Agenda Item 16

Enclosure 13

Health and Care Professions Council
19 September 2018

Professional Standards Authority's Lessons Learned Review

To note

From John Barwick, Executive Director of Regulation

Council, 19 September 2018

Professional Standards Authority's Lessons Learned Review

Executive summary and recommendations

Introduction

In May 2018, the Professional Standards Authority (PSA) published its Lessons Learned Review of the Nursing and Midwifery Council's (NMC) handling of concerns about midwives' fitness to practise at the University Hospitals of Morecambe Bay NHS Foundation Trust.

This paper provides a high-level review of the PSA's findings and recommendations and identifies our current approach in these areas and any opportunities for improvement for us.

The report was also considered by the Tribunal Advisory Committee at their meeting in May 2018, and a statement of their view on how lessons learned should be applied to the independent panels and their recruitment and training is also included for information.

Decision

The Council is requested to note the document. No decision is required.

Background information

In February 2017, the Secretary of State for Health and Social Care asked the PSA to undertake a lessons learned review of the NMC's handling of concerns about midwives at the University Hospitals of Morecambe Bay NHS Foundation Trust, which arose in the midwifery unit at the Furness General Hospital.

The PSA's full report is available at:
https://www.professionalstandards.org.uk/docs/default-source/publications/nmc-lessons-learned-review-may-2018.pdf?sfvrsn=ff177220_0

Resource implications

Resourcing for identified fitness to practise development is provided for in the FTP Improvement Plan

Financial implications

None.

Appendices

Appendix 1 – NMC lessons learned paper
Appendix 2 - Statement from HCPC Tribunal Advisory Committee

Date of paper

5 September 2018

Appendix 1: PSA's Lessons Learned Review, May 2018

The NMC's handling of concerns about midwives' fitness to practise at the Furness General Hospital.

1. Introduction

1.1. In May 2018, the Professional Standards Authority (PSA) published its Lessons Learned Review of the Nursing and Midwifery Council's (NMC) handling of concerns about midwives' fitness to practise at the University Hospitals of Morecambe Bay NHS Foundation Trust.

1.2. This paper provides a high-level review of the PSA's findings and recommendations and identifies our current approach in these areas and any opportunities for improvement for us.

2. Background

2.1. Concerns about the midwifery care provided at Furness General Hospital (FGH) arose between 2004 and 2014. The NMC received its first complaint about midwives at the hospital in 2009 and it did not complete its work until 2017.

2.2. The concerns were the subject of an independent investigation[1] in March 2015, which found serious concerns about the clinical competence and integrity of the midwifery unit at the hospital. During 2004 and 2014 there had been a number of avoidable deaths of mothers and babies.

2.3. In February 2017, the Secretary of State for Health asked the PSA to conduct its review. The terms of reference made clear that it was a lessons learned review and included a review of the NMC's handling of complaints against midwives in the hospital arising out of events in 2008 and later, and in particular:

- The NMC's approach to managing the complaints
- The administration of the cases; and
- The relationship management with witnesses, registrants and other key stakeholders

2.4. The PSA concentrated on the processes and activities undertake by the NMC in investigating and prosecuting the cases and its approach to those with whom it works.

3. Main findings

3.1. The PSA, at section 4 of its report, discusses the issues it identified in the NMC's handling of the cases and from which lessons can be learned for the NMC and other health and social care regulators. The issues were:

[1] The Report of the Morecambe Bay Investigation, March 2015 by Dr Bill Kirkup CBE

- Record-keeping
- Identifying the key concerns and investigating complaints
- The management of the cases
- Looking at concerns beyond the individual cases
- The length of time taken
- Communication with families
- Transparency
- Problems with the legal framework of FTP

3.2. The PSA provides its lessons learned in relation to each of these issues at section 5 of its report. These relate to:

- Record keeping
- Identification of the issues
- Working with third party investigators
- Looking beyond the individual cases
- Working with others
- The treatment of families
- Transparency
- Flaws in the fitness to practise system

3.3. We provide a summary below of the findings, lessons learned and our current approach, and improvement opportunities under each relevant heading below.

Findings	Lessons learned	HCPC's approach and improvement opportunities
Record keeping		
The NMC's record keeping was, prior to 2014, poor. Whilst correspondence and information received from the parties to the case and third parties were usually saved on the case file, records of internal discussions, instructions and decisions were not consistently recorded or saved. This included discussions between the NMC staff and its external lawyers and case presenters, complainants, witnesses and registrants and their representatives. It also included conversations and meetings with senior members of the NMC's executive. Poor record keeping created a risk of a lack of continuity in approach and/or of ongoing understanding of the case, particularly when cases were handled by several individuals in succession. It made it	*Accurate and complete record-keeping is essential to keep sight of the issues in a case and its development and to enable the organisation to maintain a full audit trail of actions*. Record keeping, by its nature, is only as good as the individuals keeping the records and it encourages us to find ways in which we can monitor and encourage staff to maintain completed records of documents, conversations and decisions on the relevant files.	Our current case management system (CMS) supports good quality record keeping with built in controls, which retain all documents and correspondence received, produced and shared throughout the life of the case. It also contains a number of forms designed to record the decisions and reasons made by those managing our cases, which require management approval. Any requests for further instruction from the Case Manager, from our external lawyers is received via a dedicated email inbox. Details are then recorded on our Case Management System, and any further clarification done via the weekly teleconference. **Improvement opportunities:** the PSA audited a number of our fitness to practise cases in May 2017 and did not raise any widespread concerns about our record keeping. It identified that we could improve our recording of reasons for decisions relating to the SOA. We have, as part of the FTP Improvement Plan, implemented preliminary changes to address the concerns raised by the PSA about our application of the SOA. These have included the development and introduction of a new form for the recording of reasons for the SOA decision. This provides for better recording of the discussions and decisions made.

Findings	Lessons learned	HCPC's approach and improvement opportunities
difficult to establish what had happened in the past.		The importance of recording good quality reasons, and particularly identifying the decisions made in light of legal advice, formed part of the training on applying the SOA that was provided to all Case Managers and Case Team Managers in November 2017. We are doing a wider review of the SOA and its application and intend to introduce during the course of this year further improvements, which will also take account of these lessons learned.
Identifying the key concerns and investigating complaints		
The NMC had not identified all the issues in the cases or acted on information that could have been followed up. The causes of this included: • a lack of clinical knowledge in both its fitness to practise teams and external lawyers • over-reliance on local investigatory reports • failures to engage with the points raised by the families • failures to engage with information provided by Cumbria Police This meant that the investigations did not address all the possible	*Those analysing and investigating complaints need to have the time, expertise and support, including access to clinical advice to enable them to identify the concerns properly and to following them through.* The PSA identifies that there is no substitute for an intelligent analysis of a complaint by staff who have the time, skills and access to the right advice to ensure that right concerns are identified and taken forward. The PSA confirm that to achieve this, the regulators' staff:	Our Case Managers have access, when required, to registrant assessors who are able to provide clinical advice or an expert opinion on the issues arising in cases. Our operational guidance emphasises that the need for such advice or opinion will be required at the early stages of the investigation and prior to the drafting of any formal allegation. We have run a programme of profession specific workshops for our case management staff to inform them of the profession's scope of practice, working environment and the challenges that raise or relate to fitness to practise allegations. To date these have included workshops on social work and paramedic, physiotherapy and occupational therapist practice. In December 2016, we completed a realignment of the fitness to practise department, which has created teams that specialise in and focus on different parts of the fitness to practise process. This includes our Investigations Team whose specialism and

Findings	Lessons learned	HCPC's approach and improvement opportunities
concerns and decisions, such as whether to seek an interim order, were not informed by all of the issues.	• need to have the right expertise • are properly trained and supported • have access to expert advice, particularly clinical advice • are able to manage and criticise the work of external lawyers	core role is to investigate the concerns referred to it and to formulate allegations. New Case Managers complete an intensive induction programme, which includes training on key elements of our fitness to practise process, including assessing risk and applying the Standard of Acceptance. This is now supported through our e-learning platform. Ongoing development and training is provided to our staff. Each year we have a programme of development aimed at supporting the delivery of good quality fitness to practise work. In response to an increasing investigations caseload, we developed a Case Progression Plan, considered by Council in March 2018. This includes provision for the outsourcing of some investigation work and an increase in the resource in our Case Reception and Triage team. As part of our planned development work for 2017/18, aimed at improving the quality of our investigations and allegations, we: • piloted a new approach to investigation planning, which provides for the early identification of all the issues in the case that need investigating, the development of a focussed investigation plan and critical analysis of the information and evidence obtained. • developed our Draft Allegation template document to include a summary of the case produced by the Case Manager, a table requiring the Case Manager to identify the evidence supporting each particular of the allegation and a means of recording any matters that are not being proceeded with as they do not meet the SOA.

Findings	Lessons learned	HCPC's approach and improvement opportunities
		• Provided allegation drafting training to our Case Managers. This emphasised the need to prepare a plan before evidence gathering that included the identification of all concerns raised, to consider what evidence is needed to establish an allegation and how to draft an allegation and, in particular, how to draft allegations of dishonesty and lack of competence. • developed our Case Investigation Report template to include a summary of the case, identification of the primary and supporting evidence obtained and any rebuttal to any of the particulars made by the registrant. **Improvement opportunities:** the FTP Improvement Project includes a review of the role competences, skills, knowledge and behaviours for key fitness to practise roles and also an analysis and identification of actual time required to progress fitness to practise cases to the quality and timeliness required. The outcome of this work will inform a development programme for existing staff and a future resourcing plan and recruitment and retention strategy, ensuring we continue to have the right expertise and sufficient resource in the fitness to practise team. A new approach to investigation planning has been rolled out across the Investigation team following the successful pilot conducted earlier in the year. A policy setting out our approach to the identification and investigation of health allegations was approved by Council in May 2018. We review the input from our external lawyers at the monthly service level agreement meetings. We also seek written

Findings	Lessons learned	HCPC's approach and improvement opportunities
		feedback from the supplier on complaints from parties to the case, and on the lessons learned from cases where a final hearing panel do not find the facts or the grounds of a case.
Working with third party investigators		
Significant delays in the progression of the cases occurred as a result of the NMC putting their investigations on hold whilst third party investigations took place. An example provided was the delay of more than three years whilst the NMC waited for the outcome of an inquest and a police investigation. This approach was inconsistent with the GMC, who had not delayed its own investigation. The PSA also reports that both the police and Coroner were content for the NMC to continue with an investigation whilst their inquiries continued. The PSA recognises that there are a number of reason why you would postpone a fitness to practise investigation, which include: • the regulators investigation may prejudice police inquiries	*Regulators should work closely with other investigators and regulators to ensure that, so far as possible, they are able to act to protect the public and unnecessary delays are not caused by other investigations.* The NMC, at the time, had no specific guidance for its staff on the approach that should be taken when there were external investigations. Guidance now exists confirming that the starting point is that the investigation should take place without delay. Clear and compelling reasons for why an investigation should be put on hold must be provided and recorded and should include why doing so is considered to be in the public interest. The PSA welcomes this guidance	We outline above the steps we have and continue to take to ensure that our staff have the necessary specialism, skills and support to undertake their roles, including our Investigations case management team. Our case progression operational guidance clearly places the responsibility for managing the relationship and receipt of information from third parties on the Case Manager. The guidance identifies when and how requests for information should be made and chased. An escalation process exists for Case Managers to seek support and assistance from more senior colleagues when they are not receiving the responses or information they need in good time. When necessary, we will use the powers provided in Article 25(1) of the Order to require the disclosure of documents or evidence from third parties. The existence and use of the powers is explained in our operational guidance. We have number of memorandum of understandings with other organisations specifically designed to facilitate the sharing of fitness to practise information. This year we have been working with the Care Quality Commission (CQC) to develop an Emerging Concerns Protocol that provides for the early identification of serious, systemic and/or widespread concerns and for the sharing of that

Findings	Lessons learned	HCPC's approach and improvement opportunities
• the police and coroners have stronger investigatory powers and this can provide improved evidence for the regulator's own proceedings • the outcome of the investigations might affect decisions by the regulator • if there is a criminal conviction this means that the regulator can rely on the fact of the conviction as proof of the facts, and this can considerably shorten the regulators' own process.	and adds that each case is different and requires thoughtful analysis by properly supported staff who are familiar with the case and the issues and who communicates clearly with the third party investigators.	intelligence or information with other professional and systems regulators. **Improvement opportunities:** the FTP Improvement Plan provides for a review of our case management operational guidance and consolidation of this into one composite manual. This provides an opportunity for us to develop guidance that more expressly explains how we should manage our investigation when there are also ongoing third party investigations in to the same matters.
Looking beyond the individual cases		
The NMC tended to concentrate on the substance of the cases and whether they, as individual, cases could be proved. It did not consider whether information from one case might impact on others or that there might be wider public protection concerns. The NMC did not engage soon enough with allegations of	*Regulators should ensure their processes enable them to take account of all available and relevant information about cases and that intelligence is properly shared.* The NMC now has an Employer Link Service and Risk and	Our signposting operational guidance identifies a number of organisations that may be better placed than us to deal with certain types of concerns. It also identifies that we may wish to share information with these organisations. We also have prompts within some of our procedure documentation to cause a Case Manager to consider whether a referral to another organisation might be appropriate.

Findings	Lessons learned	HCPC's approach and improvement opportunities
dishonesty that were raised in many of the cases. Also, concerns about supervisory reports did not trigger questions about the quality of care provided by the midwives both generally and in the individual cases. The concerns involved questions of attitude and culture which were outside of the NMC's remit but which were within the remit of both the Trust and of the CQC. These wide failings were identified and possible solutions considered. These were left for discussion with more senior colleagues but the PSA could find no record of such discussion.	Intelligence Unit, which the PSA agrees should address many of the problems they saw. The PSA confirms that the success of these functions will depend upon the staff making up these teams and the leadership and guidance they receive.	We provide guidance on identifying information that raises a concern about education programmes and how this should be managed within the HCPC. We link cases on our CMS to ensure that, where appropriate and necessary, individual cases do not progress or are not considered in isolation of the other case(s). Our process for assessing risk in our fitness to practise cases requires the Case Manager to complete an assessment of risk on receipt of new information, this ensures the Case Manager promptly reads and considers the information received, in light of other information and evidence obtained in that and linked case. We explain above the steps we have and continue to take to ensure that our Investigations Case Managers identify all concerns that arise from the information we receive during our investigations. **Improvement opportunity:** we will be developing our operational guidance this year, as part of the FTP Improvement Plan, which provides an opportunity for us to expand our guidance to address this learning, where necessary. When the Emerging Concern Protocol is implemented, we will be providing training to our staff on the Protocol and the importance of identifying wider concerns that may be apparent in a case will form part of that training.
Working with others		
Concerns about the midwifery care provided were explored and/or	*Regulators must work with others in the health and care*	We explain above how we ensure that we are able to identify the issues that we ought to be investigating in our fitness to practise

Findings	Lessons learned	HCPC's approach and improvement opportunities
investigated by the Trust, police, coroner and CQC. Within its report the PSA comments on the engagement between the NMC and some of these organisations and the impact this had on the progression of the NMCs case and the decisions it was taking. Of particular note is the PSA's view that, as the NMC was not properly aware of the issues it ought to have been investigating, it was not in a position to challenge other organisations or press for information. For example, the PSA identifies that the NMC's investigations were hampered by the fact that the Trust was slow to answer its requests for information and, at times, indicated a confidence in its registrants' fitness to practise that was subsequently shown to be misplaced.	*systems to address concerns about patient safety.* The PSA saw some examples of the NMC working closely with Trusts and other regulators and its newly established Employer Link Service has the potential to achieve strong relationships with key stakeholders, including Trusts and the CQC. There remained a concern about what the NMC's position should be if a Trust or other regulator were failing to recognise a problem and whether it has powers to protect the public adequately in those circumstances. The PSA recognises that regulatory reform might be required to provide proportionate powers to ensure the public are protected in such situations.	cases. We also provide examples of how we work with organisations such as the CQC to identify, share and action information and intelligence that raises a public protection concern. We engage with and support employers to understand our role and to identify and mange fitness to practise concerns. This includes written guidance developed with employers, employer events and one-to-one meetings with specific Trusts and Councils. We have entered into a number of MOUs with organisations that inspect and/or investigate UK health services or are a UK devolved regulators of the professions we regulate in England. These MOUs outline our working relationships and promote patient safety and high quality care. We also have a joint operating protocol with the CQC setting out the operational model for the sharing of information. We continue to develop these working relationships and have, for example, recently entered into a new MOU with Care Council for Wales. We have MOUs with regulators in the other devolved states. We regularly engage with our registrants' professional associations and representative bodies to ensure they remain updated on our work, the developments we are making and the wider regulatory developments and challenges. This is well-attended open forum providing for constructive sharing of ideas to improve the way we work together. Improvement opportunity: in May 2018, Council considered our stakeholder communication and engagement plan for 2018/19. This identifies how we will be exploring with employers how we

Findings	Lessons learned	HCPC's approach and improvement opportunities
		can work with them to prevent concerns arising and ensure appropriate referrals. Council in March 2018 considered our Surrey Research Action Plan, which outlines what we will do to progress the recommendations made. These include exploring how we can continue to promote the importance of raising and escalating concerns and openness and honesty in light of reports of a blame culture, and when to refer and self-refer a fitness to practise concern to the HCPC.
The treatment of families		
The NMC's communication with the families was poor, sporadic and often confusing.	*Regulators must engage with patients and service users, ensure that they are informed of the processes and progress, and analyse and take their evidence seriously if they are to properly identify problems and hold public confidence.* The NMC has made major improvements to its work in providing support to witnesses at hearings. Some improvements with the regularity with which complainants were contacted after 2014	We have a robust witness support program in place for all witnesses attending hearings. Support mechanisms are in place to ensure that witnesses as well as patients and families feel supported before, during and after a hearing. We routinely request witness feedback after a hearing to help inform and improve our processes. Where issues are highlighted we will follow up with the witness to ensure that any concerns are addressed. **Improvement opportunities:** we can strengthen our approach in this area and we have reviewed our post-hearing witness de-briefing procedures to ensure follow up contact is made where relevant with witnesses to discuss their experience and ensure their wellbeing. We will continue to review the information available for witnesses, patients and families on our website to ensure that it is accessible and provides relevant information about the HCPC's fitness to practise process. A virtual tour of our

Findings	Lessons learned	HCPC's approach and improvement opportunities
	The PSA report that it found that culturally the NMC did not recognise the value that patient and family evidence provides or that patients and families have an interest in cases which, as a regulator, it needs to take seriously. Information for complainants - the families knew little about the NMC's process. Sharing the registrants' responses with complainants - the PSA had previously provided policy advice to regulators that supported the sharing of registrants' responses to concerns/allegations with the complainant.	dedicated hearing facilities is already on our website but we feel this could be strengthened with further online content, including relevant information and signposting for other sources of support for complainants, patients and families. We will also be strengthening our procedures to ensure that patients and families (who may not be a witness) but who nonetheless have an interest in the case are contacted and updated with information about fitness to practise cases. We do not automatically share registrants' responses with complainants. This is predominantly because registrants may provide information about their personal circumstances or sensitive information, which it would not be right to share with the complainant. We have some concerns too about the potential impact on length of time. This said, other regulators take a different approach and we intend looking again at this. However, doing so would be a significant change in our approach and it is not something that we propose to introduce until careful consideration has been undertaken. The ability to clarify elements of a case following receipt of registrants' responses is important and our current approach is to do this by questioning a complainant or witness at a later stage in our investigation. The PSA, in its review of our performance for 2016/17, raised concerns that our application of the Standard of Acceptance (SOA) created a barrier for members of the public who wished to raise concerns with us. Immediate, interim steps were taken to address these concerns in the short-term. We have now commenced a full review of the SOA and Council will be asked

Findings	Lessons learned	HCPC's approach and improvement opportunities
		to consider our revised approach in July 2018. The learning from this review will feed into that review and revised approach.
Transparency		
There were concerns about the transparency of the NMC during the investigation of these cases. In particular, these concerns relate to the NMC's engagement with one of the fathers (Mr A). Mr A requested sight of information and made a subject access request for information relating to him and his wife. Some documents disclosed to Mr A were heavily redacted to the point that it was not possible for him to understand the context of the information in the documentation. Also, two internal documents, that contained puerile and disrespectful comments about Mr A were not disclosed. The PSA report that had there been a commitment to transparency throughout the NMC, the documents could have been redacted in a more proportionate	*Regulators should aim to publish as much as they legitimately can so that they consider improve public confidence through transparency.* The PSA reports that, in its view, transparency involves being open about mistakes, demonstrating learning and includes providing information even where the organisation is not required to do so or where a more restrictive approach is permissible. The PSA considers that the NMC needs to look critically at its approach to providing information to the public in a way which goes beyond its published guidance and which actively attempts to be as open as it legitimately can without	The disclosure of information to parties who are involved in a live case always needs careful consideration. Not only do the usual requirements set out in the data protection laws apply, but also the need to ensure that potential witnesses and the evidence that they may provide are not compromised. We approach each subject access request on a case by case basis and respond to these 'in house' which we believe enables a greater sensitivity towards the individual case circumstances and requestor. Redactions are done by HCPC employees, not by external suppliers. We also use the mediation process as a vehicle to actively engage with complainants who may have concerns about how a case has been managed or how they have be dealt with to identify learning points where mistakes may have been made.

Findings	Lessons learned	HCPC's approach and improvement opportunities
way. It also considers it regrettable that the two documents were not disclosed, particularly as Mr A was interested in the NMC's culture. The PSA links its concerns about transparency with its comments about the NMC's approach to the families involved in these cases (see above) and that, having recognised it had made mistakes, it did not disclose the problems that had occurred.	damaging its own or other people's rights.	
Flaws in the fitness to practise system		
Significant clinical and cultural concerns about the midwifery unit at FGH were identified and further avoidable deaths occurred while the NMC were considering the complaints. It took the NMC eight years to complete its consideration of these concerns within its fitness to practise process. The PSA confirms that its review of these cases has strengthened its view that the fitness to practise process is not well suited, of itself,	*Regulators should work closely with employers and other stakeholders to deal with concerns which can be remedied without fitness to practise procedures and should avoid those processes where this can be done without compromising patient safety or the public interest.* The PSA report that when concerns of this sort are raised in the future, the regulator should:	We have welcomed and responded to the Department of Health's consultation *Promoting professionalism, reforming regulation*. Our response highlights the urgent need for legislative reform to deal with fitness to practise cases more flexibly and proportionately, avoiding the costs of lengthy investigations. We also confirm that we are keen to secure, as soon as possible, the immediate legislative changes we need to improve the effectiveness and efficiency of our regulatory functions. We annexed to our response our priorities for legislative changes, many of which are about driving improvements in our handling of fitness to practise cases. We are currently reviewing our approach to the Standard of Acceptance and will be able to take account of the PSA's outlined approach as part of this review. The challenge is to

Findings	Lessons learned	HCPC's approach and improvement opportunities
to with the range of concerns that arose at FGH. The The PSA acknowledged that immediate problems of competence, culture and attitude should be addressed by the employer and the CQC, in England, should deal with problems that arise out of systemic failings.	• Seek information from the employer about the registrant's practice generally and whether there are any other concerns which ought to be addressed • Analyse the information the employer critically and, if necessary, look directly at the other information available. • Consider with the employer whether it is possible to address those concerns by action at the local level without the need for regulatory procedures and, if so, monitor progress with the employer. • If there are concerns about the employer, involve the CQC at an early stage to address those concerns. • Only use fitness to practise process where it is clear that the employer is not taking satisfactory action or the employer does not have the levers to do so or if	achieve the appropriate balance between protection of the public and a proportionate, right touch regulation approach.

Findings	Lessons learned	HCPC's approach and improvement opportunities
	there are concerns about deep-seated incompetence, behaviour or attitudes which call into question whether the registrant should remain in the profession.	

Appendix 2: Statement from HCPC's Tribunal Advisory Committee

In May 2018, the HCPC's Tribunal Advisory Committee (TAC) considered the PSA's Lessons Learned Review, and noted the key areas of the report relating to fitness to practise proceedings in light of their terms of reference which primarily relate to the qualities/ competences required of Panel Members and the arrangements for their selection, training and assessment as well as advising on matters of practice and procedure relating to HCPC fitness to practise proceedings.

The TAC considered that Health and Care Professions Tribunal Service's tribunal 'culture' aims to be non-adversarial which is a strength and should be protected. However, the review highlights the important role of all Panel Members in ensuring that any inappropriate conduct towards witnesses at hearings is appropriately challenged and that any distress for witnesses giving evidence is minimised and appropriate support provided throughout the process. These responsibilities are embedded in the recently revised competences, especially those for Panel Chairs who are primarily responsible for controlling the tone of the hearing and setting expectations from the outset of a hearing. As a result of the report the TAC proposes to review, at its next meeting in September 2018, the relevant Practice Notes which provide guidance for all hearing participants.

The TAC also agreed that taking into account the voice of the complainant and/or patients/ families is vital, and regarded effective engagement with them throughout the fitness to practise process as particularly important in helping them understand the role of the regulator and HCPC's fitness to practise proceedings.