides the cumulative percentage to consider those cases.

Table 19 – Length of time to conclude cases from the date of the Investigating Committee to Final Hearing, 2013 and April to July 2014

Number of Months	13/14 YTD	% of cases	Cumulative %	14/15 YTD	% of cases	Cumulative %
1-4	16	6	6	3	3	3
5-8	109	41	47	54	46	48

9-12	79	30	76	29	25	73
13-16	28	10	87	20	17	90
17-20	12	4	91	7	6	96
21-24	7	3	94	3	3	98
25-28	5	2	96	1	1	99
29-32	9	3	99	0	0	99
33-36	0	0	99	0	0	99
>36	2	1	100	1	1	100
Mean Months	11			11		
Median Months	9			9		
Total Cases	267	100	100	118	100	100

21. Open Final Hearing Cases

21.1 At the end of July 2014, there were 397 post-ICP cases that had not yet been concluded by a final hearing panel.

21.2 The tables below demonstrates the length of time those cases have been open for since receipt, since the date the Standard of Acceptance was met and since referral by a panel of the Investigating Committee.

Table 20 – Open post-ICP cases from receipt of complaint and date SOA met (as at 31 July 2014)

Age since receipt	Number	%	Cumulative %	Age since SOA	Number	%	Cumulative
0 to 7 months	39	10	10	0 to 7 months	127	32	32
8 to 12 months	129	33	43	8 to 12 months	125	31	63
13 to 15 months	77	19	62	13 to 15 months	49	12	75
16 to 20 months	69	17	79	16 to 20 months	51	13	88
21 to 24 months	49	12	91	21 to 24 months	18	4.5	92.5
>24 months	34	9	100	>24 months	27	7.5	100
Mean months	15			Mean months	12		
Median months	14			Median months	10		
Total cases	397			Total cases	397		

Table 21 – Open Post ICP cases from date of ICP (as at 31 July 2014)

Age since ICP	Number	%	Cumulative %
0 to 5 months	199	50	50
6 to 7 months	45	11	61
8 to 12 months	90	23	84
13 to 15 months	30	8	92
16 to 20 months	17	4	96
21 to 24 months	11	3	99
>24 months	5	1	100
Mean months	7		
Median months	5		
Total cases	397		

21.3 At end the end of July 2014, there are 24 per cent of cases that are ready to fix, 41 per cent of cases that are being prepared for final hearing and 35 per cent of cases that have a date fixed for final hearing.

22. Final Hearing Outcomes

22.1 The table below shows the mean and median length of time to conclude final hearing cases from receipt of complaint from the date the Standard of Acceptance was met by outcome at final hearing in 2013-14 and between April and July 2014.

Table 22 – Mean and Median Length of time to conclude final hearing from receipt of complaint and from date SOA met by sanction type, 2013-14 and April to July 2014

Type of Sanction	2013-14				April - July 2014			
	Receipt to Final Hearing		SOA to Final Hearing		Receipt to Final Hearing		SOA to Final Hearing	
	Mean average	Median average	Mean average	Median average	Mean average	Median average	Mean average	Median average
Caution	13	12	12	10	17	15	15	13
Conditions of Practice	16	15	16	13	16	14	14	12
Consensual disposal	22	18	20	15	28	22	25	20
No Further Action	22	17	20	15	12	12	10	10
Not Well Founded	19	17	17	13	16	16	14	13
Suspension	19	17	18	15	19	17	16	13
Struck Off	19	17	18	16	20	20	15	15
Total mean average	18		17		18		16	
Total median average	16		14		16		13	

Total number of cases	267				118			
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22.2 The overall length of time from receipt to conclusion of final hearing has remained stable for the last two years. This may be due to cases taking this amount of time to pass through all stages of the FTP process, so cases that were concluded in 2014-15 at a final hearing would have started their lifetime in early 2013-14. It will therefore not be possible to know whether there is a change in the average duration of a case concluding at a final hearing for those complaints received in 2014-15 until 2016.

22.3 There is variation in the time to conclude cases, depending on the final outcome. Broadly, cases resulting in sanctions at the lower end of the spectrum of severity take less time to conclude and to meet the SOA. Cases where there is either a finding of no further action or where there is a consensual disposal take longer. This is likely due to the often lengthy discussions with parties over the evidence or the consensual disposal agreement.

23. Length of time by source of complaint

23.1 The table below demonstrates the mean and median length of time to conclude final hearings from receipt of complaint and date the Standard of Acceptance was met by complainant type in 2013-14 and between April 2014 and July 2014

Table 23 – Mean and Median Length of time to conclude final hearing from receipt of complaint and the date the Standard of Acceptance was met, by complainant type, 2013-14 and April to July 2014

Source of Complaint	2013-14				April to July 2014			
	Receipt to Final Hearing		SOA to Final Hearing		Receipt to Final Hearing		SOA to Final Hearing	
	Mean average	Median average	Mean average	Median average	Mean average	Median average	Mean average	Median average
Anonymous / Article 22(6)	23	23	20	17	23	26	18	19
Employer	17	15	16	13	19	17	17	15
Other	20	13	19	13	17	17	14	15
Other Registrant	36	36	35	35	17	17	15	15
Police	20	21	19	21	15	13	14	11
Professional Body	18	18	18	18	8	8	7	7
Public	23	21	22	18	17	16	12	11
Self-Referral	12	12	10	10	15	15	11	10
Total mean average	18		17		18		16	

Total median average	16		14		16		13	
Total number of cases	267				118			

23.2 Overall closure times from receipt to final hearing have remained stable since 2013-14. The time taken to conclude a final hearing from the point where the Standard of Acceptance is met has decreased by a month since April 2014.

23.3 There is variation between the mean and median closure times for the different type of sources of complaint. This is partly due to the relative sizes of the groups, and also due to the familiarity of the complainants with our processes. For instance, it takes approximately two months from receipt to Standard of Acceptance for employer sourced complaints, whereas it is five or more months for those that come as anonymous / article 22(6), or from members of the public. As employers and members of the public are the largest sources of complaints, these differences skew the overall durations; with employer complaints having a reducing effect, and public originating complaints having an increasing effect. We know that more complaints from employers reach final hearings. As the time from SOA to final hearing for complaints received from the public has fallen from an average of 20 to 12 months, and the average time for complaints received from employers has increased from 16 to 17 months, the overall effect of the changes in these two largest groups has resulted in a decrease in the overall time from SOA in 2014-15 so far.

24. Length of time by Representation

24.1 The table below demonstrates the mean and median length of time to conclude a case at final hearing from receipt and from the date the Standard of Acceptance was met by representation in 2013-14 and between April and July 2014.

Table 24 – Mean and Median Length of time to conclude final hearing from receipt of complaint and the date the Standard of Acceptance was met, by complainant type, 2013-14 and April to July 2014

	2013-14				April - July 2014			
	Receipt to Final Hearing		SOA to Final Hearing		Receipt to Final Hearing		SOA to Final Hearing	
Type of representation	Mean average	Median average	Mean average	Median average	Mean average	Median average	Mean average	Median average
Represented	19	16	17	14	19	19	17	15
Represented Self	18	15	16	12	16	14	14	13
None	18	15	17	14	18	15	15	11
Total mean average	18		17		18		16	

Total median average	16		14		16		13	
Total number of cases	267				118			

24.2 The overall mean and median times from receipt to final hearing remains the same in both years. There has been a decrease by one month in the time taken from meeting the Standard of Acceptance to the conclusion of the hearing. This is likely to relate to our increased concentration on driving cases through the system and the focus of our work with representatives.

24.3 Cases where there is representation take longer to conclude. This may be because of the additional complexity in the logistics of fixing hearing dates, or due to the nature of presenting the defence for the registrant. Cases where the registrant represents themselves take the least time to conclude. This is likely to relate to the engagement in the process, and the ready availability of the parties when fixing the final hearing.

25. Length of time – All cases

25.1 Cases can be closed without consideration by the Investigating Committee if they do not meet the Standard of Acceptance. They can also be closed no case to answer by the Investigating Committee, or at a final hearing. The following tables provide a breakdown of each closure stage, and of the overall time to closed cases in 2013-14 and April to July 2014.

Table 25 – Mean and Median length of time to close cases – all closure types 2013-14

Stage of case	2013-14		
	Number closed	Mean average	Median average
Pre-ICP	1080	5	4
No Case to Answer	322	7	6
Final Hearing	267	18	16
All cases	1669	7	5

Table 26 – Mean and Median length of time to close cases, all closure types, April to July 2014

Stage of case	April – July 2014		
	Number closed	Mean average	Median average
Pre-ICP	316	5	4
No Case to Answer	130	8	7
Final Hearing	118	17	15
All cases	564	8	6

25.2 The tables below demonstrate the cumulative length of time to close cases in 2013-14 and between April and July 2014. It can be seen that in 2013-14 90% of cases were closed in under 15 months and between April and July 2014 86% of cases were closed in under 15 months.

Table 27 – Length of time to close all case types, 2013-14

	Receipt to conclusion	%	Cumulative %	SOA to conclusion	%	Cumulative %
0 to 2 months	298	18	18	85	14	14
3 to 4 months	380	23	41	155	26	41
5 to 8 months	525	31	72	81	14	54
9 to 12 months	221	13	85	109	19	73
13 to 15 months	79	5	90	38	6	79
16 to 20 months	69	4	94	43	7	87
21 to 24 months	36	2	96	28	5	92
>24 months	61	4	100	50	8	100
Total	1669	100		589	100	

Table 28 – Length of time to close, all case types, April to July 2014

	Receipt to conclusion	%	Cumulative %	SOA to conclusion	%	Cumulative %
0 to 2 months	80	14	14	40	16	16
3 to 4 months	111	20	34	50	20	36
5 to 8 months	172	30	64	35	14	50
9 to 12 months	79	14	78	61	25	75
13 to 15 months	41	7	86	19	8	83
16 to 20 months	43	8	93	24	10	92
21 to 24 months	15	3	96	4	2	94
>24 months	23	4	100	15	6	100
Total	564	100		248	100	

26. Transfer vs. Non Transfer Cases Length of time

- 26.1 This section focuses on the length of time to conclude cases transferred from the GSCC on 1 August 2012. The overall mean and median length of time to close a GSCC transfer cases is 10 months for both types. This is longer than the equivalent closure time for non-transfer cases is the time period which this report focuses on.
- 26.2 The tables below show the mean and median average to close a GSCC transfer case across all closure types. It also shows the length of time to close GSCC transfer cases. The proportion of cases closed without consideration by an Investigating Committee Panel is lower in the GSCC transfer case group than for non-transfer cases. As these cases are generally closed earlier in the process, the impact on the overall length of time for all cases is to lengthen the mean and median length of time for GSCC transfer cases.

Table 29 – Mean and Median length of time to close GSCC transfer cases, August 2012 to July 2014

Stage of case	All closed GSCC cases		
	Number closed	Mean average	Median average
Pre-ICP	69	5	4
No Case to Answer	37	8	7
Final Hearing	129	14	14
All cases	235	10	10

Table 30 – Length of time to close GSCC transfer cases, August 2012 to July 2014

	Receipt to conclusion	%	Cumulative %	SOA to conclusion	%	Cumulative %
0 to 2 months	29	12	12	12	6	6
3 to 4 months	11	5	17	12	6	12
5 to 8 months	61	26	43	47	24	36
9 to 12 months	53	22	65	50	26	62
13 to 15 months	26	11	76	30	15	77
16 to 20 months	47	20	96	36	18	95
21 to 24 months	9	4	100	9	5	100
>24 months	0	0	100	0	0	100
Total	236			196		

27. Decision Review Group

- 27.1 In December 2014, a Fitness to Practise Decision Review Group (DRG) was created to improve fitness to practise decision making and to support proactive organisational learning. The group assures the review and audit process of decisions made by Fitness to Practise panels in order to ensure

that they are in line with current operational guidance, legislation and HCPC Council policy; and to make recommendations where necessary.

- 27.2 The Directorate undertakes four strands of review on an on-going basis in order to monitor the standard of decision making at hearings. These are as follows:
- a) Post-hearing decision reviews are conducted immediately after the event by Hearing Team Managers. If an outcome is considered to be unreasonable or unduly lenient, legal advice will be sought and the Director of Fitness to Practise will determine whether any further action is required.
 - b) Feedback from hearing participants is collected and studied so that concerns can be addressed and trends analysed.
 - c) Analysis of PSA feedback points are conducted on a monthly basis and formal responses are provided. Where concerns are recognised, this information is communicated to the panel members concerned and fed into the development of guidance material.
 - d) Individual studies of hearing activities (in particular papers on adjournment, not well found outcomes and preliminary activity) are drafted on a quarterly basis.

Through each of these reviews a body of information is collected, which is analysed by the DRG consisting of managers from each area of the Fitness to Practise Department, on a quarterly basis. Recommendations are made at each meeting for revisions to guidance or policy documents, the development of content for staff and panel member training and the management of any performance issues identified.

28. Feedback Mechanisms

- 28.1 We receive feedback about our FTP through our complaints process. We also have a feedback form and a specific feedback email address for witnesses and specific feedback email addresses for employers and representatives. We use the feedback we receive via these mechanisms to review our processes and to identify areas of good practice or areas of improvement.
- 28.2 We are currently working on a project to enhance these feedback mechanisms by developing a process to seek feedback from complainants and registrants at the conclusion of cases. We intend to do this by sending them a form to complete and return to us which will focus on how we manage cases, our accessibility and whether our processes have been understood. Again, the feedback we receive will be used to review our processes and to identify areas of good practice or areas of improvement.

29. Future Developments

29.1 Alongside the developments mentioned elsewhere in this report, we are undertaking a range of other activity which may impact or contribute to our case progression activity. That includes:

- the pilot looking at the use and value of mediation in HCPC's regulatory processes;
- the work looking at mechanisms to enhance independence in adjudication;
- the on-going statistical analysis and data review;
- the management of the contract with our legal services provider;
- practice note review and development;
- continued development of the case management system and in particular the use of escalation actions;
- the development of the trade union and professional body partnership forum;
- a study looking at the economic costs of out fitness to practise cases; and
- a research study on what causes registrants to become disengaged from their profession.

30. Conclusions

30.1 The analysis demonstrates that for cases that are concluded at final hearing, the 'perfect' case should take 10 months to conclude. The statistics show that in 2013-14 this happened in less than a quarter of cases. This report demonstrates that a number of issues impact on the progression of a case and the Executive recommends that efforts are continued to ensure the timely and expeditious management of a case whilst at the same time ensuring fairness and proportionality to all parties.

Professional Standards Authority for Health and Social Care

Annual Report and Accounts and Performance Review Report 2013/14

Volume II

Performance Review Report 2013/14

Professional Standards Authority for Health and Social Care

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About the Professional Standards Authority

The Professional Standards Authority for Health and Social Care¹ promotes the health, safety and well-being of patients, service users and the public by raising standards of regulation and voluntary registration of people working in health and care. We are an independent body, accountable to the UK Parliament.

We oversee the work of nine statutory bodies that regulate health professionals in the UK and social workers in England. We review the regulators' performance and audit and scrutinise their decisions about whether people on their registers are fit to practise.

We also set standards for organisations holding voluntary registers for people in unregulated health and care occupations and accredit those organisations that meet our standards.

To encourage improvement, we share good practice and knowledge, conduct research and introduce new ideas including our concept of right-touch regulation.² We monitor policy developments in the UK and internationally and provide advice to governments and others on matters relating to people working in health and care. We also undertake some international commissions to extend our understanding of regulation and to promote safety in the mobility of the health and care workforce.

We are committed to being independent, impartial, fair, accessible and consistent. More information about our work and the approach we take is available at www.professionalstandards.org.uk.

¹ The Professional Standards Authority for Health and Social Care was previously known as the Council for Healthcare Regulatory Excellence.

² CHRE. 2010. Right-touch regulation. Available at <http://www.professionalstandards.org.uk/policy-and-research/right-touch-regulation> [Accessed 22 May 2014].

Contents

1. Chief Executive's foreword.....	1
2. Executive summary.....	2
3. The Professional Standards Authority.....	8
4. The health and care professional regulators.....	9
5. The performance review.....	10
6. Our approach to regulation.....	13
7. How are the regulators performing against the <i>Standards of Good Regulation?</i> ..	14
8. The regulators in numbers.....	36
9. The individual regulators' performance review reports.....	39
10. The General Chiropractic Council (GCC).....	40
11. The General Dental Council (GDC).....	56
12. The General Medical Council (GMC).....	80
13. The General Optical Council (GOC).....	93
14. The General Osteopathic Council (GOsC).....	103
15. The General Pharmaceutical Council (GPhC).....	112
16. The Health and Care Professions Council (HCPC).....	121
17. The Nursing and Midwifery Council (NMC).....	134
18. The Pharmaceutical Society of Northern Ireland (PSNI).....	156
19. Conclusions and recommendations.....	165
20. Annex 1: Index of regulated health and care professions.....	166
21. Annex 2: Our Standards of Good Regulation.....	167
22. Annex 2, Section 1: Overview.....	168
23. Annex 2, Section 2: Guidance and standards.....	169
24. Annex 2, Section 3: Education and training.....	171
25. Annex 2, Section 4: Registration.....	173
26. Annex 2, Section 5: Fitness to practise.....	175
27. Annex 3: Third-party feedback.....	178

1. Chief Executive's foreword

The regulators we oversee have had a demanding year; the publication of the Francis Report, the Law Commissions' review of the legislative framework, concerns from the government about international registrations, and the need to develop individual approaches to continuing fitness to practise all demanded new thinking and added to their workload. In addition, each regulator has had its own ambitions to achieve and its own problems to deal with.

Overall, we think they have risen to those challenges; there has been serious commitment to collaborating better following the Francis Report, all the regulators have put huge effort into the Law Commissions' review, hoping for significant reform, and there will be great disappointment from them if a government bill is not forthcoming. They have varied in their approach to continuing fitness to practise, but we welcome this as we consider this is an area where professional risk and context should shape the solution.

These changes and innovations show a regulatory sector which is generally alive to public expectations and ready to respond. This is to be welcomed and there is no doubt that the direction of health and care professional regulation in the UK is of interest to, if not always emulated by, the rest of the world.

As we report, the majority of regulators meet all the Standards, some fail on a few, a few on more. We don't believe any are complacent, nor can they afford to be: the protection of the public and the maintenance of professional standards is too important for that. We also report our concern that performance may be falling slightly, that the quality of the data we received this year was less consistent than before, and that the performance of the regulators was more variable. This is not a welcome finding for them or for us. There may be reasons: a significant increase in complaints across the whole sector; the need for cost savings; the need for internal quality assurance; and the external pressures of social and policy change.

Just as we think the regulators should develop and improve, we challenge ourselves to do the same. In this report, we bring together comparative data, audit information, performance measurement and third-party views. We look forward to beginning to work with the regulators to look at how we can make our performance reviews even more effective, focused and useful.



Harry Cayton
Chief Executive

2. Executive summary

Introduction

- 2.1 The purpose of professional regulators is to protect patients, service users and the public, to uphold the standards of their profession and to ensure public confidence in regulation. The Professional Standards Authority oversees the professional regulators and reports annually on their performance. We share with the regulators a commitment to the public interest and effective regulation.
- 2.2 This report contains both an overview of our general findings (section seven) from our performance review of the regulators and our individual detailed reports about the performance of each of the regulators against the *Standards of Good Regulation* (section nine). The performance review took place between September 2013 and May 2014 and draws on evidence of performance during the 2013/14 financial year.

How are the regulators performing against the *Standards of Good Regulation*?

- 2.3 In this performance review, we conclude that all of the regulators are performing well or adequately against most of the *Standards of Good Regulation*. However, we have greater concerns than we have noted in previous reviews about the performance of some of the health and care regulators in relation to the Standards for registration and fitness to practise. We consider that the quality of regulation and the level of protection provided to the public differs between the regulators.
- 2.4 In each of the individual regulator's performance review reports, we have identified where the regulators have or have not met the *Standards of Good Regulation*. In summary, in 2013/14 we considered that:
- Four of the regulators met all of the *Standards of Good Regulation* – the GMC, the GOC, the GOSc, and the HCPC. However, we note that we raised concerns about the GOC's and the HCPC's performance against one or more of the Standards and will look for improvement in these areas in the performance review 2014/15
 - Two of the regulators (the GPhC and the PSNI) met all but one of the *Standards of Good Regulation*
 - Three of the regulators did not meet several of the Standards. In particular, we note that: the GCC did not meet four of the Standards and performed inconsistently against one; the GDC did not meet eight of the Standards;³ and the NMC did not meet seven of the Standards and performed inconsistently against two others.

³ Please note that we are currently unable to come to a view on the GDC's performance against one of the Standards of Good Regulation for fitness to practise. Further information about this can be found at paragraphs 11.4-11.10.

2.5

We have also reported in the individual reports on where we consider the regulators' performance has improved in response to concerns we identified in the performance review 2012/13. In summary, in 2013/14 we considered that:

- The GCC now meets the seventh Standard for fitness to practise, as it has improved the level of customer service that it provides to those involved in fitness to practise cases
- We now have sufficient evidence to report that the GPhC meets the tenth Standard for fitness to practise, which relates to retaining fitness to practise information securely, and the PSNI meets the fourth Standard for fitness to practise which relates to ensuring that all fitness to practise cases are adequately risk-assessed and that interim orders are imposed without delay.
- While the NMC still does not meet a number of the Standards that it did not meet in 2012/13, it has made some progress and improved its performance against them. For example:
 - In relation to the Standards for education and training, the NMC is developing a model of revalidation
 - In relation to the Standards for registration, the NMC has improved the processing of overseas registration applications started to introduce online registration, reduced the time to process registration appeal applications and has improved the accuracy of its register
 - In relation to the Standards for fitness to practise, the NMC has improved the handling of serious cases at the initial stages of the fitness to practise process, improved the timeliness of its case progression, improved its customer service and decision-making, and reduced the number of data breaches.

2.6

In relation to those Standards which were not met, we note that these were in relation to the registration and fitness to practise functions of the regulators, with the exception of one Standard.⁴ In particular, we identified the following:

Registration

- One of the regulators (the GDC) did not have appropriate processes in place to ensure consistently that only those who met its standards were registered at all times
- One of the regulators (the NMC) failed to ensure that its registration processes were effective and efficient
- Two of the regulators (the GDC and the NMC) did not ensure that they maintained accurate registers

⁴ Although the NMC has made progress in developing a system of revalidation, it continues not to meet the relevant Standard.

Fitness to Practise

- One of the regulators (the GDC) did not have adequate processes for managing risk in fitness to practise cases; one of the regulators (the NMC) had a significantly high rate of applications for court extensions to the interim orders in place on its cases, which was a matter of concern to us because it indicates a failure to swiftly progress serious cases to a conclusion; one regulator (the GCC) performed inconsistently against the relevant Standard and we raised concerns about the performance of one of the regulators (the HCPC) as we considered that if its performance continued to decline, there was a risk that it would not meet the Standard in the performance review 2014/15
- One of the regulators (the NMC) performed inconsistently in ensuring that its fitness to practise process is transparent, fair, proportionate and focused on public protection
- Four of the regulators (the GCC, the GDC, the GPhC and the NMC) did not ensure that their fitness to practise cases were progressed without undue delay. We also raised concerns about the performance of one of the regulators (the HCPC), which we considered would result in it not meeting the Standard in the performance review 2014/15 if it continued to decline
- Two of the regulators (the GDC and the NMC) did not ensure that they provided good customer service to all parties involved in the fitness to practise process
- Three of the regulators (the GCC, the GDC and the NMC) did not ensure that all fitness to practise decisions were well-reasoned, protect the public and maintain confidence in the regulated professions
- Two of the regulators (the GCC and the GDC) did not ensure that all fitness to practise decisions (apart from those relating solely to the health of registrants) were published and communicated to relevant stakeholders
- Five of the regulators (the GCC, the GDC, the HCPC, the NMC and the PSNI) failed to ensure that fitness to practise information was securely retained.

2.7 We will expect the regulators to demonstrate to us in the performance review 2014/15 that they have remedied their performance in the areas highlighted above. Where relevant, we will also look for evidence of improvement when we carry out the 2014 audits of the initial stages of the regulators' fitness to practise processes.⁵

⁵ In 2014, we will audit the initial stages of the fitness to practise processes of the GCC, GDC, GOSc, NMC and PSNI.

The GDC investigation

- 2.8 In February 2013, we published our report to the Secretary of State for Health in response to his request to us to investigate concerns that had been raised by the former Chair of the GDC upon her resignation in May 2011. In our special investigation report, we concluded that there were deficiencies in the support and operation of the GDC's Investigating Committee, which impacted on its efficiency and effectiveness and which should not have remained unaddressed. However, we concluded that these deficiencies did not amount to a failure by the GDC to carry out its statutory functions.
- 2.9 Since publishing our special investigation report, new evidence has come to light about poor practices in the support and operation of the GDC's Investigating Committee. In July 2013, a member of the Investigating Committee raised concerns under the GDC's whistleblowing policy that certain processes were compromising the independence of the Investigating Committee's decision-making. In August 2013, in response to the whistleblower's disclosure, the GDC commissioned an independent review. The review looked at the guidance and processes used by the Investigating Committee and how they were applied in practice. In particular, it considered whether the application of the guidance and processes had:
- The potential for compromising the independence of the Investigating Committee
 - The potential for inappropriate influence on the Investigating Committee's decision-making
 - Resulted in non-compliance with the *Investigating Committee Guidance Manual* on drafting reasons
 - The potential for consequential reputational damage to the GDC on Judicial Review, especially if a statutory committee or GDC employee was held to be acting *ultra vires*.
- 2.10 The review also looked at the role of the Investigating Committee's secretaries and manager in providing advice to the Investigating Committee, as well as the quality of that advice.
- 2.11 The final review report was received by the GDC on 23 December 2013. The overall conclusion of the review was that there was no evidence that the independence of the Investigating Committee had been compromised. However, the report identified a number of serious concerns about the GDC's Investigating Committee process and practices, including:
- The holding of private discussions between the Investigating Committee's secretaries and Chairs about individual cases prior to Investigating Committee meetings
 - Preparation of draft decisions or parts of draft decisions by the Investigating Committee's secretaries in advance of Investigating Committee meetings
 - Substantial changes made by GDC staff to Investigating Committee decisions following the meetings.

- 2.12 The GDC accepted all of the recommendations of the review and appointed an external solicitor to develop a detailed action plan. The action plan was subsequently approved by the GDC's Council and Audit and Risk Committee and we understand from the GDC that it is being implemented steadily.
- 2.13 We note that the whistleblower also raised concerns with us about the GDC's management of their disclosure and the detriments they believe they have suffered as a result of this disclosure. As a result of our concerns about this evidence, we decided in April 2014 to undertake an investigation. The matters to be investigated are as follows:
1. The GDC's:
 - a) Management of the processes and support for its investigating committees which post-dates the publication of our Investigation report '*An investigation into concerns raised by the former Chair of the General Dental Council (February 2013)*'
 - b) Response to the recommendation contained within our report, which was to review the processes and support that it has in place for its investigating committees, including the arrangements for gathering and monitoring feedback received.
 2. The adequacy of the GDC's whistleblowing policy and the operation of this policy as evidenced by:
 - a) Its response to a disclosure by a whistleblower about the GDC's management of the processes and support of the Investigating Committee
 - b) Its management of a complaint by the whistleblower of detrimental treatment because of their disclosure.
- 2.14 We have agreed that we will publish a separate report on our investigation and that this will be presented to the Health Select Committee.

Conclusions and recommendations

- 2.15 There is much to commend in the work of the nine health and care regulators: their active consideration of their roles and responsibilities, their attempts to improve their work, their serious responses to the Francis Report and to the challenge of continuing fitness to practise and to legislative change. The regulators have worked constructively with the Law Commissions and the Department of Health on proposals to reform the legal framework of professional regulation in the UK.
- 2.16 Less positive is the variation in performance of regulatory functions and persistent weakness in some regulators in registration, fitness to practise and data security. We expect the regulators to address the issues relevant to them and will review progress in 2014/15.
- 2.17 We have drawn attention, at the end of each of the sections within each regulator's performance review report, to the areas of that regulator's work that we intend to follow up on in next year's performance review. We have also included within each regulator's performance review report any recommendations about areas of concern. In addition to this, we make the following general recommendations.

For the regulators

- 2.18 We recommend that the regulators should:
- Review this year's performance review report as a whole, taking account of our views, and consider whether they can learn and improve from the practices of the other regulators
 - Address any areas of concern that are highlighted in this year's performance review report
 - Ensure that their Councils review and discuss the performance review report in a public Council meeting.

For the Authority

- 2.19 We will begin to revise the approach that we take to the annual performance review during 2014. We will seek the views of our stakeholders during the development of the revised process. We will also take account of good practice in relation to the performance review, both within and outside of the health sector.

For the Departments of Health in the UK

- 2.20 Following the publication of the Law Commissions' proposed Bill, we recommend that the Departments of Health in the UK take account of our commentary and findings in this report if and when they prepare the government's own Bill in relation to changes to health and care regulation.

3. The Professional Standards Authority

3.1

The Authority promotes the health, safety and well-being of patients, service users and other members of the public through our scrutiny of the nine professional regulators that we oversee. We do this in six main ways:

- We annually review the performance of the regulatory bodies to identify areas where regulators are doing well and where they can improve
- We audit the initial stages of the regulators' fitness to practise procedures. The audit has two aims: to assess whether the regulators' decision-making processes are effective; and to assess whether the decisions they make protect the public
- We examine final decisions made by the regulators' fitness to practise panels about whether health professionals in the UK and social workers in England are fit to practise. We may refer decisions to court where we believe they are unduly lenient and do not protect the public
- We conduct research, share learning with the regulators, and hold events to explore ways of understanding and managing new regulatory challenges
- We advise the Secretary of State for Health and health ministers in Northern Ireland, Scotland and Wales on matters relating to the regulation of health professionals in the UK and social workers in England
- We keep up to date with European and international policies to improve our policy decisions on the regulation of health professionals in the UK and social workers in England. We inform colleagues in other countries of the outcome of our policy projects that might be relevant to them.

4. The health and care professional regulators

4.1 The nine health and care professional regulators that we oversee are:

- The General Chiropractic Council (GCC)
- The General Dental Council (GDC)
- The General Medical Council (GMC)
- The General Optical Council (GOC)
- The General Osteopathic Council (GOsC)
- The General Pharmaceutical Council (GPhC)
- The Health and Care Professions Council (HCPC)
- The Nursing and Midwifery Council (NMC)
- The Pharmaceutical Society of Northern Ireland (PSNI).

4.2 Details of the professions regulated by each body can be found in Annex 1: Index of regulated health and care professions.

4.3 These regulatory bodies have four main functions. They:

- Set and promote standards that professionals must meet before and after they are admitted to the register
- Maintain a register of those professionals who meet the standards. Only those who are registered are allowed to work as health professionals in the UK or as social workers in England
- Take appropriate action when a registered professional's fitness to practise has been called into question
- Ensure high standards of education for those training to be a health professional in the UK or a social worker in England. In some cases, they set standards for those who continue to train and develop as health professionals in the UK or social workers in England.

5. The performance review

5.1 The performance review is our annual check on how effective the regulators have been in protecting the public and promoting confidence in health professionals in the UK, in social workers in England and in the regulators themselves. We are required to report our findings to Parliament and to the devolved administrations.

5.2 The performance review has two important outcomes:

- It enables improvements in the work of the regulators, as we identify strengths and areas of concern in their performance and recommend changes
- It informs everyone about how well the regulators are protecting the public and promoting confidence in health professionals in the UK and social workers in England, as well as the system of regulation in their work.

How do we carry out the performance review?

5.3 The regulators are asked to provide evidence of how they meet the *Standards of Good Regulation*. The Standards describe what the public expect the regulators should do, but they do not set out how they should do it.

5.4 To help us to judge the regulators' performance, we use the standards to:

- Identify the strengths and areas for improvement in each regulator's performance
- Identify good practice.

5.5 The *Standards of Good Regulation* are grouped under the four regulatory functions:

- Guidance and standards
- Education and training
- Registration
- Fitness to practise.

5.6 We can consider that a Standard is met, not met or that the regulator has demonstrated improvement in its performance against that Standard.

5.7 A regulator meets a Standard when it provides sufficient evidence of good performance against it which is in line with the evidence framework. An intention to meet a Standard in the future does not mean that a Standard is met at the time we undertake our assessment of performance.

5.8 We consider that a regulator shows improvement against a Standard by achieving better performance in terms of quality and/or timeliness and/or transparency and/or accountability and/or engaging with stakeholders compared with its performance in the previous performance review.

- 5.9 When a regulator does not provide sufficient evidence or provides evidence of poor performance, we consider that a regulator has not met a Standard. A single major failure or several minor failures might indicate that a Standard is not met if they reveal an underlying weakness in the regulator's systems or an absence of policy or process.
- 5.10 There are also a few instances where a regulator has demonstrated inconsistent performance against the Standards. We have reached this view because the regulator has either performed poorly against one aspect of the requirements of the Standard or because we do not consider its performance was poor enough to fail the Standard nor good enough to meet it.
- 5.11 We report publicly in a regulator's individual performance review report where a regulator has or has not met a Standard, or where it has demonstrated improvement against a Standard.

The performance review process

- 5.12 The performance review took place between September 2013 and May 2014. There were seven stages to the performance review:

Stage 1

The regulators provided written evidence of how they met the *Standards of Good Regulation*.

Stage 2

We examined and tested the regulators' evidence using information we had collated from other sources, including our scrutiny of the regulators' fitness to practise decisions, the complaints that we received from members of the public and others, and the third-party feedback we received.

Stage 3

We wrote to the regulators with our requests for additional information or clarification of their evidence.

Stage 4

We held face-to-face meetings with each of the regulators to discuss our outstanding queries, areas of concern and/or areas of good performance.

Stage 5

We considered any additional information provided by the regulators and reached a final view on their performance.

Stage 6

We drafted a report summarising our view on each regulator's performance. We shared the report with each regulator and asked for their comments on the factual accuracy of the report.

Stage 7

We considered the comments made by the regulators and finalised each regulator's performance review report. We also produced an overarching

report which included our views on emerging themes and issues in health and care professional regulation.

- 5.13 We are grateful for the feedback received from third parties. We found this information very helpful in forming our views about the regulators' performance. A full list of third-party organisations that provided feedback can be found in Annex 3: Third-party feedback.

6. Our approach to regulation

- 6.1 In 2010, we published *Right-Touch Regulation*.⁶ We developed this approach as a result of our experience working with the regulators and in advising the government on areas of regulatory policy. Right-touch regulation builds on the principles of good regulation identified by the UK Better Regulation Executive. These are: proportionality, consistency, targeted, transparency and accountability. To these principles, we have added a sixth principle of agility. Agility in regulation means looking forward to anticipate change, rather than looking back to prevent the last crisis from happening again.
- 6.2 Right-touch regulation is the minimum regulatory force required to achieve the desired result. Too little regulation is ineffective, too much is a waste of effort and resources. We have identified the following eight elements to help us, and others who work in regulation, to focus on right-touch regulation in practice:
- Identify the problem before the solution
 - Quantify the risks
 - Get as close to the problem as possible
 - Focus on the outcome
 - Use regulation only when necessary
 - Keep it simple
 - Check for unintended consequences
 - Review and respond to change.
- 6.3 We consider that there are a number of benefits to using right-touch regulation in our work. These include:
- Describing outcomes in terms of the beneficiaries of regulation
 - Enabling organisations to react appropriately to issues as they arise
 - Enabling collaboration and co-operation across the regulatory and health/social care system
 - Enabling regulation to remain relevant to the needs of today's society
 - Considering whether the costs of regulation are really worth the benefits.
- 6.4 We have used right-touch regulation as a framework to guide our consideration of each regulator's performance, and when discussing the current issues and concerns we have identified in health and care professional regulation.
- 6.5 We expect and want to be challenged if our own approach is not right-touch: that is risk-based, proportionate, outcome-focused and agile.

⁶ CHRE. 2010. Right-touch regulation. Available at <http://www.professionalstandards.org.uk/policy-and-research/right-touch-regulation> [Accessed 22 May 2014].

7. How are the regulators performing against the *Standards of Good Regulation*?

Summary of the regulator's performance against the *Standards of Good Regulation*

- 7.1 In this performance review, we conclude that all of the regulators are performing well or adequately against most of the *Standards of Good Regulation*. However, we have greater concerns than we have noted in previous reviews about the performance of some of the health and care regulators in relation to the Standards for registration and fitness to practise. We consider that the quality of regulation and the level of protection provided to the public differs between the regulators.
- 7.2 In each of the individual regulator's performance review reports, we have identified where the regulators have or have not met the *Standards of Good Regulation*. We have also reported on where we consider their performance has improved in response to concerns we identified in the performance review 2012/13.
- 7.3 In summary, in 2013/14 we considered that:
- Four of the regulators met all of the *Standards of Good Regulation* – the GMC, the GOC, the GOSc, and the HCPC. However, we note that we raised concerns about the GOC's and the HCPC's performance against one or more the Standards and will look for improvement in these areas in the performance review 2014/15
 - Two of the regulators met all but one of the *Standards of Good Regulation* – the GPhC and the PSNI
 - Three of the regulators did not meet several of the Standards. In particular, we note that: the GCC did not meet four of the Standards and performed inconsistently against one; the GDC did not meet eight of the Standards;⁷ and the NMC did not meet seven of the Standards and performed inconsistently against two others.
- 7.4 We have also reported in the individual reports on where we consider the regulators' performance has improved in response to concerns we identified in the performance review in 2012/13. In summary, in 2013/14 we considered that:
- The GCC now meets the seventh Standard for fitness to practise as it has improved the level of customer service that it provides to those involved in fitness to practise cases
 - We now have sufficient evidence to report that: the GPhC meets the tenth Standard for fitness to practise, which relates to retaining fitness to practise information securely; and the PSNI meets the fourth Standard for

⁷ Please note that we are currently unable to come to a view on the GDC's performance against one of the Standards of Good Regulation for fitness to practise. Further information about this can be found at paragraph 11.4-11.1011.34.

fitness to practise, which relates to the ensuring that all fitness to practise cases are adequately risk assessed and that interim orders are imposed without delay.

- While the NMC still does not meet a number of Standards that it did not meet in 2012/13, it has made some progress and improved its performance against them. For example:
 - In relation to the Standards for education and training, the NMC is developing a model of revalidation
 - In relation to the Standards for registration, the NMC has improved the processing of overseas registration applications, started to introduce online registration, reduced the time to process registration appeal applications, and has improved the accuracy of its register
 - In relation to the Standards for fitness to practise, the NMC has improved the handling of serious cases at the initial stages of the fitness to practise process, improved the timeliness of its case progression, improved its customer service and decision-making, and reduced the number of data breaches.

7.5 We note that all of the Standards that were not met relate to the registration and fitness to practise functions of the regulators, with the exception of one Standard.⁸ In particular, we identified the following:

Registration

- One of the regulators (the GDC) did not have appropriate processes in place to consistently ensure that only those who met its standards were registered at all times
- One of the regulators (the NMC) failed to ensure that its registration processes were effective and efficient
- Two of the regulators (the GDC and the NMC) did not ensure that they maintained accurate registers.

Fitness to Practise

- One of the regulators (the GDC) did not have adequate processes for managing risk in fitness to practise cases; one of the regulators (the NMC) had a significantly high rate of applications for court extensions to the interim orders in place on its cases, which was a matter of concern to us because it indicates a failure to swiftly progress serious cases to a conclusion; one regulator (the GCC) performed inconsistently against the relevant Standard and we raised concerns about the performance of one of the regulators (the HCPC) as we considered that if its performance continued to decline, there was a risk that it would not meet the Standard in the performance review 2014/15

⁸ Although the NMC has made progress in developing a system of revalidation, it continues not to meet the relevant Standard.

- One of the regulators (the NMC) performed inconsistently in ensuring that its fitness to practise process is transparent, fair, proportionate and focused on public protection
- Four of the regulators (the GCC, the GDC, the GPhC and the NMC) did not ensure that their fitness to practise cases were progressed without undue delay. We also raised concerns about the performance of one of the regulators (the HCPC) which we considered if it continued to decline would result in it not meeting the Standard in the performance review 2014/15
- Two of the regulators (the GDC and the NMC) did not ensure that they provided good customer service to all parties involved in the fitness to practise process
- Three of the regulators (the GCC, the GDC and the NMC) did not ensure that all fitness to practise decisions were well-reasoned, protect the public and maintain confidence in the regulated professions
- Two of the regulators (the GCC and the GDC) did not ensure that all fitness to practise decisions (apart from those relating solely to the health of registrants) were published and communicated to relevant stakeholders
- Five of the regulators (the GCC, the GDC, the HCPC, the NMC and the PSNI) failed to ensure that fitness to practise information was securely retained.

7.6 We will expect the regulators to demonstrate to us in the 2014/15 performance review that they have remedied their performance in the areas highlighted above. Where relevant, we will also look for evidence of improvement when we carry out the 2014 audits of the initial stages of the regulators' fitness to practise processes.⁹

7.7 We highlight below some of the activities and outcomes that the regulators have reported to us during the 2013/14 performance review which led to our overall judgement about their performance against the Standards.

Guidance and standards

7.8 There are four *Standards of Good Regulation* for guidance and standards (see Annex 2: Our Standards of Good Regulation). These Standards require the regulators to ensure that their standards and guidance documents prioritise patient safety and patient-centred care and that their guidance helps registrants to apply the regulators' standards in relation to specific issues. We check that guidance and standards are publicly available and that the regulators take account of the views of stakeholders and external developments when developing new standards and guidance. We are pleased to report that all of the regulators have met all of the Standards in this area during 2013/14.

⁹ In 2014, we will audit the initial stages of the fitness to practise processes of the GCC, GDC, GOsC, NMC and PSNI.

7.9 We describe below four areas of activity that the regulators have undertaken during 2013/14 which are relevant to our assessment of their performance against the *Standards of Good Regulation* for guidance and standards.

Reviews of the regulators' core standards

7.10 As we note in the individual performance review reports, many of the regulators have begun, or plan to begin during 2014, a review of their core standards documents for registrants. They have carried out a number of tasks to ensure that their reviews are well informed. The tasks they have already undertaken include:

- Obtaining the views of stakeholders, including seeking out the views of specific or 'hard-to-reach' patients and service users so that they can take these views into account when checking that the standards are comprehensive and address the needs of those who should benefit from them
- Taking account of external developments, such as the recommendations from the Francis Inquiry¹⁰ and the government's response to the Francis Inquiry reports¹¹
- Analysing information from across their functions to inform the reviews of the standards – for example, reviewing their fitness to practise caseloads to identify gaps or areas that may require strengthening within the standards. One outcome from such activity has been the identification of a gap in some regulators' Standards relating to the use of social media.

7.11 We consider that taking a wide approach to information gathering when reviewing the core standards is a valuable part of developing credible, comprehensive and robust standards. We also consider that, once the revised standards are drafted, sufficient time should be built into the regulators' project plans to allow for public consultation on the draft standards and for proper consideration of consultation responses so that the regulators can be confident that the revised standards are appropriate. Finally, we consider that the regulators should reflect on whether the use of an independent organisation to analyse the results of their consultations would be beneficial in terms of enhancing public confidence in the independence and objectivity of their handling of consultation responses.

Developing resources to facilitate registrants'/patients' understanding of the regulators' core standards

7.12 Many of the regulators that have just published their revised core standards have developed additional resources to help registrants apply them in practice. These include: publishing frequently asked questions; publishing

¹⁰ Francis, R. 2013. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, chaired by Robert Francis QC, 2013. Available at <http://www.midstaffpublicinquiry.com/report> [Accessed 22 May 2014].

¹¹ Department of Health, 2013. Patients First And Foremost: The Initial Government Response to the Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry (Cm. 8576), para 2.32. Available at <https://www.gov.uk/government/publications/government-initial-response-to-the-mid-staffs-report> [Accessed 22 May 2014].

practical interactive case studies; and developing a microsite to store all information related to the standards. We consider that the development of such resources is a good example of how the regulators can help registrants engage with the standards and improve their awareness of them.

Learning from fitness to practise cases

- 7.13 Two of the regulators (the GOC and the GDC) have carried out work to categorise their fitness to practise complaints by reference to the standards that the registrants concerned may have breached. The aim of this work is to enable the regulators to identify which areas of practice are most likely to be problematic, so that they can then provide additional guidance to assist registrants with those areas, if appropriate. We consider that this is an example of the regulators using the information they hold to meaningful effect.

Good practice in guidance and standards

- 7.14 We set out below the examples of good practice in guidance and standards that we identified during the performance review 2013/14.
- 7.15 *What to Expect from your Doctor* – the GMC developed this guide for patients, which is based on its key standards document (*Good Medical Practice*). The GMC worked with several patient support organisations to promote and distribute this resource, including: Patient Advice and Liaison Services; the Citizens Advice Bureau; and representatives of HealthWatch. We consider that the GMC's decision to produce this resource specifically for patients regarding its core standards represents good practice that other regulators may wish to emulate.
- 7.16 *Effectiveness of osteopathic regulation* – during 2013/14, the GOsC has continued its research into the effectiveness of osteopathic regulation. We consider that commissioning this research is an example of innovation and good practice. We expect that the research outcomes will provide insights into the ways osteopaths interact with the GOsC's regulatory regime, and may help improve their compliance with professional standards, and therefore ultimately patient care.
- 7.17 *Developing guidance to support the safe and effective supply of Pharmacy (P) medicines* – in November 2013, the GPhC issued a background paper for discussion with stakeholders prior to finalising its guidance. The GPhC took that step following objections which had been raised by pharmacy stakeholders (following the publication of the *Standards of Registered Pharmacies* in September 2012) to the approach the GPhC intended to take to the regulation of the open display of pharmacy medicines. We consider that the publication of a background paper to encourage and facilitate discussion of an issue for which there is no current professional consensus is an example of good practice.
- 7.18 *Stakeholder engagement* – we consider that the breadth of methods used by the HCPC and its inclusion of a number of different stakeholder groups and organisations in its work to comprehensively review the *Standards of*

Conduct, Performance and Ethics is an example of good practice. The HCPC has:

- Hosted workshops with specific groups of patients, service users and carers to seek their views on the standards and their accessibility
- Gathered feedback and information from employers, from registrants, and from employees within its fitness to practise department (through their work these staff have direct knowledge of the standards which are most commonly breached by registrants)
- Concluded its research with registrants and service users about the relevance of the standards.

7.19 We look forward to seeing how the HCPC has used this information in its revision of the *Standards of Conduct, Performance and Ethics* which is due to conclude in 2016.

7.20 *The relaunch of the Raising concerns guidance* – the NMC secured the support of Helene Donnelly, a nurse with direct experience of raising concerns¹² to relaunch its refreshed *Raising concerns* guidance. This support helped to raise the profile of guidance which is key to public protection.

Education and training

7.21 There are five *Standards of Good Regulation* for education and training (see Annex 2: Our Standards of Good Regulation). The standards for education and training require the regulators to ensure that their standards for education are linked to their standards for registrants and that there is a proportionate process for the quality assurance of education programmes so that the public can be assured that education providers provide students, trainees and professionals with the skills and knowledge to practise safely and effectively. We also require regulators to have a system in place to assure themselves of the continuing fitness to practise of registrants.

7.22 We are pleased to report that all the regulators, with the exception of the NMC, have met all of the *Standards of Good Regulation* for education and training in 2013/14.

7.23 We note that although the NMC has not met the Standard which requires it to have in place a system of revalidation or continuing professional development, it has made progress in the relevant workstream to put such a system in place during 2013/14.

7.24 We describe below two areas of activity that the regulators have undertaken during 2013/14 which are relevant to our assessment of their performance against the *Standards of Good Regulation* for education and training.

¹² Helene Donnelly is a former nurse at Mid Staffordshire NHS Foundation Trust and now Ambassador for Cultural Change at Staffordshire and Stoke-On-Trent Partnership Trust.

Continuing fitness to practise

- 7.25 We have previously published our guidance about the role that professional regulation plays in supporting registrants to demonstrate that they are fit to practise throughout their practising lives in our paper, *An Approach to Assuring Continuing Fitness to Practise based on Right-Touch Regulation Principles*.¹³ We note that the regulators remain at different stages in developing/implementing schemes to provide assurance about the continuing fitness to practise of their registrants. We are pleased to see that the regulators are following the recommendations in our paper and tailoring their proposed approaches to the risk profile(s) of their various groups of registrants. We consider it appropriate that there will, as a consequence of the regulators adopting a risk-based approach, be some variation in the format of the continuing fitness to practise schemes that are ultimately adopted by each regulator.
- 7.26 We summarise below each of the regulator's approaches to continuing fitness to practise. Further information on their schemes can be found in their individual performance review reports.
- 7.27 The GMC and the GOC have already implemented schemes to provide assurance of their registrants' continuing fitness to practise. The two schemes are different from each other, as would be expected given the different risks relevant to the professions the two organisations regulate. The GMC has implemented a full revalidation scheme, which is progressing in line with its expectations, with Responsible Officers having made recommendations about doctors' continued fitness to practise in the period from 31 December 2012 to 6 December 2013 for 33,047 doctors or 99.78 per cent of the expected figure. By the end of the first year of operation (31 December 2013) of the GOC's Continuing Education and Training scheme, 97 per cent of all registrants had completed at least the minimum required activities for that year. The remaining three per cent of registrants received targeted communication from the GOC warning them that they were at risk of being removed from the register unless remedial action was taken. The majority of those registrants responded to the GOC's notification by meeting the CET requirements. Forty five registrants were removed from the register in April 2014 on the basis that they undertook no CET activities. We are pleased that these two schemes have been implemented and that the vast majority of registrants appear to have engaged with them. We look forward to seeing evidence of the impact of these schemes on public protection and public confidence in regulation in due course.
- 7.28 While the above two schemes have been implemented, we note that the other seven regulators' schemes are still under development and are based on different models of assurance, as summarised below:
- During 2013/14, the HCPC has continued to gather evidence (such as undertaking an assessment of the role and value of patient and service

¹³ CHRE, 2012. An approach to assuring continuing fitness to practise based on right-touch regulation principles. Available at <http://www.professionalstandards.org.uk/library/document-detail?id=69393f02-d5a3-4ae0-a1bb-a7b437dc3485> [Accessed 22 May 2014]

user feedback in providing independent evidence about the practice of registrants) to inform its decision about whether it should amend its current continuing professional development scheme. We consider that evidence of continuing professional development activity is not, by itself, sufficient to demonstrate continuing fitness to practise of a registrant because it does not demonstrate what impact that activity has had upon the registrant's performance. We hope that, as a result of all the HCPC's evidence gathering, it will develop its continuing professional development scheme to ensure it is outcome-focused and therefore adequate to assure the continuing fitness to practise of its registrants

- The GCC, the GDC and the PSNI have decided to develop schemes based upon enhanced continuing professional development (CPD). The GDC's scheme will be based on an audit of registrants' CPD activities, alongside a review of additional performance management and monitoring indicators (we note that the GDC has undertaken considerable evidence-gathering which will inform its scheme). The GCC and PSNI are yet to determine the detail of how their schemes will work in practice.¹⁴ We consider that evidence of continuing professional development activity is not, by itself, sufficient to demonstrate continuing fitness to practise because it does not demonstrate what impact that activity has had upon the registrant's performance. We encourage the PSNI and the GCC to consider how they can make their schemes outcome-focused in order to ensure that they are adequate to assure the continuing fitness to practise of their registrants
- The GPhC has decided to develop a continuing fitness to practise scheme based on peer review, a review of continuing professional development records, and external performance indicators (it plans to develop these indicators in consultation with the profession). The GPhC's aim is to ensure that the scheme allows due account to be taken of the different scopes of practice and context within which various registrants work when assessing their continuing fitness to practise. That aim is in line with the approach set out in our guidance
- The GOsC has continued work to develop a continuing fitness to practise scheme based on a combination of each registrant's self-reflection, objective evidence, and peer review. The scheme has taken account of the suggestion from the evaluation of the GOsC's revalidation pilot that osteopaths are more likely to behave in accordance with standards if they have access to a forum in which they can discuss the standards, as well as any incidents that may have occurred in the course of their practice. We consider that the work the GOsC is undertaking to develop this idea, the associated research it has commissioned exploring 'formative space' in the context of osteopathy, and its linking of that idea to its continuing fitness to practise scheme is interesting and may be of use to other

¹⁴ We note that the PSNI commissioned and funded independent research into approaches to continuing fitness to practise which provided a report which recommended building on continuing professional development and suggested components that should be considered.

regulators, particularly those that regulate professionals working in independent practice

- The NMC is developing a scheme of revalidation. The NMC's scheme will be based on a registrant's self-confirmation that they continue to be fit to practise, evidenced by third-party feedback. We have concerns about the adequacy of the NMC's scheme and the robustness of the evidence on which it will be based. We detail these concerns in paragraphs 17.10–17.12.

Equality and diversity

7.29 Two of the regulators have carried out work during 2013/14 to assess the fairness of the examinations that students/registrants are required to sit. The GPhC's analysis of its registration examination identified that those candidates who identified themselves as Black-African performed significantly less well in the examination than candidates in other (self-declared) groups. The GMC commissioned a review of the Royal College of General Practitioners clinical skills assessment examination, which identified significant differences between the results of male and female graduates, and especially between the results of white, and black, minority and ethnic (BME) UK, and BME international graduates. Both regulators are currently working with interested parties to follow up on these results. We consider that these were both useful pieces of work which should help the regulators to take action to ensure that the outcomes of the education and training processes are fair and free from discrimination. We would encourage other regulators to consider whether carrying out similar work might be of value to them.

Recent government reports on the education of social workers

7.30 In February 2014, two independent reviews of social work education were published. The reviews were commissioned respectively by the Secretary of State for Education, Michael Gove MP,¹⁵ and by the Minister of State for Health, Norman Lamb MP.¹⁶ These two reports contain some conflicting findings and recommendations in terms of the regulation of social workers and social work education.¹⁷ For example, the Narey report recommended that consideration should be given to transferring responsibility for the regulation of social workers to the College of Social Work (the recently established professional body for social workers). In contrast, the Croisdale-Appleby report concluded that there was little support for the College of Social Work taking on a regulatory role, because of concerns about the

¹⁵ Narey, M., 2014. Making the education of social workers consistently effective. Report of Sir Martin Narey's independent review of the education of children's social workers. Available at <https://www.gov.uk/government/publications/making-the-education-of-social-workers-consistently-effective> [Accessed 22 May 2014]

¹⁶ Croisdale-Appleby, D., 2014. Re-visioning social work education: n independent review. Available at <https://www.gov.uk/government/publications/social-work-education-review> [Accessed 22 May 2014].

¹⁷ We note that the HCPC has only regulated social workers in England since 2012. Prior to this, social workers in England were regulated by the General Social Care Council.

conflict between regulating and representing the interests of the profession. However, both reports are critical of:

- The content of the HCPC's existing *Standards of Proficiency* – concluding that those standards do not adequately describe the knowledge and abilities required of a newly qualified social worker
- The content of the *Standards of Education and Training* – concluding that the standards are neither sufficiently specific nor sufficiently demanding
- The HCPC's processes for approving and endorsing education and training programmes – on the basis that they are insufficiently robust.

7.31 We have not identified any evidence to indicate that the HCPC's approach to the areas criticised by the two reports set out above is inappropriate. During 2012/13 and 2013/14, the HCPC met the relevant *Standards of Good Regulation* applicable to the development of standards and the quality assurance of education programmes. For example, we note that the HCPC:

- Followed an appropriate process when developing the required standards. The *Standards of Proficiency* were developed by a professional liaison group which included a variety of stakeholders, and they were subject to public consultation
- Focused its *Standards of Education and Training* appropriately on outcomes and on ensuring that students are fit to practise at the point of entry to the register
- Found as a result of its quality assurance process that the *Standards of Education and Training* appear to be sufficiently robust, as none of the programmes had been approved without conditions being attached
- Taken an approach to quality assurance that is in line with that we expect of the health and care regulators. The HCPC's quality assurance is based on consideration of documentation, a visit to the programme (which includes speaking to students, staff, service users, and carers) and takes account of any concerns raised with the HCPC by third parties about the performance of the programme.

7.32 We are supportive of the HCPC's planned approach to address some of the criticisms of its work. It plans to review the *Standards of Proficiency*, once all the visits to approved social work programmes have been concluded (by the end of the 2014/15 academic year) and is considering how best to review the content and scope of its *Standards of Education and Training*. This work should ensure that the HCPC's standards are amended and updated to incorporate any learning from its experience of the regulation of social workers in England since 2012.

7.33 We do not disagree that the education of social workers should be improved, but we consider that so soon after the regulation of social workers has transferred to the HCPC from the GSCC, further disruption to the education and training of social workers would not be in the interests of the profession, nor of service users and their carers.

Good practice in education and training

- 7.34 Below are the examples of good practice we identified during the performance review 2013/14 in the area of education and training.
- 7.35 *A joint approach to quality assurance of education providers* – three of the GOC’s visits to education providers were conducted in conjunction with the provider’s quality review panels. The GOC found this joint approach to be particularly useful in relation to areas of common interest to both organisations, such as equality and diversity monitoring and governance. We consider that this partnership working is an example of good practice because it demonstrates a proportionate and targeted approach to quality assurance.
- 7.36 *Supporting students experiencing mental health conditions* – the GMC published new guidance in July 2013 to assist medical schools in supporting students experiencing mental health conditions. The guidance included steps the medical schools could take to encourage students with mental health conditions to come forward and seek help, made suggestions about the types of support the schools might wish to offer to their students, and set out the relationship between student health and fitness to practise. In November 2013, the GMC also published a risk assessment tool on its website to help medical schools identify students who may have mental health concerns. We consider that the GMC’s work in this area is an example of good practice, although we note that no assessment of its impact has yet been carried out.
- 7.37 *Targeted reviews of emergency medicine departments* – during 2013/14, the GMC carried out targeted inspections of the emergency medicine departments of seven local education providers (LEPs) in England and Jersey. These inspections were prompted by concerns about junior doctors working unsupervised at night. Two of the LEPs were selected because reports suggested that they demonstrated good practice. Five were selected as reports suggested concerns. The GMC produced ‘site-specific’ reports on each of the LEPs, setting out both concerns and good practice. It also produced a ‘summary report’ identifying common themes. We consider that the targeted reviews of the seven LEPs demonstrate that the GMC is able to respond appropriately to specific concerns it receives.

Registration

- 7.38 There are *five Standards of Good Regulation* for registration (see Annex 2: Our Standards of Good Regulation). These Standards cover the need for regulators to ensure that only those who meet their standards are registered and that they are registered through a process which is fair, efficient and effective. They also cover that in order to enhance public protection and maintain confidence in the system of regulation, regulators should hold accurate information on the register about the current and historical fitness to practise of registrants and make this information publicly available. In addition, they cover the need for employers to be aware of the need to check the registration status of registrants and that the regulators have processes in place to manage the registration process and prevent individuals practising illegally.

7.39 We note: that one of the regulators (the GDC) did not have appropriate processes in place to ensure that only those who met its standards were registered at all times; that one of the regulators (the NMC) failed to ensure that its registration processes were effective and efficient; and that both of those regulators (the GDC and the NMC) did not ensure that they maintained accurate registers. We report on the detail of these matters in the regulator's individual performance reports.

7.40 We describe matters relating to the regulators' registration functions below which are relevant to our assessment of their performance against the *Standards of Good Regulation* for registration in 2013/14.

Registration processes

7.41 In this report, we raise concerns about the robustness of the registration processes operated by two of the regulators. Our concern about the GDC related to its failure on a number of occasions to ensure that only those who had met its standards were registered. In contrast, with the NMC, our concern related to several elements, such as: its failure to demonstrate that it had a registration process which was efficient and its failure to provide consistently good customer service to those using the registration processes. Registration processes which are not carried out efficiently and effectively undermine confidence in the regulator's conduct of this key function.

Accuracy of registers

7.42 We are disappointed to report that we identified errors in three of the regulators' registers (the GDC, the HCPC and the NMC). The significance of each error, its cause and our confidence in the effectiveness of the regulator's remedial action differed across the regulators. We only identified one error related to the HCPC's register and we are confident that effective action has been taken to prevent any recurrence – we therefore concluded that the HCPC had met the relevant Standard.¹⁸ Whereas in the case of the GDC, there were multiple errors on the register which were identified by both ourselves and by the GDC; the causes of the errors differed (some were due to human error, others were IT related, or due to the movement of data from one registration system to another). In the case of the NMC, we reported that there was a small number of errors in relation to its register and while it had demonstrated an improvement in terms of the numbers of errors identified from 2011/12 and 2012/13, we were concerned about its performance because it appeared that the action taken in response to previous concerns raised about the accuracy of the register had not yet proved effective in eliminating further errors. Incorrect and outdated entries on the regulators' registers can have serious implications for public protection, can raise concern about the overall integrity of the register, and can also damage confidence in the regulator. We hope to see an improvement in the accuracy of the NMC's and GDC's registers during our 2014 audits of the initial stages

¹⁸ The third Standard of Good Regulation for registration: Through the regulators' registers, everyone can easily access information about registrants, except in relation to health, including whether there are restrictions on their practice.

of their fitness to practise processes, as well as in the performance review 2014/15.

Professional indemnity arrangements

- 7.43 The implementation of a new legal requirement for all registrants of the UK health and care regulators¹⁹ to have professional indemnity arrangements in place has been delayed from 25 October 2013 to July 2014. This was outside of the control of the regulators and was a result of practical problems relating to implementation of the requirement.²⁰ We are pleased that, where relevant, the regulators have taken action to prepare for implementation by publishing guidance and information for their registrants, and giving consideration to the best method of assuring that registrants hold indemnity cover throughout the period of their registration.
- 7.44 Requiring registrants to have professional indemnity arrangements in place ensures that patients can secure compensation when they suffer harm through negligence by health professionals. We therefore hope that there will be no further slippages in the implementation of this requirement. We also hope that, once the requirement has been implemented, failure to have professional indemnity arrangements in place will consistently be treated more seriously by regulators' fitness to practise panels than is currently the case. We hope that in future we will not identify:
- In our audits of the regulators' initial stages of their fitness to practise processes, cases where insufficient checks have been carried out to establish whether the registrants in question have appropriate indemnity insurance
 - In our review of final fitness to practise decisions, case outcomes which are 'unduly lenient' because insufficient action was taken against the registrant when there was evidence that they practised without professional indemnity insurance.

Lapsing from the register and Section 29 appeals

- 7.45 Under Section 29 of the National Health Service Reform and Health Care Professions Act 2002 (as amended), the Authority has a limited period within which it can lodge an appeal against an 'unduly lenient' decision made by a regulator's final fitness to practise panel. While some of the regulators that the Authority oversees have the legal power to hold a registrant on their register until any Court appeal that has been lodged by the Authority has been concluded, this is not the situation in relation to the NMC. The NMC's legal framework means that once the NMC's own fitness to practise hearing

¹⁹ This area of concern does not affect the Pharmaceutical Society of Northern Ireland as The Pharmacy (1976 Order) (Amendment) Order (Northern Ireland) 2013 came into operation on 7 November 2013. The Amendment Order introduced the statutory requirement for practising pharmacists to have appropriate cover under an indemnity arrangement in respect of liabilities which may be incurred in practising as a pharmaceutical chemist. Enabling regulations to support the introduction of this statutory requirement were laid at the Northern Ireland Assembly on 1 May 2014 and come into operation on 1 June 2014.

²⁰ This would implement the recommendations from the Finlay Scott report 'Independent review of the requirement to have insurance or indemnity as a condition of registration as a healthcare professional' and ensure compliance with the new EU Cross Border Healthcare Directive.

is concluded, the nurse may 'lapse' from the NMC's register if they have not complied with the requirements for renewing their NMC registration, even if the Authority has lodged a court appeal against the fitness to practise panel's decision.

- 7.46 The Authority's only course of action, should we become aware that a nurse or midwife is about to lapse from the register in relation to a case where we may decide to appeal the fitness to practise panel's decision to the court, is to seek interim relief from the court to require the NMC to hold the registrant on the register until any appeal has been concluded. We have had to do this on two occasions recently, including in relation to our appeal of the NMC fitness to practise panel's decision in the case of the former Director of Nursing at the Mid Staffordshire District General Hospital NHS Trust.²¹
- 7.47 In the High Court judgement in that case, Mrs Justice Lang, said:
'...my preliminary view is that the Authority's interpretation is likely to be correct. I note that this matter has come before the court on an interim basis on previous occasions and the court on those occasions also considered that there was a difficulty with the effectiveness of an Authority's appeal if registration had lapsed. The Authority contends that Miss Harry's case falls outside the bar on lapse of registration for two reasons. First, because she was only given a caution not a suspension order, nor a conditions of practice order. Second, because Article 12 and the Rules only operate in respect of allegations or proceedings under Part V or VI of the 2001 Order, which do not include referrals or appeals by the Authority. This appears to be an oversight in the drafting of the order. As I have said, the matter has come before the court on previous occasions in situations of considerable urgency.
- 'I would ask the Authority and the NMC formally to raise this matter with the Secretary of State for Health and request that it be addressed by a change in the Rules as soon as possible.'*
- 7.48 We have discussed this matter with officials at the Department of Health and the NMC. We also alerted the Health Committee to it during a hearing in front of the Committee in July 2013. We also wrote to the Secretary of State for Health, to request a change in the NMC's rules. It is the Authority's view that the oversight in the legislative framework needs to be corrected without delay, in order to ensure that the public can be protected by the proper use of our powers.

Good practice in registration

- 7.49 Below is the example of good practice in registration which we identified during the performance review 2013/14.
- 7.50 *Illegal practice* – the GDC reached agreements with several companies which allow tooth whitening products and services to be sold on their

²¹ see Professional Standards Authority, 2014. Former Mid Staffordshire Chief Nurse struck off register. 6 February 2014. Available at <http://www.professionalstandards.org.uk/footer-pages/news-and-media/latest-news/news-article?id=5901589e-2ce2-6f4b-9ceb-ff0000b2236b> [Accessed 22 May 2014]

websites that those companies would check the registration status of anyone advertising tooth whitening treatment deals, and that they would only advertise deals provided by registered dental professionals. The GDC issued a joint press release with Groupon to raise public awareness of their collaborative work to guard against the illegal practice of tooth whitening, which resulted in a reduction in the number of complaints being referred to the GDC about Groupon. We consider that the GDC's joint working with Groupon and other 'daily deal' companies is likely to raise patient awareness of illegal tooth whitening, and lead to enhanced public protection and public confidence in the profession and the GDC as a regulator. We have therefore concluded that the GDC's work in this area amounts to good practice.

Fitness to practise

7.51

There are 10 *Standards of Good Regulation* for fitness to practise (see Annex 2). These Standards cover performance throughout the fitness to practise function. We are disappointed to report that during 2013/14, five of the regulators did not meet one or more of these Standards and that we also had concerns about two of the regulators' performance against these Standards. There was commonality in the Standards that were not met. Our general concerns about the regulators' performance in fitness to practise are summarised below:

- *Risk assessments and interim orders* – we saw evidence that risk assessments were not regularly being carried out by three regulators (the GCC, GDC and HCPC). It is important that risk assessments are conducted at the start and throughout the lifetime of a case, as they may lead to a decision to apply for an interim order restricting a registrant's practise while they are under investigation. Any delay in applying for an interim order (or a failure altogether to apply for an order) has implications for public protection. We also saw that the NMC struggled to progress cases promptly where the registrant involved had an interim order, meaning that it had to apply to the High Court/Court of Sessions 619 times for extensions to those orders and both it and the GDC identified two cases each where interim orders lapsed before the fitness to practise proceedings were concluded.
- *Progressing fitness to practise cases without undue delay* – we saw evidence that four of the regulators (the GCC, GDC, GPhC, HCPC and NMC) had difficulties in progressing cases through their fitness to practise process. The reasons for this varied across the regulators and we note them in their individual reports. Failure to progress cases promptly can: lead to risks to patient safety (unless an interim order is put in place); have an adverse impact on the quality of the evidence that is available at the final hearing; and/or cause unnecessary distress to all those involved, as well as damage confidence in the regulator.
- *Providing good quality customer service* – we saw evidence of: two regulators (the GDC and NMC) not acknowledging or responding to correspondence promptly; and regulators failing to keep parties regularly updated on the progress of fitness to practise cases and of sending out inaccurate correspondence. Providing poor customer service can

undermine the parties' confidence in the process and may make complainants, employers, and others reluctant to co-operate with regulatory processes in future.

- *Making reasonable decisions which are well reasoned* – we saw evidence of poorly reasoned decisions which did not adequately protect the public and uphold confidence in the profession and in the system of regulation in both our 2013 audits of the initial stages of the regulators' fitness to practise processes and through our review of all final fitness to practise decisions. In 2013/14, we referred 1-in-300 final fitness to practise hearing outcomes to court, compared to 1-in-600 during 2012/13 – our rate of court referrals doubled. We also provided feedback to the regulators in 25 per cent of the cases that we reviewed. The number of referrals appears to show a significant change, but as the number of appeals we have made has fluctuated since our inception (although not to this extent), we consider that it is too early to draw conclusions about the overall quality of the regulators' panels decision-making. We will keep this matter under review during 2014/15.

7.52 Poor performance in the fitness to practise function can have a significant impact on public confidence in the individual regulators, as well as on public trust in the system of regulation of health and care professionals more generally. This is because the fitness to practise function is the only way in which individual members of the public generally have contact with the regulator (as complainants or witnesses). Fitness to practise cases are also the area of the regulators' work that generates the most public interest and media attention. We report later on the reasons for four of the regulators not meeting all of the *Standards of Good Regulation* for fitness to practise in the regulators' individual performance review reports and the reasons why we have concerns about two other regulators' performance, as well as commenting on whether we consider that any remedial action they have taken or plan to take is sufficient to address our concerns. We will look for improvement in the performance of the regulators in the 2014 audits of the initial stages of the fitness to practise process and in the performance review 2014/15.

Voluntary removals/erasures

7.53 Some regulators already have in place, or plan to introduce, processes that permit registrants whose fitness to practise is under investigation to voluntarily remove (or erase) their names from the register. Once an individual has voluntarily removed their name from the register, they can no longer practise, which means that the public are protected from any further harm by them. However, it also means that any fitness to practise case against them ends. It is therefore important that any voluntary removal/erasure process requires anyone making the decision about whether or not to grant a voluntary removal application to consider whether the public interest in the fitness to practise case going ahead means that the application should be refused. In order to maintain public confidence that voluntary removal/erasure is not being used to shut down cases 'behind closed doors', it is also important that the regulators put enough information into the public

domain about the reasons why a voluntary removal/erasure application has been granted, so that members of the public and other registrants can understand the decision.

- 7.54 During 2013/14, the NMC introduced a voluntary removal process for the first time. In our 2013 audit of the initial stages of the NMC's fitness to practise process, we audited approximately half of the cases where voluntary removal applications had been granted by the NMC during the first six months of the scheme's operation.²² We were disappointed to identify concerns in every voluntary removal case that we audited. In particular, we identified concerns about the guidance that the NMC had put in place around the voluntary removal process, as well as about the way in which it had applied that guidance in individual cases, and about the impact of the voluntary removal process on public protection and the maintenance of confidence in the system of regulation. We made a number of specific recommendations to the NMC about the future operation of the process. We would encourage any other regulators wishing to introduce voluntary removal/erasure in future to take account of our audit findings and recommendations at an early stage of the planning process.

Information breaches

- 7.55 We found that five of the regulators (the GCC, GDC, HCPC, NMC and PSNI) had failed to ensure that fitness to practise information was securely retained on a consistent basis. We also raised concerns about the performance of the GPhC in this area. Failures to protect information can cause harm to individuals and can damage public confidence in the regulator. We consider that regulators should:
- Have comprehensive information security policies and procedures in place
 - Ensure that their staff (both temporary and permanent) are trained in those policies and that contractors are also aware of their obligations to protect information
 - Ensure that compliance with the policies is regularly monitored and remedial action taken promptly
 - Have in place a formal log of data breach incidents which detail the type of incident, the risks associated with the incident, the outcome of the investigation into the breach, and any remedial action taken to address the breach.
- 7.56 While we note that a 'one-off' human error can occur and is inevitable when dealing with such large volumes of personal data, we consider that repeated human errors of a similar nature and those which resulted from a regulator's failure to have appropriate processes, training and reporting systems in place are unacceptable. We consider that failing to have such systems in place,

²² Professional Standards Authority, 2014. *Audit of the Nursing and Midwifery Council's initial stages fitness to practise process*. Available at <http://www.professionalstandards.org.uk/docs/default-source/audit-reports/nmc-ftp-audit-report-2013.pdf?sfvrsn=0> [Accessed 22 May 2014]

such as those noted in the bullet point list above, may increase the likelihood of data breaches and limit the regulators' ability to learn from them. We encourage all the regulators to review their own systems to ensure that they are sufficiently robust.

Good practice in Fitness to practise

- 7.57 Below are the examples of good practice we identified during the performance review 2013/14 in relation to the regulators' performance in fitness to practise.
- 7.58 *Guidance for staff on dealing with vulnerable parties* – GPhC staff received training on dealing with vulnerable parties, which was delivered by the Samaritans and focused on engaging with individuals with mental health difficulties. We have previously noted this type of training as good practice and continue to believe this to be the case.
- 7.59 *Doctors Support Service (DSS)* – during 2012/13, the GMC introduced a pilot Doctors' Support Service (run by the British Medical Association on behalf of the GMC) to provide confidential peer emotional support for doctors whose fitness to practise was being investigated. In 2013, the GMC commissioned an independent review of the pilot DSS; while, at the time of writing, that review had not concluded, the GMC have told us that the interim review results are positive and indicate that doctors find the DSS valuable. We look forward to seeing the final review results in the performance review 2014/15.

Other issues affecting health professional regulation

The Francis Report

- 7.60 In February 2013, the second report from the Francis Inquiry was published, containing 290 recommendations,²³ some of which were directed at specific health and care regulators (the NMC and GMC) and some of which either directly or indirectly affect the work of the regulators. During the performance review 2013/14, we were pleased to see evidence that the regulators had reviewed and taken account of the Francis Inquiry reports' recommendations in their current and planned work. In particular, the regulators had taken account of the Francis Inquiry reports' recommendations concerning putting patients first/the standards of behaviour required of health and care professionals, effective complaints handling, and working with others. Examples of the relevant activities by the regulators are set out below:
- Development of memoranda of understanding and operational protocols with system regulators (such as the Care Quality Commission). We consider that these documents should facilitate the sharing of information about the performance of both individuals and organisations and therefore enable prompt and effective regulatory action to be taken

²³ Francis, R, 2013. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, chaired by Robert Francis QC, 2013. Available at <http://www.midstaffpublicinquiry.com/report> [Accessed 22 May 2014]

- Actions to raise patients' awareness of the relevant regulators and their role, for example by requiring registrants to display information which indicates that they are registered and regulated
- Taking account of the findings of the Francis Inquiry when revising or reviewing core standards and guidance related to professional practice or education and training. In particular, the regulators focused on giving due weight to values-based care, such as requiring professionals delivering services to be compassionate and caring
- Continued work on regulators' actual/proposed schemes for assuring that registrants remain up to date and fit to practise: whether each regulator's scheme is based on a revalidation model, on an enhanced continuing professional development model, or on some other model
- Improving the information available to anyone wishing to make a fitness to practise complaint, as well as any witnesses providing evidence for the purposes of the fitness to practise process. The aim of this work is to make the fitness to practise process more accessible to potential complainants and remove any barriers to their raising concerns, and to improve the overall fitness to practise experience for complainants and witnesses.

7.61 We hope that this work will achieve the overall aim of improving both public protection and public confidence in the system of regulation.

Law Commissions' Draft Bill

7.62 The Law Commissions' review was published on 2 April 2014. It has reviewed the legal frameworks of all the health and care regulators with the aim of simplifying and modernising them. We published a press release welcoming the prospect of a single legislative framework that applies across the regulators that we oversee, and the potential advantages this offers in terms of consistency and efficiency in the delivery of professional regulation and for the Authority's oversight of the sector.

7.63 However, we raised concerns that, if the proposals were implemented without amendment, they were likely to lead to less transparency, accountability and focus on patients, which runs counter to the recommendations made in the Francis Inquiry report,²⁴ as well as the work that has been undertaken since 2007 to implement the recommendations made in the Department of Health's White Paper *Trust, Assurance and Safety*.²⁵ For example, we commented that:

- The Law Commissions' proposals introduce greater scope for decisions about the fitness to practise of registrants to be taken outside of public hearings without clear guidance on what the published decision should

²⁴ Francis, R., 2013. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, chaired by Robert Francis QC, 2013. Available at <http://www.midstaffpublicinquiry.com/report> [Accessed 22 May 2014].

²⁵ Department of Health, 2007. *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*. Available at <https://www.gov.uk/government/publications/trust-assurance-and-safety-the-regulation-of-health-professionals-in-the-21st-century> [Accessed 22 May 2014].

contain. This measure was introduced to improve the efficiency of the fitness to practise process and could compromise the transparency of important decisions taken in the interests of the public

- The Law Commissions' proposals seem to demote the importance of the role of regulation in maintaining public confidence in the profession and declaring and upholding standards of conduct and behaviour by professionals. We consider it important that regulation serves those purposes, as well as directly protecting the public
- The Law Commissions propose to change the current category of impairment of fitness to practise that is known as 'serious professional misconduct' to 'disgraceful misconduct'. We raised a concern that it is not clear what impact such a change would have; in particular, it is not clear whether the change would mean that, in future, fewer complaints about misconduct will result in a finding of impaired fitness to practise
- The Law Commissions proposes to change the legal test that the Authority has to apply when deciding to refer a regulator's final fitness to practise outcome to court. Our concern is that it is not clear what impact the proposed change is intended to have, or what impact it will actually have in practice
- The Law Commissions' proposals do not require there to be a majority of lay people on fitness to practise hearing panels. We are concerned that having a registrant majority on a panel may have a negative impact on public protection and/or maintaining public confidence in the regulatory process, particularly as the Law Commissions have also proposed that one of the general objectives of running a hearing should include 'using the expertise of the panel'. This objective may be perceived that the views of the experts on the panel, the registrant members, should triumph over the views of the lay members on the panel
- The Law Commissions' proposals create a default position for all the regulators that fitness to practise complaints that are more than five years old should not be taken forward, except for in defined circumstances.²⁶ The proposals also do not provide for any review of a decision a regulator makes about the application of this 'five year rule'. We consider that this proposal is likely to damage public confidence in the regulatory process generally, particularly because there is no provision for any oversight of the decisions the regulators make, nor is there any mechanism for requiring such decisions to be reviewed (other than asking the court to conduct a judicial review).

7.64 We are confident that the concerns that we have identified about the Law Commissions' proposals can be addressed by making straightforward changes to the proposed framework. We have shared our concerns with the

²⁶ Law Commission, Scottish Law Commission, Northern Ireland Law Commission, 2014. Regulation of Health Care Professionals, Regulation of Social Care Professionals in England. Available at <http://lawcommission.justice.gov.uk/publications/Healthcare-professions.htm> [Accessed 22 May 2014]. Part 6, Fitness to Practise, Chapter 1, Section 123 subsection 4.

Department of Health, and hope that they will be taken into account in the government's own Bill if and when it is published.

Effective governance

- 7.65 In our report, *Fit and Proper? Governance in the public interest*,²⁷ we highlighted that each regulator's governing body (its Council) needs to understand how the organisation is performing and that they need to have confidence in the performance reports that they receive from the executive, so that they can make judgements about what is happening in their organisation without being overwhelmed with nonessential detail.
- 7.66 Our concerns about the performance of some regulators in their fitness to practise functions during 2013/14 led us to review the performance information that was presented to their Councils during the last quarter of 2013/14. As a result of our review, we identified a number of potential problems with the data provided by regulators to their Councils, including:
- In circumstances where key performance indicators were not achieved, the information provided to the regulator's Council was often inadequate or unclear about the reasons for non-achievement, the remedial action being taken, or the impact that remedial action was expected to have during a particular timeframe
 - Insufficient detail was sometimes presented to explain the significance of the data provided, the trends illustrated by the data, or the regulator's forecast of future performance based on the current data
 - In some cases, the volume of information provided was excessive and potentially unhelpful to Council members' understanding of performance
 - Sometimes the data provided was not likely to assist in understanding the regulator's performance in a function over a period of 12 months; in particular, some regulators only provided their Councils with data relating to performance during the period since the previous Council meeting
 - Some data was presented in a graphic way that made it potentially difficult to understand and interpret.
- 7.67 We recommend that each regulator's executive and Council undertakes a joint review of the performance management information that is routinely presented to its Council. The reviews should ensure the performance management information is focused on meaningful and useful data, that it provides informative comparisons and trends, and that it is proportionate to the purpose for which it is collected. We recognise that a number of the regulators already have such reviews under way. While we do not consider it to be our role to prescribe how the regulators should present performance data to their Councils, in light of our concerns set out above, we intend to follow up the outcomes of any changes made in this area in the performance review in 2014/15.

²⁷ Professional Standards Authority, 2013. *Fit and Proper? Governance in the Public Interest*. Available at <http://www.professionalstandards.org.uk/library/document-detail?id=d53298ac-3d5d-45cf-85fe-5004132741e0> [Accessed 22 May 2014].

The individual performance review reports

- 7.68 In the reports on the individual regulators that follow this overview, we report in more detail on their work. There is much to commend: their active consideration of their roles and responsibilities, their attempts to improve their work, and their serious response to the Francis Report, the challenge of continuing fitness to practise, and legislative change. The regulators have worked constructively with the Law Commissions and the Department of Health on proposals to reform the legal framework of professional regulation in the UK.
- 7.69 Less positive is the variation in performance of regulatory functions and persistent weakness in some regulators in registration, fitness to practise and data security. We expect the regulators to address these issues relevant to them and will review progress in 2014/15.

8. The regulators in numbers

- 8.1 In this section, we provide some basic numerical data on the regulators' performance. The regulators themselves have provided this information and it has not been audited by us.
- 8.2 The data provides some context about the size of the regulators, in terms of the number of professions and professionals that they regulate and the size of their workloads.
- 8.3 When reading this data for each of the regulators, care should be taken to ensure that misleading comparisons are not made. There are differences in the size of the regulators, both in terms of staff numbers and registrants: they all work to differing legislation, rules and processes, they have a varying caseload in terms of registration applications and fitness to practise referrals, and are dependent to a greater or lesser extent on information from third parties, which can impact on the timeliness of their work.
- 8.4 As part of our review of the performance review process in 2014/15, we will work with the regulators to try to ensure that any data collected and presented in the report is consistent across them all, so that it is easier to understand.

Data relates to the financial year 2013/14, unless otherwise stated in the notes.	GCC	GDC	GMC	GOC	GOsC	GPhC	HCPC (excluding GSCC cases)	HCPC (GSCC cases)	NMC	PSNI
REGISTRATION ACTIVITY										
Number of registrants	2,959	103,765	259,826	Individuals: 24,421 Bodies corp.: 2,311	4,810	Individuals: 71,221 Premises: 14,306	322,037		680,858	Individuals: 2,155 Bodies corp.: 550
Number of new initial registration applications received	113	10,210	13,246	Individuals: 2,585 Bodies corp.: 365	266	Individuals: 3,793 Premises: 567	19,857		28,959	Individuals: 193 Bodies corp.: 2
Number of registration appeals received and concluded and the outcomes of the appeals	Received: 0 Concluded: 0	Received: 12 Concluded: 11	Received: 43 Concluded: 47	Received: 2 Concluded: 2	Received: 0 Concluded: 0	Received: 3 Concluded: 3	Received: 63 Concluded: 46		Received: 51 Concluded: 49	Received: 0 Concluded: 0
Outcomes of registration appeals concluded	n/a	Upheld: 3 Rejected: 7 Withdrawn: 1	Upheld: 4 Rejected: 28 Withdrawn: 15	Upheld: 2 Rejected: 0 Withdrawn: 0	n/a	Upheld: 0 Rejected: 3 Withdrawn: 0	Upheld: 15 Rejected: 30 Withdrawn: 1		Upheld: 16 Rejected: 23 Withdrawn: 4	n/a
Median time taken to process initial registration applications for:										
• UK graduates	1 day	19 days	1 day	1 day	2 days	12 days	7 working days		6 days	n/a ²⁸
• International non-EU graduates	1 day	82 days	19 days ²⁹	1 day	81 days	12 days	43 working days		7 days	None received
• EU graduates	1 day	46 days	26 days	1 day	57 days	22 days	30 working days		6 days	2 days
Annual retention fee	£800	Dentists: £576 DCPs: ³⁰ £120	With licence to practise: £390 Without licence: £140	Qualified professionals: £260 Students: £20	1st year: £340, 2nd year: £455, 3rd and later years: £610 ³¹	Pharmacists: £240 Pharmacy technicians: £108 Premises: £221	£76 ³²		£100	Qualified professionals: £372 Students: 194
EDUCATION ACTIVITY										
Number of educational institutions the regulator is responsible for quality assuring	3	49	57	16	11 ³³	87	151		79	2
FITNESS TO PRACTISE ACTIVITY										
Number of cases <u>considered</u> by an investigating committee	105	781	2,373	262	35	132	707	52	2,961	5
Number of cases <u>concluded</u> by an investigating committee	101	545	2,119	239	35	97	682	47	2,821	5
Number of cases <u>considered</u> by a final fitness to practise committee	30	136	241	38	20	70	311	119	2,332	5
Number of cases <u>concluded</u> by a final fitness to practise committee	27	84	241	34	20	69	267	93	1,756	5

28 The PSNI notes that initial registration applications are processed as part of the administration of an individual's final training year, and not as a separate process.

29 The GMC's data relates to EEA rather than EU graduates.

30 DCP (Dental Care Professional).

31 The GOsC reduced its retention fees from 1 May 2014, to £320 for the first year of registration, £430 for the second year, and £570 for the third and subsequent years.

32 The HCPC's annual retention fee rose from £76 to £80 on 1 April 2014.

33 The GOsC notes that its governing legislation requires it to quality assure qualifications rather than institutions. It quality assures 24 qualifications offered by 11 institutions.

	GCC	GDC	GMC	GOC	GOsC	GPhC	HCPC (excluding GSCC cases)	HCPC (GSCC cases)	NMC	PSNI
FITNESS TO PRACTISE ACTIVITY continued										
The time taken from receipt of initial complaint to the final investigating committee decision:										
• Median time taken to conclude	23 weeks	46 weeks	29.2 weeks	25 weeks	16 weeks	45 weeks	27 weeks	52 weeks	39 weeks	25 weeks
• Longest case to conclude	258 weeks	187 weeks	387.7 weeks	148 weeks	73 weeks ³⁴	230 weeks	162 weeks	85 weeks	226 weeks ³⁵	38 weeks
• Shortest case to conclude	3 weeks	5 weeks	1.1 weeks	9 weeks	5 weeks	15 weeks	4 weeks	35 weeks	10 weeks	14 weeks
The time taken from receipt of initial complaint to final fitness to practise hearing determination:										
• Median time taken to conclude	97 weeks	100 weeks	97 weeks	89.5 weeks	51.5 weeks	97 weeks	68 weeks	64 weeks	97 weeks	74 weeks
• Longest case to conclude	174 weeks	320 weeks	381.4 weeks ³⁶	286 weeks	135 weeks	260 weeks	231 weeks	86 weeks	571 weeks ³⁷	135 weeks
• Shortest case to conclude	29 weeks	38 weeks	17 weeks	46 weeks	28 weeks	42 weeks	23 weeks	35 weeks	28 weeks	64 weeks
The median time taken from final investigating committee decision to final fitness to practise hearing decision	56 weeks	46 weeks	34.4 weeks	56.5 weeks	35 weeks	35 weeks	37 weeks	34 weeks	44 weeks	16 weeks
The median time taken from initial receipt of complaint to interim order decision, and from receipt of information indicating the need for an interim order to an interim order decision:										
• Receipt of complaint	3 weeks	45 weeks	8.4 weeks	18 weeks	2 weeks	14 weeks	15 weeks	37 weeks	3.7 weeks	4 weeks
• Receipt of information	2 weeks	3 weeks	2.7 weeks	4.5 weeks	2 weeks	n/a	2.6 weeks	2.6 weeks	n/a ³⁸	4 weeks
Number of open cases that are older than:										
• 52 weeks	8	364	919	18	3	159	298	28 ³⁹	1,249	4
• 104 weeks	5	99	330	8	0	37	42	0	323	1
• 156 weeks	1	44	76	3	0	1	2	0	53	1
Number of registrant/Authority appeals against final fitness to practise decisions:										
• Registrant appeals	0	3	36	1	0	4	8	1	54	0
• Authority appeals	1	3	5	1	0	0	3	0	4	0

³⁴ The GOsC notes that this case was subject to judicial review and was referred back to the GOsC by the Court.

³⁵ The NMC notes that this case has been delayed by a third-party investigation.

³⁶ The GMC notes that this case was subject to criminal proceedings.

³⁷ The NMC notes that this case has been delayed by third-party investigations and court action.

³⁸ The NMC notes that it does not collect this data; it measures from the time it receives a referral.

³⁹ The HCPC calculates the ages of GSCC transfer cases from the date on which it took them over from the GSCC, which was 1 August 2012.

9. The individual regulators' performance review reports

9.1 Our individual performance review reports for the regulators set out:

- Whether the regulators have met or not met the 24 *Standards of Good Regulation* which cover the four regulatory functions
- How the regulators have demonstrated that they have met or not met the 24 *Standards of Good Regulation* and the reasons for our view
- The areas for improvement we have identified
- The areas we will follow up on in the performance review 2014/15.

10. The General Chiropractic Council (GCC)

Overall assessment

- 10.1 The GCC met the majority of the Standards of Good Regulation during 2013/14, but did not meet four of the Standards for fitness to practise. These were the fourth, sixth, eighth and ninth standards.⁴⁰ We also found inconsistent performance against the tenth standard.⁴¹ These related to: failing to have a system which enables the regulator to assess risk throughout the lifetime of a case and, where appropriate, refer a case to an interim orders committee; failing to progress fitness to practice cases in a timely manner; the Investigating Committee's failure to make adequate decisions about the fitness to practice of registrants; and the failure to ensure that all fitness to practice decisions are communicated to relevant stakeholders.
- 10.2 In our 2012/13 performance review, we concluded that two of the Standards of Good Regulation for fitness to practise were not met. The GCC took steps to address our concerns and improved its performance in these particular areas. Specifically, it:
- Concluded the remaining fitness to practise complaints and enquiries, which had not been properly recorded or processed and were discovered in early 2012 (see paragraph 10.33)
 - Improved its timescales for obtaining interim order decisions (see paragraph 10.34)
 - Reduced the length of time taken to communicate Investigating Committee decisions to the parties (see paragraphs 10.26–10.27)
 - Introduced a number of measures aimed at keeping the parties updated on the progress of their fitness to practise case and supporting them to participate effectively in the process (see paragraph 10.24).
- 10.3 However, our 2013/14 performance review identified a number of new concerns, which are summarised below:
- A failure to consistently carry out and record risk assessments or its decisions about applying for interim orders (see paragraphs 10.29–10.30)

⁴⁰ The fourth Standard of Good Regulation for fitness to practise: All fitness to practise complaints are reviewed on receipt and serious cases are prioritised and, where appropriate, referred to an interim orders panel.
The sixth Standard of Good Regulation for fitness to practise: Fitness to practise cases are dealt with as quickly as possible taking into account the complexity and type of case and the conduct of both sides. Delays do not result in harm or potential harm to patients and service users. Where necessary, the regulator protects the public by means of interim orders.

The eighth Standard of Good Regulation: All fitness to practise decisions made at the initial and final stages of the process are well reasoned, consistent, protect the public, and maintain confidence in the profession.

The ninth Standard of Good Regulation: All final fitness to practise decisions, apart from matters relating to the health of a professional, are published and communicated to relevant stakeholders.

⁴¹ The tenth Standard of Good Regulation for fitness to practise: Information about fitness to practise cases is securely retained.

- The timeliness of the progression of cases through the GCC's fitness to practise process, and the development of a 'backlog' of cases awaiting a final panel hearing (see paragraphs 10.36–10.37)
- Ongoing concerns about the quality of the decisions of the GCC's Investigating Committee, following external audit reports in 2012 and 2013 (see paragraphs 10.41–10.42)
- The adequacy of the GCC's system for promptly notifying stakeholders of final fitness to practise hearing outcomes (see paragraphs 10.46–10.49)
- Two data security breaches, one of which was reported to the Information Commissioner's Office (see paragraph 10.52).

10.4 We would encourage the GCC's Council to consider our findings carefully and implement any necessary improvements so that it can demonstrate compliance with the relevant standards in next year's performance review.

10.5 The GCC has maintained its performance across its other functions (guidance and standards, education and training and registration) during 2013/14. Our findings on the GCC's performance in these areas are set out in the relevant sections of the report.

10.6 During 2013/14, the GCC focused on implementing the recommendations of an independent study on its governance arrangements. We have been told by the GCC that the rationalisation of the GCC's governance structure has allowed Council members to focus more clearly on strategic activities, to manage the GCC's resources more efficiently, and to demonstrate that all Council members have sufficient oversight of GCC activity. We were pleased to see that, in amending its governance arrangements, the GCC took account of our paper on fit and proper governance in the public interest⁴² and our investigation report into the concerns raised by the former Chair of the General Dental Council.⁴³

Guidance and standards

10.7 The GCC continued to meet the *Standards of Good Regulation* for guidance and standards in 2013/14. It demonstrated this by launching a review of its standards of competence as well as conducting and commissioning an external review of fitness to practise complaints to determine whether additional guidance was needed in specific areas. The GCC also engaged with stakeholders to develop and revise its standards and guidance. We provide further details and examples of this work below.

- In September 2013, the GCC launched a review of its *Code of Practice and Standard of Proficiency*. The *Code of Practice and Standard of Proficiency* sets out, for patients, the quality of care they are entitled to

⁴² Professional Standards Authority, 2013. Fit and Proper? Governance in the Public Interest. Available at <http://www.professionalstandards.org.uk/library/document-detail?id=d53298ac-3d5d-45cf-85fe-5004132741e0> [Accessed 22 May 2014].

⁴³ Professional Standards Authority, 2013. An investigation into concerns raised by the former Chair of the General Dental Council: advice to the Department of Health. Available at: <http://professionalstandards.org.uk/library/document-detail?id=bb3693d3-e343-427f-8ed3-ee907a41c12e> [Accessed 22 May 2014].

receive from chiropractors; and, for chiropractors, the benchmarks of conduct and practice they will be measured against if a complaint is made to the GCC. The main purpose of the review is to ensure that the *Code of Practice and Standard of Proficiency* is up to date and reflects good practice. The review will take into account: changes in legislation; responses to the GCC's consultation on its proposed scheme to provide assurance about the continuing fitness to practise of chiropractors; an independent review of fitness to practise complaints between 2010 and 2013; and relevant reports on healthcare regulation. The GCC expects to publish the revised *Code of Practice and Standard of Proficiency* in February 2015

- In our 2012/13 performance review report, we noted the GCC's decision not to continue its work on developing procedures for chiropractors in relation to the Ionising Radiation (Medical Exposure) Regulations 2000. The GCC decided instead to focus on developing guidelines for chiropractors who use x-rays in their practice. During 2013/14, the GCC played a role in facilitating the preparation of guidelines for chiropractors using x-rays in their practices, through its participation in a joint technical group led by the Health Protection Agency. This group comprised representatives from the enforcement agencies, education providers, chiropractors and chiropractic professional organisations. The GCC has communicated these guidelines to professional associations, registrants and education providers, and is in discussions with the Health Protection Agency regarding ownership of the guidelines. This is an example of the GCC's engagement and collaboration with stakeholders to develop guidance necessary for public protection
- The GCC did not publish any additional guidance during 2013/14. However, we did not see any evidence to indicate that additional guidance was needed to help registrants apply the *Code of Practice and Standard of Proficiency* to specific issues (but see our comments in paragraph 10.9 below). We note that the GCC commissioned an external review to analyse and identify any themes arising from fitness to practise complaints for the period 2010 to 2013. One of the outputs of this work was to 'identify opportunities to develop targeted standards guidance'. We will follow up on the outcome of this work, and any additional guidance issued by the GCC as a result, in the performance review in 2014/15.

10.8 While we consider that the GCC has met the *Standards of Good Regulation* for guidance and standards, we identify below two concerns regarding its practice, which we recommend it considers.

10.9 The first concern relates to the second *Standard of Good Regulation for standards and guidance*.⁴⁴ In the 2012/13 performance review report, we expressed concern about the GCC's decision to withdraw its supplementary guidance on the advertising of chiropractic services. We note that there was

⁴⁴ The second Standard of Good Regulation for standards and guidance: Additional guidance helps registrants apply the regulators' standards of competence and conduct to specialist or specific issues including addressing diverse needs arising from patient-centred care.

an increase, albeit a small one, in the number of advertising-related complaints received by the GCC during 2013/14, compared to the number received in 2012/13. While we acknowledge that it is not possible to attribute the small increase in the number of complaints to the withdrawal of the supplementary guidance, we welcome the GCC's commitment to re-examine its approach to advertising-related complaints, as part of its review of the *Code of Practice and Standard of Proficiency* and in light of the outcome of the external review of fitness to practise complaints (referred to in paragraph 10.22 below).

- 10.10 The second relates to the third *Standard of Good Regulation for standards and guidance*.⁴⁵ In November 2013, the GCC published an online survey to gather initial feedback from registrants, patients and the public on the *Code of Practice and Standard of Proficiency*. The GCC alerted relevant stakeholders, including registrants, education providers, the Royal College of Chiropractors, the four professional associations and the Chiropractic Patients Association to the survey and received a total of 127 responses. Given the significance of the review of the Code, we raised concerns about whether the GCC had built sufficient time into its project plan to consult with relevant stakeholders on the proposed changes, ahead of publishing the revised *Code of Practice and Standard of Proficiency*. We are pleased that the GCC gave further consideration to this phase of the review, and adjusted its timetable so that it could consult more fully with key stakeholders on the proposed changes. We understand that the GCC's decision to extend its timetable was also influenced by the need to examine the results of the independent review of fitness to practise cases (see paragraph 10.22). We will follow up on the outcome of this work in the performance review 2014/15. In particular, we will consider how the GCC has ensured that the revised *Code of Practice and Standard of Proficiency* incorporates the views of key stakeholders.

Education and training

- 10.11 The GCC continued to meet the Standards of Good Regulation for education and training in 2013/14. It demonstrated this by maintaining and planning a review of its standards for education and training (the Degree Recognition Criteria) and through its quality assurance of educational programmes, the outcomes of which are available from its website. The GCC also continued to work towards developing a continuing fitness to practise scheme for chiropractors. We provide further details of the GCC's work in these areas below.

Quality assuring educational programmes

- 10.12 The GCC is responsible for monitoring five educational programmes run by three different educational establishments. During 2013/14, the GCC carried out three recognition visits to check whether or not the educational

⁴⁵ The third Standard of Good Regulation for standards and guidance: In development and revision of guidance and standards, the regulator takes account of stakeholders' views and experiences, external events, developments in the four UK countries, European, international regulation and learning from other areas of the regulator's work.

programmes were meeting the GCC's requirements, as set out in the *Degree Recognition Criteria*. The outcome of these visits was recommendations that all three programmes should be recognised by the GCC, subject to conditions which would be followed up in the annual monitoring process. The GCC confirmed that the conditions for recognition of the programmes were all met to its satisfaction. We were pleased to see that the GCC focused on, and was able to identify good practice in relation to, the involvement of patients and the public in degree programmes during its recognition visits in 2013/14. This demonstrates that the GCC's quality assurance process takes into account the views of patients and encourages providers to focus training on patient-centred care.

- 10.13 During 2013/14, the GCC adopted a slightly different approach to its annual monitoring process for education providers. Providers were invited to meet with the Education Committee as a group, to discuss their annual monitoring submissions and themes such as patient and public involvement in teaching. We were pleased to see that, as a result of this change of approach, the GCC was able to encourage the sharing of good practice among providers, particularly in the area of involving patients in student learning and assessment (see paragraph 10.12).

Continuing Fitness to practise (CFtP) and continuing professional development (CPD)

- 10.14 In December 2012, the GCC consulted on a proposed scheme for providing assurance about the continuing fitness to practise (CFtP) of chiropractors, based on a five-yearly self-assessment, combined with audits of compliance by independent (lay and chiropractic) trained assessors. After reviewing the consultation responses it had received, the GCC's Council decided in October 2013 to put this work 'on hold', pending developments in the approaches taken by other healthcare regulators. In February 2014, the Council reviewed the position and decided to discontinue the GCC's work on its proposed CFtP scheme. The Council also approved proposals for work to build on its existing continuing professional development (CPD) scheme, to include within it enhancements made by other regulators such as peer review and patient feedback. While we consider that valuable learning can be gained from the approaches being taken by other regulators, we would encourage the GCC to ensure that its approach to CFtP is tailored to its particular registrant group, the environment in which they operate, and the specific risks they present.⁴⁶ The GCC expects to complete its review of the CPD scheme by January 2016 and we will follow up on its progress in the performance review in 2014/15.
- 10.15 In the performance review in 2014/15, we will follow up on two additional matters:
- The GCC's plans for undertaking a review of the *Degree Recognition Criteria*. The GCC plans to commence that work once it has concluded

⁴⁶ CHRE, 2012. An approach to assuring continuing fitness to practise based on right-touch regulation principles. Available at <http://www.professionalstandards.org.uk/library/document-detail?id=69393f02-d5a3-4ae0-a1bb-a7b437dc3485> [Accessed 22 May 2014]

the review of the *Code of Practice and Standard of Proficiency*. The review of the *Degree Recognition Criteria* will assess: the degree recognition process and paperwork; annual monitoring of providers; and the procedures for raising concerns about educational programmes. We have highlighted to the GCC the lack of information available on its website for those wishing to raise a concern about a GCC-recognised educational programme. We are pleased that, in response to our concern, the GCC has added relevant information to the Education Providers page on its website, including an email address to which any concerns can be sent.

- The outcome of the GCC's review of the *Test of Competence*, and its work in developing mutual recognition systems with other chiropractic regulators across the world, which is scheduled for completion in September 2014. The *Test of Competence* is the test which chiropractors from outside the UK, who do not hold a qualification recognised by the GCC, must pass to show they meet the GCC's requirements. In October 2013, the GCC's Council agreed proposals for taking this work forward, including:
 - Developing guidance for applicants with qualifications from outside the UK, explaining the UK context and the differences they might find if they wish to practise in the UK
 - Replacing the current *Test of Competence* with a simpler form of assessment
 - Actively engaging with the worldwide chiropractic community to develop mutual recognition processes (see paragraph 10.47, where we detail a concern about the GCC's current processes for engaging with overseas chiropractic regulators).

Registration

10.16

The GCC continued to meet the *Standards of Good Regulation* for registration in 2013/14. The GCC continued to maintain an accurate register of chiropractors, which includes details of any restrictions on registrants' practice and is available to the public. Examples of how the GCC has demonstrated that it met the Standards are noted below:

- The GCC introduced an audit mechanism in its registrations department and carried out its first audit of registration applications and decisions in January 2013, as well as a follow-up audit in January 2014. The GCC has informed us that it intends to audit its registration process on an annual basis going forward. The overall finding from the 2013 and 2014 audits was that the GCC's registration function is operating efficiently. Some recommendations were made for improvements to the process, including recommended changes to the procedure manual to mitigate the risks that result from only one member of staff dealing with the registration process. The GCC plans to implement the audit recommendations by the end of March 2014 (this work had not been completed at the date of writing). We consider that the changes being implemented (including the provision of guidance to support staff members in decision-making on registration

matters) should mitigate any risks to public protection that arise from only having one member of staff who deals with the registration process on a day-to-day basis

- The GCC performed well against its key performance indicators for its registration function during 2013/14. We consider that this provides evidence of the efficiency of the GCC's registration process
- The GCC implemented measures to ensure that chiropractors have appropriate professional indemnity insurance cover in place throughout their registration period and not just at the point of registration.⁴⁷ The measures introduced by the GCC included: adding a declaration to registration application forms to emphasise that it is the registrant's responsibility to ensure they have adequate professional indemnity insurance in place (this was a recommendation from the January 2013 registration audit report); and sharing of monthly registration data with the professional associations – with whom many registrants arrange their insurance. The GCC also plans to put in place measures to check that registrants have renewed their professional indemnity insurance by contacting the insurer or the registrant directly. We welcome the action the GCC has taken to ensure that chiropractors have ongoing insurance arrangements in place (particularly in light of concerns that we detail in paragraph 10.47) and we will follow up on these activities in the performance review in 2014/15
- The GCC published guidance for those considering applying for registration in June 2013. In addition, it revised its registration forms to clarify the information required from the applicant.

10.17

We were concerned to learn that the GCC was not aware of the changes introduced by the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975 (Amendment) (England and Wales) Order 2013 ('the Order') and the impact of the Order on its registration process. The Order creates a new category of 'protected' cautions and convictions⁴⁸ which registrants are not required to disclose during the registration process. Since we brought this to the GCC's attention, it has reviewed its registration decisions in order to assure itself that no errors have been made; it has also updated its registration application forms and website accordingly. On this basis, we conclude that the GCC's failure to identify for itself the relevant changes does not mean that it has failed to meet any of the *Standards of Good Regulation* for registration in 2013/14.

⁴⁷ Professional indemnity insurance is the means by which patients who have suffered harm as a result of negligence by a professional can obtain financial redress.

⁴⁸ The definition includes cautions which were received over six years ago (or two years if the offender was under 18) and convictions which were received over 11 years ago (or five and a half years if the offender was under 18 at the time), provided the offender received a non-custodial sentence and has no other convictions. It does not apply to a 'listed offence', such as violent and sexual offences.

Dealing with misuse of title and unregistered practice

- 10.18 In our 2011/12 performance review, we expressed concern about the GCC's lack of a formalised process for sending or following up on 'cease or desist' letters to individuals practising chiropractic while unregistered with the GCC. However, in our 2012/13 performance review, we concluded that the GCC met the fifth standard after it introduced:
- An automated system to ensure that case officers follow up on 'cease and desist' letters until an undertaking has been obtained from the individual or a criminal prosecution has been commenced
 - A policy to deal with registration applications from individuals who admit to having practised chiropractic in the past while unregistered.
- 10.19 We have considered the steps the GCC has taken to monitor the effectiveness of introducing these measures. We note, in particular, the follow-up processes implemented by the GCC, including periodic checks of individuals' websites to ensure compliance with undertakings, and, where necessary, using external investigators to carry out inspection visits to chiropractic practices. In 2013/14, the GCC investigated 18 cases: 12 of those cases have been satisfactorily concluded, and the GCC's further compliance checks indicated that the 12 individuals concerned were complying with their undertakings. We have therefore concluded that the GCC has addressed our concerns in this area and that the fifth standard continues to be met.

Fitness to practise

- 10.20 During 2013/14, the GCC met five of *the Standards of Good Regulation* for fitness to practise, but did not meet four standards (the fourth, sixth, eighth and ninth Standards).⁴⁹ We also found inconsistent performance against the tenth standard.⁵⁰ This means that the GCC has only met half of the *Standards of Good Regulation* for fitness to practise during 2013/14.
- 10.21 We set out below the concerns that we have previously raised about the GCC's performance against the *Standards of Good Regulation* for fitness to practise in 2012/13, as well as the action taken by the GCC to improve its performance during 2013/14. We also highlight some further areas of concern which we identified during 2013/14.
- 10.22 We first set out the evidence to demonstrate that the GCC met the remaining five Standards of Good Regulation for fitness to practise.
- The introduction of an online complaints form which improves the accessibility of the fitness to practise process to complainants. The website itself shows the complaint as pending until it is allocated to provide a further check that the complaint has been allocated. A response email is also sent immediately to confirm receipt of the complaint. This should ensure that complaints do not get lost and receive a prompt acknowledgement

⁴⁹ See footnote 40.

⁵⁰ See footnote 41.

- The GCC referred three cases to the Disclosure and Barring Service (formerly the Independent Safeguarding Authority) and two cases to other healthcare regulators
- The GCC's continued work to develop a conditions bank, to support panel members imposing conditions of practice orders. This work was slightly delayed as it was due for completion by February 2014, but it was completed by the GCC in April 2014
- The GCC commissioned an independent review of fitness to practise cases between 2010 and 2013, with the aim of identifying improvements to the four regulatory functions covered by our *Standards of Good Regulation*. We understand that the report was received in April 2014 and that a number of recommendations were made, which are due to be considered by the Council at its June 2014 meeting. In particular, this work is expected to recommend a system for categorising fitness to practise cases and analysing delays, to help the GCC identify any problems in progressing its fitness to practise caseload and to devise appropriate solutions. The GCC also plans to set standards for the completion of cases based on the outcome of this review, and implement those standards as key performance indicators. We look forward to seeing the outcome of this work in the performance review 2014/15.

The seventh Standard of Good Regulation for fitness to practise: All parties to a fitness to practise case are kept updated on the progress of their case and supported to participate effectively in the process

10.23 The GCC did not meet the seventh standard in 2012/13. We are pleased to report that the GCC has improved its performance and therefore met this standard in 2013/14.

10.24 We highlight below a number of measures which the GCC implemented during 2013/14 to improve its performance against the seventh standard:

- It implemented a new case management system, which alerts staff members to provide updates to the parties on a two-weekly basis. The GCC has confirmed that this will be monitored through the provision of a report to the Head of Fitness to Practise, as well as the external audit of individual case files
- In October 2013, the GCC introduced a system to gather feedback from witnesses, registrants and other parties. The GCC received an initial report in April 2014 analysing the feedback generated, and no issues requiring urgent attention or general trends were identified. It also expects to produce quarterly reports going forward, to allow it to improve its customer service
- The GCC has improved its handling of witnesses and the relevant support processes (this was work continued from 2011/2012) including by providing training for staff members on how to deal with and support vulnerable witnesses, and adding a section to the fitness to practise procedure manual about this.

- 10.25 The outcome of these measures is not yet clear, but we will follow up on this in the performance review 2014/15 and, where appropriate, in our 2014 audit of cases closed at the initial stages of the GCC's fitness to practise process.
- 10.26 In our 2012/13 performance review, we expressed concern about the length of time taken by the GCC to communicate to the parties the outcomes of the Investigating Committee's consideration of individual cases. We considered that the delays in this process had the potential to undermine confidence in the GCC's regulatory process and we encouraged the GCC to consider any further steps it could take to improve the efficiency of the process.
- 10.27 We are pleased to note that changes made by the GCC to the system for drafting minutes and allegations following Investigating Committee meetings have resulted in decisions being communicated to the parties more quickly during 2013/14. During 2013/14, the GCC notified complainants and respondents of Investigating Committee decisions within 24 hours of the meeting and, on average, full reasons were sent to the parties within seven days. Prior to these changes, the process took at least one month to complete.
- 10.28 Given the improvements made by the GCC to its performance in this area (and the activities referred to in paragraph 10.24), we have concluded that the seventh standard was met in 2013/14. Notwithstanding that conclusion, we note a concern that in one case, the parties were not sent full reasons for the Investigating Committee's decision until 16 days after the meeting. We would encourage the GCC to ensure that the average time for sending full reasons for Investigating Committee decisions to the parties (seven days) is met, if not improved upon, in all cases. We will consider the GCC's performance in this area further in our 2014 audit of cases closed by the GCC in the initial stages of its fitness to practise process.

The fourth Standard of Good Regulation for fitness to practise: All fitness to practise complaints are reviewed on receipt and serious cases are prioritised and where appropriate referred to an interim orders panel

- 10.29 The GCC met the fourth standard in 2012/13. However, we concluded that this standard was not met in 2013/14, due to concerns about the GCC's practice in relation to carrying out and recording risk assessments. The GCC provided us with an external audit report on 20 fitness to practise complaints received during 2013, which were at varying stages of the investigation process. One of the main areas for improvement identified in the audit report related to recording key decisions, including recording who had decided whether or not an interim order should be applied for, and the reasons for that decision. The report recommended that a new checklist should be introduced to record the initial assessment by reference to the risk factors set out in the fitness to practise manual and to document any later reviews of that decision.
- 10.30 We were concerned that the audit report suggests that during 2013 there was a widespread practice amongst GCC staff of failing to record their decisions about whether or not an interim order application should be made. The

GCC's processes require all fitness to practise staff to consider whether an application for an interim order should be made. Conducting risk assessments on receipt of new complaints is an essential part of any regulatory system that is risk-based and focused on protecting the public. Unless the regulator has carried out a proper evaluation of the risk at the outset and documented its decision, it is difficult to make sound judgements about whether regulatory action is necessary: in particular, whether an application should be made for an interim order to restrict the registrant's ability to practise while the complaint is being investigated. The GCC has informed us that the recommendations from the audit will be incorporated into an action plan, to be considered by the Audit Committee, and reported to the Council. We understand that the changes will include risk assessments being carried out by its fitness to practise lawyer and the introduction of a third tier of management to enhance the general supervision of cases.

- 10.31 Based on the findings and recommendations of the external audit report, we have concluded that GCC did not meet the fourth standard during 2013/14. We will follow up on this in the performance review 2014/15 and in our 2014 audit of cases closed at the initial stages of the GCC's fitness to practise process.

The sixth Standard of Good Regulation for fitness to practise: Fitness to practise cases are dealt with as quickly as possible, taking into account the complexity and type of case and the conduct on both sides. Delays do not result in harm or potential harm to patients and service users. Where necessary, the regulator protects the public by means of interim orders

- 10.32 The GCC did not meet the sixth standard in 2012/13. While the GCC took steps to address the concerns we highlighted in the 2012/13 performance review (see paragraph 10.34), we have identified further concerns about the timeliness of the GCC's fitness to practise process which have led us to conclude that it continued to not meet the sixth standard in 2013/14 (see paragraphs 10.36–10.39).
- 10.33 In early 2012, the GCC discovered 128 fitness to practise complaints and enquiries which had not been properly recorded or processed (the 'unprocessed complaints'). In our 2012/13 performance review, we reported on the action taken by the GCC to ensure that, where possible, those cases were investigated and brought to a satisfactory conclusion. By March 2013, only 13 complaints still awaited consideration by the Investigating Committee. We were pleased to note that these cases were concluded by the GCC during 2013/14. We will consider the GCC's handling of any unprocessed complaints that were closed in the initial stages of its fitness to practise process as part of our 2014 audit.
- 10.34 We expressed concern in the performance review in 2012/13 about the increase in the median time taken for the GCC to progress a complaint from initial receipt of the complaint to the making of an interim order decision – from 6 to 17 weeks. We also noted that the median time taken from the receipt of information indicating the need for an interim order to the making of the interim order decision had increased from 6 to 11 weeks. We saw a

marked improvement in GCC's performance against these measures during 2013/14: the median time taken from initial receipt of the complaint to the interim order decision decreased from 17 weeks to 3 weeks; and the median time taken from receipt of information indicating the need for an interim order to the making of an interim order decision also decreased from 11 weeks to 2 weeks.

- 10.35 The GCC informed us that these improvements were achieved because, unlike in previous years, none of the complaints received in 2013/14 carried any risk of the GCC's investigative action jeopardising a police investigation into serious criminal offences. The GCC's policy in cases where such an investigation is under way is to maintain regular contact with the police, seek a written justification for any request for the GCC not to take investigative action, and, if possible, find a way to proceed. We consider that such cases are likely to occur rarely. However, if they do arise, we would encourage the GCC to take all reasonable steps to mitigate risks to public protection.
- 10.36 We highlight above the GCC's improved performance in relation to the timeliness of its investigation of the unprocessed complaints discovered in 2012, and in making interim order application decisions. However, we have also identified new concerns about the GCC's ability to progress cases through its fitness to practise process efficiently. In particular, we have noted an increase in:
- The median time taken from receipt of initial complaint to the final outcome of the fitness to practise panel hearing – from 68 weeks in 2012/13 to 97 weeks in 2013/14. The longest case took 174 weeks to conclude, compared with 101 weeks in 2012/13
 - The median time taken from the final Investigating Committee decision to the outcome of the fitness to practise panel hearing – from 35 weeks in 2012/13 to 56 weeks in 2013/14.
- 10.37 The GCC informed us that there were three reasons for the delay in its handling of fitness to practise complaints. First, there was an increase in the number of complaints received in 2013 compared with 2012. Second, the GCC concluded the unprocessed complaints in 2013/14. Third, a backlog of cases awaiting a final panel hearing developed due to the impact of the unprocessed complaints on the overall caseload (17 of the 31 complaints considered at a final panel hearing in 2013/14 were unprocessed complaints).
- 10.38 We noted that the external audit report of GCC case files (see paragraph 10.29) reported '*an absence of any, or very few, reviews of case plans at the points identified in the FTP Manual*'. The report found that where such reviews had been carried out, they tended to consist of factual updates rather than being treated as an opportunity to re-evaluate the direction and progress of the investigation in light of any new information received. Given the delays in its fitness to practise process, we would encourage the GCC to review its current practice and consider how it can be improved to make best use of case plans.

10.39 We were encouraged to see that the GCC brought the matter of timeliness of its fitness to practise process to the attention of its Council and obtained approval to increase the number of final panel hearing days in 2013 and 2014, with the aim of clearing the backlog by October 2014. We note that the GCC has also taken other steps which it considers will improve the timeliness of its fitness to practise process, including appointing an in-house advocate in May 2014, as well as commissioning an independent review of fitness to practise cases to provide data that the GCC can then use to analyse the delays and devise appropriate key performance indicators (see paragraph 10.22). While we welcome the steps taken by the GCC to address the delays in its fitness to practise process, we are unable to conclude that the sixth standard is met until improvements are seen in practice.

The eighth Standard of Good Regulation for fitness to practise: All fitness to practise decisions made at the initial and final stages of the process are well reasoned, consistent, protect the public and maintain confidence in the profession

10.40 The GCC met the eighth standard in 2012/13. However, we have concluded that this standard was not met in 2013/14 due to concerns about the quality of the Investigating Committee's decisions in 2013.

10.41 The GCC provided us with an external audit report on decisions made by the Investigating Committee and decisions made at final panel hearings during 2012. The audit raised concerns about the adequacy of the reasons set out in the Investigating Committee's decisions in 2012 in 22 of the 64 Investigating Committee decisions that were reviewed. The report made a number of recommendations aimed at improving reasons for decisions and providing more information to the parties about the process. The GCC confirmed that the audit recommendations have been implemented.

10.42 The second external audit report, produced in 2013, identified a significant improvement in the quality of the Investigating Committee's decisions; however, it was noted that some of the reasoning provided in the decisions was still deficient. The improvement had been attributed to the use of the Legal Assessor who was present at the Investigating Committee's meeting to draft the minutes and allegations. We comment on the improved timeliness of the process following the introduction of this change in paragraphs 10.26–10.27. However, the report also said that there had not been a consistent improvement across those decisions made by the final fitness to practise panels.

10.43 We review all final fitness to practise hearing decisions made by the regulators to consider whether they are unduly lenient and do not protect the public. We have appealed one decision made by a GCC panel during 2013 (see paragraph 10.47). We are awaiting the outcome of this appeal.

10.44 We note that the Investigating Committee and final panel hearing members underwent training (induction and refresher training) during 2013/14 which the GCC considers has resulted in better quality decision-making. We will look to see evidence of an improvement in the quality of the Investigating Committee's decisions in our 2014 audit of cases closed at the initial stages

of the GCC's fitness to practise process, and of improvement in the quality of the final hearing panel's decisions in our ongoing review of all such decisions.

- 10.45 In conclusion, we were pleased to see evidence of improvement in the quality of the Investigating Committee's decision-making in 2013. However, we consider that it is too early to say whether the changes made to the Investigating Committee process have resulted in sustained improvement in the provision of adequate reasons and greater consistency in Investigating Committee decisions. This, along with the concerns raised about the consistency of final fitness to practise panel decisions, has led us to conclude that the eighth standard is not yet met. We will look for further evidence of improvement in our 2014 audit of cases closed at the initial stages of the GCC's fitness to practise process and through our review of final fitness to practise decisions.

The ninth Standard of Good Regulation for fitness to practise: All final fitness to practise decisions, apart from matters relating to the health of a professional, are published and communicated to relevant stakeholders

- 10.46 The GCC met the ninth standard in 2012/13. However, we concluded that this standard was not met in 2013/14, after we identified concerns about the GCC's system for notifying stakeholders, including the Authority of its fitness to practise decisions.
- 10.47 In January 2014, we appealed a decision made by a final hearing panel of the GCC in a case concerning an individual who had provided chiropractic treatment during a period when they were registered as a non-practising chiropractor, and who had not had appropriate indemnity insurance in place. The GCC's final hearing panel imposed a six-month suspension which would expire without there being a review hearing, and made an additional order which had the effect of suspending the individual from practice with immediate effect. We discovered that the same individual had successfully registered as a chiropractor with the Australian Health Practitioner Regulation Agency (AHPRA). The GCC had issued a Certificate of Current Professional Status,⁵¹ which made reference to the ongoing fitness to practise proceedings which were under way at the time, but it had delayed in notifying AHPRA of the outcome of the hearing (that the individual had been suspended from practising in the UK with immediate effect). The GCC only notified AHPRA some two and a half months after the decision was made, and only after we brought the matter to its attention.
- 10.48 The GCC informed us that the failure occurred as a result of 'human error' because the member of staff who was responsible for ensuring the relevant notifications were provided was away on leave at the time. At the time of

⁵¹ This is a certificate which the GCC issues to overseas regulators so that registrants can register to work in another country. It includes the registrant's registered name, date of birth and gender; the registrant's qualification and registered address; whether there have been any findings against the registrant; and whether there are any current investigations against the registrant.

writing, the GCC was introducing changes and further staff controls to prevent this situation from recurring, including:

- Changes to the fitness to practise procedure manual in relation to the procedure for informing parties of the outcome of a fitness to practise hearing
- Introducing monitoring of all cases by senior staff, including the newly appointed fitness to practise in-house advocate
- Development of a formal closure procedure for cases, to ensure that all relevant actions have been completed.

10.49 In addition, we were concerned to note that the GCC did not notify us until 26 March 2014 regarding a final fitness to practise decision that its final hearing panel had made on 28 November 2013. We depend on the regulatory bodies to notify us of all decisions made by their final hearing panels promptly in order that we can comply with our 40-day statutory time limit for reviewing those decisions under Section 29 of the National Health Service Reform and Health Care Professions Act 2002. The GCC's delay in notifying us of this particular decision meant that our time limit had expired by the time we received it. After reviewing the decision, we did not conclude that it was 'unduly lenient' or that any action was required on our part. However, this incident gives rise to further concerns about the GCC's performance against the ninth standard in 2013/14.

10.50 The sharing of information about fitness to practise concerns with relevant stakeholders is an important part of any fitness to practise process that is focused on protecting patients. A joined-up approach to fitness to practise mitigates the risk to public protection from regulators working independently. We note the remedial steps the GCC has committed to take in response to its failure to notify AHPRA of the final fitness to practise decision in the case referred to above. We would also encourage the GCC to examine its current procedure for notifying the Authority of its final fitness to practise decisions to prevent any further omissions in the future. The errors in these cases were basic but fundamental failings which, in our view, are likely to have occurred due to the lack of appropriate systems, checks and balances in place at the time. In the absence of any evidence to show that the GCC has put appropriate measures in place and that these have been effective in practice, we concluded that the GCC has not met the ninth standard in 2013/14.

***The tenth Standard of Good Regulation for fitness to practise:
Information about fitness to practise cases is securely retained***

10.51 The GCC met the tenth standard in 2012/13 (it was not met in the previous year) after the GCC's Council reviewed its operational procedure in September 2012 and GCC staff received relevant training and supervision.

10.52 The GCC informed us of two data security breaches that occurred during 2013/14:

- One incident which was serious enough to be referred to the Information Commissioners' Office (ICO), but the ICO decided to take no further action

- A further incident in which documents that had been sent to the GCC by a registrant's solicitor were forwarded on to the complainant by the GCC, without first checking whether they contained any sensitive or personal data. This incident was not reported to the ICO.

10.53 During 2013/14, the GCC introduced a number of policies and procedures to improve its performance in this area, including: a system to ensure that all CDs and DVDs within the office are encrypted; and the transfer of case bundles to FTP Committee members electronically rather than in paper format.

10.54 We were disappointed to note that there were two data security breaches during 2013/14, despite the improvements outlined above. We were particularly concerned about the second incident, and the GCC's failure to carry out its own checks to ensure that the documents it sent on to the complainant did not contain any personal or sensitive data that should have been removed. The GCC told us that this was as a result of human error. It hopes that an additional tier of management oversight will prevent such errors occurring in the future.

10.55 We concluded that these breaches meant that there was inconsistent compliance with the tenth standard during 2013/14. We will follow up on this in the performance review in 2014/15 and in our 2014 audit of cases closed in the initial stages of the GCC's fitness to practise process.

11. The General Dental Council (GDC)

Overall assessment

General performance

- 11.1 In the 2013/14 performance review, we found that the GDC:
- Met all of the *Standards of Good Regulation* for standards and guidance
 - Met all of the *Standards of Good Regulation* for education and training
 - Met three of the five *Standards of Good Regulation* for registration. It did not meet the first and third Standards.⁵² We also found weaknesses in the GDC's performance against the second Standard,⁵³ although we concluded that it continued to be met
 - Met three of the ten *Standards of Good Regulation* for fitness to practise. It did not meet the fourth, sixth, seventh, eighth, ninth and tenth Standards.⁵⁴
- 11.2 Please note that we are unable to confirm the GDC's performance against the third *Standard of Good Regulation* for fitness to practise⁵⁵ at the time of writing this report. Further details on the reasons for this can be found in paragraphs 11.4–11.5.
- 11.3 Detail about the GDC's specific performance in each of the areas we had concerns about can be found in the relevant sections of the report. We have set out where we considered its performance to have improved or declined since 2012/13 and our reasons for that assessment.

⁵² The first Standard of Good Regulation for registration: Only those who meet the regulator's requirements are registered.

The third Standard of Good Regulation for registration: Through the regulators' registers, everyone can easily access information about registrants, except in relation to their health, including whether there are restrictions on their practice.

⁵³ The second Standard of Good Regulation for registration: The registration process, including the management of appeals, is fair, based on the regulators' standards, efficient, transparent, secure, and continuously improving.

⁵⁴ The fourth Standard of Good Regulation for fitness to practise: All fitness to practise complaints are reviewed on receipt and serious cases are prioritised and where appropriate referred to an interim orders panel.

The sixth Standard of Good Regulation for fitness to practise: Fitness to practise cases are dealt with as quickly as possible, taking into account the complexity and type of case and the conduct of both sides. Delays do not result in harm or potential harm to patients and service users. Where necessary, the regulator protects the public by means of interim orders.

The seventh Standard of Good Regulation for fitness to practise: All parties to a fitness to practise case are kept updated on the progress of their case and supported to participate effectively in the process.

The eighth Standard of Good Regulation for fitness to practise: All fitness to practise decisions made at the initial and final stages of the process are well reasoned, consistent, protect the public and maintain confidence in the profession.

The ninth Standard of Good Regulation for fitness to practise: All final fitness to practise decisions, apart from matters relating to the health of a professional, are published and communicated to relevant stakeholders.

The tenth Standard of Good Regulation for fitness to practise: Information about fitness to practise cases is securely retained.

⁵⁵ The third Standard of Good Regulation for fitness to practise: Where necessary, the regulator will determine if there is a case to answer and if so, whether the registrant's fitness to practise is impaired or, where appropriate, direct the person to another relevant organisation.

Our investigation

- 11.4 In February 2013, we published our report to the Secretary of State for Health in response to his request that we investigate concerns that had been raised by the former Chair of the GDC upon her resignation in May 2011.⁵⁶ In our special investigation report, we concluded that there were deficiencies in the support and operation of the GDC's Investigating Committee, which impacted on its efficiency and effectiveness and which should not have remained unaddressed. However, we concluded that these deficiencies did not amount to a failure by the GDC to carry out its statutory functions.
- 11.5 Since publishing our special investigation report, new evidence has come to light about poor practices in the support and operation of the GDC's Investigating Committee. In July 2013, a member of the Investigating Committee raised concerns under the GDC's whistleblowing policy that certain processes were compromising the independence of the Investigating Committee's decision-making. In August 2013, in response to the whistleblower's disclosure, the GDC commissioned an independent review. The review looked at the guidance and processes used by the Investigating Committee and how they were applied in practice. In particular, it considered whether the application of the guidance and processes had:
- The potential for compromising the independence of the Investigating Committee
 - The potential for inappropriate influence on the Investigating Committee's decision-making
 - Resulted in non-compliance with the *Investigating Committee Guidance Manual* on drafting reasons
 - The potential for consequential reputational damage to the GDC on Judicial Review, especially if a statutory committee or GDC employee was held to be acting *ultra vires*.
- 11.6 The review also looked at the role of Investigating Committee secretaries and manager in providing advice to the Investigating Committee and the quality of that advice.
- 11.7 The final review report was received by the GDC on 23 December 2013. The overall conclusion of the review was that there was no evidence that the independence of the Investigating Committee had been compromised. However, the report identified a number of serious concerns about the GDC's Investigating Committee process and practices, including:
- The holding of private discussions between Investigating Committee secretaries and Chairs about individual cases prior to Investigating Committee meetings
 - Preparation of draft decisions or parts of draft decisions by Investigating Committee secretaries in advance of Investigating Committee meetings

⁵⁶ Professional Standards Authority, 2013. An investigation into concerns raised by the former Chair of the General Dental Council: advice to the Department of Health. Available at <http://professionalstandards.org.uk/library/document-detail?id=bb3693d3-e343-427f-8ed3-ee907a41c12e> [Accessed 22 May 2014].

- Substantial changes made by GDC staff to Investigating Committee decisions following the meetings.
- 11.8 The GDC accepted all of the recommendations of the review and appointed an external solicitor to develop a detailed action plan. The action plan was subsequently approved by the GDC's Council and Audit and Risk Committee and we understand from the GDC that it is being implemented steadily.
- 11.9 We note that the whistleblower has also raised concerns with us about the GDC's management of their disclosure and the detriments they believe they have suffered as a result of this disclosure.
- 11.10 As a result of our concerns about this evidence we decided in April 2014 to undertake an investigation with the following terms of reference.
1. The GDC's:
 - a) Management of the processes and support for its investigating committees which post-dates the publication of our investigation report, *An investigation into concerns raised by the former Chair of the General Dental Council (February 2013)*
 - b) Response to the recommendation contained within our report, which was to review the processes and support that it has in place for its investigating committees, including the arrangements for gathering and monitoring feedback received.
 2. The adequacy of the GDC's whistleblowing policy and the operation of this policy as evidenced by:
 - a) Its response to a disclosure by a whistleblower about the GDC's management of the processes and support of the Investigating Committee
 - b) Its management of a complaint by the whistleblower of detrimental treatment because of their disclosure.
- 11.11 The assessment provided in this report is therefore accurate as of 11 April 2014, but may be subject to change as our investigation progresses. We will, in due course, publicly report on our investigation as a supplementary report to the Health Select Committee.

Guidance and standards

- 11.12 The GDC continued to meet the *Standards of Good Regulation* for guidance and standards in 2013/14. It demonstrated this by introducing new and updated standards of conduct and competence which prioritise patient-centred care, and publishing new guidance documents on specific issues. The GDC also engaged with stakeholders to develop and communicate its standards and guidance. We provide further details and examples of this work below:
- In August 2013, the GDC introduced new *Standards for the Dental Team* ('the Standards') which took effect on 30 September 2013. The Standards are centred on patient expectations and care, and are based on nine principles – the first of which is 'Put patients' interests first'. For each of the nine principles, the document sets out:

- What patients can expect from registered dental professionals (for example, one of the expectations for the first principle is ‘To be listened to and have their preferences and concerns taken into account’)
- The standards registrants are expected to comply with
- Guidance on how registrants can meet those standards.
- The GDC developed a section on its website called ‘Focus on Standards’ to accompany the Standards. This includes case studies, scenarios, frequently asked questions, and other learning materials which explain how the Standards should be applied in practice. We found the additional resources on the GDC’s website useful and considered that the scenarios and case studies would help registrants to put the Standards into context
- The GDC communicated and raised awareness of the Standards through a variety of means, including email, media coverage, press releases, social media, events and the annual patient and registrant surveys. The GDC also surveyed its registrants to assess their awareness of the new Standards. We are interested in the outcome of this work, and will revisit this in the performance review 2014/15
- In September 2013, the GDC introduced two new guidance documents: *Guidance on reporting criminal proceedings* and *Guidance on using social media*. These guidance documents were issued following research conducted by the GDC (as part of the development of the Standards), which indicated that registrants would find additional guidance in these areas useful
- The GDC removed the barrier to Direct Access and introduced new guidance in this area, which took effect from 1 May 2013. This means that patients now have the option to see certain dental care professionals⁵⁷ without a prior referral or prescription from a dentist. Under *Direct Access*, these dental care professionals can provide direct to patients any care, assessment, treatment or procedure that is within their scope of practice and for which they are trained and competent. *Direct Access* is expected to lead to increased patient choice and improved access to dental care. The GDC plans to carry out an initial evaluation of the impact of *Direct Access* in terms of take-up or planned take-up by registrants and usage by patients in early 2014
- The GDC published an updated version of its *Scope of Practice* guidance in September 2013. The guidance sets out the skills and abilities each registrant group should have, as well as ‘additional skills’ that could be developed if a registrant wishes to increase their scope of practice. This work was put on hold pending the finalisation of *Direct Access*, and we

⁵⁷ At the date of writing this report, direct access applies to dental hygienists and dental therapists for their full scope of practice; dental nurses undertaking public health initiatives; and orthodontic therapists carrying out IOTN screening (IOTN is the Index of Orthodontic Treatment Need – a method of assessing patients to establish their need and eligibility for orthodontic treatment based on a dental health component and an aesthetic component). Direct access has not been extended to dental technicians or clinical dental technicians (unless the latter is seeing edentulous patients directly for the making of full dentures).

are pleased to see that the GDC concluded its work in this important area during 2013/14

- At the end of 2013, the GDC started reporting on new complaint categories which had been created within its case management system to align with the Standards at the end of 2013. The GDC hopes that this will enable more effective reporting of breaches of the Standards, and highlight any areas where new guidance may be needed.
- In August 2013, the GDC finalised an action plan which seeks to address the recommendations of the *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* ('the Francis report').⁵⁸ The action plan includes (among other things) a plan to recruit an online patient panel from across the four countries, based on demographic, socio-economic and behavioural criteria relating to attendance for dental treatment; and a plan to work with the NHS Information Centre to gain a better understanding of the profile of patients who use dental care services, to enable the GDC to target its messages to different patient groups more effectively.

Education and training

11.13 The GDC continued to meet the *Standards of Good Regulation* for education and training in 2013/14. Examples of how it demonstrated this are noted below:

- The GDC implemented and carried out an initial review of its *Standards for Education*⁵⁹ which were introduced in September 2012 (a wider post-implementation review is planned during 2014). The GDC gathered feedback from inspectors and providers following the first round of inspections against the new *Standards for Education* in the 2012/13 academic year. The GDC informed us that the initial feedback was generally positive. The GDC also carried out a series of exercises which looked across all of the providers inspected and compared inspection findings against the *Standards for Education*. The GDC informed us that the outcome of these exercises provided assurance that inspection judgments were consistent. We are pleased to note that the GDC did not identify any significant early implementation issues with the *Standards for Education* during 2013/14. We will follow up on the outcome of its wider post-implementation review in the performance review 2014/15
- The GDC began a review of its Specialist Lists⁶⁰ and is currently developing an approach to the quality assurance of specialist education and training. Specifically, the GDC is:

⁵⁸ Francis, R., 2013. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, chaired by Robert Francis QC, 2013. Available at <http://www.midstaffspublicinquiry.com/report> [Accessed 22 May 2014].

⁵⁹ The Standards are used to assess whether a programme is producing graduates who demonstrate certain learning outcomes and therefore meet the GDC's standards for registration. These standards also provide the framework for the GDC's quality assurance process.

⁶⁰ Specialist Lists are held by the GDC; they are lists of registered dentists who meet certain conditions and are entitled to use a specialist title. Any registered dentist can work in a particular field of dentistry (e.g. oral surgery) but only those on specialist lists can call themselves a 'specialist' because they have met certain requirements and been given the right by the GDC to use the title 'specialist'.

- Reviewing whether there are additional risks posed by those practising in particular areas of dentistry, and how effective the GDC’s Specialist Lists are in mitigating those risks. During 2013/14, the GDC completed the first phase of this work, which involved: research with patients, the public and registrants; comparative research on the approaches of other countries/professions; and an initial analysis of fitness to practise data in relation to the 13 specialties. The GDC informed us that it expects to consult with key stakeholders on the proposed changes, including to the relevant legal rules, in the second/third quarter of 2014
- Working with its Specialist Dental Education Board (made up of experts in postgraduate and specialty education) to develop Standards for Speciality Education and a quality assurance process for specialist education and training. This is a continuation of work that was commenced in 2011/2012. We acknowledge that the GDC’s first priority was to develop and implement the new Standards for Education and apply any lessons learned. We will follow up on this matter with the GDC in the performance review 2014/15.
- The GDC investigated the risks to patient safety posed by newly registered dentists or dental care professionals to determine whether a further period of post-graduation supervised training should be introduced (‘pre-registration training’). In September 2013, the findings were presented to Council. The findings indicated that there is insufficient evidence to support the introduction of a requirement for a pre-registration training period. We consider that the GDC adopted a ‘right touch’ approach to its work in this area. It considered and evaluated the risk it was trying to regulate, and concluded that there was a more proportionate way to manage the risks than managing them through regulation. The GDC’s Council has authorised further work on this, including whether there is a role for the GDC in leading or facilitating a joint approach across the sector (e.g. with dental schools and deaneries). This work is intended to address the gaps the GDC identified in the overall responsibility for supporting new registrants in the transition to independent practice, and the lack of common understanding and/or sharing of information between the relevant stakeholders. This work is in keeping with a further aspect of right-touch regulation: the need for all parts of the system to play their part in providing an appropriate response to the problem
- The GDC continued its quality assurance of educational programmes. We note that during 2014 the GDC will be carrying out a thematic analysis of recent inspections in order to identify any common themes, strengths, and areas for development. We consider that this work could be beneficial to its education providers, as a tool to learn from the work of others in the same sector
- The GDC contacted dental care professionals (DCPs) who were approaching the end of their continuing professional development (CPD) cycle in order to raise awareness of the consequences of not making a compliant CPD declaration by the due date. The GDC took this action

after identifying that 63.47 per cent of DCPs approaching the end of their CPD cycles had not made a compliant declaration. The GDC also issued press releases and articles in the professional press, and sent targeted emails and text messages to registrants who were at most risk of non-compliance. This resulted in 94.75 per cent of dental care professionals meeting their CPD requirements by the end of the CPD cycle on 28 August 2013.

The GDC's ongoing work to develop its enhanced Continuing Professional Development scheme

- 11.14 The GDC does not yet have legal powers to introduce revalidation or other means of assuring a registrant's continuing fitness to practise. However, if this power is granted, the GDC plans to expand its enhanced CPD scheme, to include additional performance management and monitoring requirements, and ultimately to deliver a revalidation scheme based on the three-stage model which it consulted on in 2010 (with some modifications).⁶¹ We are pleased to report that, in 2013/14, the GDC made demonstrable progress with the first phase of its work to introduce its enhanced CPD requirements for dental professionals from 2015. We welcome the GDC's efforts to adopt an evidence-based approach to its work in this area, as demonstrated by the further work it conducted in 2013/14. In 2013/14, the GDC:
- Completed a public consultation on its proposals (in January 2013). The consultation indicated significant support for the proposed enhanced CPD scheme. The GDC's proposals aim to link the registrant's CPD to the GDC's standards and retention of registration. In our response to the consultation, we welcomed the scheme's emphasis on outcomes rather than inputs, and on the maintenance of core standards. We did, however, note that we would have liked to have seen clearer messages about the purpose and aim of the CPD scheme and what 'revalidation' would add. We would encourage the GDC to bear these issues in mind in its further development of the scheme
 - Prepared new draft secondary legislation which underpins new rules for CPD for dentists and dental care professionals, working in conjunction with the Department of Health (this went out for public consultation in December 2013)
 - Commissioned an independent analysis of the costs and impact of the GDC's proposals for an enhanced CPD scheme (this was completed in November 2013)
 - Received the report on a Rapid Industry Assessment it had commissioned of CPD provision in UK dentistry. The report found (among other things) that the topics covered by CPD providers varied significantly, but overall the core topics defined by the GDC accounted for a large

⁶¹ This model was based on a three-stage process, which would apply at the end of each five-year cycle: Stage 1 – compliance check involving a declaration submitted by dentists to demonstrate that they meet the GDC's standards (this will apply to all dentists); Stage 2 – remediation phase, which will provide an opportunity for dentists who do not pass Stage 1 to remedy deficiencies; and Stage 3 – in-depth assessment, which will apply to dentists who fail to demonstrate their compliance at the end of the remediation phase.

portion of provision. The GDC informed us that it is raising awareness of the findings of the report through presentations to a range of audiences, including CPD providers.

11.15 We note that, in March 2013, the GDC also issued a call to CPD providers and dental professionals to encourage better quality CPD. For example, CPD providers were encouraged to quality assure their CPD products and services, and registrants were encouraged to make careful choices as consumers of CPD. The GDC also published new information for registrants about how they can make appropriate choices when selecting CPD activities, and revised its guidance about the current CPD requirements (these were published in September 2013).

Registration

11.16 In our 2012/13 performance review, we reported that the GDC met all of the *Standards of Good Regulation* for registration. In 2013/14, the GDC met three of the five *Standards of Good Regulation* for registration but we concluded that it did not meet the first and third Standards.⁶² We set out our conclusions about the GDC's performance against these standards in paragraphs 11.24–11.32. While we consider that the second Standard of Good Regulation⁶³ is met, we note in this report three areas of weakness which we consider the GDC should address. We discuss this in paragraphs 11.19–11.23.

11.17 Examples of how the GDC demonstrated that it met the three *Standards of Good Regulation* for registration are noted below.

- A suite of guidance documents and standard operating procedures were developed. The purpose of this work was to ensure that well-reasoned decisions are made and a consistent approach is adopted to both decision-making and process
- New temporary registration guidance was introduced (on 1 August 2013) together with a more systematic system for auditing references from overseas qualified dentists who are applying for temporary registration. The purpose of this is to ensure that only those who meet the GDC's standards are registered
- The GDC made improvements to the administration of the overseas registration exam, such as increasing the number of exam sittings. This is an area we have raised concerns about in previous performance reviews, so we are pleased to note that these changes resulted in a reduction in the number of people waiting to sit part two of the exam
- The GDC continued work aimed at improving the procedures and practice of its illegal practice team. This included: providing training for staff members and new Investigating Committee members; simplifying the information available on the GDC's website; developing internal guides and a checklist for GDC staff to use when deciding whether to prosecute

⁶² See footnote 52.

⁶³ See footnote 53.

a case. In addition to this work, the GDC reached agreements with several companies that allow tooth whitening products and services to be sold on their websites; the companies agreed that they would check the registration status of those advertising tooth whitening treatment deals, and that they would only advertise deals provided by registered dental professionals. The GDC issued a joint press release with Groupon to raise public awareness of their collaborative work to guard against the illegal practice of tooth whitening which resulted in a reduction in the number of complaints being referred to the GDC about Groupon. We consider that the GDC's joint working with Groupon and other 'daily deal' companies is likely to raise patient awareness of illegal tooth whitening, and lead to enhanced public protection and public confidence in the profession and the GDC as a regulator. We have therefore concluded that the GDC's work in this area amounts to good practice

- We expressed concern in the performance review 2012/13 after 13 registrants who had not paid their annual retention fee and/or complied with their CPD requirements were removed from the register by the GDC, despite being subject to fitness to practise investigations at the time. Administrative lapses from the register, which result in fitness to practise investigations and/or hearings terminating without any findings being reached, have the potential to adversely affect public confidence in the regulatory process and could impact on public protection. We noted in the performance review report 2012/13 that the GDC had put in place a new procedure to prevent further incidents of this nature. We are pleased to report that during 2013/14 the GDC did not identify any further administrative lapses from the register of registrants who were the subject of fitness to practise proceedings. We would encourage the GDC to maintain its performance in this area going forward. In May 2014, the GDC completed a project aimed at ensuring that its current procedures for the removal of registrants from the register are robust; we will follow up on the outcome of this work in the performance review 2014/15.

11.18 We note that the GDC planned to contact (by the end of 2013) any DCPs who had been removed from the register for non-payment of the annual retention fee at the end of July 2013, and who had neither been restored to the register or had informed the GDC that they were no longer practising. This was an area of work we said we would follow up in this year's performance review report. However, the completion of this work has been delayed, due to an unexpected increase in the calls received by the GDC's Customer Advice and Information Team. However, the GDC informed us that it did send a letter by recorded delivery to notify the DCPs in question that they should no longer be practising and where the mail has been returned, they will be contacting the DCPs by telephone. A similar exercise by telephone only was carried out in relation to all dentists removed for non-payment of the annual retention fee at the end of 2013 with no indication of illegal practice.

The second Standard of Good Regulation for registration: The registration process including the management of appeals, is fair, based on the regulator's standards, efficient, transparent, secure and continuously improving

- 11.19 We identified three concerns in relation to the GDC's performance against this Standard. We do not consider that these are serious enough for the Standard not to be met, but we will want the GDC to demonstrate it has improved in all three areas in the performance review 2014/15.
- 11.20 We note that there was an increase in the median time taken to process all types of initial registration applications in 2013/14, compared to 2012/13. The figures provided by the GDC showed an increase of eight calendar days for UK graduates, 34 calendar days for EU applicants, and 71 calendar days for non-EU applicants. The GDC informed us that this was due to a number of factors, one of which was the migration of the registration function to the new CRM system and the implementation of new standard operating procedures. The GDC expects this increase in processing times to be a short-term consequence of introducing the new CRM system. We acknowledge that the CRM system was only introduced in May 2013, and that the transition to a new system could account for delays in processing registration applications. Furthermore, we did not see any evidence that the delays had adversely affected public confidence in the GDC: for example, there was no evidence of an influx in complaints because of these delays.
- 11.21 The GDC has continued to work with the Department of Health in relation to the change in legislation needed to introduce professional indemnity insurance as a condition of registration.⁶⁴ The relevant legislation is expected to come into force in July 2014 (this is subject to Parliamentary approval procedures). The GDC published additional online guidance (dated 30 September 2013) which provides information about the types of professional indemnity insurance that are recognised by the GDC. We consider that this guidance would be clearer if it explained the circumstances in which 'it would be acceptable for [registrants] not to have any cover' and where 'the risk of a patient making a claim against [a registrant] is absolutely zero'. We are pleased that in response to our feedback, the GDC has agreed to consider including a non-exhaustive list of examples within the guidance.
- 11.22 The GDC also has a policy which requires registrants to provide proof of indemnity insurance if they become subject to fitness to practise proceedings. However, in our 2013 audit of cases closed at the initial stages of the GDC's fitness to practise process, we identified five cases where we considered that insufficient checks had been carried out to establish whether the registrants in question had appropriate indemnity insurance arrangements in place.⁶⁵ We also reached an agreement in an appeal we made against an 'unduly lenient' GDC final fitness to practise panel

⁶⁴ Professional indemnity insurance is the means by which patients who have suffered harm as a result of negligence by a professional can obtain financial redress.

⁶⁵ Professional Standards Authority, 2013. Audit of the General Dental Council's initial stages fitness to practise process. Available at: <http://www.professionalstandards.org.uk/docs/default-source/audit-reports/gdc-ftp-audit-report-2013.pdf> [Accessed 22 May 2014].

determination involving a registrant who was practising without professional indemnity insurance. We hope that the more stringent requirements, which are to be introduced at the registration stage, will filter through to the GDC's fitness to practise process, and that we will see an improvement in this area going forward.

- 11.23 We were concerned to note that the GDC's Guidance on reporting criminal proceedings was not promptly amended to take into account the changes introduced by the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975 (Amendment) (England and Wales) Order 2013 ('the Order'). The Order created a new category of 'protected' cautions and convictions, which registrants are not required to disclose during the registration process.⁶⁶ We understand from the GDC that it has now updated its guidance and registration forms to reflect the Order, and that these will be published shortly.

The first Standard of Good Regulation for registration: Only those who meet the regulator's requirements are registered

The third Standard of Good Regulation for registration: Through the regulator's registers, everyone can easily access information about registrants, except in relation to their health, including whether there are restrictions on their practice

- 11.24 Each year, as part of the performance review process, we carry out a random check of each regulator's register to ensure that it accurately reflects the registration status of its registrants. Where registers contain information that is inaccurate or out of date, this could have implications for public protection, as well as casting doubt on the integrity of the register.

- 11.25 During our check of the GDC's register in 2013/14, we were unable to locate a number of records that we searched for using the online register. After we fed back our concerns about this, the GDC carried out its own checks on the register, as well as IT testing, in order to establish why we had been unable to locate the records. The GDC subsequently told us that it had identified an issue with the advanced search function on the online register. Specifically, the GDC explained that the advanced search function requires a precise search: so if, for example, the user included an additional space before or after the forename or surname of a registrant, it would not produce any results unless the 'include surnames that sound like' box was also ticked. The GDC was not previously aware of this issue, but confirmed that the problem had been rectified so that if a user inadvertently included a space before or after the registrant's name when carrying out a search on the online register, it would now produce positive results.

⁶⁶ The definition includes cautions which were received over six years ago (or two years if the offender was under 18) and convictions which were received over 11 years ago (or five and a half years if the offender was under 18 at the time), provided the offender received a non-custodial sentence and has no other convictions. It does not apply to a 'listed offence', such as violent and sexual offences.

- 11.26 We subsequently carried out a further check on the GDC's register, and were able to locate the records and verify that the issue had been resolved. However, the problem we identified with the GDC's online register resulted in us being unable to locate a number of registrants' records, and could have had similar consequences for members of the public. It therefore affected the GDC's performance against the third standard and, specifically, the ability for everyone to '*easily access information about registrants...including whether there are restrictions on their practice*' through the GDC's register.
- 11.27 The GDC also provided us with details of incidents investigated under its serious incident reviews process (which was introduced on 1 February 2013). We are pleased that the GDC has a system in place for reporting and investigating serious incidents. We understand that investigations are undertaken by a senior manager, and that regular updates are provided to the Audit and Risk Committee about the number and nature of serious incidents. The serious incident reviews process also identifies lessons learned and recommends any necessary remedial action. However, we noted that a number of incidents involving accuracy issues with the register were recorded and investigated by the GDC during 2013/14. We set out below examples of these incidents:
- Published warnings in relation to a registrant's fitness to practise not appearing on the online register in two cases for a period of approximately two to three months
 - Two registrants not showing on the online register for a limited period (approximately one day)
 - DCPs (a total of 280 registrants) qualifications not being recorded on the online register for approximately one month
 - DCPs who are the subject of fitness to practise cases not appearing on the register.⁶⁷
- 11.28 While the GDC's audit of its registration processes found that 97 per cent of the applications passed its compliance test and had been appropriately granted, we note that three incidents call into question some of the GDC's decisions to grant registration in particular cases:
- A registrant was allowed to join the register on the premise that they had passed their exams when they were in fact in the process of resitting them (the GDC told us this was due to the educational institution providing incorrect information)
 - Registration was allowed while the registrant was under investigation for illegal practice
 - Two applications to join the register were incorrectly granted without staff input.

⁶⁷ The investigation into the matter highlighted in this bullet point is still ongoing at the time of writing this report.

- 11.29 The GDC has assured us that it took immediate steps to correct the registration status of the relevant individual. However, we note that the investigations into the underlying causes of these errors have not yet been completed.
- 11.30 Some of the serious incident reviews highlighted issues with the introduction of the CRM system and raised concerns as to whether sufficient testing/checks that related to moving the data over from the old system had been carried out prior to implementation of the CRM system. The reviews also recorded that a 'root and branch' review to ensure that no further data was missing from the register was to be carried out. Following this, the GDC commissioned an external audit of its CRM system to test the robustness of the controls it had in place to ensure the accuracy of the data. Its compliance team also carried out checks of the online register for each of the following groups: registrants with published warnings; registrants with warnings; registrants with confidential conditions; and those who have been erased from the register. The GDC has assured us that both these activities have provided assurance that the online register is now accurate.
- 11.31 The GDC had not completed its investigations into one of the incidents referred to in paragraph 11.27 and the three highlighted in paragraph 11.28 at the date of writing this report. We therefore had incomplete information about the scale and impact of the problems identified in these cases. However, we are concerned that the nature of these incidents creates clear risks for patient safety, and the maintenance of public confidence in the GDC as a regulator. We are also concerned that, as some of the GDC's investigations are still ongoing particularly in relation to decisions to grant registration, we could not be completely confident that appropriate remedial action had been taken to prevent similar problems from recurring in future.
- 11.32 Taking into account the problem we identified with the GDC's online register and the available information in relation to its serious incident reviews, we have concluded that the GDC did not meet the first and third *Standards of Good Regulation* for registration during 2013/14.

Fitness to practise

- 11.33 During 2013/14, the GDC met three of the *Standards of Good Regulation* for fitness to practise. However, it did not meet the fourth, sixth, seventh, eighth, ninth and tenth standards.⁶⁸ By comparison, we found that the GDC met all of the standards, except the sixth standard, in 2012/13. This represents a significant decline in the GDC's performance in fitness to practise during 2013/14. We consider that this is an issue that needs to be the subject of an elevated level of scrutiny by the GDC's Council and its Audit and Risk Committee.
- 11.34 We are unable to confirm the GDC's performance against the third Standard of Good Regulation for fitness to practise at the time of writing this report. We will be in a position to do this once we have completed our investigation. As

⁶⁸ See footnote 54.

noted in paragraph 11.10, we will publicly report on our investigation findings in a supplementary report to the Health Select Committee.

11.35 Examples of how the GDC demonstrated that it met the three of the ten *Standards of Good Regulation* for fitness to practise are noted below.

- The GDC updated its *How to Report a Dental Professional to Us* pamphlet which received a 'Plain English' Crystal Mark. The pamphlet sets out the role of the GDC, what patients can expect from those registered with the GDC, and the types of issues that are dealt with through the GDC's fitness to practise processes. The GDC's web pages on how to raise a concern were also updated to include more helpful advice about who can help with complaints about dentists and DCPs, and how the GDC investigates fitness to practise complaints
- The Memorandum of Understanding between the Dental Complaints Service (DCS) and the GDC's fitness to practise team was replaced by a document which outlines factors to consider before referring cases to the GDC's fitness to practise team. The GDC said that this change will encourage the DCS to adopt a more risk-based approach when referring cases to the GDC's fitness to practise team and contribute to managing complainant's expectations more effectively, as well as preventing any unnecessary delays in seeking a resolution to their complaint
- An information sharing protocol with the Care Quality Commission (CQC) was agreed. The protocol provides greater specificity on the types of information that will routinely be shared between the two regulators at the early stages of both bodies' investigative processes.

11.36 We outline below the GDC's performance against the six standards which were not met in 2013/14, as well as the steps taken by the GDC in 2013/14 to address the concerns we previously identified in the performance review in 2012/13.

The fourth Standard of Good Regulation for fitness to practise: All fitness to practise complaints are reviewed on receipt and serious cases are prioritised and where appropriate referred to an interim orders panel

11.37 The GDC met the fourth standard in 2012/13. However, we have concluded that this standard was not met in 2013/14 due to concerns about:

- The GDC's failure to carry out and record risk assessments at the triage stage and refer cases to an interim orders panel without delay⁶⁹
- Incidents reported and investigated under its serious incident reviews process, including one case where it lost jurisdiction to investigate or continue its investigations into fitness to practise cases
- An increase in the time taken to obtain interim order decisions.

⁶⁹ 'Triage' is the process by which new complaints or referrals are assessed on receipt against a set of criteria. This results in either closure or allocation to a caseworker for investigation.

- 11.38 Conducting risk assessments on receipt of new complaints is an essential part of any regulatory system that is risk-based and focused on protecting the public. Unless the regulator has carried out a proper evaluation of the risk at the outset, it is difficult to make sound judgements about whether regulatory action is necessary and, in particular, whether an application should be made for an interim order to restrict the registrant's ability to practise while the complaint is being investigated.
- 11.39 Our 2013 audit of cases closed at the initial stages of the GDC's fitness to practise process ('the 2013 audit') identified concerns with the GDC's practice for carrying out and recording risk assessments in 61 of the 100 cases that we audited.⁷⁰ These concerns included:
- The absence of records to show that consideration had been given to whether an interim order might be required at the triage stage in 24 cases. We did not consider that interim order applications should have been made in any of these cases. However, we were critical of the GDC's failure to follow its procedure and the risk this gave rise to of poor decision-making in the future
 - Failure to record the reasons for the decision not to apply for an interim order at the triage stage in a further 24 cases
 - Failure to make timely interim order applications in three cases. We were particularly concerned about these cases, as we considered they had implications for maintaining public confidence in the regulatory process and the GDC as regulator.
- 11.40 In response to our 2013 audit, the GDC committed to implement the following changes (these actions had not been completed at the date of writing this report):
- Revising the process for recording risk assessments, so that risk assessments are attached to each decision point during the casework process and are recorded on the CRM system
 - Providing training for triage decision makers, to ensure that a full justification is provided for the decisions made at this stage, including providing specific reasons for the referral or non-referral of a case to the Interim Orders Committee.
- 11.41 The GDC also planned to carry out:
- An audit of high-risk cases where interim orders had not been applied for, in order to address our most serious concerns about the GDC's failure to make timely referrals to the Interim Orders Committee
 - Research into whether referrals to the Interim Orders Committee could have been made at an earlier stage in the process. We look forward to seeing the outcomes of this work in the performance review 2014/15 and hope that it will positively impact on the performance of the GDC.

⁷⁰ See footnote 65.

11.42 We set out above (paragraph 11.27) details of the GDC's serious incident reviews process, which was introduced on 1 February 2013. In addition to the incidents already described in its registrations function, we were concerned to note that there was one instance during 2013/14 where an interim order application was not heard and two occasions where the GDC lost jurisdiction to investigate or continue its investigations into fitness to practise complaints. We provide details of these incidents below:

- An Interim Orders Committee hearing in relation to a registrant with a serious communicable disease and possible drug addictions was adjourned, on the grounds that the registrant had not been informed of the change of venue. The original venue had been double-booked so the GDC sent an email to the registrant the day before the hearing informing him of the change. However, this was not considered to be reasonable notice of the change in venue. It is of concern that an administrative error by the GDC resulted in the interim order application not being heard as scheduled. However, we understand from the GDC that the case was rescheduled and brought before the Interim Orders Committee within 14 days. We note that the registrant was suspended as a result
- Two incidents of interim orders expiring before a review hearing could be held. This meant that the registrants became free to practise without restriction without any assessment of whether the risk they had previously posed still existed.⁷¹

11.43 As with the registration serious incident reviews, the GDC had not completed its investigations into two of the incidents referred to above at the date of writing. We therefore have limited information about the cause and likely impact of the problems or the remedial action taken by the GDC. We note that the serious incident process was only introduced in 2013/14 and we are therefore unable to compare the number of incidents reported and investigated with previous years. However, regardless of the fact that we cannot compare performance in 2013/14 with previous years, we are concerned that the nature of these incidents created clear risks for patient protection and the maintenance of public confidence in the GDC as a regulator.

11.44 We expressed concern in the performance review report 2012/13 about the median time taken from the receipt of the initial complaint to an interim order

⁷¹ One of these cases related to an interim order which was in place while a registrant appealed a final fitness to practise decision. The GDC said that the Dentists Act is unclear as to whether an interim order needs to be reviewed while the appeal is ongoing. Due to conflicting legal advice that the GDC received on this matter, it decided that the safest option was to assume that it had lost jurisdiction. This allowed it to take further action (a new interim order hearing) which put beyond any doubt that the registrant should have an interim order in place against his practice. The GDC has suggested that changes to its Act are necessary to enable its powers in similar situations to be clearer. One of these cases related to a registrant who was in prison at the time the interim order lapsed. He was released from prison on 27 December 2013. The substantive hearing of his case had been re-arranged for 28 January 2014 (to limit the time that he was out of prison and unrestricted) but he made an application for a postponement, on the grounds that he had not had sufficient time to prepare his case and line up witnesses. That application was heard and granted on 20 January 2014. An interim order hearing was held on 21 January 2014 which imposed an interim suspension order on his registration for four months. The registrant was not restricted from practising for just under four months: 27 September 2013 to 21 January 2014. He was in a position to try to perform dentistry for fewer than four weeks between his release from prison on 27 December 2013 and 21 January 2014. We note that the registrant was subsequently erased by the final fitness to practise committee.

decision (23 weeks at that time). We are disappointed to report a significant increase in the GDC's timescales for obtaining interim order decisions in 2013/14, with the median time being 45 weeks. We note that the GDC has been dealing with an increase in the number of referrals. The GDC has informed us that at the end of October 2013, 167 referrals had been made to the Interim Orders Committee and it expected there to be in the region of 200 referrals by the end of 2013. By way of comparison, there were 179 referrals to the Interim Orders Committee in 2012, and 175 in 2011. In our view, the increase in the number of referrals is not significant enough to warrant the decline in performance in 2013/14. Delays in imposing interim orders create risks for public protection.

- 11.45 We welcome the steps the GDC has taken and/or is taking to address the concerns raised in our 2013 audit. However, until real and continuous improvements are seen in practice, we are unable to reach a view on the effectiveness or otherwise of the measures the GDC has implemented. We hope to see an improvement in the GDC's practice for carrying out and recording risk assessments, making timely referrals to the Interim Orders Committee and its timescales for obtaining interim order decisions going forward. We will consider the outcome of the changes implemented by the GDC in this area in the performance review 2014/15 and in our 2014 audit of cases closed at the initial stages of the GDC's fitness to practise process.

The sixth Standard of Good Regulation for fitness to practise: Fitness to practise cases are dealt with as quickly as possible taking into account the complexity and type of case and the conduct of both sides. Delays do not result in harm or potential harm to patients. Where necessary the regulator protects the public by means of interim orders

- 11.46 The GDC did not meet the sixth standard in 2012/13. Given our concerns about the time taken for cases to progress through the fitness to practise process, we continued to consider that this standard is not met in 2013/14. We remain concerned about the GDC's performance against this standard, as the timely progression of cases is an essential element of a good fitness to practise process.
- 11.47 In 2013/14, we noted an increase in:
- The median time taken from receipt of initial complaint to the final fitness to practise hearing determination – from 80 weeks in 2012/13, to 100 weeks in 2013/14
 - The median time taken from receipt of initial complaint to the final Investigating Committee decision – from 33 weeks in 2012/13 to 46 weeks in 2013/14.
- 11.48 Our 2013 audit also identified delays in 30 of the 100 cases that we audited. The delays occurred at various stages of the investigation process and ranged from two weeks to two years.
- 11.49 The GDC highlighted the increase in the number of complaints referred to its fitness to practise team during 2013/14. We note that the quarter four 2013 performance report to Council referred to a 31 per cent increase in complaints received in 2013, compared with 2012, and the challenge this

was posing to its ability to run the fitness to practise process effectively. The GDC has informed us that the extent of the increase, which exceeded its predictions, had exerted pressure on resources within the fitness to practise function, and made it more difficult for the GDC to meet targets consistently.

- 11.50 We note that the quarter four 2013 performance report to the Council raised particular concerns about the GDC's performance against its nine month target for progressing cases from Investigating Committee to a hearing by a final fitness to practise committee (60 per cent in quarter four 2013) and its target to triage cases within 14 days (46.93 per cent in quarter four 2013).
- 11.51 The GDC has also developed a 'backlog' of cases at the triage⁷² and assessment⁷³ stages of its fitness to practise process which it has quantified as 771 more live cases than it would have in a 'steady state'. The GDC plans to address the backlog by introducing an additional casework team for a period of nine months. It expects that the backlog will be resolved within six months of the team becoming operational and is anticipating being in a 'steady state' by the end of December 2014. The GDC informed us that the reasons for the backlog of cases are twofold. Firstly, the increase in cases over the last two years was not anticipated in its budgeting for 2012/13, resulting in a delay in securing additional resources. Secondly, the GDC has experienced high staff turnover during the last year in particular (of the 24 casework staff in post in January 2014, only seven had completed their six-month probationary period at that time). We were concerned to learn that in 2013/14 this has resulted in inexperienced caseworkers managing large caseloads of 70 cases on average.
- 11.52 While we acknowledge the increase in the number of complaints received by the GDC, we consider that it has been slow to respond to this problem. The GDC saw a 44 per cent increase in complaints in 2012 compared with 2011, but appears to have taken no significant action to secure additional resourcing at this stage. We would encourage the GDC to closely monitor complaints levels and act quickly if the backlog worsens. We would also recommend that the GDC takes steps to address what appears to be a staff turnover problem as a matter of priority.
- 11.53 The GDC has informed us that it has and/or is implementing a number of changes to improve its performance in this area, including:
- Increasing the number of Investigating Committee meetings to be held in 2014
 - Increasing the number of fitness to practise panellists, which will enable the GDC to run additional concurrent hearings in the later part of 2014, once the new panellists have built up their experience
 - Restructuring and expanding its fitness to practise teams.

⁷² See footnote 69.

⁷³ At this stage, the complaint/information is assessed to decide whether it should be closed or referred to the Investigating Committee.

- 11.54 We also identified concerns about the accuracy of the performance data which the GDC submitted to us in 2012/13 and 2013/14, and the reliability of its reporting systems. In particular, we note the following:
- The data it provided in relation to 'old' cases in 2012/13 was inaccurate, as it excluded cases it categorised as 'on hold'. These are cases where ongoing investigations are being conducted by another agency (e.g. the police) and the GDC is therefore prevented from actively investigating the case
 - We reported in last year's performance review that the 'GDC has reduced the numbers of cases which were received three or more years ago from 55 in the 2011/12 performance review to 16, which is a positive indicator of improvement in timeliness'. In fact, the GDC has now confirmed that the total number of cases which were more than 156 weeks old was 51 as at 2012/13. However, the GDC has informed us that as the 2011/12 data did not include 'on hold' cases either, there was a genuine reduction in the number of cases that were received three or more years ago
 - It made an error in the provisional data it provided us with in 2013/14, by counting cases twice across the age bands which we ask the regulators to report against. It also included a group of cases in the provisional data which were erroneously categorised as at the Investigating Committee stage, when they had in fact been referred for a full final fitness to practise hearing.
- 11.55 We are very concerned about the provision to us of inaccurate data given that this report is laid before Parliament. We note that the GDC informed us as soon as it became aware of the error and that it has apologised.
- 11.56 We welcome the steps that the GDC has taken and/or is taking to address the delays in its fitness to practise process. However, until improvements are seen in practice, we are unable to conclude that the sixth Standard is met. We hope to see an improvement in the GDC's progression of fitness to practise cases going forward. We will consider the outcome of the initiatives introduced by the GDC in this area in the performance review 2014/15. We will also look to see if there has been any improvement in the timeliness of the GDC's handling of complaints in our 2014 audit of cases closed at the initial stages of the GDC's fitness to practise process.

The seventh Standard of Good Regulation for fitness to practise: All parties to a fitness to practise complaint are kept updated on the progress of their case and supported to participate effectively in the process

- 11.57 The GDC met the seventh Standard in 2012/13. In 2013/14, we noted the improvements it had made to its processes and guidance for witness support. However, we have concluded that this standard is not met, due to concerns about the GDC's failure to consistently update parties on progress during fitness to practise cases, and, more generally, to provide good customer service.

- 11.58 During 2013/14, the GDC undertook a number of activities to improve its performance against this standard, specifically in relation to supporting witnesses to participate effectively in the process. These included:
- Replacing the previous witness support leaflet with two leaflets: the first for complainants whose case has been referred to a final fitness to practise panel hearing by the Investigating Committee; and the second for complainants when they have been called to act as a witness. Both leaflets have received a 'Plain English' Crystal Mark
 - Enhancing the witness advice section of the GDC's website to add an information sheet about the witness support officer, as well as a video which includes interviews with staff from the hearings team and a current fitness to practise panellist
 - Providing training for GDC staff (and additional training for the witness support officer) from Victim Support
 - Developing a standard information template to send to witnesses in advance of the hearing, as well as a feedback form for witnesses, and undertaking ongoing analysis of the feedback received.

11.59 However, we saw evidence of poor performance in terms of providing updates to the parties in fitness to practise cases, and providing a good level of customer care. In particular, in our 2013 audit report, we identified 75 instances of poor customer service across 54 cases. These instances included the GDC's failure to provide updates in accordance with its target (every six weeks) in 25 of the 100 cases that we audited: inaccurate letters being sent out; failures to apologise for poor service once it had been brought to the GDC's attention; failures to promptly acknowledge correspondence; and sending correspondence to an incorrect address. In addition, we note that the GDC's own compliance team identified that the GDC had only kept all parties fully informed, in accordance with its six-week target, in 31 per cent of the 118 cases audited.

11.60 Good customer service is essential to maintaining confidence in a regulator. Based on the above evidence, we concluded that the GDC did not meet the seventh Standard during 2013/14. We will follow up on the GDC's performance in this area in the performance review 2014/15 and in our 2014 audit of cases closed at the initial stages of the GDC's fitness to practise process.

The eighth Standard of Good Regulation for fitness to practise: All fitness to practise decisions made at the initial and final stages of the process are well reasoned, consistent, protect the public and maintain confidence in the profession

11.61 The GDC met the eighth Standard in 2012/13 (having previously not met the standard in 2011/12) after we identified an improvement in the quality of its recorded decisions during our 2012 audit of cases closed at the initial stages of the fitness to practise process. In the performance review report 2012/13 we said that we would look for further evidence of good quality decisions by the GDC in our 2013 audit.

- 11.62 We are therefore disappointed to report that our 2013 audit identified concerns about the GDC's decision-making in 36 of the 100 cases that we audited. For the most part, our concerns related to inadequate reasons being recorded and/or communicated to the parties, rather than inappropriate case closures which presented risks to public protection.⁷⁴ However, ensuring that detailed reasons are given for decisions, which clearly demonstrate that all the relevant allegations/issues have been addressed, is essential to maintaining public confidence in the regulatory process. The provision of well-reasoned decisions also acts as a check to ensure that the decisions themselves are robust.
- 11.63 In addition, we note that the GDC's own internal audit for quarter three 2013 highlighted concerns about its decision-making at the triage stage.⁷⁵ The audit provided an overall rating of 'provides limited assurance'. It confirmed that none of the issues raised in the audit represented a 'clear and definitive threat' to patient safety. However, the audit found:
- Thirty one per cent (99 of 315 decisions audited) of decisions made at the triage stage were 'questionable'. Sixty five per cent of those 99 decisions considered questionable were decisions to adjourn rather than final decisions
 - In 12 per cent of cases, insufficient reasons were given for decisions
 - In 16 per cent of cases, potentially deficient decisions to close cases were made. This included cases which were closed despite complainants requesting further time to provide information or consent to proceed
 - Several instances where there was a lack of reasons for decisions to allocate or close cases.
- 11.64 Many of the findings reflect the concerns that we highlighted in our 2013 audit. We note that the GDC is taking action to address these concerns, including briefing staff about the findings of the audit. However, we would encourage the GDC to consider whether there are any other steps it could take to improve its performance against this standard.
- 11.65 In relation to final fitness to practise decisions, we note that during 2013/14 we lodged two court appeals against 'unduly lenient' GDC final fitness to practise panel decisions under our powers which allow us to review all final fitness to practise decisions to consider whether they are unduly lenient and do not protect the public. We have also fed back learning points to the GDC that its decisions contain an inadequate level of detail about the panel's findings and decisions.
- 11.66 Given the evidence of poor quality decisions by the GDC, we do not consider that this Standard is met. We will follow up on the GDC's performance in this

⁷⁴ There was, however, one case where we had significant concerns about the final decision which was an application for Voluntary Removal. See paragraph 2.55 of: Professional Standards Authority, 2013. Audit of the General Dental Council's initial stages fitness to practise process. Available at: <http://www.professionalstandards.org.uk/docs/default-source/audit-reports/gdc-ftp-audit-report-2013.pdf> [Accessed 22 May 2014].

⁷⁵ See footnote 74.

area in the performance review 2014/15 and in our 2014 audit of cases closed at the initial stages of the GDC's fitness to practise process.

The ninth Standard of Good Regulation: All final fitness to practise decisions, apart from matters relating to the health of a professional, are published and communicated to relevant stakeholders

The tenth Standard of Good Regulation: Information about fitness to practise cases is securely retained

- 11.67 The GDC met the tenth Standard in the performance review 2012/13 (we reported inconsistent compliance in the previous performance review), after undertaking further training with its staff to raise awareness of its information security policies, and the introduction of electronic bundling which was intended to reduce the risk of data security breaches.
- 11.68 We are therefore disappointed to report that we have seen a decline in the GDC's performance against this Standard in 2013/14. We are also disappointed that a number of data breaches that occurred in 2013/14 related to the GDC's erroneous publication of fitness to practise decisions (in 13 cases), which impacted on its ability to meet the ninth Standard of Good Regulation.
- 11.69 Our 2013 audit identified a total of 12 breaches of confidentiality and/or data security. We consider that this is an unacceptably high number of incidents in a sample of 100 cases. Examples of the types of breaches we saw were as follows:
- Information being sent to unrelated parties
 - Information being sent to a complainant about another matter involving the registrant
 - Incorrect identification of a registrant who was then sent information about the case
 - Information relating to another case being included in a bundle to National Clinical Assessment Service (NCAS)
 - Dental records being returned to the wrong dentist
 - Orders being published on the GDC's website which should not have been made public (in two cases)
 - Caseworkers sharing information about cases with third parties where there was no apparent consent for them to do so
 - A registrant being sent a copy of an internal email which disclosed that there was a police investigation and a CQC investigation into the owner of the practice at which the registrant worked.
- 11.70 The GDC informed us of two further data security breaches which it reported to the Information Commissioners' Office (ICO) during 2013/14:
- On 10 July 2013, the GDC self-reported a data breach to the ICO arising from accidental publication (in 11 cases) of private conditions relating to a registrants' health. The GDC reviewed the matter under its serious

incident reviews process, and it was reported to the Audit and Risk Committee. The ICO decided that no further action was necessary, and confirmed that the case had been closed. We understand from the GDC that it has improved its process for making changes to the online register to minimise the risk of this happening again. We are particularly concerned about this incident, which resulted in private health conditions being visible on the GDC's online register for approximately one month. We also noted that the GDC did not identify the problem itself and it was brought to its attention by one of the registrants in question. We understand that the issue arose due to problems with the transfer of data from the CRM system to the online register (see our concerns at paragraph 11.25). Incidents of this nature may undermine public confidence in the system of regulation and the GDC as regulator

- In 2011, a registrant who was the subject of a fitness to practise complaint was misidentified when the investigation was opened. The mistake went unnoticed, until the complaint was sent to the wrong registrant. In early 2013, the registrant affected by the data security breach made a complaint to the ICO. The ICO decided not to take any further action in relation to the matter. However, it identified as key learning points the importance of staff training and exhaustive testing and checking being completed before IT systems are reconfigured.

11.71 During 2013/14, a further data security breach was recorded and investigated under the GDC's serious incident reviews process. This incident related to an email which was sent by the registrations team to fitness to practise panel members in error. The email contained a screenshot of a registrant's details, including their date of birth, contact number, and the fact that they had received a written warning.

11.72 The GDC informed us of the following initiatives which it has introduced or plans to introduce in order to improve its performance in this area. These include:

- Revision of induction and refresher training for staff, council members and panellists
- Revision of guidance for staff in relation to responding to requests for information (completed in December 2013)
- Revision of information security policies (completed in April 2014)
- The launch of a '*Think Privacy*' campaign in December 2013, which the GDC said will be a continuous theme of its work
- Electronic bundling for Investigating Committee members
- The introduction of a clear desk policy in the Regulation Directorate and audits of its adherence to it by the compliance team (we note that there was only a 82 per cent achievement rate in quarter three 2013)
- The introduction of a process for sending Investigating Committee bundles to informants, registrants and defence organisations on double-encrypted CDs in order to prevent accidental disclosure of information to a third party.

11.73 We welcome the steps the GDC has taken and/or is taking to improve its performance in the area of data security. However, we are mindful that data security breaches can adversely affect public confidence in the regulator, particularly where they are of the scale and nature we have seen in 2013/0214 (and that we have seen in previous performance reviews). Until improvements are seen in practice, we are unable to conclude that the GDC meets the ninth and tenth *Standards of Good Regulation* for fitness to practise. We hope that the embedding of new policies, guidance and training for GDC staff during 2013/14 will result in fewer data security breaches in 2014/15. We will also look to see if there has been any improvement in the GDC's handling and retention of information about fitness to practise cases in our 2014 audit of cases closed at the initial stages of the GDC's fitness to practise process.

12. The General Medical Council (GMC)

Overview

- 12.1 In the performance review 2012/13, we found that the GMC met all the *Standards of Good Regulation*. In 2013/14, we found that the GMC continued to meet all the *Standards of Good Regulation*.
- 12.2 We note that the GMC consulted widely with stakeholders and undertook surveys and reviews in 2013/14 in order to improve its understanding of its register and the context in which it exercises its functions. It also gathered extensive information to serve as a resource to help improve its performance in the future.
- 12.3 Examples of the GMC's information gathering exercises during 2013/14 (which we comment on in more detail by reference to the relevant *Standards of Good Regulation* below) include:
- The continued and effective use of the GMC's Regional Liaison Service and Employer Liaison Service (see paragraphs 12.11–12.12 and 12.57–12.58)
 - The *Shape of Training* review (see paragraphs 12.19–12.21)
 - The Revalidation Implementation Advisory Board (RIAB). The RIAB helps the GMC monitor revalidation by gathering and analysing information from doctors, Responsible Officers (ROs), patients, employers, and the public (see paragraph 12.30)
 - The *National Training Survey* (see paragraphs 12.34–12.36)
 - The initiation of a survey of complainants (see paragraph 12.52).
- 12.4 We consider these activities show that the GMC has sought to understand the regulatory environment in which it operates, and to draw on wide sources of information to assist it in carrying out its functions. We consider that this approach represents good practice. We expect that the GMC's wide collection and analysis of data will prove valuable as it aims to continue to improve its performance in the future.

Guidance and standards

- 12.5 The GMC met the *Standards of Good Regulation* for guidance and standards in 2013/14. For example:
- The GMC published a number of pieces of supplementary guidance in 2013 to help doctors apply its core guidance *Good Medical Practice* (GMP). The supplementary guidance addressed issues such as: maintaining boundaries with patients; personal beliefs and medical practice; acting as a witness in legal proceedings; and financial and commercial arrangements and conflicts of interest
 - The GMC made use of its information resources, including fitness to practise information, when developing guidance. For example, in 2013, it began to use information from its fitness to practise cases to create

learning exercises for use in *Good Medical Practice in Action* (an online resource for registrants)

- The GMC used a variety of methods to engage with its registrants and the public in the development and promotion of its guidance
- The GMC made its guidance available through a number of different media, both traditional and electronic.

12.6 In the performance review 2012/13, we noted the GMC's intention to develop guidance to assist doctors in treating older people. The GMC told us in December 2013 that it had decided new guidance was not necessary, but that it would contribute to a campaign to highlight the role of doctors and the standards people should expect.

12.7 In the performance review 2012/13, we reported that the GMC was undertaking a review of how it develops guidance. The aim was to produce guidance that was widely read, understood, and respected by the medical profession. We note that this work was completed in December 2013 and that a report will be published in June 2014. We will follow up on that report in the performance review 2014/15 and review its relevance to the other health and care regulators that we oversee.

12.8 In the performance review report 2012/13, we also said that we would follow up on the GMC's use of its 2012 research into factors influencing doctors' decisions to follow guidance and standards. The GMC told us during this performance review that the research would inform future guidance and methods to encourage registrant adherence to GMP and supplementary guidance. We are supportive of this and will revisit the use of this research in the performance review 2014/15.

Guidance supporting Good Medical Practice

12.9 In the performance review report 2012/13, we commented on the new edition of GMP (published in April 2013) and the GMC's approach of supporting it through supplementary guidance and resources to encourage understanding of how the guidance is applied in practice. The first of these resources was *Good Medical Practice in Action* – a collection of practical interactive scenarios to help registrants apply GMP to their practice published in April 2013. The GMC provided evidence during this performance review showing that the resource was being used by registrants and that it had been well received.

12.10 The second resource was *What to Expect from your Doctor* – a guide for patients based on GMP. The GMC worked with several patient-support organisations to promote and distribute this resource including: Patient Advice and Liaison Services; the Citizens Advice Bureau; and representatives of HealthWatch. We consider that the GMC's decision to produce a supplementary resource for patients explaining its core standards is good practice that other regulators may wish to emulate.

Regional Liaison Service's impact on guidance and standards

- 12.11 One of the primary ways in which the GMC promoted its existing guidance and gathered information when developing new guidance during 2013/14 was through its Regional Liaison Service (RLS). The RLS was used as a means to engage with registrants, students, patients, and the public in consulting on and disseminating information about its guidance and standards.
- 12.12 The GMC used the RLS to promote the 2013 edition of GMP and supporting guidance, and to gather evidence on how registrants implemented the GMC's standards when providing clinical care. We consider that the RLS remains a good idea and a useful conduit of information on guidance and standards.

Education and Training

- 12.13 The GMC met the *Standards of Good Regulation* for education and training in 2013/14. For example, the GMC:
- Produced new guidance to support the medical education and training institutions in their delivery of education. An example of this was new guidance that was published in July 2013 to assist medical schools in supporting students experiencing mental health conditions. The guidance: included steps the medical schools could take to encourage students with mental health conditions to come forward and seek help; makes suggestions about the types of support the schools might wish to offer to their students; and sets out the relationship between student health and fitness to practise. In November 2013, the GMC also published a risk assessment tool on its website to help medical schools identify students who may have mental health concerns. We consider that the GMC's work in this area was an example of good practice, although we note that no assessment of its impact has yet been carried out
 - Piloted a programme for doctors new to practice in the UK to help them understand the cultural context of working in the UK and the professional standards expected of them. The programme includes an online ethical scenario-based self-assessment tool. This tool allows doctors to explore ethical scenarios they may encounter in UK practice. The tool's scenarios cover: confidentiality; raising concerns; respect for patients; team working; and professional knowledge and skills. We consider that this is an important area of work in terms of facilitating consistency in the standard of doctors registered in the UK
 - Continued its quality assurance of the provision of education and training. In 2013/14, the GMC reviewed the quality of medical education and training across the North West by visiting medical schools (Liverpool, Manchester and Lancaster), the organisations responsible for postgraduate training, and the NHS Trusts responsible for delivering training at a local level. The GMC said that this approach allows it to identify trends and issues common to all stages of medical education and training, from undergraduate through to specialty (including GP) training, and to explore transitions between different stages of training. It also reduces the burden on the local education providers (LEPs) being visited

– those providers might otherwise have received a separate quality assurance visit for each stage of training. We consider that this approach seems proportionate and sensible.

12.14 In the performance review report 2012/13, we said that we would follow up on the GMC's planned review of its quality assurance processes. During 2013, the GMC's Council considered (but did not reach any decisions about) the GMC's role in approving educational environments, as well as potential further changes to its quality assurance inspections processes. We will follow this up in the performance review 2014/15.

12.15 We also said that we would follow up on the GMC's review of the impact of *Tomorrow's Doctors* (which was published in 2009) – the GMC's standards for undergraduate medical education. The key focus of this review is to assess the preparedness of recent graduates for medical practice, and for further training. In 2013, the GMC commissioned a literature review, research on the topic, and reviewed information it already held from sources such as its quality assurance processes. The GMC will publish a report on its findings in 2014 and we will follow up on this in the performance review 2014/15.

Concerns raised about Medical Royal College of General Practitioners (MRCGP) examinations

12.16 In March 2013, the GMC commissioned a review of the MRCGP clinical skills assessment examinations to assess whether they met the GMC's standards: in particular, the standards relating to equality, diversity, and opportunity.

12.17 The review identified significant differences between the results achieved by white UK graduates compared to black, minority, and ethnic (BME) UK and especially BME international graduates, as well as significant differences between male and female graduates.

12.18 The GMC has told us that it is considering the report's recommendations, and in the meantime it is working with all the Royal Colleges to ensure their examiners have suitable equality and diversity training. We will revisit this in the performance review 2014/15 to determine what action the GMC has taken in response to the report.

The Shape of Training review and credentialing

12.19 In 2013/14, the GMC co-sponsored research into medical training in the UK (the *Shape of Training* review) and a report was produced. One relatively innovative recommendation in the report was the reference to the need for 'credentialing' as a key priority in the regulation of UK medical training. Credentialing formally accredits a doctor's competency in a defined area of practice. One area of practice where credentialing may be useful is cosmetic surgery. Currently, there are no agreed clinical standards that cosmetic surgeons must meet, and introducing credentialing may improve the public's ability to identify which doctors have the appropriate skills in this field.

12.20 The GMC's Council has agreed, in principle, to set up a regulatory framework for credentialing. The GMC anticipates that any framework would create specialty credentials subject to strict criteria. The GMC has set up a working group to develop a potential credentialing framework – that group is due to

report in 2014. We will follow up on its progress in the performance review 2014/15.

- 12.21 We welcome the GMC's focus on public protection in undertaking this work to improve the regulation of certain specialties; although we note that some important issues are as yet unresolved, including the question of how credentialing will link to the GMC's register.

Revalidation

- 12.22 In the performance review 2012/13 we noted that the GMC had begun revalidation in December 2012, and that it had written to all licensed doctors in January 2013 to inform them of their revalidation dates.
- 12.23 The GMC's system of revalidation is founded on connecting the majority of doctors to designated bodies, such as NHS Trusts (known as a prescribed connection), where they are matched with ROs (see paragraph 12.3). The ROs assess whether doctors have met their revalidation requirements, and make recommendations to the GMC.
- 12.24 The GMC informed us that as at 8 September 2013, 230,999 doctors were subject to revalidation in the first cycle (3 December 2012–31 March 2018). As at 31 December 2013, ROs had made recommendations for 33,047 doctors, or 99.78 per cent of the expected figure for that time period.
- 12.25 As at 30 January 2014, the GMC reported that 1,074 doctors had not responded to requests for information to support their revalidation. The GMC is now withdrawing those doctors' licences to practise.
- 12.26 Also as at 30 January 2014, 35,634 doctors did not have a prescribed connection with a designated body. The GMC categorised these doctors as follows:
- The 1,074 doctors referred to in paragraph 12.25 who had not engaged
 - 21,803 doctors who were either new to the register and did not yet have a prescribed connection, or who were not currently employed and were therefore disconnected from one body but not yet connected to another
 - 12,757 doctors who confirmed that they do not have a prescribed connection with a designated body.
- 12.27 Of the 12,757 doctors who have no prescribed connection:
- Fifty-nine per cent were practising wholly outside the UK
 - Sixteen per cent were based in the UK but not practising.
- 12.28 The GMC's view, which we share, was that these doctors do not require a UK licence to practise medicine. They were advised accordingly.
- 12.29 The GMC has published guidance that will apply to the remaining 25 per cent of the 12,757 doctors (approximately 3,189 doctors) who wish to maintain their licence but who do not have a prescribed connection to a designated body. This group of doctors will be required to provide significant evidence about their practice that has been independently verified by appraisers, employers, and other regulators. We consider that the GMC has set clear and rigorous revalidation requirements for doctors who fall into this category.

- 12.30 The GMC launched the Revalidation Implementation Advisory Board (see paragraph 12.3) in March 2013. The GMC told us that the RIAB focused on data gathering in 2013 and that it will move on to evaluating the data collected during 2014. This should inform the GMC's understanding of how successful revalidation has been to date. We will examine the RIAB's findings in the performance review 2014/15.
- 12.31 The GMC also told us that it used RLS (see paragraph 12.11) to support the implementation of revalidation. The support provided took the form of promotion, advice, and information gathering, as well as communication with stakeholders. The GMC told us that the feedback from doctors, students, and the public on their engagement with the RLS is very positive. The Service represents an approach to stakeholder engagement that is (at time of writing) unique among the regulators we monitor and we are encouraged that it appears to be operating well and is considered to be valuable by its users more than a year after its introduction.

Medical Education Risk Profile

- 12.32 We note the GMC's use of its Medical Education Risk Profile (MERP) as part of its quality assurance of medical education institutions. The MERP collates the risks associated with each education institution's performance that have been identified through means such as the *National Training Survey*, deanery reports, Royal College annual specialty reports, and information given to the GMC by individuals within or associated with the institutions themselves.
- 12.33 The MERP is part of an approach that is aimed at minimising the need for legal intervention by the GMC in the medical education institutions' work by identifying and mitigating risks. We consider this to be an appropriate approach, given that any statutory intervention would inevitably be disruptive.

National Training Survey

- 12.34 During 2013/14, the GMC carried out its annual *National Training Survey* to seek the views of trainee doctors, as well as smaller reviews of medical specialties where specialty-related information was not captured by the main survey.
- 12.35 The GMC shared the results of the *National Training Survey* with all medical education and training institutions, as well as: following up on any concerns with the deaneries and local education institutions; and publishing reports on any particularly serious issues identified in the survey, such as patient safety concerns and the bullying of students.
- 12.36 The GMC told us that the survey is a valuable source of intelligence and one of its primary methods of identifying where targeted inspections of education and training institutions might be required. We will examine how the GMC uses the survey data in future performance reviews, and we will follow up on the GMC's planned review to examine whether the survey remains fit for purpose in the performance review 2014/15.

Targeted inspections of emergency medicine departments

- 12.37 During 2013/14, the GMC carried out targeted inspections of the emergency medicine departments of seven local education providers (LEPs) in England and Jersey. These inspections were prompted by concerns about junior doctors working unsupervised at night. Two of the LEPs were selected as reports suggested they demonstrated good practice. Five were selected as reports suggested concerns.
- 12.38 The GMC produced 'site-specific' reports on each of the LEPs, setting out both concerns and good practice. It also produced a 'summary report' identifying common themes. These were the need for: collective responsibility for patient care across hospital departments; better public education on non-emergency pathways to healthcare; changes to how students are trained; promotion of emergency medicine as a specialty; the combination of multiple emergency medicine services in a given locality; and greater co-operation between LEPs, Local Education Training Boards (LETBs), and deaneries to reduce student burnout and help students transition between stages of training. We understand that the five LEPs where there were concerns accepted the GMC's recommendations and put programmes in place to implement them. We consider that the targeted reviews of the seven LEPs demonstrate that the GMC is able to respond appropriately to specific concerns it receives. We consider this work to be an area of good practice.

Registration

- 12.39 The GMC met all the *Standards of Good Regulation* for registration in 2013/14.
- 12.40 Examples of ways in which the GMC demonstrated that it met the *Standards of Good Regulation* for registration are:
- The GMC made numerous improvements to its processes for managing the registers. For example, it strengthened relationships between its specialist applications team and the Royal Colleges, resulting in: a new process to speed up applications to the General Practice and Specialist registers; and a quality assurance process for awarding Certificates of Completion of Training (which are required before doctors are admitted to the General Practice register or a Specialist register), leading to applications for Certificates being 'right first time' more often.
 - The GMC investigated 141 individuals who were alleged to be either practising while unlicensed/unregistered, or practising outside the scope of their licence. The GMC issued cease-and-desist letters and made referrals to the police where its investigations revealed this was necessary.

The first Standard of Good Regulation for registration: Only those who meet the regulator's requirements are registered

- 12.41 In June 2013, the GMC made a 'one-off' error when it added 97 doctors to its GP and specialist registers early. As soon as the mistake came to light, all of the affected doctors were removed from the specialist or GP registers and

subsequently re-entered on to those registers on the correct date. It commissioned a Significant Event Review (SER), the purpose of which was to investigate the cause of the mistake, the GMC's response to it, any weaknesses that existed in its systems, and what, if any, measures needed to be taken to prevent a similar recurrence in the future. We note that the SER identified that the error had been caused by an IT problem which, though difficult to foresee, might have been identified by more rigorous testing of the software pre-implementation. We are satisfied that there was no risk to patients or the public in this case. All the doctors concerned had already passed their specialist examinations, had been recommended for inclusion on the specialist or GP register by their Royal College, and had paid their fee to join the appropriate register. The doctors were only a few weeks from being included on the specialist and GP registers legitimately and it would have been improbable that any of them could have found a GP or specialist position in the intervening time. There was no impact on patients and the GMC apologised to the doctors concerned, removed them from the registers, and ensured they were re-entered on the correct date. Due to the circumstances of this error, we did not consider that it affected the GMC's overall performance against the first Standard of Good Regulation *for registration*.

English language proficiency

- 12.42 During 2013, the GMC made a number of changes to its approach to doctors' English language proficiency.
- 12.43 In partnership with the Department of Health, the GMC pursued reforms to its legislative framework (that is, the Medical Act and associated secondary legislation). Its objectives were to:
- Ensure that registrants trained in the European Economic Area (EEA) have acceptable levels of English before the GMC licenses them
 - Define clearly the GMC's ability to take fitness to practise action against licensed doctors where concerns are raised about their language skills.
- 12.44 We were consulted on these reforms and expressed some concerns.⁷⁶ However, we recognise that the reforms were motivated by a desire to safeguard the standard of medical care in the UK and uphold public confidence. We also note that the reforms will not affect the GMC's recognition of EEA medical qualifications. We hope that these reforms will contribute to patient protection and public confidence without adding undue complexity to medical regulation.

⁷⁶ Professional Standards Authority, 2013. *Response to the Department of Health consultation: Language Controls for Doctors – Proposed Changes to the Medical Act 1983*. Available at <http://www.professionalstandards.org.uk/library/document-detail?id=b74d589e-2ce2-6f4b-9ceb-ff0000b2236b> [Accessed 22 May 2014]; and Professional Standards Authority, 2013. *Response to the GMC consultation: Making sure all licensed doctors have the necessary knowledge of English to practise safely in the UK*. Available at <http://www.professionalstandards.org.uk/library/document-detail?id=b74d589e-2ce2-6f4b-9ceb-ff0000b2236b> [Accessed 22 May 2014].

12.45 Two other programmes of change are linked to the legislative reforms above: a review of the GMC's Professional Linguistics and Assessment Board (PLAB) and a review of the suitability of the International English Language Testing System (IELTS) used by the PLAB.

12.46 We consider these reviews of the system used for assessment of language skills to be important, given the proposed changes to the legislative scheme detailed in paragraph 12.43 – which mean that the consequences of having inadequate language skills will change. Both reviews are due to be completed in 2014 and we will report on their outcomes in the performance review 2014/15.

Changes to GMC regulations limiting the length of provisional registration

12.47 In the performance review report 2012/13, we said we would follow up on the GMC's proposed changes to the regulations on provisional registration. At that time, there was no limit to the length of time for which a doctor could hold provisional registration, and a number of doctors remained provisionally registered for years.

12.48 Provisional registration allows a doctor to undertake the first year of the Foundation Programme for trainee doctors (F1). One of the reasons for seeking to limit the length of time any doctor could be provisionally registered was to address risks arising from a doctor who has not progressed beyond the F1 year continuing to have prescribing rights for unlimited periods of time.

12.49 In 2013, the GMC drafted regulations to limit the maximum period of provisional registration to three years and 30 days. The GMC told us it will be consulting on these draft regulations and intends to implement them in early 2015 (depending on the outcome of the consultations). We will follow up on the progress of this work in the performance review 2014/15.

Review of the information the GMC publishes about registrants

12.50 In the performance review 2012/13, we said that we would follow up on the GMC's planned review of its publication and disclosure policy in relation to information published about its registrants. That planned review was postponed in 2013/14, pending the completion of a review of the GMC's indicative sanctions guidance (ISG), on the basis that the content of the revised ISG may have a significant impact on the policy. We will follow up on this work in the performance review 2014/15.

Fitness to Practise

12.51 The GMC met the *Standards of Good Regulation* for fitness to practise in 2013/14.

12.52 Some examples of how GMC demonstrated that it met the Standards are as follows:

- The GMC ensured that there are a wide variety of avenues for members of the public to make complaints, taking into account the needs of people with a disability and those without internet access

- The GMC routinely shared fitness to practise information with other regulators, with employers through its Employer Liaison Service, and with medical education and training institutions
- In September 2013, the GMC began a survey of complainants with the aim of gaining a better understanding of their experiences. It intends to publish the results of that survey in September 2014 and we will follow up on this in the performance review 2014/15
- The GMC started a programme of giving doctors copies of complaints about them (that are not referred to a fitness to practise panel hearing) in circumstances where the complainant consents to that disclosure and where the GMC identifies potential learning value for the doctor. As at October 2013, the GMC had sought to do this in 91 cases, but had obtained complainant consent in only 23 cases
- The GMC began to assess doctors who were under suspension or conditions of practice orders before their orders expired. This was to check if the doctor was safe to return to practice (and to allow for fitness to practise action to be taken if not)
- In our 2013 audit of the initial stages of the GMC's fitness to practise processes, we found that GMC had reached well-reasoned decisions in 95 per cent of the cases we audited. While we identified concerns about some aspects of the GMC's case-handling and made some recommendations for improvement, none of these issues impacted on our overall assessment that the GMC's initial stages fitness to practise process protects the public and maintains public confidence.

The sixth Standard of Good Regulation for fitness to practise: Fitness to practise cases are dealt with as quickly as possible, taking into account the complexity and type of case and the conduct of both sides. Delays do not result in harm or potential harm to patients or service users. Where necessary, the regulator protects the public by means of interim orders

12.53 We note that the median time taken in 2013/14 by the GMC to progress cases to a decision at a final hearing has increased by nine weeks, taking it to 97 weeks. The GMC's explanation for this is that the complexion of its caseload that progresses beyond the 'investigation stage' of the fitness to practise process to a final hearing has changed during 2013/14, with significantly more cases than ever before now being concluded by agreeing undertakings with the doctor, rather than being referred for a hearing.⁷⁷ This means that a greater proportion of the cases that are not closed at the

⁷⁷ The GMC is the only regulator where the fitness to practise process allows for cases that would otherwise have to be decided at a panel hearing to be closed by the use of undertakings at the end of the investigation stage of the fitness to practise process. The decision to close a case at that stage by agreeing undertakings with the doctor is taken by two senior GMC staff members (case examiners) or by the Investigation Committee. Undertakings can only be offered if:

- There is no 'realistic prospect' that at a hearing the panel might order the doctor to be struck off (erased); and
- They are satisfied that undertakings are sufficient to protect patients and the public and are an effective way of addressing the concerns about the doctor.

'investigation stage' but progress to final hearings are complex and therefore lengthier to prepare and conclude. The GMC has also noted a decrease in the number of criminal conviction cases it has handled during 2013/14, which has similarly contributed to the change in the balance of its caseload progressing to final hearings.

Information sharing with CQC

- 12.54 We note the GMC's new information-sharing protocol with the Care Quality Commission (CQC) that was secured via a memorandum of understanding in August 2013 and an operational protocol in September 2013. We consider that these protocols are tools which provide practical advice for staff on how and when to share information with the CQC. We recognise that these measures represent action that implement some of the recommendations of Mid Staffordshire NHS Foundation Trust Public Inquiry report,⁷⁸ and are intended to ensure that concerns about fitness to practise or organisational performance are brought to the relevant regulator's attention in good time. We look forward to considering how this protocol works in practice in future performance reviews.

GMC receipt of complaints and triage processes

- 12.55 In early 2013, the GMC carried out an efficiency review of its process for receiving and triaging complaints. The triage process involves an assessment of each complaint to decide if an investigation should be opened, if the matter should be referred to another organisation, or if it should be closed. As a result of the review, the GMC introduced an improved online complaints process, a new information management process, and changes to its decision letters and the forms used to request advice. The GMC reports that following the improvements made to its online complaints page, the number of visits to the page has doubled: this appears to demonstrate that the GMC has successfully made its complaints process easier to access.
- 12.56 Our 2013 audit of the cases closed by the GMC at the initial stages of the fitness to practise process revealed no concerns about the processes in place for receipt and assessment of complaints.

Employer Liaison Service (ELS)

- 12.57 In 2013/14, the GMC conducted a post-implementation review and evaluation of the ELS, including a survey of its users, in 2013, 96 per cent of responding employers said they had found the ELS valuable, 95 per cent said it assisted exchanges of information regarding underperforming doctors, and 84 per cent said it had improved their knowledge of GMC fitness to practise thresholds.

⁷⁸ Francis, R., 2013. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, chaired by Robert Francis QC, 2013. Available at <http://www.midstaffpublicinquiry.com/report> [Accessed 22 May 2014].

12.58 We are pleased that employers are finding the ELS valuable and that its involvement appears to be of significant help to employers determining whether or not a referral to the GMC should be made.

Doctors' Support Service

12.59 In the 2012/13 performance review report, we noted that the GMC had introduced a pilot Doctors' Support Service (DSS) to provide confidential peer emotional support for doctors whose fitness to practise was being investigated, and that the GMC had commissioned the British Medical Association to run the pilot DSS on its behalf.

12.60 In 2013, the GMC commissioned an independent review of the pilot DSS. At the time of writing, that review had not concluded. The GMC told us that the interim review results were positive, with doctors finding the DSS valuable.

12.61 The pilot DSS appears to be an example of good practice by the GMC which other regulators may wish to adopt or adapt, once the GMC has evaluated its effectiveness. We will follow up on the report of the independent review in the performance review 2014/15.

Operation of the Medical Practitioners Tribunal Service (MPTS)

12.62 The MPTS has been in operation since June 2012. The MPTS is an operationally separate part of the GMC, which is responsible for adjudicating on all GMC fitness to practise cases that are referred for a panel hearing (including interim order hearings). The MPTS is funded by the GMC and reports twice yearly to the GMC's Council, as well as reporting to Parliament annually.

12.63 The MPTS conducted an efficiency review of its operations in 2013. As a result, it made a number of changes which it said resulted in:

- An estimated saving of 78 hearing days in 2013
- A reduction in the average length of new hearings from 5.89 to 5.6 days.

12.64 We have raised some concerns with the GMC about the MPTS's ability to consistently provide us with hearing transcripts in order for us to consider exercising our right of appeal. In 2013, delays in providing us with transcripts meant that we were not able to consider three MPTS panel decisions in full before the expiry of the timeframe within which we could lodge an appeal. We note that the processes relating to the prioritisation and monitoring of delivery by external transcribers have now been revised in an effort to address these concerns. Work on a Memorandum of Understanding with the MPTS is underway, removing the need for the redaction of transcripts. The GMC and MPTS have assured us that this should improve the timeliness of the process.

12.65 We note that we have appealed four MPTS panel decisions to the High Court during 2013/14 on the basis that the decisions were unduly lenient. While this represents a significant increase on the number of GMC decisions we have appealed each year in the last three years, the numbers involved are relatively small. We therefore do not consider that it is possible, as yet, to

base any conclusions about the quality of the MPTS panel's decision-making generally on the number of appeals lodged in 2013/14.

Pilot meetings with doctors and complainants

- 12.66 In our 2012/13 performance review report, we said we would follow up on the GMC's pilot programme of holding meetings with doctors and complainants. In the doctors' pilot, meetings take place at the end of the investigation stage, while in the complainants' pilot, meetings are offered at both the beginning of the process and once the case outcome is known. The aim of the doctors' pilot is to provide an opportunity to share information early in the fitness to practise process so the GMC can make better-informed decisions about whether to refer the case to a hearing. At the meetings, the GMC explains its view of the case and there is an opportunity to discuss what evidence the doctor might provide relevant to the GMC's decision on whether or not the case should be referred for a formal hearing or resolved by other means. The meetings with complainants provide an opportunity to ensure that the GMC fully understands the details of the complaint, and for complainants to gain an understanding of the GMC's role and procedures.
- 12.67 The GMC did not complete the meetings pilots in 2013, as it did not meet the target number of meetings. We consider the GMC's objectives regarding complainants to be useful and that could lead to a better experience for them. As we noted in our response to the GMC's consultation before it implemented the pilots, we consider that the doctors' pilot presents a risk of undermining public confidence in the fitness to practise process. Although it aims to increase the information available to decision makers and provide an opportunity to dispose of a larger number of cases (under existing powers to impose warnings or agree undertakings), it will do this more often without a public hearing and thus with more limited information going into the public domain. We note that, once completed, the pilots will be subject to independent review. We will follow up on the outcome of that review with interest in the performance review 2014/15.

13. The General Optical Council (GOC)

Overall assessment

- 13.1 We are pleased to report that the GOC has maintained its performance as an effective regulator across each of its regulatory functions and continued to meet all of the *Standards of Good Regulation* in 2013/14. However, we are concerned about a decline in its performance against the fourth Standard of Good Regulation *for fitness to practise*.⁷⁹ There has been an increase in the median time taken for between receiving a complaint and an interim order decision being made.⁸⁰ We consider that the GOC may be at risk of not meeting this Standard in the future if it does not improve its performance in this area. We note that the new fitness to practise rules introduced on 1 April 2014 should enable the time taken for a decision to be made to be reduced. We discuss this issue further in paragraphs 13.24 and 13.25.
- 13.2 However, the GOC's general performance is notable when considered against the backdrop of the ambitious programme it set itself in recent years to introduce new initiatives. For example: its Continuing Education and Training (CET) scheme commenced on 1 January 2013; the introduction of a customer relationship management (CRM) system is due to go live in July 2014; and its new fitness to practise rules came into force on 1 April 2014. At the same time, the GOC was conducting research into the risks related to illegal practice and the merits of maintaining a regulatory regime for students, and developed proposals for changes in legislation in relation to the regulation of optical businesses. More information about each of these projects is provided in this report.
- 13.3 The GOC has acknowledged that it may have been overly confident in the scale of the programme of work it set itself in recent years, and the additional financial costs incurred to support its delivery. We note that the GOC has recognised and addressed the need for closer oversight of its resources and their deployment and that it has made changes to its governance structure to provide its Council with greater oversight of its work. The GOC also devised its strategic plan for 2014/15 to 2016/17 by concentrating on setting realistic and deliverable goals.

Guidance and standards

- 13.4 The GOC has continued to meet the *Standards of Good Regulation* for guidance and standards. Examples of how it demonstrated this are noted below:
- The GOC provided a clear statement for registrants about its approach to the withdrawal from the UK market (by the sole supplier) of CE-marked fluorescein strips (which can be used by registrants to aid the

⁷⁹ The fourth Standard of Good Regulation for fitness to practise: All fitness to practise complaints are reviewed on receipt and serious cases are prioritised and where appropriate referred to an interim orders panel.

⁸⁰ Regulators can apply for an interim orders which if imposed can restrict a registrant's practice during the course of a fitness to practise investigation. Delays in applications for such orders therefore have the potential to impact on public protection.

identification of vision problems). Before providing that guidance to registrants, the GOC took appropriate legal advice and obtained the opinion of the Medicines and Healthcare products Regulatory Agency (MHRA) as well as obtaining the professional opinion of a clinical consensus panel

- The GOC collaborated with other bodies on articles it published in its e-bulletins to ensure that registrants understood how standards and guidance could be applied in practice. For example, the GOC co-wrote an article with NHS Protect to raise awareness about how registrants can collaborate together to tackle fraud in the NHS. The GOC published in its registrant newsletter an article by the Driver and Vehicle Licensing Agency about new requirements for testing the eyesight of drivers of large vehicles
- The GOC carried out a stakeholder survey which indicated that 60 per cent of registrants thought the GOC's standards are easy to access (only seven per cent disagreed) and 86 per cent of stakeholder bodies felt well-informed about the GOC's standards.

Standards framework review project

- 13.5 We reported in 2012/13 that we would follow up on the outcomes of the review of the *Standards of Competence, Conduct and Performance* that had been initiated that year, as well as the GOC's activities to evaluate the effectiveness of the revised standards.
- 13.6 During 2013/14, the GOC has continued work on this project and expanded its scope to take account of the implications of the recommendations in the *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*⁸¹ (published in February 2013) and the government's response to those recommendations. In particular, the GOC has identified the need to ensure that its standards require registrants to achieve higher professional standards of practice in the care they deliver to patients, and that the standards focus on attributes such as openness, being caring and compassionate towards patients, and ensuring that individual needs of patients (particularly those who are vulnerable) are addressed. As well as obtaining comments from stakeholders, as part of the review, the GOC has conducted an analysis of its fitness to practise data in order to identify which of the current standards registrants have difficulty complying with, and to establish the strengths of, the existing standards.
- 13.7 Alongside the GOC, a number of professional bodies also produce guidance relevant to the optical professions, for example the College of Optometrists' publish the *Code of Ethics* and *Guidance for professional conduct*. In 2013/14, the GOC has contributed to the College of Optometrists' ongoing review of the *Code of Ethics* and *Guidance for professional conduct*. We consider that this should help to ensure the compatibility of the GOC's standards and those of the professional body.

⁸¹ Francis, R., 2013. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, chaired by Robert Francis QC, 2013. Available at <http://www.midstaffpublicinquiry.com/report> [Accessed 22 May 2014].

- 13.8 We do not regard the delay to the GOC's completion of its review of the *Standards of Competence, Conduct and Performance* as unreasonable or unjustified. However, we will expect the GOC to ensure that there are no further delays in completing this work.

Education and training

- 13.9 The GOC has continued to meet all the *Standards of Good Regulation* for education and training. Examples of how it demonstrated this are noted below:
- The GOC continued to work collaboratively with education providers and other agencies in 2013/14 to reduce the duplication of effort in relation to reporting on compliance and performance by education providers. Memoranda of Understanding have been agreed and implemented with the Quality Assurance Agency and the Office of Qualification and Examinations Regulation to enable these organisations to share information and reports with the GOC
 - Visits to three education providers were conducted in conjunction with the provider's quality review panels, who were conducting their own five-yearly reviews. The GOC found this joint approach to be particularly useful in relation to areas of common interest to both organisations, such as equality and diversity monitoring and governance. We consider that this partnership working demonstrates good practice in that it demonstrates a proportionate and targeted approach to quality assurance
 - The GOC considered it necessary in 2013/14 to devise a remedial action plan for one provider of an undergraduate education programme which was in the process of being accredited by the GOC but which failed to meet the education standards. Students were adversely affected by having to repeat part of their training. The GOC took steps to ensure that the students received additional support to enable them to graduate at the planned time. A full external review of this event will be commissioned to take place at the end of the accreditation process in order to identify learning points for the GOC. We commend the GOC for acting decisively on the evidence in order to uphold standards, and in securing an outcome which meant that the completion of students' training was not jeopardised. We will follow up in the 2014/15 performance review on the GOC's assessment of the outcomes of the external review and how effective the GOC has been in addressing any learning points identified
 - The GOC used learning points identified from its quality assurance of individual programmes to develop additional guidance for education providers. It published guidance about its requirements for providers to:
 - Ensure that students working directly with patients are adequately supervised throughout by an experienced and approved registrant
 - Ensure that students maintain a portfolio of supervised clinical work
 - Demonstrate how they will assess that students have attained core competencies.

- The GOC uses visitor panels (of registrants and non-professionals) to assess education providers and to make recommendations to the GOC about the approval of courses. All visitor panels now include an appointed patient champion who is not a professional. The patient champion plays a particular role in the approval visits: they are responsible for identifying how the education provider has involved patients when developing and then evaluating their training programmes, and they speak to patients and members of the public using the university clinic to capture their experience in respect of trainees' performance. We note that the GOC's approach enables patient views to be considered before conclusions are reached about the quality of education programmes. We consider this modification of approach has enhanced the GOC's performance in relation to assuring education and training for students.

Continuing Education and Training scheme

- 13.10 The GOC's Continuing Education and Training (CET) scheme commenced on 1 January 2013. We noted in the performance review 2012/13 that the scheme was capable of providing assurance about a registrant's continuing fitness to practise because it requires each registrant to undertake a variety of specific developmental activities in each year of a three-year period in order to be retained on the GOC's register (and therefore able to practise).
- 13.11 By the end of the first year of operation on 31 December 2013, 97 per cent of all registrants had completed at least the minimum required activities for that year. The remaining three per cent of registrants received targeted communication from the GOC warning them that they were at risk of being removed from the register unless remedial action was taken. The majority of those registrants responded to the GOC's notification by meeting the CET requirements. Forty-five registrants were removed from the register in April 2014 on the basis that they undertook no CET activities.
- 13.12 Of the total number of registrants who satisfied the CET scheme's requirements for the first year, over half had participated in activities which enabled their practice to be discussed with other registrants in a system known as 'peer review'. Peer review and interaction with other professionals had been identified originally by the GOC as important elements in promoting a culture of openness and self-reflection within the profession, and to support, in particular, those who work alone or have limited contact with other registrants.
- 13.13 We are pleased that the initial data from the first year of the CET scheme showed a good level of compliance by registrants with the GOC's range of requirements, and that registrants have taken the opportunity to use a variety of learning methods. The effectiveness of the CET scheme will be reviewed by the GOC in 2016, following the conclusion of the three-year cycle on 31 December 2015. In the performance review 2014/15, we will look for evidence of the ways in which the process of auditing a sample of registrants' statements reflecting on the impact of their CET activities has identified any fitness to practise issues, or any areas in which clearer standards or guidance are required, or any other learning and improvement opportunities for the GOC. We will be particularly interested in the GOC's assessment of:

- The value of the feedback from patients being routinely submitted by registrants as part of their CPD portfolio of activities which may demonstrate the actual impact of CET activities on registrants' practice
- Whether, and to what extent, registrants who work alone or have limited interaction with colleagues have engaged in the early stages of the CET scheme and participated in peer review and interactive activities.

Assuring the performance of education providers

13.14 The GOC approves in advance the learning activities undertaken by registrants within the CET scheme to ensure that the learning activities meet its standards and will deliver the required learning outcomes for registrants. The GOC has established a process whereby providers of the activities must comply with a Code of Conduct and have mechanisms in place to:

- Verify which registrants have participated in which activities
- Confirm that registrants have achieved the learning objectives of the activities
- Receive and address feedback from registrants.

13.15 In 2013, the GOC began its process of conducting random audits of the learning activities, in order to assure the quality and effectiveness of the learning activities provided by CET providers (as well as to provide a mechanism to identify and verify concerns about providers and activities, if required). At the time of writing, this had not resulted in any CET provider being required to take remedial action. Although relatively early in the scheme as a whole, this does imply that the GOC's procedures to approve the learning activities are robust.

13.16 We are pleased to note that the GOC has established a comprehensive framework within which assurance can be gained about the quality of CET scheme activities.

Registration

13.17 The GOC continued to meet all of the *Standards of Good Regulation* for registration in 2013/14. Examples of how it demonstrated this are noted below:

- Continued efficient processing of applications for registration and retention. This is noteworthy because there was an eight per cent increase in the size of the register during 2013 (approximately 2,000 additional registrants)
- The GOC reported a reduction in the number of registrants being removed from the register for failing to renew their registration in time. The GOC has an online facility through which registrants: record their CET activities during the year; keep their personal and contact details up to date; and can apply to renew their registration. The GOC considers that this online tool has facilitated its communication with registrants, and helped to ensure that deadlines and requirements are well known, as well

as providing a simple mechanism for registrants to use to provide the GOC with information

- In November 2013, the GOC published up-to-date guidance for its three registrant groups (students, fully qualified registrants, and businesses) reflecting a change in the legislation in November 2013⁸² which broadened the category of convictions and cautions which no longer need to be declared to the GOC. We consider that this demonstrates that the GOC responded appropriately and promptly to external legislative developments relevant to its duties as a regulator
- In July 2013, the GOC published a report of research it had commissioned in 2012 to identify the risks associated with optical business practices. The report identified a number of risk areas, including: the competing interests of commerce and clinical care; and risks to public safety in relation to businesses that do not meet the criteria for registration with the GOC fitting contact lenses and selling spectacles to those under the age of 16. In December 2013, the GOC (having first conducted a public consultation) proposed a change from its current legislation that GOC registration was only required if a business used a protected title. The GOC's proposed new approach, which focuses on the actual functions of the optical business, would bring approximately 4,000 businesses within the GOC's regulatory remit. The legislation required to make that change is unlikely to be brought into effect before 2016/17. We welcome the GOC's development of evidence-based recommendations in this area, which should lead to improved patient safety and public confidence in optical business regulation
- In March 2014, following the completion of research on the risks arising from the online sale of contact lenses, the GOC published a proposed strategy to deal with illegal practice. As well as affirming its commitment to its current practice of considering and acting on complaints about illegal practice, the GOC also proposed to: develop a voluntary code of practice for unregistered suppliers who supply contact lenses safely and legally; raise public awareness by providing information about the importance for contact lens wearers to have regular check-ups and follow aftercare advice; and to extend its role in enforcing the law in collaboration with others (for example, trading standards authorities). These suggestions appear to represent a proportionate and targeted response to the risks identified and we will consider in 2014/15 the GOC's performance under the illegal practice strategy implemented
- In July 2013, the GOC consulted on a proposal for it to stop formally registering optical students.⁸³ During the consultation, a number of concerns were raised about the proposed change: in particular, about how employers would deal with any fitness to practise concerns that arise

⁸² Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975 (Amendment) (England and Wales) Order 2013.

⁸³ We note that the GOC shared our view as set out in our 2008 advice to the Secretary of State for Health on the fitness to practise of students and trainees during their education and training, in which we concluded that there was insufficient evidence to suggest that registration of students was necessary to ensure the protection of patients and the public.

in pre-registration training (when students are not under the remit of an education provider). Our response to the GOC's consultation in 2013⁸⁴ set out options for making pre-registration trainees subject to continuing oversight in respect of their fitness to practise. The GOC plans to undertake further research and seek additional stakeholder feedback before finalising its strategy on student registration. We note the Law Commissions included in the draft Bill concerning the regulation of health and social care professions that the possibility of compulsory student registration should be retained for all the regulators.⁸⁵

- 13.18 We note that all GOC registrants are required to have professional indemnity arrangements in place and to make a declaration of those arrangements to the GOC. The GOC does not currently verify whether registrants hold the required arrangements, and has not pursued its planned pilot study to share such data with insurance providers, pending the introduction of legislative change across the regulatory sector.⁸⁶ The GOC plans to develop a proportionate strategy, with other regulators, based upon the assessment of risk – which may mean checking whether a registrant holds appropriate insurance only if a complaint is received about their fitness to practise. We were disappointed that the GOC did not pursue its pilot study in 2013/14, as we consider that the study might have provided valuable information that could have informed the future development of a risk-based approach. However, we note that it might carry out this work in the future and we will be interested to see the outcomes should it decide to do so.

Fitness to practise

- 13.19 The GOC has continued to meet each of the *Standards of Good Regulation* for fitness to practise. However, we do have some concerns about a decline in its performance against the fourth Standard⁸⁷ which are set out in paragraphs 13.21 and 13.22.
- 13.20 Examples of how the GOC has demonstrated it is meeting the Standards are noted below:
- It reduced the median length of time taken to conclude fitness to practise cases (from the date of initial receipt of the complaint to the date of the final outcome) from 99 weeks in 2012/13 to 89.5 weeks in 2013/14. This has been achieved despite a 16 per cent rise in the number of complaints requiring consideration by the Investigation Committee⁸⁸ and a 36 per cent increase in the number of final hearings. This is a positive achievement for public protection.

⁸⁴ Professional Standards Authority, 2013. *Response to consultation on student registration*. Available at <http://www.professionalstandards.org.uk/library/document-detail?id=bd3c589e-2ce2-6f4b-9ceb-ff0000b2236b> [Accessed 22 May 2014].

⁸⁵ Law Commission, Scottish Law Commission, Northern Ireland Law Commission, 2014. *Regulation of Health Care Professionals, Regulation of Social Care Professionals in England*. Available at <http://lawcommission.justice.gov.uk/publications/Healthcare-professions.htm> [Accessed 22 May 2014].

⁸⁶ Health Care and Associated Professions (Indemnity Arrangements) Order 2013.

⁸⁷ The fourth Standard of Good Regulation for fitness to practise: All fitness to practise complaints are reviewed on receipt and serious cases are prioritised and, where appropriate, referred to an interim orders panel.

⁸⁸ The Investigation Committee decides whether there is a realistic prospect of proving that a registrant's fitness to practise is impaired and if so, refers the complaint for hearing by a Fitness to Practise Committee.

- The GOC reported that two data breaches occurred in 2013/14. It investigated the breaches and took remedial action to minimise the risk of repetition. Neither breach was considered to be sufficiently serious to be referred to the Information Commissioner's Office (ICO) and from our understanding of the breaches, the risks related to possible harm were minimal. The GOC's strategy (initiated in 2012) to develop data protection, management and retention policies were implemented, and all staff, Council members, case examiners and panel members trained in how to apply them. Due to the completion of the GOC's programme of improvement in relation to information governance, and the fact that no incidents were reported to the ICO, we are satisfied that it has effective processes in place to deal with any incidents.
- We lodged an appeal against one of the GOC's final FTP committee's decisions during 2013/14 under our powers which allow us to review all final fitness to practise decisions to consider whether they are unduly lenient and do not protect the public. We also frequently fed back to the GOC that its final FTP committee decisions were brief and lacking in sufficient detail to enable a reader to clearly understand its decision. We note that the GOC uses our feedback to guide the content of its training for panellists so that panellists are aware of the importance of providing comprehensive, easily understood reasons.
- The GOC is working with the General Osteopathic Council (GOsC) to develop a system for peer review of fitness to practise cases that have concluded. The aim of this process is to provide useful feedback (including the identification of good practice) about the regulator's handling of all stages of the process, including the way in which investigations have been conducted and decisions have been reached and explained. In December 2013, a pilot of this arrangement began and the GOC reviewed cases closed at final fitness to practise stage of the GOsC process. At the time of writing, the GOsC had not reviewed any of the GOC's cases. We consider this to be an example of innovation and collaborative working, and, depending on the final outcome, it may constitute good practice.

The fourth Standard of Good Regulation for fitness to practise: All fitness to practise complaints are reviewed on receipt and serious cases are prioritised and, where appropriate, referred to an interim orders panel

13.21 We note that the median time taken from the receipt of a complaint to a decision being made on an application for an interim order has increased in 2013/14. The median time taken was 18 weeks in 2013/14⁸⁹ compared to 12 weeks in 2012/13. This is of concern, given the potential implications for public protection. The GOC told us that it dealt with some complex cases in 2013/14 which involved criminal investigations and it either did not have the information on which to make an interim order application, or had been

⁸⁹ The Investigation Committee rather than the GOC makes the decision as to whether or not to apply for an interim order.

requested by the police not to make an application immediately. The increased time taken to apply for an interim order in those cases involving criminal investigations has had an effect on the median time for all cases.⁹⁰ We do not consider that the decline in performance in this area alone means that the GOC failed to meet the fourth Standard in this performance review, but it does raise concerns about its performance against it and we will be mindful of this in the next review in 2014/15. We are therefore pleased that the GOC has reassured us that it will make significant efforts to improve its performance in this area.

- 13.22 We note that changes made to the process for applying for an interim order (as detailed in the following section) should make the process quicker. The changes include the Chief Executive and Registrar being empowered to apply directly for an interim order rather than waiting for the Investigation Committee to make that initial decision. We therefore expect to see improvement in the GOC's performance in the performance review 2014/15.

Preparation for new fitness to practise rules from 1 April 2014

- 13.23 In November 2013, the GOC consulted on guidance relating to its new fitness to practise rules, which then came into effect with the rules on 1 April 2014. The new rules implement changes to the way in which the GOC handles fitness to practise cases, makes decisions about their progress, and deals with them at hearings. The GOC anticipates that the changes will mean that cases are progressed more quickly at each stage of the process. Key changes brought into effect by the new rules are set out below.

- 13.24 Under the new rules, the GOC can:
- Decide whether the complaints it receives raise issues about the fitness to practise of its registrants; if not, the GOC can close them. Under the previous regime (the 2005 Fitness to Practise Rules), only the Investigation Committee⁹¹ could close cases, which led to delays because the committee had to consider every complaint
 - Apply for interim orders without a referral from the Investigation Committee. This should result in significantly quicker timeframes for the imposition of interim orders, where necessary pending the outcome of the fitness to practise case
 - Refer certain particularly serious types of cases directly for a hearing in front of a panel, without the case needing to be considered by the Investigation Committee first. One example of the type of case this applies to would be a conviction for a criminal offence that has resulted in a custodial prison sentence
 - Notify a registrant's employer about the outcome of a final fitness to practise hearing. Previously, the GOC only had the statutory power to

⁹⁰ The GOC made 14 applications for interim orders in 2013/14.

⁹¹ The Investigation Committee makes decisions about whether or not a complaint should be referred for a final hearing by the Fitness to Practise Committee.

notify an employer about the commencement of a fitness to practise investigation, not its outcome

- Use two case examiners to make most decisions about whether a case should be referred for a panel hearing. This should result in quicker timeframes for referral to hearings, because the Investigation Committee no longer needs to be involved.

13.25 The rules also made the fitness to practise process fairer and more proportionate by:

- Requiring applications for interim orders to be heard in private rather than in public
- Enabling the Investigation Committee and case examiners to review a decision not to refer a case for a panel hearing within five years of that decision being made (with discretion for the five-year requirement to be waived in exceptional circumstances).

13.26 In order to prepare for the implementation of these changes, the GOC: introduced a full suite of guidance documents for those affected, including registrants and representative bodies; recruited and trained lay and professional case examiners, as well as training staff, Investigation Committee members, and panel members on the new procedures; and undertook an end-to-end review of the entire caseload (in order to identify any causes of delay). The scale and importance of the changes cannot be underestimated and we will look in the performance review 2014/15 for evidence that these rules have improved the GOC's performance.

14. The General Osteopathic Council (GOsC)

Overall assessment

- 14.1 In the performance review 2012/13, we were able to conclude that the GOsC met all the *Standards of Good Regulation*. We consider the GOsC met all the *Standards of Good Regulation* once again in 2013/14.
- 14.2 Many of the GOsC's activities in 2013/14 were characterised by co-operation and collaboration with registrants and the public, other osteopathic organisations, and other regulators. We set out examples of this under a number of the *Standards of Good Regulation* below. In particular, the GOsC worked with the British Osteopathic Association (BOA), the Osteopathic Alliance, the National Council for Osteopathic Research (NCOR), and the Council of Osteopathic Education Institutions (COEI) on eight project plans setting out the objectives, scope, and deliverables of a shared agenda for the development of the profession.
- 14.3 We are supportive of the GOsC's contribution to the development agenda, which we consider to be promising and useful, especially given the relatively small and decentralised nature of the osteopathic register. We note that osteopathy is characterised by a high percentage of practitioners who are not attached to large healthcare organisations such as NHS Trusts; indeed, osteopaths are often sole practitioners. We acknowledge the GOsC's work with its partners to encourage membership of regional osteopathic societies and to incorporate these societies into its planning for continuing fitness to practise (see paragraph 14.17). We consider this has the potential to support continuing fitness to practise (CFTP) and reduce professional isolation by providing forums where osteopaths could draw on the experiences and feedback of their peers.
- 14.4 We will review the progress made on the shared development agenda in the performance review 2014/15.

Guidance and standards

- 14.5 The GOsC met all of the *Standards of Good Regulation* for guidance and standards in 2013/14. It demonstrated this by maintaining the *Osteopathic Practice Standards* and additional guidance and keeping these documents under review. In doing this work, it engaged with a variety of stakeholders. By way of example, the GOsC:
- Produced new guidance addressing issues of significance for registrants; including three pieces of guidance on patients' capacity to give consent (one each for England and Wales, Scotland, and Northern Ireland)
 - Worked with partners including the BOA and the NCOR to develop a resource to categorise the types of risks involved in delivering osteopathic care, and the types of complaints made about osteopaths
 - Reviewed how effectively its core guidance (the *Osteopathic Practice Standards*) has been implemented since its introduction in September 2012. We consider it is desirable for regulators to measure the effectiveness of their core guidance periodically, especially where that

guidance has recently been introduced. We will ask about the outcomes of that review in the performance review 2014/15

- Promoted its guidance through its monthly e-bulletin, bi-annual fitness to practise e-bulletin and bi-monthly magazine, and developed e-learning resources to help registrants put Osteopathic Practice Standards into practice.

Effectiveness of osteopathic regulation research

14.6 In December 2012, the GOsC's Council agreed to commission a large piece of research into the effectiveness of osteopathic regulation.

14.7 The GOsC made the following progress on this research in 2013/14:

- In July 2013, the GOsC appointed three academics from the universities of Warwick, Nottingham, and Oxford to conduct the research, each with extensive expertise and experience in the study of professional regulation
- The GOsC Council approved the scope of the work on 27 February 2014 following receipt of the researchers' first report.

14.8 We consider that commissioning this research is an example of innovation and good practice. We expect that the research outcomes will provide insights into the ways osteopaths interact with the GOsC's regulatory regime, and may help improve their compliance with professional standards, and therefore ultimately patient care.

Advertising standards

14.9 We consider that compliance with advertising standards is important to maintaining public confidence in osteopathy. From July to September 2013, the GOsC reviewed over 2,800 registrants' websites in order to assess their compliance with advertising standards. The GOsC identified 90 websites that raised potential concerns. This represents a substantial reduction in the number of such concerns by comparison with the results of a similar review in 2010/2011 (that review identified more than 300 concerns). The GOsC was able to resolve the 90 concerns, either through registrants agreeing to make changes to their advertising or by the GOsC directing them to the Advertising Standards Authority (ASA) for advice. The GOsC followed up on these matters until it was content that registrants had removed the advertising and made amendments to its satisfaction, or to that of the ASA.

14.10 The GOsC also promoted registrant compliance with advertising standards by clarifying the information shown on its registrant-only website ('the o zone') about how registrants can obtain ASA advice about their advertising.

Consultation on new standards

- 14.11 In 2013, the GOsC consulted on two new pieces of guidance for registrants. The first piece of guidance concerns patients' capacity to give consent, and the second is about the 'Rule 8'⁹² procedure for disposal of fitness to practise cases.
- 14.12 In developing these pieces of guidance, the GOsC engaged with registrants and the public through its Public and Patient Partnership Group and a number of focus groups brought together for specific consultations.
- 14.13 The GOsC told us that registrant and public involvement was invaluable in developing the guidance. For example, in the case of the 'consent' guidance, the consultations identified the need for more practical scenario-based examples, and less technical/legalistic content.
- 14.14 We note that the GOsC also engaged independent reviewers to analyse the results of some of its consultations. We consider this to be a prudent measure likely to assist the GOsC to improve its consultation processes.

Education and training

- 14.15 The GOsC met the *Standards of Good Regulation* for education and training in 2013/14. For example, the GOsC:
- Evaluated its student fitness to practise guidance and provided additional detail about the information that osteopathic education institutions (OEs) should provide on student fitness to practise matters
 - Carried out quality assurance review visits of two OEs and published reports about this work
 - Developed tools to measure student osteopaths' views on professionalism, and compared students' views on sanctions with those of faculty members. The GOsC found that these views were mostly aligned except in relation to dishonesty. The GOsC then arranged discussion sessions and good practice seminars with OEs aimed at addressing this disparity between students' and OEs' views
 - Drafted and consulted on osteopathic pre-registration guidance following the previous work done in 2012/13 to align education outcomes with the GOsC's core guidance (*Osteopathic Practice Standards*).
- 14.16 The GOsC also continued to make good progress in developing its plans for CFTP, as detailed below.

⁹² Rule 8 is a mechanism which allows a fitness to practise panel to order a case to be concluded by way of an admonishment, without a full hearing taking place. This is only available if the panel considers it appropriate, and if the osteopath accepts all of the allegations (including admitting unacceptable professional conduct and/or professional incompetence).

Continuing fitness to practise

- 14.17 We noted in the performance review 2012/13 that the GOsC had presented the results of a pilot of a proposed CFTP scheme to its Council early in 2013. Throughout 2013, the GOsC continued its work with stakeholders to develop the scheme, and it published a draft CFTP framework in October 2013.
- 14.18 The GOsC's proposed scheme involves a combination of registrants' self-reflection, objective evidence, and peer review. This is then assessed in order to decide whether or not the osteopath remains fit to practise and, if not, what support they need in order to reach the appropriate standard. The scheme was partly founded on the principle of 'formative space', based on research suggesting that professionals are more likely to behave in accordance with standards if they have access to a forum in which to discuss the standards and any incidents that may have occurred in the course of their practice. The GOsC has commissioned research to explore this in the osteopathic context (see paragraphs 14.6 and 14.7).
- 14.19 The GOsC's approach is that the 'formative space' required for the proposed system could be provided by various organisations, including the BOA and the regional osteopathic groups it encourages its registrants to join, as well as employers and OEIs. The GOsC's focus to date has been on the role that these groups might play in its proposed CFTP scheme and the type of quality assurance that would be needed.
- 14.20 We would encourage other regulators to make use of any lessons emerging from this work that may be relevant to them and their registrants. We look forward to examining the GOsC's further work in relation to the implementation of CFTP in the performance review 2014/15.
- 14.21 Beyond the GOsC's CFTP work, there are two other activities that we will revisit in the performance review 2014/15.

Student fitness to practise

- 14.22 The GOsC told us that it has clarified the information it requires from OEIs about student fitness to practise cases. We note that the majority of OEIs have apparently agreed to provide the information that the GOsC requires.
- 14.23 However, we also note that this clarification was only deemed necessary because in early 2013 the GOsC received a report that a single OEI was destroying student fitness to practise data one year after the conclusion of cases. The OEI in question has subsequently refused to provide the GOsC with any details of findings or sanctions relating to student fitness to practise at all.
- 14.24 This state of affairs raises concerns about whether or not the GOsC can assure itself of the fitness to practise of graduates of that aforementioned OEI who are seeking registration with the GOsC for the first time. It may also raise a wider concern about whether or not other health and social care regulators can properly assure themselves in relation to the registration of any non-osteopathic graduates of that OEI. We note that, at the date of writing, the GOsC was considering the options open to it. We will follow up on any further action the GOsC takes during the performance review 2014/15.

Review of the GOsC's quality assurance process

- 14.25 Since 2011/12, the GOsC has been reviewing its process for quality assuring OEIs' education programmes and qualifications, in order to make that process more proportionate and less bureaucratic, while maintaining its level of assurance.
- 14.26 In 2013, the GOsC had an opportunity to test the improvements it had made (in 2012) to the format of the quality assurance visits, the reporting of those visits, and the training provided to those conducting them. The feedback from the two OEIs that were subject to the improved process in 2013 was positive. In February 2014, proposals for further changes to the quality assurance processes (such as clearer guidance for OEIs, and additional ways to gather information about the quality of educational courses from patients, students, and OEI staff) were presented to the GOsC's Council.
- 14.27 We consider that the objectives and proposed scope of this ongoing review align with the principles of right touch regulation because the review seeks to maintain appropriate levels of regulatory oversight while reducing both the burden placed on OEIs and inefficiencies in the assurance process. We will revisit the GOsC's progress in reforming its quality assurance process in the performance review 2014/15.

Registration

- 14.28 The GOsC met the Standards of Good Regulation for registration in 2013/14. For example, the GOsC:
- Introduced new tools such as a 'character assessment framework'⁹³ and a new registration manual for GOsC staff, aimed at ensuring that the registration process is managed effectively
 - Published detailed information for use by any EU/EEA or Swiss national who wishes to provide temporary and occasional services in the UK. This include guidance for the applicant, as well as a GOsC statement about temporary registration
 - Amended its registration application and renewal forms to reflect the changes to the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975 (as a result of Legal Aid, Sentencing and Punishment of Offenders Act 2012)
 - Improved the content and accessibility of its register by: making its register search feature more prominent on its website; providing clearer guidance about how to search the register; including more information about registrants on the register; and linking register searches to advice about how to report an unregistered practitioner. These changes were implemented as a result of information collected by the GOsC from those using its register⁹⁴

⁹³ A tool to help GOsC staff decide whether applicants meet the GOsC's good character requirements when considering applications for admission to the register

⁹⁴ The GOsC did not carry out a public survey of the usability and accessibility of the online register, although it did make changes based on information it had obtained from a variety of means such as its 'contact us' forms.

- Monitored the use of the osteopathic profession's protected titles and issued 'cease and desist' notices. The GOsC also introduced a process for ensuring that those who report concerns about unregistered practitioners practising osteopathy are informed about the action taken by the GOsC.

14.29 In the performance review 2012/13, we said that we would follow up on the GOsC's planned survey of all registrants who joined the register in 2013. In fact, the survey closed in April 2014, just after the end of the period covered by this review; we will therefore review the survey outcome in the performance review 2014/15.

Promotion of osteopathy as a regulated profession

14.30 During 2013/14, the GOsC conducted a campaign to raise awareness of osteopaths as regulated professionals. It encouraged osteopaths to display promotional materials, identity cards and registration certificates prominently in their clinics. Upon request, it also supplied registrants with a personalised logo combining the GOsC title with the registrant's registered name and number.

14.31 As osteopaths provide healthcare, mostly independently and outside managed environments such as hospitals, we commend the GOsC's work to raise patients'/service users' awareness that osteopaths are statutorily regulated health professionals who must comply with the GOsC's standards.

Extension of the time that a registrant's fitness to practise history is published on the register

14.32 The GOsC approved a new fitness to practise publication policy in October 2013, which extended the length of time for which a fitness to practise sanction is shown on the public register. The increases were as follows: admonishments – the length of time has increased from 28 days to 6 months; conditions – the length of time has increased from the order's duration to its duration plus one year; suspension – the length of time has increased from the order's duration to its duration plus two years; and striking off – the length of time has increased from 10 months to 5 years.

14.33 We consider that the GOsC's new policy represents an improvement in practice. It is also consistent with the recommendations we have previously made⁹⁵ about the approach that regulators should take to the publication of fitness to practise sanctions.

Fitness to practise

14.34 The GOsC met the *Standards of Good Regulation* for fitness to practise in 2013/14. For example, the GOSC:

- Commissioned an external consultant to audit the decisions made by its Investigating Committee (IC) in order to identify baseline data to be used

⁹⁵ CHRE, 2010. *Health professional regulators' registers: maximising their contribution to public protection and patient safety*. Available at <http://professionalstandards.org.uk/library/document-detail?id=6375dd8e-8636-4e60-bab7-05a516c572ae> [Accessed 22 May 2014].

to monitor the effectiveness of future improvements to its fitness to practise processes. The consultant reported that all the IC decisions reviewed adequately protected the public and that the IC had been provided with sufficient information to come to its decisions. The consultant also suggested some ways in which the IC's reasoning could be strengthened. We will be auditing the cases closed by the GOsC at the initial stage of its fitness to practise process during 2014, and we will look for evidence that these recommendations have been implemented as part of that audit

- Amended its processes for investigating individual cases, in order to ensure that each case is thoroughly investigated and all the evidence obtained. The amendments include standardising the use of 'Particulars of Concern',⁹⁶ chronologies, and evidence grids across the caseload. The GOsC also hopes that these changes will improve the quality of the IC's decision making and reasons. We will look for evidence of consistent implementation of these changes when we carry out our audit
- Introduced a new *Notification of Fitness to Practise Investigations and Outcomes Policy* in October 2013. As a result, any registrant under investigation is now routinely asked to provide details about their employment and any other arrangements to provide health services (whether paid or unpaid, including activities regulated by another healthcare regulator). If their case is referred by the IC to a formal fitness to practise hearing, the GOsC informs any employer/contractor/other regulator of that referral and of the allegations, as well as of the final outcome. We commend the GOsC for these changes, which we believe will provide better public protection
- Introduced new decision-making guidance for use by the IC, as well as new indicative sanctions guidance (ISG) and a new conditions of practice bank to assist final fitness to practise panels in imposing appropriate, robust, proportionate and workable sanctions
- Introduced new 'suitability criteria' for disposing of cases without a formal hearing under the 'Rule 8' procedure (see footnote 92)
- The median time taken for both investigation and adjudication of cases was within the GOsC's key performance indicators of four and fourteen months respectively
- Organised a focus group for registrants to influence and give feedback on the GOsC's fitness to practise process. The GOsC also used this forum as a means to improve registrants' understanding of and confidence in the process.

⁹⁶ 'Particulars of Concern' provide a clear means of setting out the key issues in a case and a structure for a fitness to practise panel to follow when considering the case.

The quality assurance framework

- 14.35 The GOsC undertook a major piece of work developing a new quality assurance framework for its entire fitness to practise process in 2013/14.
- 14.36 Part of this framework involves the peer review of its investigations by colleagues at the General Optical Council (GOC). The GOsC and GOC began a pilot of this peer review arrangement in December 2013 in relation to cases where a GOsC fitness to practise panel either found that there was no case to answer or where a hearing was cancelled under 'Rule 19'⁹⁷ of the GOsC's fitness to practise rules.
- 14.37 The GOC reviewers concluded that the decisions they examined in the pilot were appropriate. They also made suggestions for improvements to GOsC documentation, and provided advice on best practice relating to disclosure of evidence. The GOsC told us that it intends to continue the pilot once it has another appropriate sample of cases ready for peer review. At the date of writing, the GOsC had not conducted a reciprocal peer review of GOC cases.
- 14.38 The GOsC Council considered other aspects of the proposed quality assurance process in September 2013. These included implementing a system of internal peer review carried out by the GOsC professional standards team.
- 14.39 We consider that the development of a new quality assurance process is likely to improve the consistency of the GOsC's customer service and the timeliness, quality, and rigour of its investigations. The reciprocal peer review arrangements that have been set up with the GOC are novel. We will review the impact of any similar peer review work in the performance review 2014/15 on the GOsC's delivery of its fitness to practise function, as well as assessing whether or not this type of arrangement should be recognised as innovative good practice.

Information governance and data breaches

- 14.40 The GOsC told us that it did not have to refer any data breaches to the Information Commissioner's Office during the performance review 2013/14 period. It also told us about a new information governance framework that it began to pilot in September 2013, which includes a new requirement to maintain a log of adverse incidents, regardless of how serious they are. That adverse incident log is reviewed after every incident (including those that may not constitute a data breach) by the GOsC's senior management team, and is also periodically reviewed by the GOsC's Audit Committee.
- 14.41 The GOsC did not keep a formal log of adverse incidents prior to September 2013, and so it was unable to provide us with any specifics about data breaches that occurred between April and September 2013. While this is a matter of some concern, we are satisfied that, since September 2013, the GOsC has implemented appropriate information governance processes to ensure that information is kept securely and incidents are dealt with

⁹⁷ Rule 19 provides for cancellation of a fitness to practise hearing in 'exceptional circumstances' where a panel decides a hearing cannot properly take place (for example, for reasons of fairness).

appropriately. We will follow up on the GOsC's handling of adverse incidents relating to information governance/data breach in the performance review 2014/15 in order to evaluate the success of the framework that was introduced in 2013.

15. The General Pharmaceutical Council (GPhC)

Overall assessment

- 15.1 The GPhC met all but one of the *Standards of Good Regulation* in 2013/14 and continued to maintain its performance as an effective regulator.
- 15.2 We had concerns about the GPhC's performance against the sixth Standard of Good Regulation for fitness to practise which relates to the timely progression of cases through the fitness to practise process. While we note that there has been some improvement at particular stages in the time taken for cases to progress through the fitness to practise process, we are concerned about the length of time taken for cases to conclude. The GPhC is taking steps to reduce delays in its process and we therefore expect to see improvement in its performance in 2014/15.
- 15.3 The GPhC is in a unique position compared to the other regulators that we oversee, as it regulates premises and professionals. Pharmacies are the point at which the majority of patients will use the services of a pharmacist, and it is vital that the supply of medicines and medical devices to service users is safe and effective. The GPhC cannot currently enforce its *Standards for Registered Pharmacies* because they are not in the form of rules, which is a requirement under the current legislative framework. We are pleased to note that as part of the Rebalancing Programme,⁹⁸ the Department of Health has agreed to amend the legislative framework to remove the requirement for standards for pharmacies to be enshrined in rules. This change, once implemented, will enable the GPhC to use its full range of enforcement powers and therefore protect the public more effectively.
- 15.4 In 2013 it was announced that the GPhC would become the principal inspector of pharmacies. Following this announcement and the introduction of the outcome-focused *Standards for Registered Pharmacies*, the GPhC has begun a programme of work to change its approach to inspecting pharmacies. Some of the changes that the GPhC plans to make (for example, the publication of pharmacy inspection reports) are dependent on the anticipated changes to its legislative framework described in paragraph 15.3.
- 15.5 We acknowledge that our *Standards of Good Regulation* do not incorporate a specific standard relating to the regulation of premises. We will consider how to take this aspect of the GPhC's regulatory role into account when we are revising the performance review process over the next year.

⁹⁸ The Rebalancing Medicines Legislation and Pharmacy Regulation Programme Board is reviewing the balance between pharmacy and medicines legislation and regulation to ensure these provide safety for users of pharmacy services, reduce unnecessary legislation, and allow innovation and development of pharmacy practice. The GPhC is a member of the Board. More information can be found at <https://www.gov.uk/government/policy-advisory-groups/pharmacy-regulation-programme-board> [Accessed 22 May 2014].

Guidance and standards

- 15.6 The GPhC has continued to meet all the *Standards of Good Regulation* for guidance and standards. It demonstrated this by maintaining and keeping under review its standards of competence and conduct and additional guidance, and engaging effectively with its stakeholders in this work.
- 15.7 Examples of how the GPhC demonstrated that it met the Standards were:
- In November 2013, the GPhC introduced a new pharmacy inspection model, ahead of it becoming the principal pharmacy inspector. It developed its *Inspection Decision Framework* with input from its stakeholders. In particular, the GPhC worked with: its professional stakeholders to identify the types of evidence which pharmacy owners could provide in order to demonstrate that they are meeting the relevant standards; and with patient groups to formulate and refine the labels and descriptors that are used to summarise the performance of pharmacies as 'poor', 'satisfactory', 'good' or 'excellent'. Pharmacy performance is now assessed against the *Standards for Registered Pharmacies* which were introduced in September 2012
 - In support of the new pharmacy inspection model, the GPhC introduced a microsite within its website to provide an online resource for pharmacies, with information about standards, guidance and inspections
 - In November 2013 the GPhC issued a background paper *Developing guidance to support the safe and effective supply of Pharmacy (P) medicines* for discussion with stakeholders prior to finalising its guidance. The GPhC took that step following objections that were raised by pharmacy stakeholders (following the publication of the *Standards for Registered Pharmacies* in September 2012) to the approach the GPhC intended to take to the regulation of the open display of pharmacy medicines. We consider that the publication of a background paper to encourage and facilitate discussion of an issue for which there is no current professional consensus is an example of good practice. We will follow up on progress with the development of the GPhC's guidance on this topic in the performance review for 2014/15
 - In January 2014 the GPhC published *Guidance for Pharmacies Preparing Unlicensed Medicines*. This is guidance of a highly technical nature aimed at ensuring the safe preparation of medicines which are not licensed for use in the UK by the Medicines and Healthcare Products Regulatory Agency but which pharmacists are legally permitted to supply in certain circumstances. The guidance has been published in draft format so that the GPhC can obtain feedback on it from registrants and stakeholders before it is finalised.
- 15.8 In the 2012/13 performance review we reported that we would follow up on the outcomes of a GPhC stakeholder survey that was to be used to test awareness and perceptions of the GPhC's core outputs. This work was postponed by the GPhC so that it did not clash with a registrant survey which was carried out in Autumn 2013. We consider that this was an appropriate decision, as running two surveys at the same time might have reduced the

number of registrants who participated in the stakeholder survey. The registrant survey achieved a very good response rate of 60 per cent (particularly when compared against the 10 per cent achieved by the Pharmaceutical Society of Northern Ireland during a similar exercise in 2013/14). An initial analysis of the registrant survey results was published in April 2014. We will follow up on the results of the registrant and stakeholder survey and the GPhC's use of the data obtained from these surveys in the performance review for 2014/15.

15.9 In the performance review for 2014/15 we will also follow up on:

- Progress with the review of the *Standards of Conduct, Ethics and Performance* due to commence in the first quarter of 2014/15. As these are the core standards for registrants it is important that they reflect up-to-date practice and legislation, and that they are focused on patient centred care. We will want to be assured that the review is robust and progressing in a timely manner
- Progress on the publication of the *Guidance for pharmacies supplying medicines over the internet* which is anticipated to take place in Autumn 2014. We recognise that it has been difficult for the GPhC to finalise this guidance, due to the complexities of the legal framework (such as EU legislation) and the evolution of methods of supply. We will seek assurance in the performance review for 2014/15 that any risks inherent in the delay in publication of this guidance since the work was initiated in 2012 have been effectively managed.

Education and training

15.10 The GPhC continued to meet all the *Standards of Good Regulation* for education and training. Examples of how it demonstrated that it met the Standards are noted below:

- In 2013/14 the GPhC carried out a review of its education and training standards: *Future Pharmacists, standards for the initial education and training of pharmacists*. The GPhC undertook this work because it had identified that the learning outcomes set out in the standards required revision in order to reflect both the increasingly clinical role of a pharmacist and the learning from the Francis reports.⁹⁹ The revised standards have not yet been consulted on, pending a timetable being put in place (by Health Education England following proposals put forward by the Modernising Pharmacy Careers Board¹⁰⁰) for proposed reforms to the structure and funding of pharmacist education. We agree that the GPhC's planned approach is appropriate; however, we expect the GPhC to monitor any risks associated with the standards not being updated should

⁹⁹ Francis, R., 2013. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, chaired by Robert Francis QC, 2013. Available at <http://www.midstaffpublicinquiry.com/report> [Accessed 22 May 2014].

¹⁰⁰ The Modernising Pharmacy Careers board was a professional board of Health Education England with responsibility for reviewing the education, training and development of the pharmacy workforce to ensure it can deliver the services of the future for patients and the public. In 2011 it submitted proposals for the reform of pre-registration pharmacist training to the Department of Health. These proposals are under consideration and will be taken forward by Health Education England.

there be any delay in implementing the Modernising Pharmacy Careers board's proposals. We will therefore follow up on progress with this in the performance review 2014/15

- In July 2011 the GPhC was given power to remove registrants from the register for non-compliance with its *Standards for continuing professional development (CPD)* through an administrative process, rather than through fitness to practise proceedings, as previously required. In 2012/13, following the GPhC's audit of all its registrant's CPD records, 99.5 per cent of registrants complied with the standards. In 2013, 46 registrants were administratively removed for failing to carry out CPD
- The GPhC quality assured 87 education courses. We were pleased to note that no serious concerns were raised this year as a result of this process. The GPhC also continued to monitor the progress of the two educational institutions which had produced poor results in the pre-registration examination in 2012, including requesting the institutions to analyse their admission data to look for any correlation between trainees' qualifications on admission and subsequent poor performance. We note that pre-registration trainees who fail the exam are unable to register with the GPhC which means that they are unable to practise and the public is protected. However, it is important that the GPhC tries to understand the reasons for the poor performance of the education institutions, so we consider it took appropriate action when it requested the institutions undertake the analysis noted above
- In Autumn 2013 the GPhC piloted interim accreditation visits to educational institutions, to take place half way through the six-yearly accreditation cycle. The GPhC reported to us that these interim visits provided a useful opportunity to speak with students and staff about the performance of the education institution in a less formal manner. We consider that such visits are likely to prove beneficial as they provide an opportunity for the GPhC to identify risks in the quality of education and training provision, at an earlier point than the six-yearly accreditation visit.

15.11 We would encourage the GPhC to introduce a procedure to facilitate the raising of concerns by students and other parties about the quality of education and training, in order to strengthen its quality assurance processes. Other regulators that we oversee have put such procedures in place, and found them to be a useful source of information, as well as providing a means of identifying risks about the quality of education and training provision outside of the accreditation visits.

15.12 The GPhC's analysis of candidates' performance in the June 2013 assessment demonstrated that candidates who identified themselves as Black-African performed significantly less well than other self-declared ethnic groups. The GPhC is undertaking further analysis and research in conjunction with those educational institutions which demonstrated the worst performance in this area, to see whether this trend can be explained. We will follow-up on the outcomes of this work in the performance review in 2014/15, as it is important that the provision of education and quality is fair for all students.

Continuing Fitness to practise (CFtP)

- 15.13 The GPhC Council agreed to the development of a framework for a CFtP scheme in November 2013. This will accommodate pharmacists and pharmacy technicians, as well as the differing practice areas that these registrant groups work within (for example, community or hospital pharmacy). The framework will have three components: (i) a peer review process, (ii) a review of CPD undertaken, and (iii) the use of external performance indicators. It is proposed that each component will be sufficiently flexible to allow each registrant's individual scope of practice to be assessed.
- 15.14 Registrants' performance will be assessed against the Standards of Conduct, Ethics and Performance. A review of these standards will commence in 2014, as the initial step in the development of the CFtP framework. Implementation of the CFtP scheme is anticipated to take place in 2018.
- 15.15 We consider that the GPhC's approach to developing a CFtP framework (set out in a paper put to the GPhC Council in November 2013)¹⁰¹ demonstrates that it has taken account of our paper; An approach to assuring continuing fitness to practise based on right-touch regulation principles.¹⁰² Before developing the framework the GPhC undertook research to assess the risks, defined the purpose of CFtP, and it proposes to assess both competency and professionalism. It is applying a proportionate approach of building on its existing CPD framework, and developing a model relevant to its diverse registrant groups. We look forward to learning more about the detail of the framework as the project continues.

Registration

- 15.16 The GPhC continued to meet all the *Standards of Good Regulation* for registration in 2013/14. While there was minimal improvement activity, we did not identify any concerns with performance; we concluded that the GPhC continued to maintain accurate registers of pharmacists and pharmacy technicians which were available to the public, and that it operated a fair registration process. The GPhC also commenced the process of moving to a new electronic case management system, which will allow it to make enhancements to its registration function, including the creation of an online registration portal for pharmacies. No other improvement work is planned, pending the introduction of that new electronic case management system.
- 15.17 One activity undertaken by the GPhC this year was to clarify the criteria for registration of pharmacy premises and publish frequently asked questions on its website to assist pharmacies in understanding the registration criteria.
- 15.18 In May 2013 changes were made to the Rehabilitation of Offenders Act 1974. Previously, registrants and applicants for registration into the health and

¹⁰¹ GPhC, 2013. *Developing a framework for assuring the continuing fitness to practise of pharmacy professionals*. Available at <http://www.pharmacyregulation.org/about-us/who-we-are/gphc-council/council-meetings/14-november> [Accessed 22 May 2014]. Item 11.

¹⁰² CHRE, 2012. *An approach to assuring continuing fitness to practise based on right-touch regulation principles*. Available at <http://www.professionalstandards.org.uk/library/document-detail?id=69393f02-d5a3-4ae0-a1bb-a7b437dc3485> [Accessed 22 May 2014].

social care professions in England and Wales were required to disclose to the regulator any criminal conviction or caution. As a result of the changes to the legislation, certain convictions and cautions no longer have to be disclosed. Initially, the GPhC did not implement changes to its registration and renewal processes to reflect this change (due to the level of IT development which would be necessary to change those processes). Instead it provided training to registration staff so that they could provide appropriate advice to registrants/applicants. However, guidance for registrants was published on the GPhC website in April 2014. We consider that the GPhC should have published that guidance more promptly; however we did not consider that the delay was sufficiently serious to impact on our conclusion that the second Standard of Good Regulation for registration was met.

Fitness to practise

- 15.19 The GPhC has met all but one of the 10 *Standards of Good Regulation* for fitness to practise. We consider that the time taken for cases to progress through the fitness to practise process means that the GPhC does not meet the sixth Standard. We discuss this further at paragraph 15.26.
- 15.20 In the 2012/13 performance review we were unable to conclude that the GPhC met the tenth standard (*information about fitness to practise cases is securely retained*) as a ruling from the Information Commissioner's Office (the ICO) in respect of a data breach was awaited. A second breach of a very similar nature subsequently occurred; however the ICO decided to take no further action in both cases. These breaches concern us, but we do not consider they are of such a significant nature as to result in a failure to meet the standard. We discuss this issue further in paragraphs 15.27–15.30 below.
- 15.21 Examples of the activities undertaken by the GPhC to enable it to demonstrate that it met the remaining *Standards of Good Regulation* for fitness to practise are:
- An online version of its complaint form was introduced to allow for easier submission of complaints
 - Guidance for complainants and registrants on the fitness to practise process was published on the GPhC's website
 - Guidance for staff on dealing with vulnerable parties was introduced in April 2013 and revised in September 2013, following input from the Business Disability Forum. Staff received training on dealing with vulnerable parties, which was delivered by the Samaritans and which focused on engaging with individuals with mental health difficulties. We consider that exploring ways to encourage all stakeholders to engage with the fitness to practise process is an example of good practice
 - In March 2013 the GPhC introduced a policy and process for ensuring appropriate referrals to the Disclosure and Barring Service (DBS) and Disclosure Scotland. The policy embeds key principles developed by DBS, the Department of Health and healthcare regulators, including the GPhC. The process should ensure that the GPhC remains compliant with legislation, and that it makes appropriate referrals in an efficient and

timely manner. To date, the GPhC has referred three registrants to the DBS

- The introduction in September 2013 of a monthly bulletin of fitness to practise decisions, which is circulated to NHS Area Health Teams and European regulators. We consider this to be a proactive approach to alerting employers to fitness to practise issues relating to employees and potential employees, and to sharing information with other regulators
- The GPhC introduced a quality assurance function and carried out a review of its investigation processes. This led to a number of initiatives to improve the timeliness of the GPhC's investigations, record keeping, and the clarity of its communications
- In February 2014 the GPhC produced a data report on the ethnicity of registrants who are the subject of fitness to practise proceedings. While the GPhC is cautious about drawing any conclusions from the fitness to practise data, given the small number of registrants and cases involved, it proposes to use this report as baseline data and to explore ways to obtain more qualitative evidence to enable it to identify equality and diversity issues. We commend the GPhC for commencing this work and look forward to following up on progress with this data interrogation project in the performance review in 2014/15
- In our audit of complaints closed by the GPhC at the initial stages of the fitness to practise process in 2012¹⁰³ we recommended that the GPhC review the risks associated with having a single decision maker responsible for closing complaints at certain points in the process. In response to our recommendation, between February and May 2013 the GPhC piloted the use of a second decision maker, to review decisions to close in a sample number of cases. That review did not identify any complaints which had been inappropriately closed; however the GPhC decided to implement a system whereby decisions made to close complaints related to the health of a registrant at an early stage are reviewed by a second decision maker. The GPhC also audited a sample of complaints which had been closed by a single decision maker in September 2013, and did not find any cases that had been inappropriately closed. We remain of the view that it is preferable for any decision to close a case to be taken by two decision makers, to ensure consistency. We recommend that the GPhC continues to keep its single decision maker closures under review.

15.22 In the performance review in 2014/15 we will follow up on the outcomes of changes implemented to the GPhC's existing case management system during 2014 designed to enable the capture of an enhanced range of data including: sources and categories of complaints; equality and diversity data; and data about case progression.

¹⁰³ CHRE, 2012. *Audit of the General Pharmaceutical Council's initial stages fitness to practise process*. Available at <http://www.professionalstandards.org.uk/library/document-detail?id=2ac9bfff-0965-4447-9c4c-0a8b85f795c2> [Accessed 22 May 2014].

15.23 We will also follow up on progress in developing the new electronic case management that has been under way since 2011/12, as this is due for implementation in 2015.

The fourth Standard of Good Regulation for fitness to practise: All fitness to practise complaints are reviewed on receipt and serious cases are prioritised and where appropriate referred to an interim orders panel

15.24 We are concerned about the time taken by the GPhC to put interim orders in place.¹⁰⁴ The median time taken was 14 weeks from receipt of the complaint, which is considerably longer than many of the regulators reported this year. The GPhC informed us that this is because, in a number of cases, adverse information requiring an interim order came to light during an investigation and was not apparent when the complaint was received. The GPhC did not collect data that enabled it to evidence the time taken between receipt of adverse information and the imposition of an interim order. It has informed us that it has now begun capturing this data and we will be able to report on this in the performance review 2014/15. We support this change in practice, as it will enable the GPhC to provide assurances that it acts promptly in seeking interim orders.

The sixth Standard of Good Regulation for fitness to practise: Fitness to practise cases are dealt with as quickly as possible, taking into account the complexity and type of case and the conduct of both sides. Delays do not result in harm or potential harm to patients. Where necessary the regulator protects the public by means of interim orders

15.25 We have reported concerns about the time taken by the GPhC to conclude the cases transferred to it from the Royal Pharmaceutical Society of Great Britain (RPSGB) in the last two performance review reports. In the 2011/12 performance review we reported that the GPhC's target date for concluding these cases was September 2012; in the 2012/13 performance review we reported that 11 cases remained open by March 2013. We were disappointed that three cases still remained open at the start of 2014 (they were closed by 1 May 2014). The GPhC has acknowledged to us that these cases could have been closed earlier.

15.26 We are also concerned to note the time taken to progress cases through the fitness to practise process. While there has been some improvement since 2012/13 in the median time taken from receipt of a complaint to the final fitness to practise hearing, and in the median time taken from receipt of a complaint to the final investigating committee meeting, we note that the median time taken from receipt of a complaint to the final fitness to practise hearing is still too long. We also note a small increase since 2012/13 in the median time taken between the investigating committee meeting until the final fitness to practise hearing. In addition, the number of open cases that

¹⁰⁴ Where a regulator receives a complaint that suggests a registrant poses a significant risk, a prompt application must be made by the regulator to a decision-making panel for an order restricting the registrant's right to practise while the case is investigated.

are older than 52 and 104 weeks has increased. Overall we have concluded that this Standard is not met. We recognise that the GPhC is taking steps to improve the timeliness of its fitness to practise processes. The GPhC has reported to us that in 2013 it reviewed all cases which had been open for more than 15 months, in order to move these forward for closure or a hearing. At the time of writing, the GPhC was reviewing all cases over 12 months old with the same purpose. The GPhC also told us that it has implemented a system to prevent delays building up at the early stages of the investigations process, whereby cases are reviewed by a legal advisor at five weeks, nine weeks and three months after opening. We therefore expect next year to see an improvement in the number of cases which have been open for longer than 52 weeks.

***The tenth Standard of Good Regulation for fitness to practise:
Information about fitness to practise cases is securely retained***

- 15.27 In the 2012/13 performance review we were unable to confirm that the GPhC met the tenth Standard of Good Regulation for fitness to practise, as a ruling from the Information Commissioner's Office (ICO) was awaited, concerning a data breach which occurred in February 2013. This data breach involved the address of a witness being included in a bundle sent to a registrant in advance of a fitness to practise hearing. The ICO decided to take no further action.
- 15.28 The GPhC put measures in place designed to prevent such a breach reoccurring including: providing staff with refreshed guidance and training; the introduction of a bundle checking process; and the introduction of an updated witness statement template to ensure that witness contact details are not included.
- 15.29 In May 2013 a further breach did occur: personal and sensitive data relating to 13 witnesses was included in a bundle sent to a registrant and their solicitor. The GPhC reported this breach to the ICO, who decided to take no further action, having taken account of the procedures that the GPhC had put in place to prevent recurrence and the staff training provided.
- 15.30 We recognise that the measures taken by the GPhC may not have been fully implemented in the three-month period between the two breaches, and that there was an element of human error in both. The GPhC has assured us that it is confident that it has taken appropriate action to mitigate against a further risk of recurrence, and it is working towards alignment with ISO27001 certification for information security management. We expect to see that the measures put in place by the GPhC ensure that it consistently complies with its data protection obligations in future.

16. The Health and Care Professions Council (HCPC)

Overall assessment

- 16.1 During 2013/14, the HCPC has maintained its performance as an effective regulator across most of its regulatory functions and continued to meet all of the *Standards of Good Regulation*.
- 16.2 While we are generally satisfied that the HCPC has performed well, we consider that its performance has declined against the fourth Standard¹⁰⁵ and the sixth Standard,¹⁰⁶ and it has performed inconsistently against the tenth Standard.¹⁰⁷
- 16.3 We concluded that the HCPC's performance declined against the fourth Standard of Good Regulation for fitness to practise because it was not regularly carrying out all required risk assessments in relation to each fitness to practise complaint it received, and because of the time taken to decide to apply for an interim order.¹⁰⁸ We considered that the combination of these factors put the HCPC at risk of not meeting this Standard, but noted that the HCPC is taking appropriate action to remedy its performance. It has also maintained its good performance in 2013/14 from 2012/13 in respect of interim order applications made in those cases where it receives information indicating the need for such an application. We discuss this issue further in paragraphs 16.32–16.35.
- 16.4 The HCPC's performance against the sixth Standard of Good Regulation for fitness to practise declined during 2013/14, in that the median time taken for the HCPC to conclude cases increased by seven weeks compared to the previous rate. Although the median time taken remains reasonable despite that increase, we are concerned to note the downturn in efficiency, which will have affected complainants, witnesses and registrants involved in fitness to practise cases. We are pleased to note that the HCPC has identified reasons for this change and has taken remedial steps, which we explore in more detail in paragraphs 16.36–16.39.
- 16.5 We concluded that the HCPC's performance in 2013/14 against the tenth Standard of Good Regulation for fitness to practise was inconsistent because several data breaches occurred, one of which was serious enough to be reported to the Information Commissioner's Office. However, we note that the HCPC has taken appropriate action to minimise the risk of such breaches

¹⁰⁵ The fourth Standard of Good Regulation for fitness to practise: All fitness to practise complaints are reviewed on receipt and serious cases are prioritised and where appropriate referred to an interim orders panel.

¹⁰⁶ The sixth Standard of Good Regulation for fitness to practise: Fitness to practise cases are dealt with as quickly as possible, taking into account the complexity and type of case and the conduct of both sides. Delays do not result in harm or potential harm to patients or service users. Where necessary the regulator protects the public by means of interim orders.

¹⁰⁷ The tenth Standard of Good Regulation for fitness to practise: Information about fitness to practise cases is securely retained.

¹⁰⁸ Regulators can apply for an interim orders which if imposed can restrict a registrant's practice during the course of a fitness to practise investigation. Delays in applications for such orders therefore have the potential to impact on public protection.

recurring in the future. We look at this in more detail in paragraphs 16.41–16.44.

- 16.6 Aside from these three areas of concern, we consider that the HCPC strengthened its performance in 2013/14, through the involvement of service users and carers in its work. We explain at paragraph 16.8 (fifth bullet) the steps taken by the HCPC to involve service users and carers in the research that contributed to its review of the *Standards of Conduct, Performance and Ethics*. In paragraphs 16.12 to 16.14 we outline the steps taken by the HCPC to expand patients', service users' and their carers' involvement in education and training. The HCPC has a wide stakeholder base (due to the number and variety of professionals that it regulates) and we commend the work it has undertaken to incorporate their views into its work.
- 16.7 2013/14 was the first full year in which the HCPC had responsibility for regulating social workers (in England). We have reported on its performance specifically in relation to the regulation of social workers under two groups of our *Standards of Good Regulation* (education and training, and fitness to practise). This reflects the greater impact in these operational areas (because of the size and scope of its responsibilities in relation to social workers) and does not seek to minimise the scale of the task undertaken across all of the HCPC's functions to assimilate the regulation of the social work profession. The HCPC has identified that the regulation of social workers has had an impact on its performance in relation to its fitness to practise function, which we discuss in paragraphs 16.37 and 16.40. We are pleased that the HCPC's preparatory work enabled it to maintain its performance overall while managing the transition successfully, and trust that it will similarly act upon the learning gained from its experience of dealing with fitness to practise cases about social workers.

Guidance and standards

- 16.8 The HCPC continued to meet the *Standards of Good Regulation for guidance and standards* in 2013/14. Examples of how it demonstrated this are noted below.
- The HCPC maintained its rolling programme of work to periodically revise the *Standards of proficiency*¹⁰⁹ for each professional group it regulates. Revised standards were published in 2013 for four professions (chiropodists/podiatrists, physiotherapists, prosthetists/orthotists, and radiographers).
 - The HCPC published separate standards for those professionals who prescribe medicine (the *Standards for prescribing*). This was in response to a change in legislation which resulted in some members of two professions (podiatry/chiropody and physiotherapy) being allowed to act as independent prescribers in specified circumstances. The standards also apply to supplementary prescribers in those professions, and in

¹⁰⁹ The *Standards of proficiency* are the professional standards which every registrant must meet in order to be initially registered by the HCPC, and must continue to meet in order to remain registered. Each profession regulated by the HCPC has its own specific standards of proficiency.

radiography. The standards have two purposes: they set out the HCPC's expectations of education providers delivering training in prescribing; they also set out the knowledge, understanding and skills the HCPC expects a prescriber to demonstrate on completion of their training.

- The HCPC continued its work with registrants on the importance of professionalism. It discussed this topic at its 'Meet the HCPC' events in 2013/14.
- As part of the work initiated in 2011/12 to review the guidance, *A disabled person's guide to becoming a health professional*, in March 2014 the HCPC's Education and Training Committee considered the outcomes of research that had been commissioned with disabled students and education providers (including staff who support disabled students and those providing students with practice placements involving direct contact with service users). The research highlighted the need for accessible guidance for people with disabilities and recommended the inclusion of personal perspectives from students with disabilities on their experience of training to become health professionals. The HCPC plans to consult on the draft guidance in mid-2014. It also intends to supplement the guidance with filmed case studies with students with disabilities. We are pleased that the HCPC's revised guidance is nearing completion, particularly as it has not been revised since 2006.
- The HCPC continued its review of the *Standards of Conduct, Performance and Ethics*. It is on track to conclude this work in 2016. In 2013/14, the HCPC:
 - Hosted workshops with specific groups of patients, service users and carers to seek their views on the *Standards* and their accessibility. For example, the HCPC: held two workshops in early 2013 with service users with hearing impairments at meetings of the charity, Hearing Link; commissioned Connect (a charity which works with people who have communication impairments as a result of a stroke) to hold focus groups with this group of service users and their carers; and commissioned Shaping our Lives (a service user-led organisation) to seek the views of service users and their carers
 - The HCPC gathered feedback and information from employers, registrants as well as employees within its fitness to practise department (through their work, these staff have direct knowledge of the *Standards* which are most commonly breached by registrants)
 - The HCPC concluded its research with registrants and service users on the relevance of the *Standards*. The key findings from this research include: the *Standards* are generally considered relevant to all of the professions by most professional groups; some specific changes were needed, in particular around strengthening requirements for raising and escalating concerns; and that there needs to be more emphasis on attributes such as empathy, compassion and partnership working between service users and professionals.

16.9 We consider that the breadth of methods used by the HCPC and its inclusion of a number of different stakeholder groups and organisations in its work to comprehensively review the *Standards of Conduct, Performance and Ethics* is an example of good practice.

16.10 In the performance review report in 2012/13, we said that we would follow up on the HCPC's work to map UK-wide advocacy and patient groups in 2013/14. That work has not yet been completed, but the HCPC has undertaken some initial work to identify the range of stakeholders across the UK, and hopes to complete the work in 2014. We have not seen any evidence that the non-completion of this work to date has impacted on the HCPC's performance. However, we look forward to the completion of this work which should enhance the HCPC's understanding of its stakeholders (particularly given the breadth of its work). We hope to report on the completion of this work in 2014/15.

Education and training

16.11 The HCPC continued to meet all the *Standards of Good Regulation for education and training* in 2013/14. Examples of how it demonstrated this are noted below:

- In September 2013, the HCPC published criteria that set out its expectations of education providers offering training that qualifies individuals as approved mental health professionals (AMHPs). The published criteria set out the HCPC's expectations of the standards that each individual will meet once trained as an AMHP. In 2013, the HCPC began its programme of assessing/approving all such programmes against the published criteria: that programme is scheduled to conclude by the end of the 2014/15 academic year
- During 2013/14, the HCPC continued to quality assure its education programmes by means of its annual monitoring process. One education programme's approval was removed, following the identification of concerns during the monitoring process. The remaining 283 programmes that were subject to the annual monitoring process in demonstrated that they continued to meet the HCPC's standards for education and training
- The HCPC's Education Committee also decided what action to take in response to seven concerns raised through the 'raising concerns' policy. It required the issues in one concern to be considered as part of a scheduled approval visit
- The HCPC continued to undertake audits to check its registrants' compliance with its standards for continuing professional development (CPD). Where necessary, registrants were asked for more information to demonstrate that the HCPC's standards had been met. At the time of writing, the audit assessments had not resulted in the removal from the register of any registrants because they had failed to meet the CPD standards.

The third Standard of Good Regulation for education and training: The process for quality assuring education programmes is proportionate and takes account of the views of patients, service users, students and trainees. It is also focused on ensuring the education providers can develop students and trainees so that they meet the regulator's standards for registration

- 16.12 We concluded in the 2011/12 performance review that the *third Standard of Good Regulation for education and training* was not met by the HCPC because its quality assurance process for education programmes did not incorporate the views and perspectives of patients and service users. Work undertaken by the HCPC on two projects relevant to this Standard meant that it was met in 2012/13. We are pleased to report that both projects were completed in 2013/14 as we note below.
- 16.13 A new standard of education and training was agreed in July 2013: that standard makes service user and carer involvement an express requirement in the design and delivery of education programmes. It will be phased in during the 2014/15 academic year and will become mandatory from the start of the 2015/2016 academic year. We are pleased with this development as we have been encouraging the HCPC to introduce such a standard since the performance review 2009/10.
- 16.14 During 2013/14, the HCPC redefined its definition of the non-registrants on its visitor panels,¹¹⁰ removing the requirement for them to have a background in education. This change provides a further opportunity (alongside that noted above) for the views of patients, service users and their carers to be taken into account formally as part of the education programme approval process. These 'lay visitors' will become part of the visitor panels from September 2014.

Regulation of social workers

- 16.15 In 2013/14, the HCPC began a programme that will involve it in approving all social work education programmes (see paragraph 16.16). It also continued to maintain the social work student suitability scheme (see paragraph 16.18).
- 16.16 In March 2013, the HCPC commenced a three-year programme to approve all social work education programmes; by the end of that academic year (Summer 2013), 72 social work education programmes had been visited. The HCPC found that the issues identified were broadly similar to issues arising in its approval of education programmes for other professions, and therefore concluded that it is appropriate to adopt the same approach to programme approval.
- 16.17 Unlike its predecessor in the regulation of social workers in England (the General Social Care Council), the HCPC is not required to hold a register of student social workers. Instead, the HCPC runs a suitability scheme for student social workers, which enables it to:

¹¹⁰ The visitor panels assess programmes run by education providers and are made up of professionals and non-professionals. The non-professionals are known as 'lay visitors'.

- Give advice and guidance to education providers about student fitness to practise issues
- Prevent unsuitable students from participating in any social work education programme in England
- Publish a list of individuals who have been prohibited from participating in any social work education programme in England.

16.18 The suitability scheme is due to run until July 2015, by which time the HCPC will have confirmed whether all social work education programmes meet its standards for education and training. The standards require providers to have processes in place to address any concerns about a student's conduct during the period they are studying, as well as to assess whether a student is ultimately fit to practise. Once an education programme has been approved by the HCPC, decisions about individual students' participation in a specific social work education programme become the responsibility of the education provider.

16.19 We commend the HCPC's evidence-based approach to implementing a mechanism for approving all social work education programmes that both provides adequate public protection and aligns with its approach to the approval of other education programmes.

Continuing professional development (CPD)

16.20 Since 2009, the HCPC has explored the evidence base for, and feasibility of, developing its current continuing professional development scheme. The HCPC's current approach is to require registrants who wish to renew their registration to confirm that they are meeting the HCPC's CPD standards by undertaking learning and development activities. The HCPC then audits a percentage of CPD records in order to assess whether the CPD has had a positive impact on the quality of the registrant's practice. Action is taken to remove a registrant from the register if their CPD records are inadequate to meet the CPD standards.

16.21 The HCPC has undertaken a variety of work to inform its decision about potential changes to its existing system. For example, it has assessed the role and value of patient and service user feedback in providing independent evidence about the practice of the registrant and the quality of their CPD activities, as well as how feedback from such individuals can be obtained and used effectively. A five-year study on professionalism in healthcare professions is also under way which will conclude in 2014/15. We will follow up on the impact of this study on this work in the performance review 2014/15.

16.22 The HCPC commenced further work early in 2014/15, as follows:

- The HCPC is planning to commission research as part of its review of the existing CPD standards and system of audit. Registrants and organisations will be asked to provide feedback on their experience of using the existing CPD systems.
- Research is being commissioned by the Department of Health to analyse data from the HCPC's audit of CPD records in order to identify whether

there is any connection between how registrants engage with CPD activities and the audit process, taking into account variable factors such as age, gender, place of registration, and the nature of the registrant's practice setting (for example, whether the registrant is supervised at work). This work excludes data relating to social workers, as they are not required to renew their registration until the end of 2014.

- 16.23 We are pleased that the HCPC is obtaining an evidence base before deciding whether a continuing fitness to practise model, an enhanced continuing professional development model, a revalidation model, or maintaining the status quo is the most appropriate way forward in ensuring that registrants are up to date and competent.

Registration

- 16.24 The HCPC demonstrated that it met all of the *Standards of Good Regulation for registration*. Examples of how it demonstrated this are noted below:

- Nearly 90 per cent of registrants used the HCPC's online facility to renew their registration. The online system enables a registrant to update their own personal and contact details, and to pay the required fee using a secure method. This makes the renewal process easier and quicker for the registrant and the HCPC, and makes it more likely that the register will be updated regularly.
- In October 2013, in collaboration with two professional bodies, the HCPC hosted its first 'tweet chat' using the Twitter social media site. It used this session to promote the HCPC's renewal and CPD processes. We consider that this use of social media is an example of innovative practice.
- The HCPC amended its application forms for registration and renewal of registration, and its associated guidance to reflect a change in legislation in November 2013¹¹¹ that broadened the category of convictions and cautions which no longer need to be declared to a professional regulator. We consider that this demonstrates that the HCPC has responded promptly and appropriately to external developments relevant to its role as a regulator.
- The HCPC provided information to registrants about the introduction of legislation¹¹² which will make registration conditional upon having professional indemnity arrangements in place (other than for social workers). It also published a schedule of 'frequently asked questions' on its website.
- Early in 2014, the HCPC commissioned NHS Protect to validate the qualifications of registrants with international qualifications. We consider that the outcomes of this work may provide the HCPC with valuable feedback about its registration procedures, as well as identifying whether any action is required in relation to individual registrants.

¹¹¹ Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975 (Amendment) (England and Wales) Order 2013.

¹¹² Health Care and Associated Professions (Indemnity Arrangements) Order 2013.

- The HCPC launched two campaigns to raise awareness among those using the services of HCPC registrants of the importance of checking the register. Given the varied nature of the types of care and treatment provided by HCPC professionals, and the settings within which they work, we are supportive of such communications which have the potential to improve public protection.
- The HCPC took appropriate action when it was notified about potential cases of illegal practice. Between November 2012 and November 2013, the HCPC was notified of 349 new illegal practice cases. Of those cases: 39 remained open at the date of writing; 119 had been closed either because the HCPC had established that there was no illegal practice involved, or because there was insufficient evidence to take action; in 140 cases, respondents complied with the Order following receipt of a warning letter from the HCPC. In a further 18 cases, respondents complied with the Order following the issuing of a cease and desist letter from the HCPC.

The third Standard of Good Regulation for registration: Everyone can easily access information about registrants, except in relation to their health, including whether there are restrictions on their practice

- 16.25 As part of our performance review of the regulators, we conduct an accuracy check of each regulator's register which this helps us assess compliance with the third *Standard of Good Regulation for registration*. This year, we identified one entry on the HCPC's register that was incorrect: a caution was not visible on the registrant's entry on the register when it came into effect (28 days after the hearing at which it was imposed).¹¹³ Our check revealed that the caution was still not visible on the register three weeks after it should have been.
- 16.26 The HCPC informed us that this error occurred because staff had not taken the appropriate action to prompt amendment of the register when the caution came into effect (although they had updated the internal case management system and completed the relevant checklist). Any member of the public or an employer checking the details of this registrant on the HCPC register during the three-week period when the caution was not visible would not have been alerted to the fact that the registrant's fitness to practise was impaired and a sanction had been imposed.
- 16.27 The HCPC informed us that its routine monthly checks identified this error at the same time that it came to light during our register check. The HCPC has taken steps to ensure the error will not be repeated by requiring additional checks be undertaken by a manager after each hearing has concluded. We note that in relation to hearings that conclude near the beginning of a month, almost four weeks can pass before the register is checked. The HCPC's introduction of a further check by a different member of staff to ensure that

¹¹³ The sanction imposed at a fitness to practise hearing does not take effect until 28 days after the date on which it is imposed in order to allow time for the registrant to appeal against the decision (Article 29 of the Health and Social Work Professions Order 2001).

specific action has been undertaken immediately after a hearing should prevent a similar error from recurring.

- 16.28 As the error we identified was a one-off and the HCPC had identified it and taken appropriate steps to correct it and prevent recurrence, we concluded that it did not mean that the HCPC had not met this Standard.

Fitness to practise

- 16.29 While we consider that the HCPC has met all of the *Standards of Good Regulation for fitness to practise*, we consider that during 2013/14 the HCPC's performance declined under the fourth and sixth *Standards of Good Regulation for fitness to practise*, and it was inconsistent against the tenth Standard.¹¹⁴ We discuss this in paragraphs 16.32–16.44 below.

- 16.30 Examples of how the HCPC demonstrated that it met the Standards are noted below.

- In 2013, the HCPC provided additional training for staff in the fitness to practise department to:
 - Facilitate communications with complainants who may experience difficulty in articulating their concerns (over half of the complaints received by the HCPC in 2013/14 involved potentially vulnerable service users)
 - Ensure staff obtain the information required at the first point of contact with complainants
 - Ensure that individuals with mental health problems are appropriately supported during the fitness to practise process
 - Redirect complainants, where appropriate, to other organisations to whom their complaints and enquiries should more appropriately be made.
- The HCPC also began a review of its general communications and its support mechanism for complainants. The review will take account of the increase in the number of individuals with vulnerabilities and/or difficulties in communicating with whom the HCPC now communicates (that increase being a consequence of the HCPC taking over the regulation of social workers in England)
- The HCPC also began a review of its 'complaints about fitness to practise' process¹¹⁵ to ensure that: it communicates the process clearly; it deals with and escalates complaints appropriately; and that it has a robust system of review to identify areas for improvement. We consider that this is a useful piece of work as it is important to public confidence in a regulator that an effective and efficient complaints system is in place

¹¹⁴ See footnotes 105, 106 and 107.

¹¹⁵ This process is for complaints about the HCPC's fitness to practise process rather than a complaint about the fitness to practise of a registrant.

- The HCPC used an escalation process to tackle difficulties it was experiencing in obtaining information from employers, particularly employers of social workers. The escalation process helps the HCPC obtain the information it requires more promptly from local authorities, which should improve the timeliness of its handling of these fitness to practise cases
- The HCPC shared information about registrants with the Care Quality Commission in the interests of public protection and within the relevant legal framework. The information was relevant to the Care Quality Commission's role in respect of organisations under its own regulatory remit. This is an example of the HCPC working effectively with a system regulator as envisaged by the *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* published in February 2013¹¹⁶
- In September 2013, the HCPC initiated a pilot study of the use of mediation as a means of resolving fitness to practise complaints.¹¹⁷ In preparation, the HCPC devised criteria and guidance for use by the Investigating Committee when deciding whether to refer a particular case for mediation. At the time of writing, no cases had been referred for mediation. We consider that the HCPC has taken appropriate steps to explore the value of mediation in fitness to practise cases, and we will review the outcome of this work once it is complete
- Our audit of the HCPC's handling of the initial stages of its fitness to practise process in 2013¹¹⁸ concluded that the HCPC has an effective casework management system in place. However, our audit also identified several cases which demonstrated weaknesses in risk assessment, information gathering, customer care, providing adequate reasons for decisions, record keeping and/or periods of inactivity. We note that the HCPC promptly put in place a plan to address the weaknesses that we identified.

16.31 We note that, in 2013/14, we appealed three of the HCPC's final fitness to practise panel's decisions to the High Court on the basis that the decisions were 'unduly lenient'.¹¹⁹ While this represents an increase on the number of HCPC decisions we have appealed each year in the last three years, the numbers involved are relatively small. We therefore do not consider that it is possible, as yet, to base any conclusions about the quality of the HCPC's panel's decision making generally on the number of appeals lodged in 2013/14.

¹¹⁶ Francis, R., 2013. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, chaired by Robert Francis QC, 2013. Available at <http://www.midstaffpublicinquiry.com/report> [Accessed 22 May 2014].

¹¹⁷ Article 26(6)(a) of The Health and Care Professions Order (2001) enables an investigating committee to decide that mediation can be undertaken in relation to a complaint.

¹¹⁸ Professional Standards Authority, 2014. *Audit of the HCPC's initial stages fitness to practise process*. Available at http://www.professionalstandards.org.uk/HCPC_initial_stages_fitness_to_practise_process_audit_report_2013 [Accessed 22 May 2014].

¹¹⁹ At the time of writing this report, one of the appeals has been resolved, another we expect to be formally settled by Consent Order shortly, as the registrant's application for voluntary removal from the register has been granted and one remains outstanding.

The fourth Standard of Good Regulation for fitness to practise: All fitness to practise complaints are reviewed on receipt and serious cases are prioritised and, where appropriate, referred to an interim orders panel

- 16.32 During our 2013 audit of the initial stages of the HCPC's fitness to practise process, we identified 31 cases in which we had concerns around risk assessments and compliance with the HCPC's operational guidance. We found that risk assessments had not been completed at all required stages in the process in 27 of the 100 cases we audited. It is important that risk assessments are conducted at the start of a case and throughout its lifetime, not least because they may lead the regulator to decide to apply for an interim order to restrict the registrant from practising without restriction while the case is investigated. The HCPC informed us that, in early 2013, it had identified, through its system of case audit and compliance monitoring, that risk assessments were not being completed at all relevant review points in all cases.¹²⁰ The HCPC has taken a number of appropriate steps to improve its performance in this area. It reviewed its open caseload to ensure that risk assessments had been carried out. It also introduced ongoing regular checks throughout the fitness to practise process, to ensure that risk assessments are carried out at the appropriate times.
- 16.33 We note that the median time taken from the receipt of a complaint to a decision being made on an application for an interim order has increased significantly in 2013/14.¹²¹ The median time was 15 weeks in 2013/14 compared to 8 weeks in 2012/13. This is of concern, given its potential implications for public protection. The HCPC is analysing its data in order to establish the reasons for this increase.
- 16.34 We note that at the same time, the HCPC maintained its good performance in 2013/14 from 2012/13 in respect of interim order applications made in those cases where it receives information indicating the need for such an application. The median time taken for this type of application is two weeks.
- 16.35 We concluded, however, that the two areas of concern mean that the HCPC is at risk of not meeting this Standard and we will expect to see improvement in the performance review 2014/15.

¹²⁰ The relevant review points are: when the case is first allocated to a case manager, if significant information is received, and when the registrant is asked to comment on the complaint before it is considered by the investigating committee.

¹²¹ The investigating committee rather than the HCPC makes the decision as to whether or not to apply for an interim order.

The sixth Standard of Good Regulation for fitness to practise: Fitness to practise cases are dealt with as quickly as possible taking into account the complexity and type of case and the conduct of both sides. Delays do not result in harm or potential harm to patients or service users. Where necessary, the regulator protects the public by means of interim orders

- 16.36 We note that the median time taken in 2013/14 by the HCPC to progress cases to a final hearing has increased by 7 weeks taking it to 68 weeks.¹²² The number of cases over 2 years old from the date of receipt had also risen from 23 in 2012/13 to 44 in 2013/14. If the downward trend in the HCPC's performance against this Standard continues we consider that it might place the HCPC at risk of failing this Standard in the performance review 2014/15.
- 16.37 The HCPC considers that its performance should be viewed against the background of increased challenges and complexity since it began regulating social workers. This is because: there has been a 16 per cent rise in the number of cases concluded at hearings compared to 2012/13; hearings have been held in 119 cases social worker cases transferred to the HCPC from the GSCC; the number of days taken per hearing increased to three days; there has been an increase in the number of threatened or actual legal challenges to HCPC decisions by way of judicial review; over half of complaints received potentially involve vulnerable service users; and the HCPC has had to use its statutory powers more frequently to obtain information. In light of the concerns that the HCPC has raised with us regarding changes in its fitness to practise caseload, it appears to us that the HCPC may have previously underestimated the impact on their caseload of the complexity and context of social worker cases, and we hope that the HCPC is able to adjust its approach accordingly.
- 16.38 The HCPC uses internal meetings involving senior staff to identify and address the reasons for the delays in individual cases, as well as to consider whether any individual cases (or parts of them) should be discontinued due to the unavailability of adequate evidence. The causes of delays generally relate to case management issues, such as difficulties in securing witnesses' attendance, lack of registrant engagement, and difficulties in scheduling hearings. Any remedial action identified is then monitored by team managers with the aim of preventing any further delays in case progression.
- 16.39 We consider that the HCPC is taking sensible steps to reduce delays in its case progression. We will look for evidence of improved timeframes in the performance review 2014/15.
- 16.40 The HCPC also intends to analyse in 2014/15 whether there are any differences between the time taken to complete fitness to practise cases that the HCPC inherited on the transfer of regulation of social workers in England, and those that the HCPC has handled from start to finish (because they were initiated in or after August 2012). We note that the median time taken for a case to progress from its receipt by the HCPC to consideration by the

¹²² In 2012/13, the median time taken was 61 weeks; in 2013/14 the median time taken was 68 weeks.

investigating committee¹²³ during 2013/14 was longer for the cases it had inherited (52 weeks) than for all other cases (including social worker cases) (27 weeks). As at the end of March 2014, 28 of the cases that had been inherited by the HCPC had not been concluded. We consider that the planned analysis should enable the HCPC to identify any particular issues affecting this group of cases, and establish strategies to address them. We will follow up on the outcomes of this work in the performance review 2014/15.

***The tenth Standard of Good Regulation for fitness to practise:
Information about fitness to practise cases is securely retained***

- 16.41 The tenth *Standard of Good Regulation for fitness to practise* requires each regulator to retain securely the information it holds about fitness to practise complaints. The HCPC reported to us that there had been five data breaches in 2013/14, four of which were not serious enough for the HCPC to report them to the Information Commissioner's Office (ICO). The ICO took no action in relation to the breach that was reported.
- 16.42 The HCPC took appropriate and proportionate steps to minimise the risk of future data breaches, including: conducting a review of its data security and information management arrangements to identify areas of risk; providing training for all staff and panellists; and providing guidance to legal services providers on anonymising documentary evidence for use in hearings. Data security is also discussed weekly at each management meeting.
- 16.43 The HCPC also gave a written undertaking to the ICO in July 2013 (following a data breach in 2011) around third parties' compliance with data security. The HCPC's compliance with its undertaking was reviewed by the ICO in October 2013 and found to be satisfactory.
- 16.44 While we recognise that it is managing a significant amount of personal and sensitive data, and that it has taken appropriate steps to minimise the risk of future breaches, we consider that these data breaches mean that the HCPC has performed inconsistently against the tenth *Standard of Good Regulation for fitness to practise*.

¹²³ The investigating committee considers whether there is a realistic prospect of a panel making a finding that the registrant's fitness to practise is impaired. If that test is met, the case is referred for a hearing in front of a final fitness to practise panel.

17. The Nursing and Midwifery Council (NMC)

Overall assessment

- 17.1 In the 2013/14 performance review, we found that the NMC:
- Met all of the Standards of Good Regulation for standards and guidance
 - Met four of the five Standards for education and training. It did not meet the Standard which requires the regulator to have in place a system for continuing professional development or revalidation
 - Met three of the five Standards for registration. It did not meet the Standard which requires the regulator to have appropriate registration processes in place, nor did it meet the Standard which requires the regulator to have an accurate and accessible register
 - Met four of the ten Standards for fitness to practise. It demonstrated inconsistent performance against two Standards, which require the regulator to: assess risk throughout the lifetime of a case, and, where appropriate, apply for an interim order to be imposed; and operate a fair process that is focused on public protection. It did not meet four of the Standards of Good Regulation for fitness to practise, relating to: the timely progression of cases; customer service to those involved with the fitness to practise process; decision making; and data security.¹²⁴
- 17.2 Detail about the NMC's performance in each of the areas we had concerns about can be found in the relevant sections of the report. The report sets out the evidence for our assessment of where the NMC's performance has improved or declined since 2012/13.
- 17.3 The NMC's programme of change has continued and we are pleased to note that it has achieved improvements across each of its regulatory functions, even though a number of the *Standards of Good Regulation* were not met. We consider that the NMC's ability to achieve consistent performance improvement may have been affected by its continued high staff turnover (which the NMC is seeking to address).¹²⁵ We are pleased that the NMC has now introduced a formal quality assurance function and going forwards; we will expect to see the NMC conduct robust quality assurance throughout its key functions, take appropriate remedial action promptly, and incorporate the learning from that process into its evaluation of its own performance and its prioritisation of and planning for future activities.
- 17.4 We note that this is the first year since our 2007/2008 performance review where we have seen a significant improvement in the NMC's performance in relation to stakeholder engagement. In our 2007/2008 performance review report, we recommended that 'the NMC should examine its stakeholder

¹²⁴ Please see Annex 2: Our Standards of Good Regulation for details of the specific Standards.

¹²⁵ The NMC has seen staff turnover reduce from approximately 33 per cent in 2012/13 to 26 per cent by the end of March 2014.

relations and communications strategy so that it is clear the NMC exists to protect patients and the public, and that it has effective and mutually respectful relationships with interested parties to achieve this.¹²⁶ From the third-party feedback that we received this year, particularly from registrants and registrant representative groups, it is clear that the NMC and its stakeholders are now benefiting from its commitment to developing effective relationships.

Guidance and Standards

17.5 The NMC met all of the *Standards of Good Regulation* for guidance and standards during 2013/14. It demonstrated this through:

- Reviewing its approach to the development, review and evaluation of standards and guidance. The NMC publishes its standards, guidance and advice in a variety of formats, such as *The Code: Standards of conduct, performance and ethics for nurses and midwives* (the Code), supplementary guidance documents, NMC Circulars, and the 'Regulation in Practice' section of its website. In September 2013, the NMC's Council decided that, in future, only the Code will contain standards of competence and conduct, and that supporting guidance will only be produced where there is evidence that it is necessary for public protection. This should achieve greater clarity for registrants, patients and others about the standards required of nurses and midwives when carrying out their work, and where they are set out. The NMC has also developed specific methodologies to guide its work in standards and guidance, which should ensure that the NMC's future approach to such work is structured, consistent and focused on public protection
- Using the revised approach noted above to ensure that it only produced guidance which is focused on public protection and is necessary to help registrants to apply the Code to specialist or specific issues. We note that the NMC used its revised policy for the development of standards and guidance in its consideration of the Liverpool Care Pathway Review recommendation about issuing urgent guidance on end of life care.¹²⁷ Using the revised policy led the NMC to conclude that it would not be effective or proportionate to develop separate guidance on end of life care, and it decided instead to consider the issue as part of its wider review of its Code, and to work with the Leadership Alliance for the Care of Dying People with the aim of developing a system-wide approach to improving end of life care. This appears to us to be a prudent approach which should contribute to the NMC's effective management of its resources

¹²⁶ CHRE, 2008. *Performance review report 2007–08*. Available at <http://www.professionalstandards.org.uk/library/document-detail?id=a8370d75-e09b-4e68-ba2f-eb22a3996835> [Accessed 22 May 2014], paragraph 3.8.4.

¹²⁷ Department of Health, 2013. *More care, less pathway: a review of the Liverpool Care Pathway*. Available at <https://www.gov.uk/government/publications/review-of-liverpool-care-pathway-for-dying-patients> [Accessed 22 May 2014].

- In September 2013, the NMC's Council agreed to develop a risk-based approach to the review of standards and guidance. That risk-based approach means taking account of factors, such as the frequency with which issues are raised by third parties, or occur in fitness to practise cases. The NMC has carried out a risk assessment exercise by reference to such risk factors, in order to identify the standards and guidance that need to be developed or reviewed over the next three years.¹²⁸ We consider that this is a right-touch approach which should help the NMC to focus its resources appropriately. However, we would recommend that the NMC keeps its three-year plan under regular review, so that it can, if necessary, re-prioritise or alter its plans to take account of changes in the external environment
- Undertaking wide engagement and consultation activities with stakeholders which have informed the revision of the Code, as well as the development of the *Standards and Guidance on the requirements for those who first apply for registration more than five years after being awarded an approved qualification*, and the revision of the *Standards for Supervisors of Midwives*
- Publicly renewing its commitment to producing standards and guidance in 'plain English' and achieving the Plain English Campaign's Crystal Mark for its key publications. We note that, in September 2013, the NMC relaunched its *Raising Concerns* guidance which was awarded the Crystal Mark
- The relaunch of the *Raising Concerns* guidance – the NMC secured the support of Helene Donnelly, a nurse with direct experience of raising concerns to relaunch its refreshed *Raising Concerns* guidance.¹²⁹ This support helped to raise the profile of guidance, which is key to public protection.

The review of the Code

17.6 The NMC began its review of the Code in June 2013. It expects the revised Code to be approved by its Council on 3 December 2014. At the time of writing, the NMC had: completed a desk-based evidence review of the Code; carried out the first stage of a public consultation on the Code; and engaged with stakeholders at various events about possible revisions to the Code. The NMC anticipates that by the time of publication of this report, a second public consultation will have been conducted. We note that the review of the Code is part of the NMC's wider work on developing a model of revalidation, and there is therefore a tight timeframe for revising and consulting on the Code (we discuss this in further detail in the education and training section of the

¹²⁸ NMC, 2014. *Standards and guidance review cycle 2014/2017 – item 10 of the Council papers for 26 March 2014*. Available at <http://www.nmc-uk.org/Documents/CouncilPapersAndDocuments/Council%202014/Council%20papers%20-%20OPEN%2026%20March%202014%20FINAL.pdf> [Accessed 22 May 2014].

¹²⁹ Helene Donnelly is a former nurse at Mid Staffordshire NHS Foundation Trust and now Ambassador for Cultural Change at Staffordshire and Stoke-On-Trent Partnership Trust.

report).¹³⁰ While we have concerns that the NMC's timetable does not allow sufficient time for proper consideration of the consultation responses or include adequate flexibility to allow for unexpected occurrences, we accept the NMC's assurance (in May 2014) that it has a robust management programme in place and that it is confident that it will deliver the revised Code on time while also taking proper account of the consultation responses that it receives. Given the importance of the Code to public protection, we will check in the performance review 2014/15 whether this work is completed on time and whether due account is taken of the views of the NMC's stakeholders.

The review of the regulation of midwives

- 17.7 In December 2013, the Health Service Ombudsman (the Ombudsman) published three reports on midwifery supervision and regulation which identified serious concerns with the way three complaints about midwives had been investigated and managed by the local supervising authority.¹³¹ The Ombudsman considered that those three cases highlighted a 'potential muddling of the supervisory and regulatory roles of Supervisors of Midwives'. The Ombudsman recommended that midwifery supervision and regulation should be separated and that the NMC should be in direct control of regulatory activity regarding midwives. In January 2014, the NMC's Council decided that an immediate review of midwifery supervision and regulation was required.¹³² The NMC has commissioned The King's Fund to carry out this work. The review will consider potential models for the future of midwifery regulation, with particular reference to the Ombudsman's recommendations and the wider concerns of the Ombudsman and ourselves, as noted in her report. It will have regard to the link between supervision and regulation and the future of supervision and the supporting infrastructure if it were no longer part of the regulatory framework. Any regulatory failures in the investigation of complaints about the conduct and competence of midwives have serious implications for public protection and for public confidence in the NMC as a regulator. We have agreed with the Parliamentary and Health Service Ombudsman that we will oversee this work; we will therefore follow up on the outcomes of this work in the performance review 2014/15.

Education and training

- 17.8 The NMC met four of the five *Standards of Good Regulation* for education and training during 2013/14. The NMC continued not to meet the second *Standard of Good Regulation for education and training* relating to having a system of revalidation or continuing professional development in place.¹³³

¹³⁰ The Code will provide a framework against which the NMC can judge whether its registrants continue to be fit to practise.

¹³¹ Parliamentary and Health Service Ombudsman, 2013. *Midwifery supervision and regulation: recommendations for change*. All reports available at <http://www.ombudsman.org.uk/reports-and-consultations/reports/health/midwifery-supervision-and-regulation-recommendations-for-change> [Accessed 22 May 2014].

¹³² We note that the current arrangements for the regulation and supervision of midwives are the result of the NMC's legislative provision and any changes to those arrangements would require action by the Department of Health.

¹³³ The second Standard of Good Regulation for education and training: Through the regulator's continuing professional development/revalidation systems, registrants maintain the standards required to stay fit to practise.

17.9 We consider that the other four *Standards of Good Regulation* for education and training are met because:

- In September 2013, the NMC confirmed that all the education institutions which run nursing courses had implemented its new *Standards for pre-registration nursing education* (2011) appropriately.¹³⁴ The first cohort of nurses trained using these standards will qualify in September 2014. The NMC is committed to evaluating the standards in 2014/15 – the first part of that evaluation will consider admission to nursing courses. As part of that work, the NMC intends to consider matters related to value-based recruitment (value-based recruitment means that recruitment and selection processes would be based on values and behaviours, as well as technical and academic skills)
- In September 2013, the NMC's revised quality assurance approach to education and training came into effect. The process has a greater focus on:
 - The outcomes of education and training in terms of public protection (rather than specifying how the courses should run)
 - Where risk is anticipated or known, or where education institutions or local supervisory authorities are considered not to be performing adequately
 - Strengthening patients' and public involvement in the design and delivery of courses, including through a requirement for a lay (non-professional) visitor to be involved in the quality assurance visits. This move has brought the NMC's approach in line with many of the other health and care regulators. It should enable a patient voice to be heard during quality assurance visits
- We have seen evidence that this change in approach has been welcomed by approved education institutions and local supervisory authorities.
- The NMC improved the transparency of its work by publishing information on the schedule for quality assurance visits to approved education institutions and local supervisory authorities. It will shortly publish a booklet about the NMC's role in education and training which is aimed at patients and the public.

The second Standard of Good Regulation for education and training: Through the regulator's continuing professional development/revalidation systems, registrants maintain the standards required to stay fit to practise

17.10 The NMC's Council approved a high-level model for revalidation in September 2013, which it agreed would be ready for implementation in December 2015. The agreed model is that:

¹³⁴ The term 'pre-registration nursing education' describes the programme that a nursing student in the UK undertakes in order to acquire the competencies needed to meet the criteria for registration with the NMC.

- Nurses and midwives will be asked to self-declare and seek third-party confirmation that they continue to be fit to practise; that confirmation will be evidenced by the nurse/midwives' reflection on feedback from patients, users and carers, colleagues and peers. It is expected that confirmation will form part of an existing appraisal process
- The standard that nurses and midwives must meet will be set out in the revised Code, rather than there being separate PREP standards (the current continuing professional development standards)¹³⁵
- The NMC will audit a random and risk-based sample of nurses' and midwives' self-confirmation profiles in order to test that the standard for revalidation is being met.

17.11

While we acknowledge that the NMC has made progress in developing a model of revalidation during 2013/14, we have concerns about the adequacy of the model it has adopted. We shared our concerns with the NMC and the Health Select Committee in October 2013, and also in response to the NMC's public consultation (which closed in March 2014).¹³⁶ Our concerns and the NMC's response to them are noted below.

- The NMC's model lacks a robust evidence base, in particular around risk. We consider that the NMC should as a first step have profiled the risks associated with different groups on its register. Without this we consider that the risks to public protection have not been identified, evaluated or quantified. Therefore it is not clear how the NMC can be confident that its proposed model will enhance public protection and bolster public confidence in regulation. Furthermore, there has been no proper discussion about the optimal cycle length for revalidation¹³⁷ – which we consider leaves the NMC open to criticism, particularly given the likelihood of an unfavourable comparison being drawn with the GMC's revalidation cycle, which is two years longer than the NMC's, even though arguably doctors present the same or greater public protection risks as nurses. The NMC said that it will reconsider the revalidation cycle once phase one of the revalidation model has been implemented and evaluated.
- Without a robust evidence base, we are not confident that the NMC can have fully considered whether a 'one size fits all' revalidation model is the most appropriate one. It might have been preferable to develop a model that allowed for differential risks posed by the different groups of nurses and midwives. The NMC has told us that it would be impractical to develop a customised risk-based approach to revalidation for different groups of registrants.

¹³⁵ The post-registration ongoing education and practice standards.

¹³⁶ Professional Standards Authority, 2014. *Response to NMC consultation on revalidation*. Available at <http://www.professionalstandards.org.uk/library/document-detail?id=25be589e-2ce2-6f4b-9ceb-ff0000b2236b> [Accessed 22 May 2014].

¹³⁷ The three-year cycle proposed has been chosen to fit with the current renewal requirements set down in its current legislation.

- The proposed model is incomplete because it does not adequately address:
 - How a system that requires registrants to provide third-party feedback as evidence of their continuing fitness to practise will work in practice
 - What information the NMC will require registrants to submit for revalidation audits, nor how the NMC will audit that information
 - How revalidation submissions will be scrutinised when they are audited
 - What will happen if: a registrant fails to engage with revalidation; a registrant engages but does not meet the standards; or concerns about conduct and/or competence are identified which meet the threshold for a fitness to practise action.
- The NMC has told us that it is addressing these issues as part of its programme to develop the revalidation model.
- There is limited information on the financial impact of the model, which means that it is difficult to assess its financial viability. Connected to this is a lack of publicly available information about the anticipated operational impact of introducing revalidation (an assessment of what additional burden of work the scheme may place on the NMC, and/or on others such as employers). The NMC informed us in May 2014 that it has now commissioned some independent work which will consider the impact of the revalidation model on third parties.

17.12 We will monitor the development of the NMC's revalidation model closely and report in the performance review 2014/15 our views on the progress made, particularly in relation to the concerns that we have noted above.

Registration

17.13 The NMC met three of the five *Standards of Good Regulation* for registration during 2013/14. It continued to not meet the second and third Standards.¹³⁸

17.14 Evidence that demonstrated how the NMC met the other three *Standards of Good Regulation* in registration is set out below:

- It made changes to ensure consistency and accuracy in its processing of registration applications. Those changes included: strengthening standard operating procedures for processing applications; improving training for staff; introducing checklists for staff to complete when considering initial registrations and renewal applications; and revising its guidance on implementing policies and procedures for EU/EEA applicants which came into effect from October 2013.

¹³⁸ The second Standard of Good Regulation for registration: The registration process, including the management of appeals is fair, based on the regulator's standards, efficient, transparent, secure and continuously improving.
The third Standard of Good Regulation for registration: Through the regulators' registers, everyone can easily access information about registrants, except in relation to their health, including whether there are restrictions on their practice.

- It used learning from rejected registration applications in order to improve the information about what is required for a successful application that is provided on the website and in the registration pack
- The timely processing of UK initial registration applications and renewal registration applications
- It used the Care Quality Commission's (CQC) communication channels with employers to promote the use of the NMC's employer register service.¹³⁹ While we are disappointed that the NMC has not been more proactive in promoting awareness of the need to check nurses' and midwives' registration status among employers and the public, its use of the CQC's established communication mechanism is positive, and means that the NMC has not had to incur additional costs
- It developed guidance and information for registrants in relation to the forthcoming requirement for all registrants to have professional indemnity insurance.

The second Standard of Good Regulation for registration: the registration process, including the management of appeals is fair, based on the regulator's standards, efficient, transparent, secure and continuously improving

- 17.15 In the performance review report 2012/13, we highlighted concerns about the progress that had been made by the NMC in: developing online registration functionality; managing its appeals in a timely fashion; customer service; and with its processing of overseas applications. These concerns led us to conclude that this Standard was not met in 2012/13.
- 17.16 The NMC has made some progress during 2013/14, but there is still either room for significant improvement or a lack of objective evidence to provide assurance of the improvement made; therefore, this Standard remains unmet in 2013/14.

Customer service

- 17.17 In the performance review 2012/13, we reported that nine per cent (38,404 calls) of the calls to the NMC's call centre had gone unanswered, and that the NMC had told us that it was improving its performance (answering calls more quickly and reducing the number of unanswered calls) by scheduling resources and analysing call patterns and trends. We noted that there was some evidence of improvement compared to performance in 2011/12.
- 17.18 We are therefore disappointed to report that the NMC has failed to achieve further improvement in its customer service during 2013/14. Between April and September 2013, 11 per cent of calls (26,956 calls) went unanswered, and the length of time callers spent in the queue was unreasonable. The NMC has told us that this decline in performance was due to several factors: an additional 5,500 calls per month to the call centre, the duration of a call increasing by 30 seconds, the 'pause' in processing of overseas

¹³⁹ The service used by the NMC to inform employer subscribers of changes to its registers on a daily basis.

applications,¹⁴⁰ the renewal cycle, and a failure of IT infrastructure. The NMC has told us that it has carried out a 'lessons learned' review and that it has actions planned to ensure there is no recurrence, including: recruiting temporary staff for a longer period to cover the peak registration period; sending reminder notices about the need to renew/register earlier in the process; and investigating alternative telephony solutions. While we are pleased that the NMC recognises the need to and is taking action to address its poor customer service, we are disappointed that the NMC did not anticipate the factors that contributed to its problems in 2013/14, given that many of them were longstanding and or foreseeable. In particular, we note that the NMC was or should have been aware that:

- There is a peak in initial registration applications in September every year, due to the academic timetable, as well as an associated peak in renewal applications
- The 'pause' in processing overseas registration applications was likely to generate an increased number of enquiries
- It was receiving a higher number of calls per month (the NMC was aware of that from early in 2013).

17.19 We note that the NMC says it was aware of the peak of activity in September each year and had planned for an anticipated increase in demand. However, it said that it could not have predicted the extent of the level of growth, nor budgeted for unforeseeable demands, since that would not be a prudent use of its finite resources. The NMC accepts that the impact of suspending the overseas process could have been better assessed, but says that this was heightened by the action taken to introduce strengthened processes to enhance public protection, the impact of which could not be assessed fully until we began reaccepting applications.

17.20 Aside from the number of calls that went unanswered and the length of the call queues, from feedback that we and the NMC have received, it is clear that inconsistent customer service was provided to those who telephone the call centre. Some callers to the NMC say that they found the service 'helpful and professional', while others found that they were provided with 'inconsistent information' and that staff were 'disappointing' and 'unreliable'. The NMC has told us that it is continuing to train staff, carry out quality assurance of calls (such as listening to calls), and feedback any learning. We hope that these activities will deliver the consistent improvement in performance that is required, but we are sceptical about the NMC's confidence that these activities will result in the required improvements given that they have not worked so far. We would therefore encourage the NMC to explore other strategies that may assist its performance in this area. Poor customer service has the potential to damage public confidence in the regulator. We will follow up on this in the performance review in 2014/15.

¹⁴⁰ The NMC did not process any overseas applications between February and April 2013 due to concerns identified about its approach in this area.

Responding to changes in legislation

- 17.21 We were concerned to learn that the NMC had not made prompt changes to its registration processes, forms and guidance following the enactment in 2013 of the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975 (Amendment) (England and Wales) Order 2013 ('the Order'). The Order creates a new category of 'protected' cautions and convictions which registrants are not required to disclose during the registration process.¹⁴¹ The NMC told us in February 2014 that it was making changes to its documentation, that training was being provided to its staff, and that steps had been taken to ensure that fitness to practise cases had not been wrongly opened on the basis of an allegation related solely to such a protected caution/conviction. We were disappointed that the NMC did not take appropriate action more promptly (although we acknowledge that delay did not create any risk to the public), and note that it is now taking appropriate steps – we will follow up on progress with this in the performance review 2014/15.

Receipt of information by registrants

- 17.22 During 2013, concerns were raised with the NMC that some reminders of renewal packs and renewal packs had not been received by registrants. The NMC considered the matter and, as a result, changed its postal provider in August 2013. The NMC has told us that the number of complaints associated with the failure to receive information through the post decreased following that change. We are pleased that the NMC took decisive action to address a problem which had the potential to significantly increase the number of registrants lapsing from its registers unnecessarily. Inadvertent lapses from the register can leave the public unprotected, as it can result in professionals practising while unregistered.

Overseas applications

- 17.23 In the 2012/13 performance review 2012/13, we reported that, in February 2013, the NMC had begun an internal review of its registration processes for overseas applicants. In the course of that review, the NMC established that it had been operating a different system for evaluating the training requirements for applicants from New Zealand, America, Canada and Australia, compared to the system for evaluating the training requirements for applicants from other non-European countries. The NMC identified that improvements were needed to strengthen the registration processes for overseas applicants and to ensure an evidence-based approach for all countries. It also identified that it needed to improve its procedures for validating identity requirements.
- 17.24 Having reviewed a sample of historical records, the NMC commissioned a statistically significant audit of the overseas register in order to assess

¹⁴¹ The definition includes cautions which were received over 6 years ago (or 2 years if the offender was under 18) and convictions which were received over 11 years ago (or 5 and a half years if the offender was under 18 at the time), provided the offender received a non-custodial sentence and has no other convictions. It does not apply to a 'listed offence', such as violent and sexual offences.

compliance with its historical procedures, and to compare those procedures to its current approach to public protection. The review identified weaknesses in the administrative processes that were operated between 2002 and 2006, but found that 'stronger controls' had been in place from 2007.

- 17.25 In April 2013, the NMC changed its arrangements for managing its registration processes for overseas applicants. It:
- Revised its application forms
 - Developed guidance on the processes and procedures for receiving, processing and assessing overseas applications, with tools to support staff undertaking that work
 - Enhanced documentation and identity checks conducted in relation to all overseas applicants, including (from September 2013) adopting a more robust system of face-to-face interviews with applicants and the use of advanced technology to verify identity documents
 - Introduced an early evidence-check of applications, to identify any errors and to notify the applicant of them promptly.
- 17.26 The NMC also consulted on introducing a test of competence for overseas applicants, and is currently considering how it could introduce such a test. This test would replace the current requirements overseas applicants are required to meet. The use of such a competency test would mirror the process used by the GMC and the GDC.
- 17.27 The NMC has taken appropriate steps to address a significant area of weakness in its processes which had the potential to impact on both public protection and public confidence in the regulator. These steps should enable it to run a fair and effective registration process that effectively protects the public.
- 17.28 We have no doubt that the NMC has learnt from this experience and that, in future, it will keep its registration processes for UK, EU/EEA and overseas applicants under regular review.

Efficiency of the registration process

- 17.29 The temporary 'pause' in processing overseas applications between February and April 2013 led to a backlog of applications awaiting processing by the time the NMC recommenced the procedure in April 2013. The NMC's performance fluctuated during 2013/14 as the numbers of applications built up and it took time for additional temporary staff to be recruited and to develop sufficient expertise to work without support. We note that the median time taken to register UK graduates also increased because of a growth in the number of applications to process between September and November 2013. We consider that the NMC should have anticipated the consequences of the 'pause' and should have made provisions to ensure the prompt processing of overseas applications earlier and should have been aware of the increase in the number of UK graduates wishing to register in the Autumn of 2013. The delays in processing all types of applications impacted on a number of stakeholders including the applicants, employers and recruitment

agencies. We hope that, in the performance review 2014/15, we will see improved performance in the efficiency of the registration processes.

Registration appeals

- 17.30 In the performance reviews in 2011/12 and 2012/13, we reported that there had been delays in the progression of registration appeals. We were therefore pleased to note that between 1 April 2013 and 31 March 2014 the NMC concluded 49 of its registration appeals, 36 of which were concluded within its 9 month target.¹⁴² This is particularly commendable as it was achieved despite a pause of two months while new registration appeal panel chairs were identified and trained. The NMC has also been able to reduce its target for the completion of registration appeals to eight months. While it is disappointing that the target has not been reduced to three to six months as previously anticipated, we recognise that the NMC has sought to set itself a realistic target, taking into account the need for Council members to sit as the chairs of registration appeal panels, and the impact on timescale of new evidence being submitted during the registration appeal process. We consider that the NMC has demonstrated an improvement in its performance in progressing registration appeals.

Online registration

- 17.31 In the performance review in 2012/13, we noted that the NMC's plans to introduce online services for registrants had been deferred to an unspecified future date, in order to prioritise other activity that was directly linked to the NMC's core regulatory functions. We considered that having online registration functionality would improve the NMC's performance in managing its registration processes and the integrity of its register, and therefore questioned the decision to defer this work. We are therefore pleased that the NMC did, in fact, begin its online registration project during 2013 (in line with its Corporate Plan 2013–16). A pilot is underway and a cohort of registrants are now able to update their personal details online and, from May 2014, should be able to renew their registration online. We will assess further progress on this in the performance review 2014/15.
- 17.32 While we note that the performance of the NMC's against this Standard improved during 2013/14, we are not yet confident to say that sufficient improvement has been made. Therefore, this Standard remains unmet.

The third Standard of Good Regulation for registration: Through the regulators' registers, everyone can easily access information about registrants, except in relation to their health, including whether there are restrictions on their practice.

- 17.33 Each year, as part of the performance review, we carry out a random check of a sample of each of the regulators' registers, to ensure that each register accurately reflects the registration status of each registrant.

¹⁴² Of those not completed within nine months, five were as a result of actions by the NMC and the remaining eight because of the actions of appellants or because of requests by them.

- 17.34 In the performance review reports in 2011/12 and 2013/14, we reported on errors we had identified during our checks of the NMC's registers. We also noted the remedial steps the NMC had taken to address those errors, such as re-training staff and introducing daily reconciliation checks of the registration and fitness to practise databases. We are pleased to note that in the 2013/14 performance review register check, we identified no incorrect entries. However, due to other errors which the NMC had itself identified (as set out in paragraph 17.35), and which we identified in our audit of the NMC's initial stages of the fitness to practise process in the summer of 2013, we consider that this Standard remains unmet.¹⁴³
- 17.35 The NMC identified 41 errors in relation to 41 cases as a result of its daily reconciliation reports, as well as further errors as a result of its weekly audit of 10 per cent of its case outcomes between April 2013 and January 2014. The errors included: a 48-hour delay in adding details of an interim suspension order; the incorrect removal of an interim conditions of practice order (this was corrected within 24 hours); incorrect start and end dates being recorded for fitness to practise orders; an interim suspension order not being amended to an interim conditions of practice order following a review hearing; inconsistent updating of the register following voluntary removal decisions; 'under investigation' flags not being removed following the conclusion of cases; and interim orders not being removed following review hearings. The NMC has told us that, in order to prevent future recurrence of such errors, it has provided staff training and updated its guidance manuals.
- 17.36 We note that the number of errors equates to a 0.37 per cent error rate, which is low. However, given the implications for public protection and public confidence, we consider each error to be significant.
- 17.37 During our audit in 2013, we checked the registration status of each registrant in the 81 cases that we audited.¹⁴⁴ We found that the register had been accurately updated throughout the cases' lifetime in the majority of cases. However, we found inaccuracies in five cases; although only two were relevant for the reporting period 2013/14.¹⁴⁵ Our findings were as follows:
- In one case, the 'under investigation' flag was not removed for five months after the case had been closed. Such an oversight presents no public protection risk, although it could have resulted in incorrect information being shared inside and outside of the organisation about a registrant.
 - In another case, the registration record showed that the individual's registration had 'lapsed'; this was inaccurate. We noted that this inaccuracy did not prevent the investigation from continuing, although the NMC no longer had jurisdiction to take any FTP action.

¹⁴³ Professional Standards Authority, 2014. *Audit of the Nursing and Midwifery Council's initial stages fitness to practise process*. Available at <http://professionalstandards.org.uk/library/document-detail?id=bfb579e-2ce2-6f4b-9ceb-ff0000b2236b> [Accessed 22 May 2014]

¹⁴⁴ We did audit 100 cases but 19 of these related to a specific group of cases and we therefore did not carry out a registration status check.

¹⁴⁵ We identified a further three cases where there were inaccuracies on the register. As these related to actions in 2012, these did not form part of our assessment on the NMC's performance against this Standard.

17.38 We note that we had highlighted errors in the NMC's register in the previous two performance review periods (2011/12 and 2012/13). While the error rate identified during 2013/14 as set out above is low, it is a concern that the action the NMC has taken in response to the issues identified in 2011/12 and 2012/13 has not yet proved effective in eliminating discrepancies between the registration and fitness to practise databases. We note that the NMC undertook an internal audit of registrants' data in March 2014; we will revisit this area of the NMC's work in the performance review 2014/15, with the expectation that we will see further improvement evidenced in part by a positive internal audit result. We will also consider this issue in our 2014 audit of the initial stages of the fitness to practise process.

Fitness to practise

- 17.39 During 2013/14, the NMC demonstrated that it met four of the *Standards of Good Regulation* for fitness to practise.
- 17.40 It also demonstrated improvement in its performance against the fourth *Standard of Good Regulation for fitness to practise*, meaning that it now demonstrates inconsistent performance against this Standard.¹⁴⁶
- 17.41 It demonstrated inconsistent performance against the fifth Standard, as a result of the implementation of two new initiatives: the use of voluntary removal from the register; and the use of consensual panel determinations.¹⁴⁷
- 17.42 The NMC has not met the sixth, seventh, eighth and tenth *Standards of Good Regulation* for fitness to practise, for the reasons set out in paragraphs 17.58–17.73 below.¹⁴⁸
- 17.43 Examples of how the NMC demonstrated that it met the other four Standards are below:
- The NMC engaged with its stakeholders in a variety of ways in order to improve its understanding of the issues that they were facing, as well as to improve their understanding of how and when to refer cases to the NMC. For example, the NMC's Director of Fitness to Practise and its Director of Continued Practice visited the 11 trusts that were placed in

¹⁴⁶ The fourth Standard of Good Regulation: All fitness to practise complaints are reviewed on receipt and serious cases prioritised and, where appropriate, referred to an interim orders panel.

¹⁴⁷ The fifth Standard of Good Regulation: The fitness to practise process is transparent, fair, proportionate and focused on public protection.

¹⁴⁸ The sixth Standard of Good Regulation: Fitness to practise cases are dealt with as quickly as possible taking into account the complexity and type of case and the conduct of both sides. Delays do not result in harm or potential harm to patients. Where necessary, the regulator protects the public by means of interim orders.

The seventh Standard of Good Regulation: All parties to a fitness to practise case are kept updated on the progress of their case and supported to participate effectively in the process.

The eighth Standard of Good Regulation: All fitness to practise decisions made at the initial and final stages of the process are well reasoned, consistent, protect the public and maintain confidence in the profession.

The ninth Standard of Good Regulation: All final fitness to practise decisions, apart from matters relating to the health of a professional, are published and communicated to relevant stakeholders.

The tenth Standard of Good Regulation: Information about fitness to practise cases is securely retained.

special measures following the Keogh Report¹⁴⁹ to discuss (among other things) possible fitness to practise referrals

- The NMC is developing an operational protocol (at the time of writing, this protocol was still to be finalised) and information-sharing agreement with the CQC which should provide clear practical guidance for staff on when and how to share information with the CQC. We will look for evidence that the guidance has been followed in our audit in 2014
- The NMC appointed staff with dedicated responsibility for ensuring that information is shared with safeguarding authorities and professional/system regulators. In August 2013, it also introduced a Standard Operating Procedure for making such referrals. We will look for evidence of appropriate cross-regulatory referrals in our audit in 2014.

The fourth Standard of Good Regulation for fitness to practise: All fitness to practise complaints are reviewed on receipt and serious cases prioritised and, where appropriate, referred to an interim orders panel

17.44 In the performance review 2012/13, we reported that the NMC had not met the fourth Standard set out above. We reached this view because the large number of applications for High Court extensions to interim orders, that had previously been imposed, indicated that cases were not being prioritised properly on receipt and progressed to a prompt conclusion.

17.45 We are disappointed to report that the NMC identified in March 2014 that there were two cases where interim orders had lapsed before the fitness to practise proceedings had concluded. The NMC said that both cases were as a result of human error and because they had been incorrectly recorded on its case management system as being 18-month interim orders rather than 12 months. The NMC said that it has investigated these errors under its Serious Event Review process and learning had been identified which should prevent repetition.

17.46 We note also that between April 2013 and March 2014, the NMC applied to the High Court/Court of Session in Scotland for extensions to interim orders 619 times. This is a significant increase from 381 times in 2012/13. The increase in the number of extensions is a matter of concern because it indicates a failure to swiftly progress serious cases to a conclusion (interim orders which restrict the ability of the registrant to practise during the investigation are only imposed in cases where there is a risk to public protection, to the registrant, or to the wider public interest). The NMC has told us that the reasons for the large number of cases requiring Court extensions of interim orders concerned the size of its caseload, as well as the high volume of cases awaiting adjudication at a panel hearing where interim orders had been imposed. The NMC has told us that it does not expect to see a reduction in the number of High Court applications for interim order

¹⁴⁹ Keogh, B., 2013. Review into the quality of care and treatment provided in 14 hospital trusts in England: overview report. Available at <http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/published-reports.aspx> [Accessed 22 May 2014].

extensions until it is able to reduce its adjudication caseload. The NMC has told us that it is committed to meeting its adjudication key performance indicator (KPI) (that KPI is for 90 per cent of cases to be progressed through the adjudication stage to the first day of a hearing or a meeting within six months) by December 2014, and it therefore expects to see a reduction in the number of Court applications for extensions to interim orders from January 2015.

- 17.47 While we are concerned about how the NMC is managing cases with interim orders during the adjudication stage of its fitness to practise process, we consider that it has improved its handling of serious cases in the initial stages of its fitness to practise process. In our 2013 audit of the initial stages of the NMC's fitness to practise process, we were pleased to find documented risk assessments in all 58 cases that we audited that had been opened after 1 February 2012 (the date that the NMC introduced an amended procedure requiring risk assessments to be documented).¹⁵⁰ We were also pleased to find that there were no delays in applying for interim orders in the 17 cases we audited that had been opened after the NMC introduced its amended risk assessment procedure.
- 17.48 The NMC's improved compliance with its risk assessment process, the introduction of new processes in March 2013, which enabled interim order applications to proceed on seven days' notice (with provision for early review hearings), and the introduction of new guidance for staff on prioritisation of cases, have also impacted on the NMC's ability to meet its interim order KPI (for 80 per cent of interim orders to be imposed within 28 days of referral). Between April 2013 and February 2014, the NMC achieved this target in 84 per cent of cases; this represents a real improvement on its previous performance. The percentage of interim order hearings that were adjourned also halved – down to 4.5 per cent.
- 17.49 In the performance review in 2014/15, we will report on research being undertaken by the NMC during 2014 to help it gain a better understanding of when and why an interim order is imposed and to develop further insight into the relationship between cases referred for an interim order and the final outcomes.
- 17.50 We consider that while the NMC has demonstrated improvement against this Standard in its performance in the initial stages of the fitness to practise process, it has not achieved similar improvement in its performance at the later stages of the process, and it has therefore demonstrated inconsistent performance against this Standard.

¹⁵⁰ Professional Standards Authority, 2014. *Audit of the Nursing and Midwifery Council's initial stages fitness to practise process*. Available at <http://professionalstandards.org.uk/library/document-detail?id=bffd579e-2ce2-6f4b-9ceb-ff0000b2236b> [Accessed 22 May 2014], see paragraph 2.14.

The fifth Standard of Good Regulation for fitness to practise: The fitness to practise process is transparent, fair, proportionate and focused on public protection

- 17.51 In the performance review 2012/13, we stated that we would look at the impact of two new initiatives affecting how some fitness to practise cases would be closed in future. These two initiatives were: consensual panel determinations; and voluntary removal from the register.
- 17.52 Consensual panel determination is a process in which the NMC and the registrant agree a written statement of facts, an admission that the registrant's fitness to practise is impaired, and a proposed sanction. The agreement is then considered by a fitness to practise panel, which has discretion to decide whether to accept the agreement or to require a hearing to be held. We review all cases closed using this process as part of our review of final fitness to practise panel outcomes, and we can appeal any 'unduly lenient' decision. We have fed back learning points to the NMC about a number of cases closed using the consensual panel determination process, highlighting concerns about the submissions made to panels by the NMC, about the extent to which the panels inquire into cases before disposing of them, about panels' reasons for accepting the agreements put forward, and about the level of information put into the public domain. The NMC undertook two reviews of its approach to consensual panel determinations: in May and December 2013. The NMC said that it is too early to draw firm conclusions about the effectiveness of this initiative, but the reviews identified improvements to be made to: processes for tracking cases; communication with registrants and registrant representatives; and training and guidance for staff, panel members and legal assessors on aspects of the processes. The NMC has told us that it has implemented these changes and has also developed a training video supported by an e-learning module to test learning. We would like to see an improvement in the handling of these types of cases in the performance review 2014/15.
- 17.53 Voluntary removal is the process by which a nurse or midwife who is awaiting the adjudication of a fitness to practise case against them can apply to have their case concluded without a hearing. The registrant has to admit that their fitness to practise is impaired and state that they do not intend to continue to practise. The NMC's Registrar makes the decision about whether or not to grant each voluntary removal application. The NMC's published guidance about the process states that the NMC will only permit voluntary removal when there is no public interest in having a public hearing and the public would be best protected by their immediate removal from the register. In our 2013 audit of the initial stages of the fitness to practise process, we audited 21 cases that had been closed using this procedure between January and July 2013. We identified concerns in all 21 cases including:
- Failure to give sufficient weight to the public interest when granting voluntary removal
 - Failure to seek verification of the future plans of the registrant (i.e. confirming whether the registrant will retire/no longer practice)

- Failure to seek comments from, or take account of, the comments from the complainant when granting voluntary removal
- Considering cases for voluntary removal where there were allegations of serious misconduct, and where the registrant has not admitted, or not clearly admitted, the allegations
- Failure to record reasons for the decision to grant voluntary removal
- Procedural errors when processing a request for voluntary removal.

17.54 In response to our audit findings, the NMC has told us that it will review its voluntary removal processes and guidance, and provide additional training to staff and panellists. We will want to see improvement in this area of work in our 2014 audit of the initial stages of the fitness to practise process.

17.55 We also identified in our 2013 audit report, concerns about the NMC's approach to reviewing its closed cases to identify any areas of improvement. We concluded that its approach was weak.¹⁵¹ We reached that conclusion because, following the publication of the *Francis Report* in February 2013, the NMC reviewed 38 of the cases it had closed involving members of staff who had worked at the Mid Staffordshire NHS Foundation Trust and had only identified record-keeping errors in 11 of the 38 cases, in addition to 6 other issues which required further review.¹⁵² This was in stark contrast to our review of the same cases, where we identified a breadth of concerns including failures to gather sufficient information or evidence, or failures to take that information/evidence into proper account when deciding whether or not to close cases; this meant that the evidential basis for some of the decisions made by NMC staff and the IC was, in our view, inadequate. This meant that either the wrong decision was made and/or the decision that was made was based on unsound or inadequate reasons. The issues we identified in the NMC's handling of these cases are particularly serious, given the level of public concern about the accountability of registrants involved in incidents of poor patient care at the Trust during the relevant period.

17.56 Outside of the audit report, we also identified a concern which we considered affected the NMC's performance against this Standard as it relates to fairness of the fitness to practise process. The NMC incorrectly informed the media that a registrant had been found guilty of misconduct before the final fitness to practise panel had announced its decision. This had implications for the registrant and their employers. We note that the NMC investigated this error and identified its cause as human error. It has told us that it has put in place procedures which should prevent repetition of this error.

¹⁵¹ Professional Standards Authority, 2014. *Audit of the Nursing and Midwifery Council's initial stages fitness to practise process*. Available at <http://professionalstandards.org.uk/library/document-detail?id=bfb579e-2ce2-6f4b-9ceb-ff0000b2236b> [Accessed 22 May 2014], see paragraph 4.3. We note that the NMC has said that its review of the cases was not meant to be a quality assurance review/full re-examination of the cases, but instead intended to identify what, if any, further action it should take.

¹⁵² Francis, R., 2013. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, chaired by Robert Francis QC, 2013. Available at <http://www.midstaffpublicinquiry.com/report> [Accessed 22 May 2014].

17.57 Given the concerns that we identified about: the two initiatives the NMC has implemented in 2013/14; our concerns about its processes for reviewing closed cases, and the matter related to the publication of an erroneous decision, we have concluded that it has demonstrated inconsistent performance against this Standard of Good Regulation for fitness to practise.

The sixth Standard of Good Regulation for fitness to practise: Fitness to practise cases are dealt with as quickly as possible taking into account the complexity and type of case and the conduct of both sides. Delays do not result in harm or potential harm to patients. Where necessary, the regulator protects the public by means of interim orders

17.58 Delays in case progression adversely impact on all those involved with the fitness to practise case. It also impacts on public confidence in the regulator. We concluded in the 2011/12 and 2012/13 performance review reports that the NMC had not met this Standard. In 2013/14, we have concluded that this Standard is still not met.

17.59 The NMC has made the following progress during 2013/14 with improving the timeliness of its case progression:

- By June 2013, the NMC had increased the number of scheduled fitness to practise hearings to 22 per day
- In 2013/14, the NMC had improved its performance against its KPI for 90 per cent of cases to be progressed through the investigation stage within 12 months. In 2012/13, it achieved this in 68 per cent of cases and in 2013/14, it achieved this in 87 per cent of cases
- In 2012/13, there were 370 cases that were older than 104 weeks in its total caseload, but that number had reduced to 323 by March 2014. In 2012/13, there were 148 cases older than 156 weeks, but that number had reduced to 53 by the end of March 2014. In 2013, the NMC conducted a number of targeted caseload reviews throughout the year. This enabled it to identify barriers to case progression and to take appropriate action to progress cases.

17.60 We are also pleased to note that, by September 2013, the NMC had closed 99.6 per cent of its historic caseload. Those six cases which remain open had previously been on hold due to third-party investigations. This is still the case for two of those cases, three of those cases are scheduled hearings in May 2014, and one is on hold due to the health of the registrant.

17.61 While some improvements in performance have been achieved, we remain concerned about the areas where there has been less progress, as set out below.

17.62 The adjournment rate for fitness to practise cases has improved since 2012/13. It was, on average, 22 per cent between April and September 2013 (in 2012/13, it was 30 per cent). The NMC has told us that it has captured and analysed data from a variety of sources in relation to the root causes of adjournments, and that it has identified a number of different factors that contributed to cases being adjourned, including: late engagement by registrants and their representatives, unexpected illness or changes in

circumstances (e.g. bereavement) among hearing participants, inadequate time estimates, inadequate case preparation, and inadequate hearing management. The NMC told us that a number of actions are underway to address these issues, such as the revision of the formula used to calculate hearing time estimates and greater involvement of lawyers in pre-hearing checks to ensure there are no outstanding legal issues. We reported that the NMC had an unacceptably high adjournment rate in the performance review 2011/12 and we still consider that this is the case, two years later. We note that some of the factors that the NMC considers contribute to adjournments are ones that should be within its direct control and we therefore expect to see improved performance in the performance review 2014/15.

17.63 The NMC's performance against its KPI for 90 per cent of cases to be progressed through the adjudication stage to the first day of a hearing or meeting within six months was poor in 2013/14. Between April 2013 and March 2014, it achieved the KPI in only 23 per cent of cases. This was a decrease from 39 per cent in 2012/13. This is particularly concerning given that the NMC has publicly committed to meeting this KPI by December 2014.

17.64 The NMC has told us: that it is confident that it will meet the KPI; that it has undertaken a review of its caseload and performance data so that it is aware of the target it should be reaching each month in order to achieve the KPI; and that it has contingency plans in place to address any potential problems that may occur. While we have concerns about the NMC's ability to meet this KPI if its performance continues at its current rate, we accept the NMC's assurance that it will meet this KPI by December 2014.

The seventh Standard of Good Regulation for fitness to practise: All fitness to practise parties are kept updated on the progress of their case and supported to participate in the process effectively

17.65 In the performance review 2012/13, we reported that the NMC did not meet this Standard because of the number of continuing weaknesses with its customer service. The weaknesses included: the NMC's failure to support witnesses who attend final fitness to practise hearings; and the NMC's failure to routinely seek and learn from feedback from those who have participated in its fitness to practise process. In 2013/14, we have concluded that the NMC continues not to meet this Standard, although we note that some improvements have been achieved.

17.66 In our 2013 audit of the initial stages of the fitness to practise process, we found failings in the NMC's customer service, including:

- Inconsistent compliance with its customer service standard (which required updates to be sent to all those involved with a fitness to practise case every six weeks). We note that the NMC is reviewing this standard to assess whether it is realistic
- Failure to acknowledge correspondence where a request for an acknowledgement had been made by the correspondent
- Inconsistent compliance in sending customer feedback forms at the conclusion of a case. The NMC now sends a link to the customer

feedback form in its decision letters, which should ensure that everyone has the opportunity to provide feedback

- Sending letters which contained inaccuracies, that requested information from an individual who would not reasonably hold that information, and sending correspondence to the wrong address over a period of time despite being told of this error.

17.67 We also received feedback from third parties about the NMC's customer service which indicated that sufficient improvements to its processes had not yet been made.

17.68 While we have evidence of continued poor customer service by the NMC, we note that the following indicate that progress against this Standard is being made:

- Between April and September 2013 the NMC sent out investigation committee decision letters within five days in 99 per cent of cases and adjudication decision letters in 97 per cent of cases.
- We saw acknowledgements of complaints in 69 of the 70 cases that we audited that had been opened after the screening team was introduced in January 2011.
- The NMC took steps to improve witnesses' experience of the fitness to practise process: it met with witnesses to discuss and learn from their experiences at hearings venues in London and Edinburgh. It also met with Victim Support to discuss its witness support arrangements and obtain advice on good practice. We will look for evidence of the impact of these activities in the performance review 2014/15.

The eighth Standard of Good Regulation for fitness to practise: All fitness to practise decisions made at the initial and final stages of the process are well reasoned, consistent, protect the public and maintain confidence in the profession

17.69 In the performance review 2012/13, we reported that we had seen some improvement in the quality of decision making by the NMC's panels. However, we did not consider that this had been sustained consistently across the caseload. We remain of the same view in 2013/14 and therefore this Standard remains unmet.

17.70 During 2013/14, we continued to generate learning points as a result of our review of final fitness to practise panel outcomes (for the purpose of deciding whether or not the outcomes are 'unduly lenient' and should be appealed to the Court). We also appealed four cases (out of 2,376 cases reviewed) where we considered that the decision made by the NMC's panel was unduly lenient and did not protect the public. Three of these appeals are outstanding at the date of writing, and one (concerning the former Director of Nursing at

Mid Staffordshire District General Hospital NHS Trust) has been settled by the parties agreeing to the registrant being struck off.¹⁵³

- 17.71 In our 2013 audit of the initial stages of the NMC's fitness to practise process, we saw improvements in the decisions to close cases at the screening stage, and in those cases closed by the investigating committee following an in-house investigation. However, we highlighted concerns about some other decisions, including decisions made in voluntary removal application cases.

***The tenth Standard of Good Regulation for fitness to practise:
Information about fitness to practise cases is securely retained***

- 17.72 In the performance reviews in 2011/12 and 2012/13, we reported that this Standard was not met because of the number and seriousness of the data breaches which had occurred. We noted that the NMC had taken action to improve its performance in this area, such as providing staff training and strengthening its policies. We hoped that this would lead to improved performance.
- 17.73 While we are pleased to report that there has been a reduction in the number of fitness to practise data breaches from 68 fitness to practise related data breaches in 2012/13 to 48 in 2013/14, we consider that the number of breaches is still high and that, combined with the seriousness of the data breaches the NMC has experienced in 2013/14, means that this Standard is still not met. These breaches included information about individual fitness to practise cases being sent to the wrong person, publishing incorrect information on the NMC website about the details of allegations, a loss of a laptop computer, and the inappropriate publication of an interim order decision where health information and other matters relating to the registrant had not been redacted. We note that the NMC has continued its work to strengthen its information security in accordance with ISO20071 and we hope that we will see real improvement in this area in the performance review 2014/15. Continued poor performance in this area could impact adversely on public confidence in the NMC, as well as on the willingness of individuals to become involved in its regulatory activities (including giving evidence in fitness to practise cases).

¹⁵³ see Professional Standards Authority, 2014. *Former Mid Staffordshire Chief Nurse struck off register*. 6 February 2014. Available at <http://www.professionalstandards.org.uk/footer-pages/news-and-media/latest-news/news-article?id=5901589e-2ce2-6f4b-9ceb-ff0000b2236b> [Accessed 22 May 2014].

18. The Pharmaceutical Society of Northern Ireland (PSNI)

Overall assessment

- 18.1 In 2013/14, all the Standards of Good Regulation, except one, were met by the PSNI. We were unable to conclude that the PSNI met the tenth Standard of Good Regulation for fitness to practise (information about fitness to practise cases is securely retained) due to a significant data protection breach which occurred in June 2013. We set out the details of this breach in paragraphs 18.28–18.30 of this report.
- 18.2 In the 2012/13 performance review, we reported that we anticipated that the changes brought about to the PSNI's powers by the Pharmacy (1976 Order) (Amendment) Order (Northern Ireland) 2012 would strengthen the PSNI's ability to protect the public more effectively. These changes included enabling the PSNI to:
- Impose a range of sanctions on registrants whose fitness to practise was found to be impaired, whereas previously it had been limited to removing registrants from its register
 - Publish sanctions imposed on individual registrants
 - Impose interim orders restricting the practice of registrants whose fitness to practise was called into question to the extent they may pose a risk to the public, themselves or the profession
 - Find a registrant's fitness to practise impaired on health grounds, and restrict their practise as necessary.
- 18.3 The legislation also introduced, for the first time, a mandatory obligation on registrants to carry out continuing professional development (CPD).
- 18.4 In the 2012/13 performance review, we reported that we were unable to conclude that, despite the introduction of the new powers above, the PSNI had met the second Standard of Good Regulation for education and training (*through the regulator's continuing professional development/revalidation systems, registrants maintain the standards required to stay fit to practise*) as the mandatory CPD scheme had not been implemented at that time. The mandatory CPD scheme has now been implemented and we are pleased to report that the PSNI has met this standard in 2013/14.
- 18.5 In 2012/13, we also reported that we were unable to conclude that the PSNI had met the fourth *Standard of Good Regulation for fitness to practise (all fitness to practise complaints are reviewed on receipt and serious cases are prioritised and where appropriate referred to an interim orders panel)* as the PSNI had made limited use of its power to impose an interim order. In 2013/14, the PSNI has used this power appropriately on five occasions; therefore, we conclude that this standard is now met.

- 18.6 The PSNI's governance arrangements altered as a result of changes made to the Pharmacy (Northern Ireland) Order 1976 during 2012/13. We note a number of new initiatives flowing from this: in particular, we welcome the *Communications and engagement strategy* which is now in place, which places patients and service users firmly at the centre of the PSNI's focus and which should enable the PSNI to engage with its stakeholders more effectively. We also commend the PSNI for introducing a formal strategic plan for internal audit, based on its risk register. We anticipate that this development should allow the PSNI to more clearly understand its performance in areas of risk, including maintenance of its obligations under the Data Protection Act 1998.
- 18.7 The PSNI plans to carry out a perceptions survey of the public in 2014. This will seek to identify public awareness of the PSNI and its role, and the PSNI proposes to use the survey results as baseline data for use in considering how best to promote public confidence in the regulator. We look forward to following up on the outcomes of this strategy in the performance review 2014/15.

Guidance and standards

- 18.8 The PSNI has continued to meet all the *Standards of Good Regulation* for guidance and standards during 2013/14. The PSNI demonstrated this by maintaining and reviewing its standards of competence and conduct and its additional guidance and by engaging effectively with its stakeholders in that work.
- 18.9 Examples of how the PSNI has demonstrated that it met these Standards are:
- Progressing the review of the *Code of Ethics* which began in 2013 with the aim of ensuring that it remained up to date, relevant to current pharmacist practice, and reflected healthcare developments, such as the *Francis Report*¹⁵⁴ and the Rebalancing Programme.¹⁵⁵ The review commenced in November and December 2013 with meetings with a variety of stakeholders to gather their views about the Code. The PSNI plans to engage further with its stakeholders and produce a discussion paper for its Council to determine policy direction in 2014, prior to consulting on a draft Code in February 2015. We will follow up on the PSNI's progress with this work in the performance review 2014/15
 - In June 2013, it became a statutory requirement for PSNI registrants to complete CPD. In May 2013, the PSNI published the *CPD Framework and Standards* which sets out the requirements and conditions registrants must meet, as well as the consequences of non-compliance. The PSNI

¹⁵⁴ Francis, R., 2013. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, chaired by Robert Francis QC, 2013. Available at <http://www.midstaffpublicinquiry.com/report> [Accessed 22 May 2014].

¹⁵⁵ The Rebalancing Medicines Legislation and Pharmacy Regulation Programme Board is reviewing the balance between pharmacy and medicines legislation and regulation to ensure these provide safety for users of pharmacy services, reduce unnecessary legislation, and allow innovation and development of pharmacy practice. The PSNI is a member of the Board. More information can be found at <https://www.gov.uk/government/policy-advisory-groups/pharmacy-regulation-programme-board> and <http://www.dhsspsni.gov.uk/pas-rebalancing-project> [Both accessed 22 May 2014].

carried out a second round of consultation in late 2013 in order to obtain views on: the removal of registrants from the register as a result of non-compliance with the standards, appeals against removal, and subsequent restoration (the PSNI was unable to consult on these issues prior to publication of the framework, due to legislative changes which were required). At the time of writing, the PSNI was evaluating the consultation responses.

- 18.10 In the 2012/13 performance review, we reported that the PSNI had issued revised guidance for registrants on raising concerns about another health professional, in response to a survey of employers which suggested a significant proportion of employers (38 per cent) did not believe action should be taken against registrants who did not raise concerns. In December 2013, the PSNI carried out a registrant survey on a range of issues, including use of the guidance and factors which might prevent them raising a concern. The results indicated that there are a number of factors which might prevent registrants from raising concerns about other health professionals, including: not knowing the process to raise a concern, fear of the effect of reporting colleagues on working relationships/jobs, and not being supported by employers. The PSNI is currently reviewing its guidance on raising concerns about another health professional, as this has been in place for a year. We will follow up on this in the performance review 2014/15; we share the PSNI's concern that there remains reluctance by some pharmacists in Northern Ireland to raise concerns about fellow health professionals.
- 18.11 The PSNI proposes to carry out an annual survey of its registrants, using the December 2013 survey results (noted above) as baseline data. We consider that this proposed annual survey has the potential to be a valuable exercise: however, we noted that the response rate to the December 2013 survey was low, at around 10 per cent which, in our view, makes it difficult for the PSNI to draw firm conclusions from the data that it generated. In our performance review report for 2012/13 we noted that the PSNI planned to consider the engagement strategies used by other regulators to forge close links with a wider range of stakeholders. We would encourage the PSNI to look again at the methods used by other regulators, in order to assess whether it could help to improve the level of stakeholder engagement it currently achieves when undertaking registrant surveys.

Education and training

- 18.12 In previous years' performance reviews, we were unable to report that the PSNI met all the *Standards of Good Regulation* for education and training because there was no mandatory regime in place by which the PSNI could assure itself of the continuing professional development (CPD) of its registrants.
- 18.13 We are pleased to report that the PSNI now meets all the *Standards of Good Regulation* for education and training because, as of June 2013, it became a statutory requirement for all PSNI registrants to complete CPD. This means that the PSNI is now able to remove from its register any registrants whose fitness to practise cannot be assured due to a failure to complete CPD. The PSNI published its *CPD Framework and Guidance* in May 2013, and June

2014 represents the deadline for the first annual submission by registrants of their CPD evidence. The PSNI will take the same approach to auditing CPD records as it adopted when CPD was purely voluntary. We look forward to seeing the outcomes of the first year of the mandatory CPD scheme.

18.14 As a result of the implementation of the mandatory CPD scheme, the PSNI is now in a better position to develop a continuing fitness to practise (CFtP) scheme. Such a scheme will enhance the assurance that the PSNI can provide to the public that its registrants continue to meet the required standards of conduct and competence. The PSNI has commissioned research into CFtP and is currently developing a CFtP model based on the existing CPD scheme. The introduction of such a scheme will require the support of the Department of Health, Social Services and Public Safety for Northern Ireland (DHSSPSNI), as further changes will be needed to the Pharmacy (Northern Ireland) Order 1976. We support the PSNI's commitment to progressing to a CFtP scheme.

18.15 The PSNI has also demonstrated that it has continued to meet the other *Standards of Good Regulation* for education and training during 2013/14, for example:

- It continued to quality assure the pre-registration training programme, including obtaining feedback from trainees, tutors and examiners
- In the 2012/13 performance review, we reported that the PSNI had implemented an online portfolio system for pre-registration trainees that mirrored the CPD system for registrants. In 2013/14, the PSNI has reported that this system allowed the early identification of trainees who may need further assistance from tutors, and that the online portfolio system has received positive feedback from trainees and the PSNI has made further enhancements to it in response to feedback from trainees and tutors. We note that the annual survey of pre-registration trainees at the point of registration, which was conducted at the end of the 2012/13 assessment year, revealed a high degree of satisfaction with the online portfolio system. We conclude that the implementation of the online portfolio system has had positive outcomes both for trainees and for the PSNI in developing its pre-registration trainee programme.

18.16 The PSNI quality assures three educational institutions in conjunction with the General Pharmaceutical Society (GPhC). We would encourage both regulators to put in place a procedure to facilitate the raising of concerns by students and other parties about educational institutions, to further support their quality assurance processes. Other regulators that we oversee have put in place such a procedure and have found it to be a useful source of information, as well as a means of identifying risks about the quality of education and training provision outside of accreditation visits.

Registration

18.17 The PSNI has continued to meet all the *Standards of Good Regulation* for registration. It has demonstrated this by:

- Ensuring that only those who meet the requirements are registered. The PSNI carried out an internal audit of its registration process in November

2013 which identified that no incorrect registration decisions had been made (although some record-keeping errors were identified). The auditors made a series of recommendations to address the record-keeping issues, which the PSNI has incorporated into an action plan. An external audit of the whole registration function is due to take place in 2014/15 as part of an audit of all business activity, and that audit should provide an indicator of the robustness of the registration function

- Publishing fitness to practise information about registrants on the online register and the PSNI website. In the 2012/13 performance review, we reported that the PSNI had put in place an interim policy about the publication and disclosure of fitness to practise information on the public-facing register, following the extension of the sanctions open to it, as of October 2012. The PSNI carried out a consultation in Spring 2013 but a final policy has yet to be put in place
- Continuing to promote to employers the importance of checking the registration status of employees: for example, the PSNI asked all pharmacy premises, on annual renewal of registration, to confirm that register checks of employees had been carried out.

Registration of pharmacy technicians

- 18.18 Pharmacy technicians in Northern Ireland are not required to be regulated by, or registered with, the PSNI. This is in contrast to pharmacy technicians in Great Britain, who must be registered with the GPhC in order to practise.
- 18.19 In the 2012/13 performance review, we reported that the PSNI would be undertaking work to consider the value of holding a voluntary register for pharmacy technicians in Northern Ireland. As part of that work the PSNI considered the results of surveys, and obtained legal advice. Following that work, it concluded that further work was required in order to ascertain the risk posed by pharmacy technicians and the need for regulation. A survey seeking to assess those risks will be undertaken in 2014. We consider that the PSNI is taking a right-touch¹⁵⁶ approach to this issue.
- 18.20 The PSNI has identified that the outcomes of the Rebalancing Programme¹⁵⁷ may strengthen the case for the compulsory registration of pharmacy technicians in Northern Ireland, as it may result in a relaxation to the direct supervision by registered pharmacists of pharmacy technicians' practice in Northern Ireland.
- 18.21 We look forward to following up on the results of the survey, as well as the PSNI's assessment of the impact of the Rebalancing Programme in the performance review in 2014/15.

¹⁵⁶ CHRE, 2010. *Right-touch regulation*. Available at <http://www.professionalstandards.org.uk/policy-and-research/right-touch-regulation> [Accessed 22 May 2014].

¹⁵⁷ See footnote 155.

Fitness to practise

- 18.22 In 2013/14, the PSNI has met nine out of the ten *Standards of Good Regulation* for fitness to practise. The PSNI did not meet the tenth Standard (*information about fitness to practise cases is securely retained*) due to a serious data protection breach which occurred in June 2013, details of which are set out in paragraphs 18.28–18.30 below. However, we are pleased to report that the PSNI’s performance against the *Standards of Good Regulation* for fitness to practise has improved generally since the performance review 2012/13, as it has demonstrated that it now meets the fourth *Standard of Good Regulation for fitness to practise (all fitness to practise complaints are reviewed on receipt and serious cases are prioritised and where appropriate referred to an interim orders panel)*.
- 18.23 Examples of the activities undertaken by the PSNI to enable it to demonstrate that it met nine of the *Standards of Good Regulation* for fitness to practise are below:
- In 2012/13, we reported that, while the PSNI had acquired new powers to make interim orders as a result of the changes to the Pharmacy (Northern Ireland) Order 1976, these powers had only been used on one occasion, and we were therefore unable to confirm that the PSNI was making appropriate use of the powers. In 2013/14, the PSNI made five interim order applications, all of which were granted; none were appealed.¹⁵⁸ We consider that the PSNI has made good use of this power in 2013/14 in the context of the number of complaints that the PSNI receives
 - In September 2013, we carried out an audit of the initial stages of the PSNI’s fitness to practise process. This provided us with the opportunity to scrutinise the PSNI’s application of its newly implemented powers and processes, following the changes to its legislative framework which we reported on in 2011/12 and 2012/13. We concluded in our audit report¹⁵⁹ that the PSNI was continuing to operate effective systems and processes in most areas of the initial stages of its fitness to practise process. We made a series of recommendations in respect of record-keeping, customer care, evidence gathering and the application of the threshold criteria which the PSNI is in the process of implementing. One of our audit findings has the potential to impact on public confidence in the PSNI. We reported our concern that the PSNI was commencing investigations into complaints which did not raise a fitness to practise issue, and we recommended that the PSNI appropriately limits the scope of its response to such complaints. We will carry out a further audit in 2014, and will look for evidence of a change in the PSNI’s approach. We were reassured to note that the PSNI’s own internal audit process similarly identified many of the issues we found during our audit

¹⁵⁸ Where a regulator receives a complaint which suggests a registrant poses a significant risk, a prompt application must be made by the regulator to a decision-making panel for an order restricting the registrant’s right to practise whilst the case is investigated.

¹⁵⁹ Professional Standards Authority, 2014. *Audit of the Pharmaceutical Institute of Northern Ireland’s initial stages fitness to practise process*. Available at: <http://www.professionalstandards.org.uk/library/document-detail?id=bfd579e-2ce2-6f4b-9ceb-ff0000b2236b> [Accessed 22 May 2014].

- An external audit of the PSNI's fitness to practise function is due to take place in 2013/14 as part of an audit of all business activity. We will follow up on the outcomes of that audit in the performance review for 2014/15
- At the end of 2013, the PSNI published on its website learning points for registrants arising from the final fitness to practise decisions made during the year. We consider this to be a valuable learning tool for registrants to highlight both the standards which are expected of them and the consequences of breaching those standards. The publication of these learning points should also assist the public to understand the standards they should expect from registrants
- Since April 2013, the PSNI has been part of the Pharmacy Network Group (PNG) which includes the DHSSPSNI and the Health and Social Care Board (HSCB). Together, these three organisations have responsibility for investigating complaints about pharmacists and pharmacies in Northern Ireland. They work collaboratively: the DHSSPSNI investigates allegations of breaches of legislation; the HSCB investigates service complaints; and the PSNI investigates allegations concerning professional conduct and competence. The PSNI informed us that the number of complaints being referred to it via the PNG has increased during 2013/14, which it believes is a result of its powers, since the legislative changes introduced in 2012, to impose a greater range of sanctions and to impose interim orders. We have not seen evidence of any increase in the number of referrals received from the PNG, but will follow this up in the performance review 2014/15. The PSNI also told us that it anticipates more complaint referrals being made to it, if the Rebalancing Programme¹⁶⁰ results in some pharmacy-related offences being de-criminalised (because those matters would cease to fall under the remit of the DHSSPSNI)
- In February 2014, the PSNI introduced a process for obtaining feedback from registrants and complainants about the service they received during the fitness to practise process. We encourage obtaining third-party feedback from participants in the fitness to practise process, as a means of both identifying areas for improvement, and demonstrating that the regulator values the contribution made by the public and registrants in investigating fitness to practise issues. We will follow up the outcomes of this work in the audit and the performance review for 2014/15; this will include any changes the PSNI makes to its processes as a result of the feedback received
- Under Section 29 of the National Health Service Reform and Health Care Professions Act 2002, we have the power to lodge a High Court appeal against any 'unduly lenient' decision made by the Statutory Committee¹⁶¹ of the PSNI. Since the widening of the range of sanctions that the Statutory Committee can impose, as of October 2012 (see paragraph

¹⁶⁰ See footnote 155.

¹⁶¹ The Statutory Committee is the decision-making panel of the PSNI which adjudicates on fitness to practise cases which have not been closed at the initial stages of the fitness to practise process.

18.2), we have not identified any Statutory Committee decisions that we consider are 'unduly lenient'. This indicates that the Statutory Committee is making appropriate use of the range of sanctions available to it.

- 18.24 The PSNI intends to review its indicative sanctions guidance (the guidance for the Statutory Committee to follow when deciding on which sanction to impose) during 2014. We will follow up on this in the performance review 2014/15. We are concerned that the PSNI did not consult on the current guidance and would encourage the PSNI to consult on any suggested revisions to it. Further, we note that the guidance is not publicly available and would encourage the PSNI to ensure it is on its website.
- 18.25 We note that, in 2013, the PSNI failed to meet its own key performance indicators (KPIs) relating to the time taken to conclude cases by the Statutory Committee. No cases met this KPI.¹⁶² The PSNI also failed to meet its KPI for the time taken for the Registrar to either close or refer cases to a decision-making panel after a report is received from the DHSSPSNI or HSCB. 46 per cent of cases failed to meet this KPI.¹⁶³ We recognise that 2013/14 was the first year that performance against these KPIs was measured, following the introduction of new fitness to practise procedures as a result of the legislative changes in October 2012, and that some delays are of historic nature. We concluded that these delays did not result in a failure to meet the sixth standard. However, we are concerned that they do have the potential to reduce public confidence in the PSNI, and would therefore encourage the PSNI to keep under review whether they are realistic and achievable. We will follow this up in next year's performance review.
- 18.26 The PSNI informed us that it has learnt from its review of the cases which were not concluded within the time specified in the KPI, and that it is confident that it will improve its performance against these indicators. Action points that the PSNI considers will enable it to improve its performance against the KPIs include: taking a more robust approach with registrants who delay in responding to requests for information; and holding case management meetings with registrants and their solicitors to agree evidence ahead of a final hearing.
- 18.27 The PSNI has already taken some steps to reduce other delay factors: it has put in place a new procedure for health assessments to improve timescales for obtaining health assessments and it has entered into a dialogue with the Police Service of Northern Ireland that has resulted in the speedier disclosure of convictions and cautions. We will follow up in our performance review 2014/15 on the outcomes of the measures that the PSNI has introduced to improve timeliness and performance against its KPIs.

¹⁶² The KPI for the time taken for a case to be closed by the Statutory Committee from initiation of an investigation is for 90 per cent of cases to be closed in less than 210 days.

¹⁶³ The KPI for the time taken for a case to be closed by the Statutory Committee following referral from the Scrutiny Committee (being the decision-making panel which decides whether to close a case or refer it to the Statutory Committee for a final hearing) is for 90 per cent of cases to be closed in less than 70 days from the point of referral.

***The tenth Standard of Good Regulation for fitness to practise:
Information about fitness to practise cases is securely retained***

- 18.28 In June 2013, personal and sensitive data relating to 80 individuals was removed from the PSNI's offices by a contractor, and left in a publicly accessible space, instead of being securely disposed. The data included highly sensitive information relating to individual fitness to practise cases and criminal investigations. The material had been erroneously categorised as being general waste by PSNI staff, and no log had been kept of the data disposed of. When the PSNI was alerted by a member of the public to their discovery of the data (several weeks after the contractor had removed it from the PSNI's offices), it took immediate steps to recover it and contacted all the individuals whose details were contained in the data discovered. The PSNI also, appropriately, referred the breach to the Information Commissioner's Office (ICO). The PSNI carried out an internal investigation to ascertain why the material had not been treated as confidential waste. It also sought legal advice and put in place an action plan designed to prevent any recurrence, including providing staff training and reviewing its policies and procedures. In light of the action that the PSNI had taken, the ICO decided not to take any enforcement action, but instead issued advice to the PSNI. As a consequence of the seriousness of the breach and the fact that we considered the PSNI did not meet our tenth Standard, we wrote to the ICO in relation to its decision. The ICO confirmed that its usual procedures were followed when it assessed the PSNI's data breach.
- 18.29 The PSNI expressed to us its regret that it had breached its duty of care to the individuals concerned and stated that it is confident that it has taken appropriate action to mitigate against a risk of repeat (for example, it revised its data protection policy, trained all staff on the implications of the policy, and put in place data protection agreements with all contractors handling data), and is working towards obtaining ISO27001 certification for information security management.
- 18.30 Due to the serious nature of this breach, we are unable to conclude that the PSNI met the tenth *Standard of Good Regulation* which requires it to retain fitness to practise information securely. We hope that the measures put in place by the PSNI will enable it to comply with data protection principles in future. We would be very concerned if a significant breach was to occur again.

19. Conclusions and recommendations

- 19.1 There is much to commend in the work of the nine health and care regulators: their active consideration of their roles and responsibilities, their attempts to improve their work, their serious response to the *Francis Report*, to the challenge of continuing fitness to practise and to legislative change. The regulators have worked constructively with the Law Commissions and the Department of Health on proposals to reform the legal framework of professional regulation in the UK.
- 19.2 Less positive is the variation in performance of regulatory functions and persistent weakness in some regulators in registration, fitness to practise and data security. We expect the regulators to address the issues relevant to them and will review progress in 2014/15.
- 19.3 We have drawn attention, at the end of each of the sections within each regulator's performance review report, to the areas of that regulator's work which we intend to follow up on in next year's performance review. We have also included within each regulator's performance review report any recommendations about areas of concern. In addition to this, we make the following general recommendations.

For the regulators

- 19.4 We recommend that the regulators should:
- Review this year's performance review report as a whole, taking account of our views, and consider whether they can learn and improve from the practices of the other regulators
 - Address any areas of concern that are highlighted in this year's performance review report
 - Ensure that their Councils review and discuss the performance review report in a public Council meeting.

For the Authority

- 19.5 We will begin to revise the approach that we take to the annual performance review during 2014. We will seek the views of our stakeholders during the development of the revised process. We will also take account of good practice in relation to performance review, both within and outside of the health sector.

For the Departments of Health in the UK

- 19.6 Following the publication of the Law Commissions' proposed Bill, we recommend that the Departments of Health in the UK take account of our commentary and findings in this report if and when they prepare the Government's own Bill in relation to changes to health and care regulation.

20. Annex 1: Index of regulated health and care professions

Regulator	Regulated profession
General Chiropractic Council	Chiropractors
General Dental Council	Dentists Dental hygienists Dental therapists Clinical dental technicians Orthodontic therapists Dental nurses Dental technicians
General Medical Council	Doctors
General Optical Council	Dispensing opticians Optometrists
General Osteopathic Council	Osteopaths
General Pharmaceutical Council	Pharmacists Pharmacy technicians
Health and Care Professions Council	Arts therapists Biomedical scientists Chiropodists Clinical scientists Dieticians Hearing aid dispensers Occupational therapists Operating department practitioners Orthoptists Orthotists Paramedics Physiotherapists Podiatrists Practitioner psychologists Prosthetists Radiographers Social workers in England Speech and language therapists
Nursing and Midwifery Council	Nurses Midwives
Pharmaceutical Society of Northern Ireland	Pharmacists

21. Annex 2: Our Standards of Good Regulation

Introduction

21.1 Our *Standards of Good Regulation* cover the regulators' four core functions. These are:

- Setting and promoting guidance and standards for the profession(s)
- Setting standards for and quality assuring the provision of education and training
- Maintaining a register of professionals
- Taking action where a professional's fitness to practise may be impaired.

21.2 The *Standards of Good Regulation* are the basis of our performance review process. They describe the outcomes of good regulation for each of the regulators' functions. They also set out how good regulation promotes and protects the health, safety and well-being of patients, service users and other members of the public, and maintain public confidence in the profession.

Using the *Standards of Good Regulation* in the performance review

21.3 We ask the regulators to submit evidence on whether they meet the standards and how they have evaluated the impact of their work in promoting and protecting the public and maintaining public confidence in the profession. To help the regulators in the drafting of their submissions, we have suggested examples of the type of evidence that they could provide us with. We will also provide an evidence template for the regulators to complete. The suggested evidence may change over time.

21.4 Once we have received the regulators' evidence, we assess their performance against the standards by:

- Identifying each regulator's strengths
- Identifying any areas for improvement
- Identifying good practice and excellence.

21.5 We also ask the regulators at the beginning of their evidence (Section 1) to comment on their overall performance by answering a set of questions.

22. Annex 2, Section 1: Overview

Introduction

22.1 This section covers general issues relating to the regulators' performance, including how they have responded to last year's review, how they comply with the principles of good regulation and their liaison with other bodies.

Response to last year's performance review

- What consideration have you given to issues raised in the previous year's performance review report, including the adoption of any good practice?
- How have you addressed the areas for improvement identified in your individual performance review report?
- Where has your performance improved since last year?
- What areas for concern have you identified in each of the four functions and how have these been addressed?
- What areas of good practice have you identified in each of the four functions?

Responding to change, learning and information

- How is learning from the following five areas taken into account in each of the functions?
- Other areas of your work such as fitness to practise, policy development or quality assurance of educational institutions?
- Organisational complaints?
- The outcomes of the Authority's work?
- Feedback from stakeholders from the four UK countries?
- Public policy programme reports from the four UK countries?
- How have you addressed information, other than formal fitness to practise complaints, which you may have received from other sources on possible failures in performance of organisations or individuals?
- How have you responded to changes in regulation or forthcoming changes in regulation?

Liaison with other bodies

- How have you worked with service regulators, other regulatory bodies or other bodies with shared interests to:
 - Ensure that relevant intelligence is shared, within legislative requirements, on individuals or organisations?
 - Ensure that cross regulatory learning is shared?

23. Annex 2, Section 2: Guidance and standards

Introduction

- 23.1 All of the regulators are responsible for publishing and promoting standards of competence and conduct. These are the standards for safe and effective practice which every health and care professional should meet to become registered and to maintain their registration. They set out the quality of care that patients and service users should receive from health and care professionals.
- 23.2 Regulators also publish additional guidance to address specific or specialist issues. These complement the regulators' standards of competence and conduct.

The *Standards of Good Regulation* relating to guidance and standards

1. Standards of competence and conduct reflect up-to-date practice and legislation. They prioritise patient safety and patient-centred care.
2. Additional guidance helps registrants apply the regulators' standards of competence and conduct to specialist or specific issues, including addressing diverse needs arising from patient-centred care.
3. In development and revision of guidance and standards, the regulator takes account of stakeholders' views and experiences, external events, developments in the four UK countries, European and international regulation, and learning from other areas of the regulators' work.
4. The standards and guidance are published in accessible formats. Registrants, potential registrants, employers, patients, service users and members of the public are able to find the standards and guidance published by the regulator and can find out about the action that can be taken if the standards and guidance are not followed.

How does good regulation through standards and guidance promote and protect the health, safety and well-being of patients, service users and other members of the public and maintain public confidence in the profession?

- Provides a clear framework that health professionals in the UK and social workers in England should meet when providing care, treatment and services to patients and service users
- Provides a clear framework so that members of the public, service users and patients can hold registrants to account by raising concerns when the standards and guidance are not followed
- The standards and guidance meet the needs of relevant stakeholders.

What evidence could be provided?

23.3

We need to know:

- How the regulators have met the *Standards of Good Regulation*
- How they have evaluated the impact of their work in this area.

23.4

The following evidence could be provided:

- The standards of competence and conduct and information on how they reflect up-to-date practice and legislation, prioritise patient safety and patient-centred care
- Guidance produced or being developed and how this will help registrants apply the regulators' standards of competence and conduct to particular issues
- Plans for reviewing or developing guidance and standards, including what stakeholders were approached and how their views and experiences were taken into account alongside external events and learning from other areas. The outcomes of the revision or development and how the learning from this work is used within and outside of the standards and guidance function
- Details of how the regulators ensure that the documents are understandable and accessible: for example, publication in different languages, easy read, plain English and circulation in GP practices and Citizen Advice Bureau
- Evidence of work undertaken to take account of the developments in European and international regulation
- The mechanisms used by the regulator to assess how they are performing and how they use the results to improve their practices.

24. Annex 2, Section 3: Education and training

Introduction

- 24.1 The regulator has a role in ensuring that students and trainees obtain the required skills and knowledge to be safe and effective. They also have a role in ensuring that, once registered, professionals remain up to date with evolving practices and continue to develop as practitioners.
- 24.2 As part of this work, the regulators quality assure and, where appropriate, approve educational programmes which students must complete in order to be registered. Some also approve programmes for those already on the register who are undertaking continuing professional development, a particular qualification or specialist training.

The *Standards of Good Regulation* relating to education and training

1. Standards for education and training are linked to standards for registrants. They prioritise patient and service user safety and patient and service user-centred care. The process for reviewing or developing standards for education and training should incorporate the views and experiences of key stakeholders, external events and the learning from the quality assurance process.
2. Through the regulator's continuing professional development/revalidation systems, registrants maintain the standards required to stay fit to practise.
3. The process for quality assuring education programmes is proportionate and takes account of the views of patients, service users, students and trainees. It is also focused on ensuring the education providers can develop students and trainees so that they meet the regulator's standards for registration.
4. Action is taken if the quality assurance process identifies concerns about education and training establishments.
5. Information on approved programmes and the approval process is publicly available.

How does good regulation through education and training promote and protect the health, safety and well-being of patients, service users and other members of the public and maintain public confidence in the profession?

- Assures the public that those who are registered have and/or continue to meet the regulator's standards
- Assures the public that those providing education and training to students, trainees and professionals give them the required skills and knowledge so that they can practise safely and effectively
- Effective stakeholder involvement in the education and training process increases everyone's trust, confidence and knowledge of health

professional regulation in the UK and the regulation of social workers in England.

What evidence could be provided?

24.3 We need to know:

- How the regulators have met the *Standards of Good Regulation*
- How they have evaluated the impact of their work in this area.

24.4 The following evidence could be provided:

- The standards to be met by students and how they link to the standards of competence and conduct for registrants
- Where available, evidence of the regulator's mechanisms, which enable them to be aware of action taken by training establishments against students on fitness to practise issues and a system for learning from these outcomes. For example, are outcomes taken into account in the quality assurance process and revision of standards?
- The standards to be met by education and training providers, how these reflect patient- and service user-centred care and protect the public, and how they link to standards of competence and conduct for registrants
- Guidance given to education and training establishments to help ensure that disabled students do not face unnecessary barriers to successful careers in health in the UK or careers in social work in England
- The plans for reviewing or developing standards for students and education and training providers, including what stakeholders were approached, how their views and experiences and other areas of learning are taken into account. The outcomes of this work and how the learning from this work is used within and outside of the education function
- Details of the monitoring and approval processes for the education and training providers, including how the views and experiences of stakeholders and other quality assuring bodies are taken into account
- Details of how many assessments were undertaken, how many concerns were identified through the quality assurance process and what action was taken to address these concerns
- Details of how stakeholders can access the regulator's final assessments of education and training providers and the regulator's approval process: for example, through publication on its website
- Details of the regulator's revalidation proposals
- Details of how the regulator ensures that continuing professional development is targeted towards the professional developing their skills and knowledge in their areas of practice and that public protection is prioritised. For example, how many audits were carried out, were issues identified and how were these addressed?
- The mechanisms used by the regulator to assess how they are performing and how they use the results to improve their practices.

25. Annex 2, Section 4: Registration

Introduction

- 25.1 In order for a health professional to practise legally in the UK, and for social workers to practise legally in England, they must be registered with the relevant regulator. The regulators only register those professionals who meet their standards. The regulator is required to keep an up-to-date register of all the professionals it has registered. The register should include a record of any action taken against a professional that limits their entitlement to practise.

The *Standards of Good Regulation* relating to registration

1. Only those who meet the regulator's requirements are registered.
2. The registration process, including the management of appeals, is fair, based on the regulators' standards, efficient, transparent, secure, and continuously improving.
3. Through the regulators' registers, everyone can easily access information about registrants, except in relation to their health, including whether there are restrictions on their practice.
4. Employers are aware of the importance of checking a health professional's registration in the UK or a social worker's registration in England. Patients, service users and members of the public can find and check a health professional's registration in the UK or a social worker's registration in England.
5. Risk of harm to the public, and of damage to public confidence in the profession, related to non-registrants using a protected title or undertaking a protected act, is managed in a proportionate and risk-based manner.

How does good regulation through registration promote and protect the health, safety and well-being of patients, service users and other members of the public and maintain public confidence in the profession?

- Assures the public that professionals are regulated and are required to meet certain standards before they are able to provide care, treatment or services to them
- Informs the public of any limits imposed on the way a registered professional is allowed to practise
- Helps the public and others to identify and report those who practise illegally.

What evidence could be provided?

- 25.2 We need to know:
- How the regulators have met the *Standards of Good Regulation*
 - How they have evaluated the impact of their work in this area.

25.3

The following evidence could be provided:

- Details of the checks carried out by the regulator to ensure that only those who are fit to practise are registered including revalidation/CPD checks
- Details of the registration process, including the management of appeals and how the regulator ensures that applications are processed efficiently
- Evidence of activity undertaken to ensure that only EEA and international registrants that meet the regulators' standards, within the legal framework, are registered
- The number of registration applications considered
- The number of appeals considered
- The number of appeals upheld
- How the case management system/process enables the collection and analysis of reliable data to ensure that there is no bias in the process, with evidence of this testing being carried out by the regulator
- How the processes and procedures in place are fair, objective and free from discrimination
- The level of detail included on the register and the reasons for this: for example, a council decision, legislation, rules or the regulator's disclosure policy
- Evidence of the regulator's compliance with its information security policies and with the relevant legislation. The number of data loss/breach incidents which have occurred
- The activities undertaken to communicate to employers the importance of checking that a professional is registered. Evidence of employers informing the regulators that a professional is no longer registered or not registered
- How the regulators make their registers available to the public, service users and patients. Evidence of the amount of contacts from public, service users and patients about the regulator's registers
- Activities undertaken to identify non-registrants using a protected title or undertaking a protected act. Details of proportionate and risk-based action taken to reduce the risk of harm to the public and damage to public confidence in the profession of non-registrants using a protected title or undertaking a protected act: for example, increasing public awareness of the importance of health and care professional registration and regulation, sending 'cease and desist' letters, and fostering relationships with organisations that have a shared interest in preventing title misuse
- The mechanisms used by the regulator to assess how it is performing and how it uses the results to improve their practices.

26. Annex 2, Section 5: Fitness to practise

Introduction

26.1 Anyone, including members of the public, employers and the regulators themselves, can raise a concern about a registered professional's conduct or competence that calls into question their fitness to practise. The regulators are required to take action under their fitness to practise procedures where they receive such concerns. This can lead to a variety of outcomes including no further action, a registered professional being prevented from practising or restrictions being imposed on their practice.

The Standards of Good Regulation relating to fitness to practise

1. Anybody can raise a concern, including the regulator, about the fitness to practise of a registrant.
2. Information about fitness to practise concerns is shared by the regulator with employers/local arbitrators, system and other professional regulators within the relevant legal frameworks.
3. Where necessary, the regulator will determine if there is a case to answer and, if so, whether the registrant's fitness to practise is impaired or, where appropriate, direct the person to another relevant organisation.
4. All fitness to practise complaints are reviewed on receipt and serious cases are prioritised and where appropriate referred to an interim orders panel.
5. The fitness to practise process is transparent, fair, proportionate and focused on public protection.
6. Fitness to practise cases are dealt with as quickly as possible, taking into account the complexity and type of case and the conduct of both sides. Delays do not result in harm or potential harm to patients. Where necessary, the regulator protects the public by means of interim orders.
7. All parties to a fitness to practise case are kept updated on the progress of their case and supported to participate effectively in the process.
8. All fitness to practise decisions made at the initial and final stages of the process are well reasoned, consistent, protect the public and maintain confidence in the profession.
9. All final fitness to practise decisions, apart from matters relating to the health of a professional, are published and communicated to relevant stakeholders.
10. Information about fitness to practise cases is securely retained.

How does good regulation through fitness to practise promote and protect the health, safety and well-being of patients, service users and other members of the public and maintain public confidence in the profession?

- Assures the public that action is taken against those professionals whose fitness to practise is impaired
- Assures the public that those whose fitness to practise is impaired are not able to continue practising or practising unrestricted
- Helps the public to understand why action is and is not taken to limit a health professional's practice in the UK or a social worker's practice in England
- A joined up approach to fitness to practise mitigates the risk to public protection from regulators working independently of each other
- Effective involvement of all parties in the fitness to practise process increases trust, confidence in and knowledge of health and care professional regulation.

What evidence could be provided?

26.2 We need to know:

- How the regulators have met the *Standards of Good Regulation*
- How they have evaluated the impact of their work in this area.

26.3 The following evidence could be provided:

- Activities undertaken to publicise how all individuals (including those with particular health or language needs) and organisations can raise concerns about the fitness to practise of health and care professionals and the evaluation of this work. For example, publication of public information/employer leaflets, information available via the telephone or email and liaison with other organisations
- Examples of where the regulator has raised and taken forward a fitness to practise concern itself. For example, the number of cases taken forward and the reasons for this
- Examples of the regulator's work with other relevant bodies on when to refer fitness to practise complaints. For example, evidence of liaison with other organisations and feedback from those organisations on the effectiveness of this help
- Examples of information that has been shared between the regulators and other relevant bodies, within legal requirements, on the fitness to practise of individuals and the results of this work; for example, exchange of information through memoranda of understanding and, where possible, discussion on what use was made of this data
- Examples of where serious cases have been identified, prioritised and, where possible, referred to an interim orders panel; for example, the number of cases identified and the process for how this is carried out

- Examples of how the case management system and case management process helps prevent excessive delay and manages identified delays. Information on current timeframes and/or delays in the system
- Examples of how the regulator ensures that all parties are regularly updated on progress of the fitness to practise case. How many complaints were received about lack of update notification?
- How the case management system/processes enables the collection and analysis of reliable data to ensure that there is no bias in the process, with evidence of this testing being carried out by the regulator
- How the processes and procedures in place are fair, objective and free from discrimination
- Activities undertaken to meet the individual needs of parties to the fitness to practise process, particularly those who are vulnerable, and the outcomes of this work; for example, use of video link facilities, witness support arrangements, participant feedback surveys and numbers of complaints from participants about lack of support
- The appointment and appraisal process for committee members, panellists and advisors to fitness to practise cases. Relevant training, guidance and feedback provided to committee members, panellists and advisors to fitness to practise cases. How this has helped improve decision-making
- Evidence of steps taken to identify and mitigate risks in fitness to practise decisions, for example, outcomes of the regulator's quality assurance of decisions, number of appeals and their outcomes. How learning from this process is used to improve decision making
- The regulator's disclosure policy in relation to fitness to practise proceedings and the disclosure of fitness to practise information to third parties
- The regulator's information security policies and compliance with the relevant legislation. The number of data loss/breach incidents which have occurred
- The mechanisms used by the regulator to assess how they are performing and how they use the results to improve their practices.

27. Annex 3: Third-party feedback

27.1 As part of this year's performance review, we wrote to a wide range of organisations who we considered had an interest in how the regulators performed against the Standards of Good Regulation, and to our public and professional stakeholder networks. We invited them to share their views with us on the regulators' performance in relation to the standards. We explained that we would use the information provided to challenge the regulators' evidence and ensure that we had a more rounded view of the regulators' performance. We also placed a general invitation to provide views on the regulators' performance on our website.

27.2 Below is a list of the third parties whose feedback we took into account:

- British Chiropractic Association
- British Osteopathic Association
- Bupa
- Care Council for Wales
- Care Quality Commission
- College of Optometrists
- Council of Deans of Health
- Denplan Ltd
- Faculty of General Dental Practice (UK)
- HCL Permanent
- Healthcare Recruiters Ltd
- Medical and Dental Defence Union of Scotland
- NEMS Community Benefit Services Ltd
- NHS Grampian
- Pharmacy Voice
- Royal College of Midwives
- Royal College of Nursing
- Royal College of Radiologists
- St John Ambulance
- St Teresa's Hospice
- The Scottish Government
- UK Committee of Postgraduate Dental Deans and Directors (COPDEND)
- UNISON
- Unite the Union
- Yeovil District Hospital
- 135 individuals.

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