Professional Standards Authority for Health and Social Care

Review of Professional Regulation and Registration with Annual Report and Accounts 2016/2017



HC 89
SG/2017/83

professional standards authority

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Foreword

This last year has seen significant developments for the Authority as we completed the implementation of our new financial arrangements, consolidated our independence as envisaged in the Health and Social Care Act 2012, revised our performance review process, expanded the Accredited Registers programme and published an important contribution to regulatory policy, *Regulation rethought*.

We have also seen significant changes to our Board. In December 2016, we said farewell to three long serving members; Andrew Hind, chair of the Audit and Risk Committee, Jayne Scott and Stuart McDonnell. All had served a full eight years and all played an important role in establishing the Authority. I am pleased to welcome Frances Done as a Board member and chair of the Audit and Risk Committee along with Tom Frawley and Moi Ali, from Northern Ireland and Scotland respectively.

We also had changes in our directorates. Mark Stobbs, joined us from the Law Society, as Director of Scrutiny and Quality, replacing Rosalyn Hayles. Linda Allen, our long-serving Director of Governance and Operations, retired and her role was taken by John McDermott, who joined us from a Primary Care Trust.

We continue to be hopeful about what everyone now agrees is the necessary reform of professional regulation to meet the needs of a modern health and care workforce. We are also frustrated by the slow progress the government is making. Plans for a formal consultation on reform, based to a significant extent on our policy work, have been postponed and parliamentary time for the necessary legislation will be in short supply given the demands of leaving the European Union. In fact, the impact on the health and care work force of ending free movement of labour is likely to be considerable which makes regulatory reform to create flexibility even more necessary.

Our revised right-touch approach to reviewing the performance of the regulators has been successfully established. It has allowed us to focus on particular areas of their performance and reduce the burden on them. We have started the process of revising the *Standards of Good Regulation* to bring them up to date and will consult extensively in the coming year.

The Accredited Registers programme grows in size and impact. Twenty-three registers are accredited, covering 80,000 practitioners in 30 occupations. The programme has struggled to get the recognition it and the registers deserve, without which the full benefits for consumer choice and protection cannot be realised. We continue to work with the Department of Health to achieve financial sustainability and greater acknowledgment of the value of this proportionate and cost-effective approach to regulation.

I look back on my first full year as Chair knowing that our own performance is strong, that our financial basis is secure and that our reputation in the UK and internationally continues to grow. This is a strong foundation on which to face the challenges ahead.

This report is divided into two parts: the first is an overview of health and care professional regulation and the work of the regulators and accredited registers; and the second is the annual report and accounts of the Authority itself.

George R Jenkins OBE
Chair

Review of professional regulation and registration

1. Introduction

1.1 This report describes our view of the regulation and registration of people working in health and care in the UK in 2016/17. It fulfils our legal duty to inform Parliament each year how effectively regulation and registration are protecting the public. Our observations draw on evidence from performance reviews, audits, policy and research activities. We have also taken note of the views of people who have contacted us about the regulators and accredited registers or responded to our consultations and have drawn on published sources of the regulators and registers as well as others.

1.2 This is the second review of professional regulation and registration in this format. It gives us the opportunity in one report to draw out general themes arising from our oversight of the nine professional regulators and 23 accredited registers as well as insights from our work in regulatory research and policy. Here we provide Parliament with our views on how well the regulatory framework is operating to protect the public, uphold standards, and maintain public confidence. We also publish separate reports on the nine regulators.

1.3 The UK professional regulatory model is widely respected. The Authority itself, is regarded internationally as a leader of regulatory thought and development. In addition to advising our UK governments, we have been called upon for advice and expertise by governments and regulators in Australia, Canada, Ireland, Hong Kong, and New Zealand. This experience has of course broadened both our exposure and our understanding of effective regulation. We are sorry therefore, to have to express some concern about the ongoing robustness of the regulatory framework in the UK.

Regulatory reform

1.4 As we set out in detail in our reports, *Rethinking regulation*, and *Regulation rethought*, the UK is operating an outdated professional regulatory framework that requires reform to protect the public effectively and to enable it to respond to changing workforce needs. Three things drive the need for change. First, as the Law Commissions recommended, change is needed to remove restrictive and disjointed legislation which gets in the way of public protection. Second, it is out of step with the needs of a contemporary health and care system, which requires flexibility to accommodate innovation. Third, our understanding of the reasons for misconduct and incompetence has advanced so that a system predicated upon finding and removing individual 'bad apples' is inadequate to protect the public.

1.5 The extent to which professional regulation is written into primary legislation across a large number of Acts makes reform complicated and slow when it needs to be agile to keep pace with the extensive changes taking place in health and social care. In the UK, two attempts at regulatory reform have foundered in the last five years and a third is at risk. The last year has seen a number of incremental changes to individual regulator's legislation that demonstrate the disadvantage of making piecemeal changes. Consensual disposal is a good example of where lack of reform is constraining innovation. Regulators are seeking to improve the flexibility and speed with which they handle complaints by disposing of cases by consent where possible. Whilst we support such innovations in principle, regulators cannot

exceed the confines of their existing legislation and so we continue to express concerns about transparency and consistency in implementation.

1.6 Despite the urgent need for legislative change there is more that can be done within the current framework. We have seen real effort on the part of regulators to share information, improve transparency, and to collect and learn from data. Many of the professional regulators are now turning their attention upstream, looking for ways to prevent or reduce opportunities for harm rather than only intervening when harm has been done.

Regulatory policy

1.7 Government policy needs to be coordinated and consistent if the regulatory system is to operate with certainty. We have noted a number of policy decisions and actions that we think are contradictory. For example, a general intention to deregulate on the one hand and the recreation of a separate social worker regulator, removing social work regulation from the Health and Care Professions Council a mere five years after disbanding the former General Social Care Council. Similarly, the decision to regulate nursing associates with its attendant costs, taken in the absence of a proper role definition, assessment of the risks and the extent of assurance needed to manage them. We are perplexed by the emphasis on transparency and the imposition of a Duty of Candour, set against the creation of confidential enquiries by the new Healthcare Safety Investigations Branch.

1.8 We have also noted missed opportunities for the government to make best use of its policy on accredited registers. The long-term success of the programme depends on consistent promotion. Without support from government and key bodies such as NHS England and others in Wales, Northern Ireland and Scotland to ensure the programme is visible and built into health and care plans, its ability to protect the public will be limited and the value and commitment of these registers and registrants to upholding standards is unrecognised.

1.9 In our last report, we reported our concern that the General Medical Council has been granted a right of appeal against decisions of the Medical Practitioners Tribunal in parallel to our own. As we predicted, this is adding complexity and increasing costs without obviously improving public protection.

Evidence-based regulation

1.10 Excellent progress has been made in the field of regulatory research and thinking. Since our literature review of 2010, which highlighted the absence of an evidence-base for regulation, both the Authority and the regulators have been working with academic institutions and researchers to address the deficit. Our revised version of *Right-touch regulation* (2015) expanded understanding of hazards, risks and harms and led us to develop a new assurance methodology for assessing and assuring occupational risk of harm.[1] Recognition that regulators are one part of the patient safety system, and that other factors, such as peer influence may have greater impact on professional standards is leading regulators to exercise their regulatory force by working in partnership and through collaboration. For example, the General

[1] Professional Standards Authority, 2016. *Right-touch assurance*. Available at: www.professionalstandards.org.uk/docs/default-source/publications/right-touch-assurance---a-methodology-for-assessing-and-assuring-occupational-risk-of-harm.pdf

Medical Council (GMC), NHS Education for Scotland and the Royal College of Physicians and Surgeons working together to support doctors' professional development. The General Pharmaceutical Council (GPhC) working with the GMC, Care Quality Commission and Medicines and Healthcare Products Regulatory Agency collaborating to address risks to patient safety from advances in online primary medical services.

1.11 Other advances in thinking include the concept of 'relational regulation', arising from research for the General Osteopathic Council (GOsC) and the use of 'formative spaces' amongst peers to encourage reflection and prevention of harms.[2] When registrants can relate to regulation as relevant and related to their practice, they are more likely to adhere to its standards.

1.12 Progress is being made in improving understanding of the interplay between the practice of individuals and the impact of the health and care environment in which they work. Our academic conference this year, *Building trust in people and places*, attracted 100 people, to hear 25 presentations on a range of research programmes. Seventeen academic centres were represented, and 16 regulators. Research papers advanced knowledge about dishonesty, professional identity, effects of erasures and suspensions. Research findings are publicly available on our website and those of the regulators we oversee.

Regulating during times of change

1.13 Innovation provides opportunities but also presents new challenges for regulators. This includes technological advances in devices, such as in those in optical practice and online developments. It also includes changes to the health and care delivery systems and workforce changes. Changes to the way in which employers deploy health and care professionals or the introduction of new roles or training routes, can impact professional scopes of practice, and quality assurance of education and training.

Four-country working

1.14 The four governments of the UK have consistently stated their support for UK-wide professional regulation, although regulation of new occupations is devolved in Scotland and Northern Ireland. The regulators are accountable to the UK Parliament, and are held to account for their performance by the Health Select Committee to whom we submit our individual performance reviews and this overview report. Notwithstanding the growing divergence between the health and social care structures and delivery systems in the four jurisdictions, professional regulation has operated effectively and consistently across them.

1.15 The decision to leave the European Union will require attention. Regulators have considered the need to think about strengthening accountabilities of regulators to the four governments. The decision by the Department of Health in England to regulate nurse associates has not yet been agreed between all four countries. We anticipate further challenges in maintaining the UK-wide regulatory approach in

[2] Professor Gerry McGivern, Dr Michael Fischer, Dr Tomas Palaima, Zoey Spendlove, Dr Oliver Thomson, and Professor Justin Waring, 2015. *Exploring and explaining the dynamics of osteopathic regulation, professionalism and compliance with standards in practice*.

changing relationships both within the UK and with Europe. Social Workers are already regulated separately by four regulators in the UK.

2. Reviewing the regulators

2.1 We assess the performance of the regulators against our *Standards of Good Regulation*. There are a total of 24 Standards divided between four different headings: Guidance and Standards, Education and Training, Registration and Fitness to Practise. The individual reviews of each regulator have been published on our website.[3] In this report, we look at particular themes arising out of those reports and record some notable work by the regulators.

2.2 This was the first year in which we adopted our revised process for reviewing performance. Overall, the GMC, the GPhC, the GOsC and the Pharmaceutical Society of Northern Ireland (PSNI) met all of the Standards; the General Chiropractic Council (GCC) and the Nursing and Midwifery Council (NMC) met 23 of them; the General Optical Council (GOC) met 22; and the General Dental Council (GDC) and the Health and Care Professions Council (HCPC) met 21. The Authority did not conduct a similar review in 2015/16 because it was introducing the new process.

2.3 The revised process[4] has worked well, allowing us to collect and use statistical data from the regulators which enables us to carry out an initial assessment of performance. We collect the data quarterly allowing us to identify trends over time. In its first year, it has helped us to drill down into particular areas of the regulators' performance and gain better understanding of strengths and weaknesses. The feedback that we have received from the regulators has been broadly positive and it is clear that they have found the process significantly less burdensome than under the previous process.

2.4 We identified eight items of statistical information that, in our view, were key comparators across the Standards of Good Regulation, and said that we would routinely report on these items. Below is a table laying the out for the period 1 April 2016-31 March 2017, the data that each of the nine health and care regulators has provided to us. This information has not been audited by us.

[3] www.professionalstandards.org.uk/publications/performance-reviews
[4] Professional Standards Authority, 2017. *Performance Review Process*. Available at: www.professionalstandards.org.uk/docs/default-source/publications/performance-reviews/performance-review-process.pdf?sfvrsn=10

Data for 1 April 2016 to 31 March 2017	GCC	GDC	GMC	GOC	GOsC	GPhC	HCPC	NMC	PSNI
Number of registrants	3,195	109,307	281,034	29,572 (includes 2,557 bodies corporate and 5,336 students)	5,253	91,688 (includes 14,403 premises)	350,330	690,773	3,112 (includes 549 premises and 184 students)
Number of new initial registration applications received	163	8,360	14,221	981	276	4,551	22,079	28,932	193
Number of registration appeals concluded where no new information was presented, and that were upheld	N/A[5]	N/A[6]	N/A[7]	N/A[8]	N/A[9]	0	6	N/A[10]	N/A[11]
Median time (in days) taken to process initial registration applications for:									
• **UK graduates**	1	11	1	4	2	18 – Pharmacist 9 – Pharmacy Technician	5	1	1
• **International non-EU graduates**	1	55	17	2	66	18 – Pharmacist N/A – Pharmacy Technician[12]	41	2	N/A[13]
• **EU graduates**	1	18	31	5	36	4 – Pharmacist 6 – Pharmacy Technician	38	13	N/A[14]
Annual retention fee	£800	£890 dentists £116 Dental care professionals	£425	£320 (£220 for lower income)	£320 (year 1) £430 (year 2) £570 (year 3 onwards)	£250 – Pharmacist £118 – Pharmacy Technician	£90, registrants pay £180 for two years	£120	£398

[5] The GCC did not receive any registration appeals where no new information was provided in 2016/17.
[6] The GDC did not receive any registration appeals where no new information was provided in 2016/17.
[7] The GMC does not currently collect this data.
[8] The GOC did not receive any registration appeals where no new information was provided in 2016/17.
[9] The GOsC did not receive any registration appeals in 2016/17.
[10] The NMC did not receive any registration appeals where no new information was provided in 2016/17.
[11] The PSNI did not receive any registration appeals in 2016/17.
[12] The GPhC did not receive any Pharmacy Technician applications from International non-EU graduates in 2016/17.
[13] The PSNI did not receive any applications from International (non-EU) graduates in 2016/17.
[14] The PSNI did not receive any applications from EU graduates in 2016/17.

	GCC	GDC	GMC	GOC	GOsC	GPhC	HCPC	NMC	PSNI
The time taken (in weeks) from receipt of initial complaint to the final investigating committee or case examiner decision									
• **Median time taken to conclude**	35	41	37.1	39	17	52.4	34	51	15
• **Longest case to conclude**	157	314	391.1	139	108	285	285	401	22
• **Shortest case to conclude**	4	7	0.7	6	4	7	7	7	12
The time taken (in weeks) from receipt of initial complaint to final fitness to practise determination:									
• **Median time taken to conclude**	64	90	106.6	121	54	93.7	97	87	34
• **Longest case to conclude**	82	367	423.6	517	98	225.7	296	395	34
• **Shortest case to conclude**	28	33	18	54	19	20.3	12	25	34[15]
The median time taken (in weeks) 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**	8	19	10	13	7	13.3	18.9	26	3
• **Receipt of information**	4	3	2.29	3	4	2	2.9	N/A[16]	3
Number of registrant/ Authority appeals against final fitness to practise decisions:									
• **Registrant appeals**	0	1	27	1	0	3	3	29	0
• **Authority appeals**	0	0	2 appeals lodged by the Authority & 2 notices of interest lodged by the Authority on GMC appeals[17]	0	0	0	2	9	0
Number of data breaches reported to the Information Commissioner	0	3	1	1	0	0	0	0	0
Number of successful judicial review applications	0	1	2	0	0	0	0	0	0

[15] The median, shortest and longest figures for the PSNI relate to a single case referred to a final fitness to practise hearing

[16] The NMC does not currently collect this data

[17] The GMC has a right of appeal against decisions made by its adjudication arm (the Medical Practitioners Tribunals Service). The PSA joined two GMC appeals as an interested party.

2.5 Variations in the statistical performance data for the different regulators reflect the size of their registers, their legislative constraints and the different environments in which they work. For example, regulators have different statutory rules governing their processes and this may affect how long they take to deal with individual cases. We recognise that regulators with smaller caseloads may well find their overall performance skewed by a couple of unavoidably lengthy cases or even very short ones. This is a reason why we do not use the statistical data in isolation to help our understanding of performance.

Achievement against the Standards of Good Regulation

2.6 We discussed the performance of each regulator against the Standards in their individual performance review reports.[18] Here we note some of the more significant headlines and themes that have arisen during this cycle.

Standards and guidance

2.7 These Standards relate to the responsibility of the regulators for publishing and promoting standards of competence and conduct for registrants.

2.8 All the regulators met all the Standards in this area. Each has produced updated or revised standards and guidance for registrants and several regulators are undertaking a more substantial revision of their standards or codes of conduct for registration.

2.9 One particular piece of work which addressed some clear concerns about a particular profession was work undertaken by the GOsC in respect of misleading advertising by osteopaths. This is an issue that has caused difficulties for the Council and is clearly an important issue for public protection. The GOsC has now agreed joint guidance with the Advertising Standards Authority and the Committee of Advertising Practice aimed at ensuring GOsC registrants' advertising only includes factual information about the osteopathic services offered and the potential benefits of osteopathic treatment. We thought this was a good example of collaborative working.

2.10 In October 2015, the NMC produced a policy on new requirements relating to English language competence for European Economic Area (EEA) trained nurses and midwives following the revision of the European Directive on Mutual Recognition of Professional Qualifications. The new policy sets out the minimum standard of English language competence required for registered nurses and midwives to practise safely and effectively.

2.11 In their work in this area, all of the regulators have carried out appropriate consultation and engagement with their stakeholders and made revisions to their proposals where appropriate. Our impression from the evidence is that the regulators take their obligations to consult seriously and we welcome this.

[18] www.professionalstandards.org.uk/publications/performance-reviews

Education and training

2.12 These Standards look at the role of the regulators to ensure that students and trainees obtain the required skills and knowledge to be safe and effective. All the regulators met all of these Standards during this cycle of performance review.

2.13 Of particular interest has been the work of the GMC and GPhC in seeking understand differences in educational attainment. In July 2016, the GMC published its annual data on the progression of doctors through key stages which suggested white UK medical graduates remain more likely to pass specialty exams than their BME counterparts, whilst doctors whose primary qualification was gained outside the UK or EEA are even less likely to do well in exams or recruitment. The GMC also published the report, *Fair training pathways for all: understanding experiences of progression*, based on independent research it commissioned University College London to conduct. This research found that BME UK graduates and doctors who qualified overseas faced risks of unconscious bias in assessments, recruitment and day-to-day working. The GMC plans to work with others to continue to address this issue, including in reviewing its *Standards for curriculum and assessment systems* by introducing specific requirements for medical education and training organisations to show they include fairness and equality in all aspects of their work.

2.14 In June 2016, the GPhC published qualitative research to explore why Black-African candidates performed least well in the pre-registration assessment for pharmacists. The report concluded that the factors behind this were complex and made suggestions for how education providers (both schools and pre-registration training providers) and the GPhC might address some of the issues.

2.15 We think it is important for the regulators to understand the issues affecting performance by different groups of registrants and potential registrants and we welcome this work.

Registration

2.16 These Standards look at how the regulators ensure that they only register those professionals who meet their standards, how they keep an up-to-date register, and record any action taken against a registrant that limits their entitlement to practise. This is an important area of work for regulators because patients, employers and others rely on the information contained in the register to make decisions about employing registrants.

2.17 Eight of the nine regulators met all the Standards for Registration. The HCPC did not meet the second Standard for Registration. It is disappointing that a number of regulators continue to make occasional errors in the information published on their online registers relating to the outcomes of fitness to practise cases.

2.18 We noted wide variation in the time it takes to process applications for registration depending on the route to registration. It appeared that some regulators take significantly longer to process applications for non-UK graduates. The reasons for these differences in processing times are unclear and we will continue to look at how the regulators process these applications to gain a better understanding of the issues that might lead to the differences we see through the statistical data.

Registration appeals

2.19 We consider that regulators should ensure that they have appropriate, robust and transparent procedures in place so that those applying for registration can understand clearly why their application for registration has been refused (and by whom), how they can appeal that decision, and how that appeal will be conducted.

2.20 We were unable to conclude that the HCPC met the second Standard for registration, as we had concerns about the way it which it was operating its registration appeals process. Our assessment was that the HCPC's process might not be fully in accordance with its governance rules and lacked transparency.

2.21 The HCPC has since changed its registration appeals process to increase transparency. The changes that the HCPC described to us appeared a pragmatic solution which addressed our concerns, and we will monitor how this new process is working.

2.22 We also noted difficulties faced by the PSNI. It has never received an appeal against a decision to refuse registration; nor has it put in place an appeals procedure. The absence of such a procedure caused difficulties as the PSNI has begun to prepare for the implementation for pharmacists in Northern Ireland (planned for 2017) of the Health Care and Associated Professions (Knowledge of English) Order 2015. The PSNI has taken steps to address this issue and we will monitor its progress.

Continuing fitness to practice

2.23 All the regulators continue to operate and develop their various schemes for ensuring the continuing fitness to practise of those on their registers. The first group of nurses and midwives completed the NMC revalidation process in April 2016. The NMC reported that 90 per cent of registrants due to revalidate in April 2016 had successfully renewed their registration through revalidation. The GPhC completed the first five-year cycle of reviewing all registrants' continuing professional development (CPD) records. It commissioned an independent review, and carried out an operational review, of the process.

2.24 The GMC appointed researchers[19] to carry out a long-term evaluation of revalidation. In April 2016, it published their interim report.[20] Some of the key findings included that four out of 10 doctors are changing their practice because of their last appraisal but that there was also scepticism amongst doctors about whether revalidation has led to improved patient safety and about whether the process will identify doctors in difficulty at an earlier stage. Responding doctors had mixed views about whether revalidation would improve standards of practice. We will be watching progress with interest.

Fitness to practise

2.25 Our fitness to practise standards describe how regulators should ensure that anyone can raise a concern about a registrant's fitness to practise. They also ensure that regulators take action where they receive such concerns.

[19] UMbRELLA (UK Medical Revalidation Evaluation collaboration).
[20] UMbRELLA, 2016. *Shaping the future of medical revalidation – interim report.* [Online] Available at: www.gmc-uk.org/UMbRELLA_interim_report_FINAL.pdf_65723741.pdf

2.26 As in previous years, performance against these Standards has been mixed.

Timeliness

2.27 As part of the changes we made to the performance review process, we asked the regulators to provide us with data about their timeliness and volumes of cases relating to fitness to practise on a quarterly basis, rather than as an annual 'snapshot'. This has enabled us to consider more sensitively how each regulator approaches the management of its cases, and the context within which it operates: both the actual figures and the 'direction of travel'.

2.28 We were unable to say, in 2015/16 that the GOC, HCPC and NMC met the Standard which requires regulators to deal with complaints as quickly as possible given the complexity of the complaint and to ensure that interim orders are sought where necessary. In all of these cases, we were concerned that there were delays in dealing with cases and we were not convinced that the performance was obviously improving.

2.29 Though we concluded that the other regulators met this Standard, we continue to monitor closely the length of time at each stage of the process for all the regulators. Some regulators are at risk of not meeting this Standard in the future if they do not maintain their performance in this area, or demonstrate that their performance can be consistent.

2.30 We recognise that timeliness is a not an easy concept: regulators measure things at different points, partly as a result of their individual legislative and governance frameworks. Some argue that their cases are inherently more complex or more closely fought than others.

Risk assessment and interim orders

2.31 The GDC and HCPC did not meet the fourth Standard for fitness to practise. This requires regulators to prioritise serious complaints and seek interim orders where appropriate. Interim orders are orders made at an early stage of proceedings to prevent a registrant from practising because the complaints and evidence available suggests that there may be risks for the public if they continue. They are an important mechanism for public protection.

2.32 The GDC has made changes to its interim orders process in April 2016, and we will follow up the effect of those changes when we next review the GDC's performance.

Consensual methods of disposal

2.33 As the number of fitness to practise cases grows, regulators continue to look at innovative ways of dealing with them quickly and efficiently. We support this work and new thinking about how to fulfil statutory duties. We know that the current system is not fit for purpose and are continuing to call for it to be comprehensively reformed.

2.34 The focus has been on two major areas: resolving cases by consent (where the registrant accepts the facts and the sanction) and at an earlier stage (where a relatively minor sanction can be imposed) so that the need for full hearings is reduced. We are currently undertaking work to establish the cases for which this approach may be suitable and how confidence and the public interest can be

maintained in less formal processes. Our experience of looking at cases through our Section 29 process suggests that there may be problems in practice.

2.35 When reviewing how the regulators have met the Standards for fitness to practise, we have tried to consider how innovative practice has been translated into process, and whether that process has led to poor decisions, outcomes that were not transparent, or other issues that might prevent the regulator from meeting any of the Fitness to Practise Standards.

2.36 In general, we found that the decisions reached by regulators under their new processes seem to have been appropriate to protect the public. However, we have raised some concerns with the regulators, both through our reviews of their performance and our Section 29 consideration of cases, about the processes being undertaken to reach those decisions.

2.37 In the NMC's performance review report, we were concerned about the transparency of decisions reached through the consensual disposal, and voluntary removal, process. We commented on the need to ensure that the maker of an allegation was asked for their comments on any application to dispose of a case via consensual means. We said that discussions between the parties regarding consensual disposal should be documented so that it can be demonstrated that the process is both transparent and consistent. It is also essential that it is clear that the decision-maker has applied the relevant guidance and considered all relevant factors, including the public interest. Failure to do so means the process will be less transparent and could undermine public confidence in the fairness of the fitness to practise process.

2.38 We noted the GMC's continued use of 'provisional enquiries' and the positive impact on timeliness that this process seems to be making. We will look at again at how this process is working in practice in our next review of the GMC's performance.

2.39 We were concerned about the GPhC's revised guidance for its Investigation Committee, and set out our concerns about transparency and consideration of the wider public interest raised by the guidance. We will follow up on this issue when we next review the GPhC's performance.

Decision-making

2.40 We were unable to reach the view that the GDC had met the Standard that decisions should be reasoned, consistent and protect the public. While the GDC has systems in place to promote consistent, well-reasoned decision-making, the evidence we saw indicated that the reasoning and consistency of decisions in its fitness to practise casework is not at the level which enables us to be satisfied that all cases are dealt with appropriately.

Discontinuance of cases

2.41 We are concerned about the application of the HCPC's Discontinuance Policy, in circumstances where a case has been referred to a full hearing and the HCPC subsequently makes an application to discontinue the case.

2.42 Our concerns are particularly acute where the application appears to be based on the potential quality of witness evidence (which is properly for the panel to assess), or on the basis of the cost of investigating concerns raised about a registrant. For

example, in one case, the HCPC's application to discontinue a case against a social worker alleged to have given false or misleading testimony to the Court during care proceedings (including unfounded allegations of sexual abuse within the family), was based in large part on the cost of obtaining the transcripts of the Court proceedings.

2.43 We were also concerned that, in some cases, panels did not give adequate scrutiny to the HCPC's application for discontinuance, either in enquiring why the existing material was insufficient when the Investigating Committee had previously considered there to be a case to answer, or in directing the HCPC to secure the evidence which was known to exist.

2.44 We shall be looking at the issue of discontinuance as part of the 2017 HCPC performance review.

3. Protecting the public – fitness to practise

3.1 In this section, we highlight recent developments and emerging patterns that we have identified from our consideration of the decisions made by regulatory panels in individual fitness to practise cases; and from our interactions with the regulators during the period under review.

Legislative changes

3.2 In September 2016, our overarching objective was amended by the commencement of the relevant parts of the Health and Social Care (Safety and Quality) Act 2015. The Authority's over-arching objective when exercising its functions is the protection of the public.

3.3 Since 31 December 2015, the Authority's power to refer a case to Court has been governed by the test of whether a decision is 'insufficient to protect the public', rather than whether it is unduly lenient.

Caseload

3.4 In this financial year, we scrutinised 4,285 determinations provided to us by the nine regulatory bodies that we oversee. This was an increase of around 15 per cent on the previous year. The overwhelming bulk of these determinations cause us no concern. We considered 200 in detail because the decisions raised concerns about whether the regulator had prosecuted the case properly or whether the panel had properly addressed the conduct or health issue involved.

Feeding back learning points to regulators

3.5 Where a case does not meet the very high bar for referral to the Court but the Authority continues to have concerns about the decision or the process of the regulators, the Authority will send learning points to the regulator.

3.6 The Authority consulted regulators on the learning point process in the summer of 2016. Following that significant or important learning points are fed back to the regulators immediately, while more generic ones are fed back to them at regular intervals. We propose to send digests of these to all the regulators in the course of each year.

Referral to Court

3.7 We exercised our discretion to refer 13 decisions to the Court:

Regulator	**No of determinations referred to Court under section 29 of the 2002 Act**	**Outcome**
NMC	8	Five settled by Consent Order. The decision of the panel was quashed in all cases. In four cases, the decision on

		sanction was substituted with a more severe sanction. In one case, the matter was remitted to a fresh panel for a rehearing of the entire case. 1 upheld by the Court. 1 dismissed by the Court. 1 withdrawn by the Authority.
HCPC	2	1 withdrawn by Authority. 1 settled by Consent Order.
MPTS	2	2 settled by Consent Order. In one case, the panel's decision to suspend the registrant was quashed and the matter remitted back for consideration of sanction. In one case, the panel's decision was quashed and the matter remitted back for consideration of whether the registrant had been dishonest and to consider the issue of impairment.
GDC	1	Settled by Consent Order. The decision

		of panel was quashed and the matter remitted for re-hearing on sanction before a differently constituted panel.

Decisions of the High Court

3.8 During the period under review, the Court delivered judgment in six cases. These included cases referred by us to the Court under our Section 29 power in the previous financial year.

3.9 The cases involved a range of serious behaviour including abusive behaviour towards an extremely vulnerable patient, significant and potentially dishonest medication errors, failure to disclose a health condition and undertaking invasive processes while suffering from it, and serious misconduct towards colleagues. Our concerns included that panels failed to address the seriousness of the behaviour, did not take account of the relevant guidance or did not have the evidence in front of them so that they could understand the full gravity of the behaviour.

3.10 The Court agreed with us in five out of the six cases. In one case, the registrant was struck off by the Court. In the others, the cases were remitted to the regulator for a further hearing. Particular points that can be gleaned from the decisions are that:

- Failure to present evidence properly can amount to a serious procedural irregularity and panels should use their powers to seek additional information or charges
- Panels need to ensure that they have regard to the full gravity of the charges and, particularly, the need for public confidence in the regulatory process and the reputation of the professions.

3.11 In the one case where the Court disagreed with the Authority, it was clear that the Court was giving a very high level of deference to the panel's decision. The case law makes it clear that the courts will be slow to overturn decisions of panels who have had the opportunity at first hand to see the evidence unless the decision was clearly wrong or there has been a serious irregularity. This case confirmed that.

GMC Right of Appeal[21]

3.12 The GMC recently gained the right itself to refer decisions of the Medical Practitioners Tribunal Service to the relevant court if it considered that they were insufficient to protect the public. The Authority may become a party to such referrals if it wishes.

3.13 In 2016/17 the GMC referred eight decisions. The Authority has become a party in two of them and has itself referred one case to the Court which the GMC did not refer. In May 2017, the Authority's case was referred back to the original panel by consent in May 2017 and the Court upheld the GMC's first appeal in the first that has been heard. The Authority supported that appeal and would, itself, have appealed if the GMC had not.

[21] Under section 40A of the Medical Act 1983

3.14 Since the Authority has the right to become a party, it considers each case referred by the GMC as if it were a case that it was considering referring itself. This includes holding a full detailed case review, together with advice from lawyers. The Authority will generally only become a party where it considers that it has something specific to contribute either on legal issues or on the substance which is not covered by the GMC (for example, under-prosecution). In the early cases, for example, we will wish to be sure that the Court is fully aware of the case law surrounding the Authority's jurisdiction. However, we would not normally wish to add to costs to registrants by becoming a party where there is no need to do so and we will review our processes in the light of developments. The fact that the Authority does not join in a case as a party should not be taken as an expression of the Authority's views of the merits or otherwise of the appeal.

3.15 It is important that the Authority continues to have jurisdiction and the right to be a party. The Court will not only look at the panel's decision but also at the way in which the GMC has prosecuted as case. The GMC cannot raise points about its own prosecutorial failings and it is therefore right that the Authority should have the power to do so.

3.16 The Authority and the GMC have worked on a protocol to ensure that each side is kept informed of the progress of cases referred by each other and have adequate information to decide whether or not to become a party.

3.17 The justification for the new power was that it would (a) cement the separation between the MPTS and GMC, (b) address problems with the very high bar that exists before the Authority can appeal and (c) that it would be likely to save money. We are doubtful about whether the first point is a strong argument for the power. As to the others, the Authority would make the following observations:

- There is no reason to believe that the courts will set a lower bar for the GMC's appeals or that it is appropriate for this to be the case
- The cases that have been referred have given rise to a number of challenges to the extent of the GMC's jurisdiction which have the potential to complicate the jurisdiction. While in the first case, *Jagjivan*, these were resolved in the GMC's favour and have not, so far, had obvious implications for the Authority's jurisdiction, the Authority will need to ensure that it is aware of and able to respond to points which may affect its jurisdiction.
- The Authority has to examine fully all cases which the GMC decides to refer, even if it does not become a party to them. So, there is no reduction in overall workload as a result of the change. In fact, it is likely that costs, overall, will increase particularly given the jurisdictional challenges which are likely to require the Authority to be represented.

Registrants' conduct in private life

3.18 The Authority conducted research into public attitudes surrounding dishonesty by health care professionals[22] which was published in June 2016. The Authority also sees a number of cases where allegations are made that behaviour in a non-clinical

[22] Professional Standards Authority, 2016. *Research into attitudes to dishonest behaviour by health and care professionals.* June 2016 research report by Policis. Available at: www.professionalstandards.org.uk/publications/detail/research-dishonest-behaviour-by-professionals

context affects an individual's fitness to practise. It is aware that there is scope to question how far a competent registrant ought to be subject to sanction in respect of actions that have nothing to do with their clinical work.

3.19 The research suggested that the public takes a nuanced view towards dishonesty outside clinical practice. For example, while it was clear that a conviction for theft would raise questions about the fitness to practise of a nurse caring for vulnerable patients, but that a tax fraud on buy-to-let property did not necessarily raise questions about a dentist's fitness to practise. Indeed, there appeared to be a distinction drawn between professions perceived to be 'practical' (dentists or osteopaths) and those where vulnerable people are involved or the care involves momentous decisions with far-reaching consequences.

3.20 There needs to be caution about individual cases simply because they are fact-sensitive and the mitigation will vary. However, the Authority has seen the following examples where sanctions less than removal from the register have been applied:

- Domestic violence against close family members
- Sexual assaults outside work
- Viewing child pornography.

3.21 The Authority also referred a case to the Court of Session in Scotland where the registrant had been found to have sexually harassed junior colleagues and it is notable that the Court disagreed, on the facts, with the Authority and with the regulator that a more serious sanction should have been given.

3.22 Equally, the Authority sees cases involving relatively trivial levels of dishonesty or behaviour which, although morally questionable, does not really seem to affect an individual's fitness to practise and where it is surprising that it was thought appropriate to use resources to put them through the process. Some indeed, are simply employment questions which do necessarily have wider implications for fitness to practise. We note in particular that, in the recent judicial review against the GPhC's[23] new Standards, the judge looked closely at arguments that the aspects of the new Standards that required a registrant to behave appropriately in their private life conflicted with individuals' right to a private life. The judge made it clear that some actions in private life, for example committing a criminal offence might directly affect an individual's fitness to practise but that more minor concerns (for example a loss of temper over a board game) would clearly not engage concerns here.

3.23 In some cases, particularly involving sexual assault, there is a clear read-across to practice. In others, however, individuals behave criminally outside their practice but, nevertheless, remain competent practitioners who pose no risk to patients. In those cases, it seems to us that there can be a debate about how far that behaviour should be the subject of sanction by a regulator so that it affects an individual's ability to be employed to a far greater extent than would be the case in an unregulated occupation. Our research suggests that public attitudes may be more nuanced than might be thought, while some panels would seem to take more lenient approaches than public opinion might support.

[23] Pitt and Tyas, R (on the application of) v General Pharmaceutical Council [2017] EWHC 809 (Admin)

The quality of panel decisions

3.24 There are a number of points that we would raise about panel decisions that we would hope that regulators will bear in mind as part of their training for panels:

- In many cases where removal from the register is a serious possibility, the level of detail in the reasons as to why removal from the register was not deemed appropriate is cursory. We would expect them to grapple with whether or not the registrant's behaviour was fundamentally incompatible with continued registration
- Panels are increasingly playing a proactive role in ensuring that a case is properly presented
- Where a panel has a legally qualified chair, but no legal assessor, we consider that there needs to be a process for dealing with advice on legal issues. In one case, it was clear that the panel had misdirected itself about the law and the presence of a legal assessor might have avoided this.
- We continue to be concerned that, in a number of cases relating to whistleblowing and the failure to escalate concerns about other registrants, panels have not made any reference to the importance of whistleblowing and the wider whistleblowing agenda within the National Health Service
- It is disappointing that, despite the joint statement on the Duty of Candour published by eight of the regulators and joint GMC/NMC guidance, we have not subsequently seen the duty reflected in the allegations drafted against the registrant or references to the Duty of Candour in panel determinations
- We continue to be concerned at the level of sanction that panels across the regulators impose in relation to practising without insurance. We have noted recent instances in which panels have simply imposed admonishments or reprimands. Failure to hold insurance is not simply an administrative failing. It can lead to patients who have been injured by a practitioner's negligence suffering significant financial loss in addition to their injury. It is also a requirement of registration
- The role of review panels was recently considered by the Supreme Court in the case of *Khan.*[24] That case discussed the limits in the power of review panels and we will monitor its impact.

NMC registrants lapsing from the register

3.25 In last year's report, it was noted that on several occasions in the past, we had been forced to seek injunctive relief from the High Court to prevent the NMC from removing individual registrants from its register before the High Court could address our referral of the relevant fitness to practise panels' decisions.

3.26 This problem occurs because of the way in which the NMC's legislative framework is set out. We repeat our frustration that the Department of Health has not yet taken steps to close the legislative 'loophole' that makes such a 'lapse' from the NMC's register possible in these circumstances, even though we first wrote to the Secretary of State on 10 March 2014 highlighting the problem and this has since

[24] Khan v General Pharmaceutical Council (Scotland) [2016] UKSC 64

been raised in the context of changes to the NMC's legislation. A similar problem exists in respect of the HCPC.

3.27 During this financial period, we have noted a number of cases in which NMC panels have decided not to impose a sanction, or have allowed an existing order to expire, on the grounds that the registrant's registration had lapsed or was shortly due to lapse. In some of these cases, we had concerns about how far the panel's decision was sufficient to protect the public.

3.28 We have recently written to the NMC seeking confirmation that effective systems are in place to ensure that, where registration has lapsed in such circumstances and nurses subsequently seek to renew their registration, any outstanding fitness to practise concerns will be fully addressed before the registrant can be allowed to practise unrestricted.

4. Accredited Registers – confidence, choice and protection

Overview

4.1 Our role also includes setting standards for registers of occupations that are not regulated by law and accrediting the registers that meet these standards. We do this so that the public, employers and commissioners can choose practitioners from voluntary registers that we have independently vetted and approved. The government is committed to proportionate regulation of healthcare professions and recognises that the accredited registers programme provides patients, the public and employers with assurance about the standards and competence of registrants.

4.2 Accredited registers meet our demanding standards, which include commitment to protecting the public, governance, education and training, risk management and complaints-handling. Practitioners on accredited registers meet approved levels of education and training and engage in continuing professional development, sign up to codes of conduct and are subject to disciplinary processes if something goes wrong. Accredited registers provide a safety net. If someone is struck off one accredited register (or by a regulator) they may not, simply join another accredited register. This important protection was tested and affirmed by Court this year.

4.3 The accredited registers programme has been operating since February 2011. Twenty-three registers have been accredited covering 30 occupations and 80,000 practitioners. Occupations covered include public health, healthcare science, genetic counselling, psychotherapy, play therapy, sports rehabilitation, acupuncture, and complementary therapies such as nutritionists. This year two non-surgical cosmetic practice registers were also accredited, putting into practice recommendations from Professor Sir Bruce Keogh's Review of the Regulation of Cosmetic Interventions.

4.4 It costs approximately £350,000 a year to operate the programme and it is managed by 3.4 staff. It is funded through accreditation fees (currently 60 per cent of income) and a subvention from the Department of Health.

4.5 All accredited registers and their registrants display our registered trade mark so that the public can distinguish them easily. Our aim is to improve public protection, promote confidence in the registers, support choice for patients and services users and improve quality. We recommend that the public, employers and commissioners choose only practitioners who are either regulated or on accredited registers. However, considerable effort is still required including by the government and others to raise awareness of the programme and its mark.

4.6 Accredited registers are a new approach to managing risks associated with health and care practitioners that is attracting attention internationally. We have advised the Hong Kong government, which is establishing its own accredited registers programme, modelled on ours. Having the ability to accredit registers in over-arching legislation, such as that set out in the Health and Social Care Act 2012, allows new registers to be established quickly and cost effectively without the need for individual primary legislation. It permits new occupations to be added and for rules and standards to be changed rapidly in response to changing needs.

List of accredited registers

- Academy for Healthcare Science
- Alliance of Private Sector Practitioners
- Association of Child Psychotherapists
- Association of Christian Counsellors
- British Acupuncture Council
- British Association for Counselling and Psychotherapy
- British Association of Play Therapists
- British Association of Sport Rehabilitators and Trainers
- British Psychoanalytic Council
- Complementary and Natural Healthcare Council
- COSCA (Counselling & Psychotherapy in Scotland)
- Federation of Holistic Therapists
- Genetic Counsellor Registration Board
- Human Givens Institute
- National Counselling Society
- National Hypnotherapy Society
- Play Therapy UK
- Register of Clinical Technologists
- Save Face
- Society of Homeopaths
- Treatments You Can Trust
- UK Council for Psychotherapy
- UK Public Health Register.

Principles and standards

4.7 We apply five principles to the operation of the accredited registers programme:

- Proportionality – our criteria and the way we apply them should be proportionate to the risk of harm to the public
- Free market – it should not create monopolies or unfairly restrict the market
- Affordability – it should avoid excluding practitioners with lower incomes
- Education – registers should determine the standards required for competent practice of an occupation
- Efficacy – we make no judgement about the efficacy of any therapy or health or care practice.

4.8 Our standards cover 11 areas:

- Hold a voluntary register of health and care practitioners
- Be committed to protecting the public
- Understand, monitor and control risks
- Be financially sound
- Inspire public confidence
- Develop knowledge
- Provide strong and effective governance
- Set good standards for practitioners
- Ensure appropriate education and training
- Run registers well
- Manage complaints fairly and effectively.

Improving performance

4.9 The impact on registers who become accredited is clear. Our report *Accredited registers: ensuring practitioners are competent and safe (*2015) demonstrated the extent of changes made by organisations preparing for and going through the accreditation process. Every register we have accredited has been required to improve its practice in one or more areas to meet the Standards for Accredited Registers before gaining accreditation. Conditions, instructions and learning points may be issued by our accreditation panels at initial accreditation and annual review to require or recommend registers to improve practice against the Standards. Conditions must be met to maintain accreditation.

4.10 The table below shows the conditions, instructions and learning points issued throughout the year.

Register	Last date accredited	Conditions	Instructions	Learning points
Academy for Healthcare Science	18 December 2016	1	0	0
Alliance of Private Sector Practitioners	01 August 2016	0	0	3
Association of Christian Counsellors	26 March 2016	1	1	3
British Acupuncture Council	14 March 2016	0	1	1
British Association of Play Therapists	26 November 2016	1	1	1
British Association for Counselling & Psychotherapy	05 March 2016	0	1	0
British Association of Sports Rehabilitators and Trainers	10 December 2016	0	0	1
British Psychoanalytical Council	20 November 2016	2	4	0
Association of Child Psychotherapists	20 November 2016	0	0	3
Complementary and Natural Healthcare Council	23 September 2016	1	0	1

Counselling & Psychotherapy in Scotland	19 June 2016	0	0	0
Federation of Holistic Therapists	09 January 2017	2	0	1
Genetic Counsellor Registration Board	10 May 2016	0	3	6
Human Givens Institute	13 April 2016	0	3	3
National Counselling Society/National Hypnotherapy Society	21 May 2016	0	0	1
Play Therapy UK	11 April 2016	3	0	1
Register of Clinical Technologists	07 September 2016	0	1	1
Save Face	11 July 2016	3	7	2
Society of Homeopaths	09 September 2016	0	0	0
Treatments You Can Trust	22 July 2016	1	11	3
UK Public Health Register	03 April 2016	0	0	1
United Kingdom Council for Psychotherapy	11 November 2016	0	0	1
		TOTAL	**TOTAL**	**TOTAL**
		15	**33**	**33**

4.11 While registers generally receive more conditions, instructions and learning points at initial accreditation, our annual review process continues to assess registers in detail and identifies areas to improve. As with the regulators, the challenges of maintaining performance against standards and hence benefiting from external scrutiny remains.

4.12 Examples of changes required of registers in the past year include:

- Improving aspects of processes for handling complaints against practitioners, to ensure these are robust, fair and focus on public protection
- Improving processes for handling complaints against the organisation holding the register
- Clarifying the education and training requirements for entry to the register
- Enhancing patient and public engagement in register functions
- Improving the accuracy of registers to enable the public to make informed choices
- Enhancing lay involvement on committees and boards
- Clarifying complaints procedures for the public
- Enhancing transparency, for example through publishing Board meeting minutes
- Improving risk management processes.

Strengthening public protection

4.13 If we determine that a register is in serious breach of the standards, we can suspend or remove accreditation from that organisation. Suspension can be lifted once a register demonstrates it has remedied the issues that brought about its suspension.

4.14 In August 2016, we suspended the Treatments You Can Trust register's accreditation following the identification of serious inaccuracies within its register and concerns over the quality assurance of this. Therefore, our panel was not convinced that the register supported the public to make informed decisions. Treatments You Can Trust resolved the issues quickly, and accreditation was restored 15 days after the suspension was imposed. Treatments You Can Trust appealed its suspension (although began taking action notwithstanding), which was the first appeal the programme had received. The appeal went through our processes, and an appeal panel determined that it was not upheld.

4.15 A key protection afforded through the accredited registers programme was tested in Court by a judicial review hearing against two accredited registers. Our accreditation standards require registers to recognise decisions regarding professional conduct made by regulators and other accredited registers when deciding whether someone should be allowed onto a register or be struck off. The judge ruled that two registers that oversee the same practitioners, and effectively have the same codes of ethics, cannot put a practitioner through disciplinary proceedings for what amounts to the same complaint. The judge importantly clarified, in relation to our standards, that 'to recognise' means that registers are bound to adhere to each other's decisions. This is important because our standard is intended to close the loophole by which someone could be struck off by a regulator or a voluntary register, for sexual misconduct or dishonesty for example, and then simply join another. For example, concern has been expressed in the past that a nurse can be struck off by the Nursing and Midwifery Council and go and work as a healthcare assistant or in a care home.

4.16 Accredited registers also act against practitioners who falsely claim to be registered with them. For example, one register referred a practitioner to the Advertising Standards Agency who ruled against the practitioner for mis-advertising. In addition, we also defend the accredited registers' trademark.

4.17 However, accredited registers cannot stop a practitioner from practising without being registered. That is why it is so important that the profile of accredited registers is raised. By choosing practitioners from accredited registers, patients can avoid poor practice.

Collaboration and cooperation

4.18 The accredited registers workforce provides an important and varied role in improving the public's health, and has the potential to have a far greater impact. We have worked with the Royal Society for Public Health on a report into how the accredited registers workforce, both working privately and commissioned by the NHS and others, could contribute further to improving the public's health. We will present our joint report with the Royal Society for Public Health in May, at our conference *Modern solutions for the modern world*.

4.19 We have worked with the Local Government Association to improve awareness of the importance of ensuring practitioners are on accredited registers. We continue to work with several partners to raise awareness of the programme, including NHS Choices, Healthwatch, the Department of Health and the Care Quality Commission.

4.20 We have supported collaboration between accredited registers, which shows marked improvement each year of the programme. We expect this will lead to, at the very least, sharing of functions across some registers, thereby increasing the efficiency of the services they provide.

4.21 Throughout the year, we have worked to gather information on how best to raise awareness with certain audiences, particularly general practitioners. We attended two GP conferences; the Royal College of GPs' annual conference and a Pulse Live event, to speak with GPs to determine the current level of awareness of the programme and how best to improve this among both GPs and patients. As a result, we are instigating a pilot with a GP consortium to encourage patients to check whether practitioners are on an accredited register.

4.22 We also encourage employers and commissioners to use practitioners on accredited registers and to remain vigilant in checking registers, which they can do using the 'Find a register' tool on our website. We publicly recommend that people use practitioners on either a regulator's register or on an accredited register.

Challenges and opportunities

4.23 The programme has supported the development and implementation of national initiatives, such as the implementation of the Modernising Scientific Careers framework and the development of a credentialing register for the life sciences industry, led by NHS England and the Academy for Healthcare Science. Save Face and Treatments You Can Trust have helped to implement the recommendations from Professor Sir Bruce Keogh's Review of the Regulation of Cosmetic Intervention. It is notable that the Academy set up its register with an initial investment from the Department of Health, and even with ongoing support from Health Education England, operates far below the £4 million quoted by the Nursing and Midwifery Council to establish a register for nurse associates. It is clear that ongoing financial commitment from the government would secure the programme's continuance and make sure it is available to flexibly accommodate developing workforce and service delivery needs.

4.24 Accredited registers have the potential to do much more. There have been several missed opportunities this year including the development of the Core Skills Education and Training Framework for the mental health workforce, which did not include any members of the accredited registers programme, and a number of relevant articles in the media where the Department of Health provided comment yet did not reference the programme. When we spotted that public health plans to mobilise the wider workforce to improve the public's health had been missed, we contacted Public Health England and began a project with the Royal Society for Public Health.

4.25 Last year we pointed out two barriers in respect of the Rehabilitation of Offenders Act and the Safeguarding Vulnerable Groups Act. The Department of Health has raised these with the Home Office and the Ministry of Justice and we hope to hear this is being progressed. There are other areas, such as prescribing, where the term

‘registered healthcare professional’ is interpreted to mean a regulated professional, which is placing constraints on plans to expand the workforce or employ them in new roles.

Reflections

4.26 The programme continues to grow, and we continue to work to increase its profile among the public, commissioners, employers and other healthcare professionals. We continue to implement and support key government policy through the programme, however remain constrained by factors mentioned, which have prevented the programme from meeting its full potential for public protection. We envisage that through greater collaborative working, and greater, high profile support, we could close this gap to improve the programme’s public protection function.

5. Conclusions

5.1 Professional regulation continues to protect the public but it would do so more effectively and efficiently with the aid of legislative reform. It is not keeping step with the changes being made and planned for health and social care and that impedes their agility and the pace of innovation. Government policy to develop a new system of assurance for unregulated occupations in the form of accredited registers works - but it needs a much higher profile if it is to deliver fully the protection and benefit of which it is capable. The UK is leading the way in developing a body of cutting edge regulatory research to support the delivery of evidence-based regulation fit for the future.

Annual Report and Accounts 2016/2017

1. Performance report

Overview

1.1 This report sets out the work of the Professional Standards Authority over the last year.

About the Professional Standards Authority

1.2 The Professional Standards Authority for Health and Social Care (the Authority) was established on 1 December 2012. Its role and duties are set out in the Health and Social Care Act 2012.[25] In brief, the Authority protects the public by raising standards of regulation and registration of people working in health and care. The Authority is an independent UK body.

1.3 The Authority has a board comprising seven non-executive members and one executive member who is appointed by the Board.

1.4 The non-executive members are appointed by the Privy Council, Scottish and Welsh ministers, and the Department of Health Northern Ireland.

1.5 From 1 August 2015 the Authority ceased to be funded by the Department of Health in England and by the devolved administrations in Northern Ireland, Scotland and Wales. It is instead primarily funded by the fees paid by the regulators we oversee.

1.6 Under the Acts of Parliament that govern what we do, we have the powers to carry out a range of activities to promote the health and wellbeing of patients, service users and the public in relation to the regulation of health and social care professionals.

1.7 We have duties and powers in relation to:

- The oversight of nine statutory bodies that regulate health and social care professionals in the UK
- The accreditation of the registers held by non-statutory registering bodies of health and care professionals
- The provision of commissions to, and undertaking investigations for, government
- The provision of advice to other similar organisations in the UK and overseas.

What we do

Regulatory and standards setting work

1.8 The Authority has powers to:

- Investigate, compare and report on the performance of each regulatory body. We are specifically required to report to Parliament on how far each regulatory body has complied with any duty imposed on it to promote the health, safety and wellbeing of patients, service users and the public

[25] Available at www.legislation.gov.uk/ukpga/2012/7/contents/enacted

- Audit the initial stages of fitness to practise cases and report on our findings in relation to each regulator
- Review the outcome of final fitness to practise cases and refer them to court if we consider that the outcome is insufficient to protect the public[26]
- Give directions requiring a regulatory body to make rules under any power the body has to do so.

1.9 We promote the health and wellbeing of patients, service users and the public in the regulation of health and social care professionals. To do this, we listen to people's views and concerns and consider them when developing our work.

1.10 We assist the Privy Council in the exercise of their appointment powers in respect of the regulatory bodies, and support the quality of appointments to regulators' councils. In consultation with the regulatory bodies, we have produced standards for the Privy Council relating to recruitment and appointments to the regulators' councils.

1.11 We scrutinise and oversee the work of the nine regulatory bodies that set standards for the training and conduct of health and social care professionals.

1.12 We promote good practice and right-touch regulation. We work with the regulatory bodies to improve quality and share good practice. For example, we share learning points arising from the scrutiny of fitness to practise cases and organise seminars to explore regulation issues.

1.13 We share good practice and knowledge with the regulatory bodies, conduct research and introduce new ideas about regulation to the sector. We work closely with, and advise, the four UK government health departments on issues relating to the regulation of health and care professionals. In addition, we monitor policy in the UK and Europe.

1.14 The regulatory bodies are the:

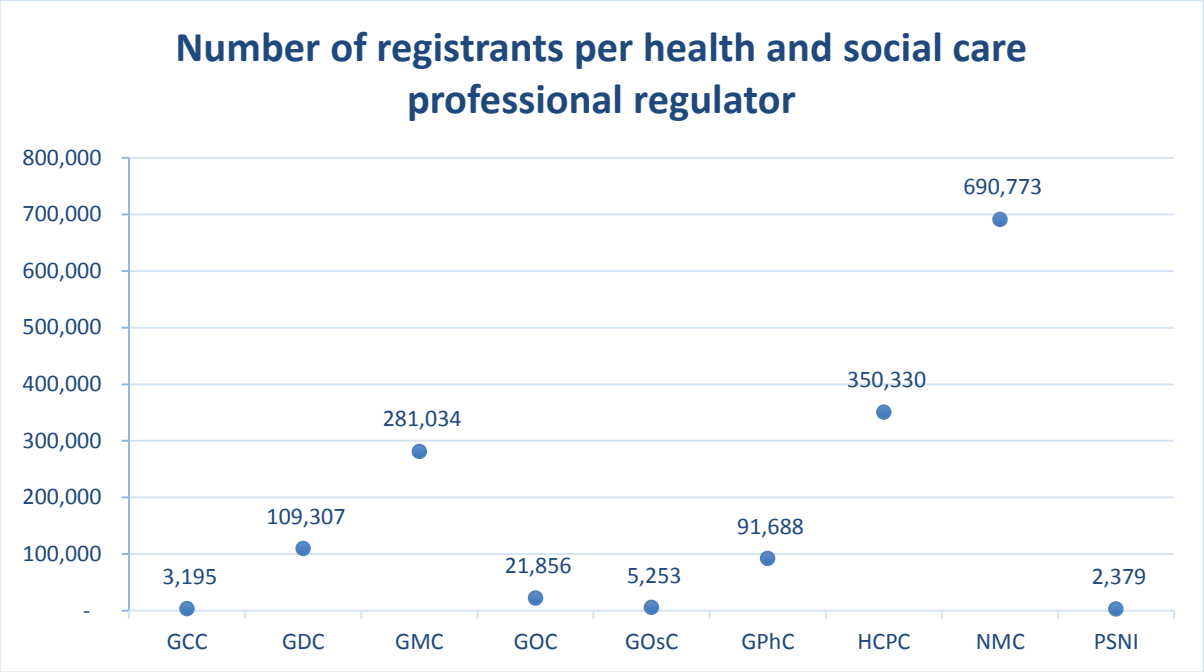
- General Chiropractic Council (GCC) which regulates chiropractors in the UK
- General Dental Council (GDC) which regulates dentists, dental nurses, dental technicians, dental hygienists, dental therapists, clinical dental technicians and orthodontic therapists in the UK
- General Medical Council (GMC) which regulates doctors in the UK
- General Optical Council (GOC) which regulates optometrists, dispensing opticians, student opticians and optical businesses in the UK
- General Osteopathic Council (GOsC) which regulates osteopaths in the UK
- General Pharmaceutical Council (GPhC) which regulates pharmacists and pharmacy technicians in England, Wales and Scotland
- Health and Care Professions Council (HCPC) which regulates arts therapists, biomedical scientists, chiropodists/podiatrists, clinical scientists, dieticians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists and orthotists, radiographers and speech and language therapists in the UK, and social workers in England

[26] As of 31 December 2015 the phrase 'insufficient to protect the public' replaced the phrase 'unduly lenient'.

- Nursing and Midwifery Council (NMC) which regulates nurses and midwives in the UK
- Pharmaceutical Society of Northern Ireland (PSNI) which regulates pharmacists in Northern Ireland.

1.15 Details of the number of registrants in each health and social care professional regulator we oversee (as at 31 March 2017) are shown below.

Table 1 Number of registrants per health and social care professional regulator



Accredited Registers

1.16 The Authority has a role in strengthening quality and patient safety by setting standards and accrediting registers of people working in occupations not regulated by law. As at 31 March 2017, there were 23 accredited registers.

1.17 The purpose of accreditation is to improve the quality of registration carried out by the organisations holding these registers and to promote good standards of behaviour, technical competence and, where relevant, business practice by their registrants. It is intended to enhance public protection and support choice by members of the public when seeking services from practitioners in occupations not regulated by law. It is a proportionate means of managing risks.

Commissions from Government(s)

1.18 We support the work of the Secretary of State for Health, the National Assembly for Wales, Scottish ministers and the Department of Health Northern Ireland by providing advice about the regulation and standards of health and care professionals. We also provide advice on other matters when asked to do so.

1.19 The Secretary of State and Health Ministers in Scotland, Wales and Northern Ireland may also ask us to investigate matters of concern. As set out in the Health

and Social Care Act 2012, the Department of Health and devolved administrations pay a fee, determined by the Authority, for this work.

1.20 We consult with the UK government and the governments in Wales, Scotland and Northern Ireland on the development of guidelines for the sector and respond to their consultations. In addition, we keep abreast of international developments, particularly in Europe, that may affect health and social care regulation in the UK. We work with colleagues in the UK and internationally, ensuring that we are aware of these developments and that we strengthen our relationships with these partners.

Advice to other organisations

1.21 Our legislation permits us to provide advice or auditing services to regulatory bodies and to others that have similar functions to those of a regulatory body, whether or not these functions relate to health or social care. This work is paid for by the organisation requesting the advice.

Our values

1.22 Our values act as a framework for our decisions. They are at the heart of who we are and how we would like to be seen by our partners. We are committed to being:

- Focused on the public interest
- Independent
- Fair
- Transparent
- Proportionate.

1.23 Our values are explicit in the way we work: how we approach our oversight of the registration and regulation of those who work in health and social care, how we develop policy advice and how we engage with all our partners. We strive to be consistent in the way we apply our values.

1.24 We are independent but hold ourselves accountable to the public and to the parliaments and assemblies of the UK for what we do and how we do it.

1.25 We listen to the views of people who receive care. We seek to ensure that their views are considered in the registration and regulation of people who work in health and social care.

1.26 We develop and promote right-touch regulation.[27] This is regulation that is proportionate to the risk of harm to the public and provides a framework in which professionalism can flourish and organisational excellence can be achieved.[28] We apply the principles of right-touch regulation to our own work.

Our aim

1.27 We work to protect the public, set standards and encourage improvement in the registration and regulation of people who work in health and social care. The safety of the public is at the heart of everything we do.

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[27] Professional Standards Authority, 2010. *Right-touch regulation*. Available at www.professionalstandards.org.uk/policy-and-research/right-touch-regulation

[28] Organisational excellence is defined as the consistent performance of good practice combined with continuous improvement

Strategic objectives

1.28 Our corporate strategic objectives which were agreed by the Board at its strategic planning meeting in May 2016 are set out below.

1.29 We will work to:

- Deliver the performance review process to a clear timeline, aiming to reduce the burden on the regulators and improve internal effectiveness. Reporting to the Health Committee to support their work
- Improve process efficiency of our Section 29 work while managing risk and using our data better to show impact and improve performance
- Ensure that the policy team is focused on and has the capacity to contribute to regulatory reform and any possible legislation; looking to improve regulatory practice, standards and public protection through the provision of comment and advice to the regulators and the four UK governments
- Keep our costs down while maintaining value for money and undertake the fee consultation efficiently and to time
- Recruit, select and induct new Board members in a timely manner and ensure an effective working relationship between the Board and the executive team
- Seek financial sustainability for the accredited registers programme, extend its reach and encourage improvement in the registers' performance as necessary
- Remain reactive for the time being in relation to its consultancy and commercial activities.

Business principles

1.30 Our Board recognised the financial and operational changes we would face after the implementation of the Fee Regulations 2015 and the particular need for clear separation of income and expenditure of our different work streams. In addition to setting revised strategic objectives, it also set for us the following business principles:

- Regulatory and standards setting work: All fees from the regulatory bodies are applied solely to our statutory functions of regulatory oversight and improvement as set out in our legislation. Any surplus or deficit generated against our budget as approved by the Privy Council will be used in the calculation of the following year's fee (after the reserves policy has been applied)
- Accredited Registers: All fees for accreditation or renewal from occupational registers are applied solely to provide and develop the accredited registers programme. Any surplus generated will be retained for the benefit of the programme (after the reserves policy has been applied)
- Commissions from Government(s): The pricing of commissions and consultancy contracts will cover all costs associated with the work. Any surplus arising will be deployed at the Board's discretion to support our organisational objectives in the public interest (after the reserves policy has been applied)
- Advice to other organisations: The pricing of commissions and consultancy contracts will cover all costs associated with the work. Any surplus arising will

be deployed at the Board's discretion to support our organisational objectives in the public interest (after the reserves policy has been applied)

1.31 To ensure transparency we will:

- Publish our annual accounts and fully disclose our audited financial statements
- Show clearly our income and expenditure in relation to each of the Authority's four functions
- Publish an auditor's statement setting out our compliance with these business principles.

1.32 In conjunction with these principles our Board has established a reserves policy.

1.33 The Authority has agreed to hold reserves of three months' total operating costs of circa £1 million, within which it draws a distinction between:

- A restricted element associated with regulatory and standards work
- An unrestricted element associated with all the Authority's work
- The intention is that over time the restricted element will amount to two months' total operating costs
- The present make-up of the reserves does not conform to this two thirds/one third split due to the opening position being largely made up of historical Grant in Aid funding from the Department of Health
- The level and make-up of our reserves will be reported through our Annual Report
- Any money taken from reserves during the year will need to be replaced in the following year(s).

Chief Executive's statement

1.34 As can be seen from the content of this report, the Authority has fulfilled its statutory duties during the year under review, it has successfully managed its new funding arrangements and it has developed the accredited registers programme.

1.35 The volume of work carried out by staff has remained high. The number of cases referred to us this year has increased by 14 per cent. The number of cases that we have discussed at case meetings and appealed has fallen, although the percentage of referrals remains constant.

1.36 In August 2015, we published *Regulation rethought* where we set out how professional regulation could be reformed to enable it to meet the challenges of future healthcare.

1.37 Our commitment to research and learning has continued with our annual academic conference, symposium and Accredited Registers Conference being well supported by high quality speakers and participants.

1.38 We have continued our international relationships and have contributed to the International Society of Dental Regulators in Geneva, the IAMRA conference in Melbourne, Australia, the International Nurse Regulatory Collaborative Forum in Chicago, USA and the World Health Executive Forum in Montreal, Canada. Our international reputation, as demonstrated by the large number of requests for advice and meetings we receive, is significant and growing.

1.39 As Chief Executive I am confident that the Authority is performing well; it is maintaining the high quality of its performance and working within its business principles and budget. The directors take personal responsibility for their budgets and for the risks and opportunities associated with their areas of work which are reviewed regularly by the directors group and overseen by the Audit and Risk Committee and the Board.

Key performance indicators

1.40 This section explains how we measure performance. In our annual business plan, we set out various key performance indicators (KPIs) for our work. We review them as part of the work programme of the directors group. We discuss them with officials in the Department of Health and the administrations in Scotland, Wales and Northern Ireland at our periodic information sharing meetings.

1.41 Our performance against those KPIs that are most likely to be of public interest during 2016/17 is set out below:

Area of work	Key performance indicators	Performance
Section 29 decisions	100% of relevant decisions considered within statutory deadline.	100% 4,285/ 4,285
Public concerns about Regulatory bodies	100% of concerns acknowledged within five working days.	98% 309/ 316
Data and Information security	All (100%) Subject Access Requests dealt with within statutory deadlines. All (100%) Freedom of Information Act requests dealt with within statutory deadlines.	100% 1/1 95% 21/22
Financial Governance and Annual Accounts	To pay undisputed invoices: 60% in five days, 100% in 10 days.	 66% 597/908 100% 908/908
Human resources	Staff sickness no more than 2% Staff turnover to be less than 10%.	2% 224/9,519 13% 6/48
Complaints about the Authority	100% of complaints acknowledged in five days Response to all complaints to be completed within 28 days.	100% 9/9 100% 9/9

Accredited Registers	90% of accredited registers will apply for continued accreditation	100% 21/21
	Timescales are met:	
	Applications are put before the Panel within 21 days of receipt of all information/documentation required	100% 23/23
	Panel reviews renewal applications within five days from the renewal date provided all relevant information and documentation has been received	90% 18/20
	Letters advising of need to apply for renewal are issued 12 weeks before accreditation ceases.	100% 21/21

Performance analysis

1.42 As this report shows, we have continued to focus on public protection, the improvement of professional regulation and registration and the effective delivery of all our statutory functions. We have worked hard to ensure that we have maintained the quality of our performance.

1.43 The volume of work carried out by staff has remained high. We are appreciative of the support and collaboration that we have received from the regulatory bodies particularly their cooperation with the business planning cycle and fee consultation.

1.44 The accredited registers programme is now fully integrated into our work plans, governance and financial management. With 23 registers accredited covering some 80,000 practitioners, it is making a valuable contribution to choice and quality in health and care.

1.45 Our policy work and our research programme have continued to grow in influence.

1.46 We are committed to best practice in governance and operations and financial management. We have spent particular time and effort in maintaining our new financial arrangements as set out in the Health and Social Care Act 2012 and the consequent Fee Regulations. The arrangements required a significant shift in our budgeting and accounting practices and caused us to think carefully about new risks and new assurances. Our Board has been particularly mindful of these matters, for example developing a reserves policy, now that our operations are no longer underpinned by government funding.

Regulatory and standards setting work

Section 29

1.47 Under Section 29 of the National Health Service Reform and Health Care Professions Act 2002, we can refer final fitness to practise decisions made by the nine regulatory bodies to court (a referral by us is treated as an appeal by the Court) if we consider that the decision is not sufficient to protect the public.

1.48 This year we have seen a 14 per cent increase in the number of fitness to practise determinations notified to us by the regulators, from 3,756 in 2015/16 to 4,285 in 2016/17.

1.49 The majority of the determinations that we reviewed (62 per cent) were NMC panel decisions.

1.50 Of the 4,285 cases we received in 2016/17, 85 per cent (3,644) were closed with no requirement for more information.

1.51 Of those cases, 887 resulted in the regulator removing the registrant's name from its register, therefore raising no concerns about public protection and requiring no Authority intervention.

1.52 During 2016/17, we considered 55 panel determinations at formal case meetings, compared to 44 meetings held in 2015/16. However, eight of these cases related to GMC appeals ('section 40B case meetings').

1.53 Following case meetings, we referred 13 cases to Court under our Section 29 jurisdiction (although we subsequently withdrew one of these appeals). In 2015/16, we referred 14 cases to the Court.

1.54 In addition, we joined two appeals initiated by the GMC as a party, under section 40B of the Medical Act 1983.

1.55 In the remaining cases that we considered at formal case meetings but which we decided not to refer to court or to join as a party to a GMC appeal, we identified learning points to feed back to the regulators.

1.56 Despite the increase in the number of cases reviewed in 2016/17 (see table 2), our trend of referring less than 0.5 percent of cases to the Court has continued in the last two years (see table 3).

1.57 Of the 13 referrals to Court that we made in 2016/17, eight related to NMC panel decisions; two to decisions made by the MPTS; two to decisions made by panels of the HCPC; and one to a decision of a GDC panel.

1.58 The relatively high proportion of NMC panel decisions that have been referred to the Court by us, reflects in part the fact that 62 per cent of all panel decisions that we receive, are from the NMC.

1.59 More information about our section 29 work can be found in paragraphs 3.1 to 3.28 in part 1 of this report.

Table 2 Number of fitness to practise cases reviewed annually

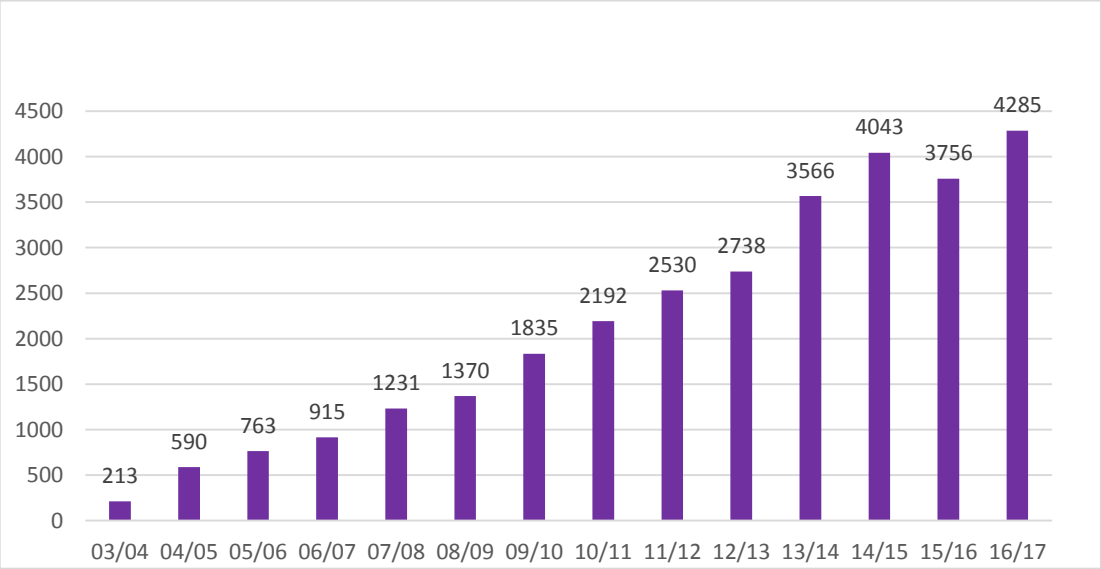
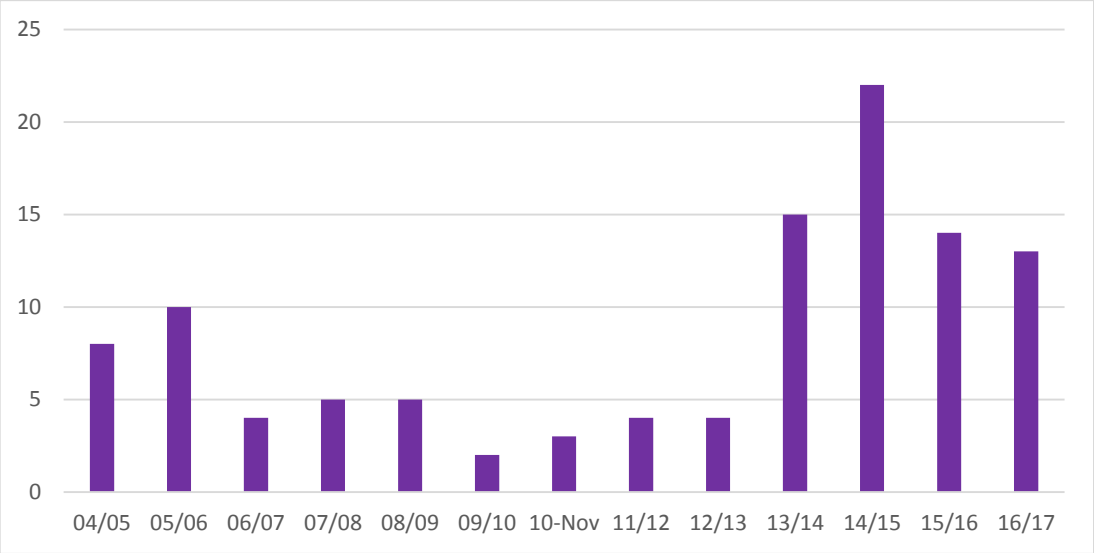


Table 3 Number of fitness to practise cases referred to court each year



* These figures represent the total number of referrals to court but also include a small number of cases which were subsequently withdrawn, for example, 1 in 2016/17.

Performance review

1.60 We have a statutory duty to report annually on the performance of each of the regulators in fulfilling their duty to protect the public. We do this by assessing their performance against a set of agreed standards (the Standards of Good Regulation). From January 2016, we commenced our reviews of performance using our revised performance review process, and have now published nine individual performance review reports. We commenced our next cycle of review in January 2017. Further information about the review of performance of the health and care regulators is found in section 2.

Scrutiny of regulators' council appointments processes

1.61 We assist the Privy Council with appointments to the regulatory bodies' councils (except the PSNI). We provide advice to the Privy Council in relation to all open

competitions for appointments and reappointments processes and, if the Privy Council requests it, in relation to any other aspect of the Privy Council's appointments function.

1.62 In 2016/17, we provided advice to the Privy Council in relation to 22 processes run by eight regulators. Twelve of these processes related to appointments via open competition, covering 24 vacancies including one Chair role. Ten of these processes related to reappointments, covering 25 vacancies including two Chair roles. We advised the Privy Council that it could have confidence in all of these processes.

1.63 In the course of our scrutiny, we have identified areas for improvement as well as instances of good practice, which we have shared with the individual regulators throughout the year. We held a seminar with the regulatory bodies in October 2016 and the consensus was that it provided a useful way of sharing good practice.

1.64 Previously our guidance on the process was held in two documents. We have now amalgamated and updated those documents to include our views of good practice on appointments processes. It has been published on our website following considerable consultation with the regulators.

Policy and research projects

1.65 We carry out a variety of work to help ensure that regulation protects the public efficiently and effectively. This includes conducting research and publishing policy advice and looking forward, to anticipate change and ensure regulation remains agile. We encourage collaboration between the regulators we oversee and academics to stimulate research, learning and improvement. Our objective is to ensure that regulation and registration is based on evidence of what works so that regulators are effective.

1.66 We have continued to work to build our relationships with academics and researchers. We now have over 100 people on our list of academics and researchers with an interest in regulation, or whose work appears to us to be relevant to regulatory improvement. On 9-10 March 2017 we held our fourth academic and research conference on *Building trust in people and places*. Our academic collaborator for the event this year was Professor Rosalind Searle, Professor of Organisational Behaviour and Psychology, Centre for Trust, Peace and Social Relations, Coventry University. One hundred people attended including from academic institutions, regulators, research organisations, professional bodies, consultants working in this field, government officials, clinicians, and a law firm. Attendees included people from all four countries of the UK, Ireland, Belgium, Canada, the US and Australia. There were 25 presentations on research in different areas of regulatory policy and practice. This year, we extended the conference and dedicated half a day to an international seminar looking at the relationship between regulation and professionals' scope of practice in different countries.

1.67 We promoted debate and discussion in the sector. Our 2017 Symposium in February was attended by 54 people and explored the theme of *Regulating in an age of uncertainty: managing risk and changing environments*. Discussions focused on cross border working, changing environments and workforces, technological innovation and maintaining standards in workplaces under pressure.

1.68 Last year we explained why regulatory reform was needed. In October 2016, we published *Regulation rethought*. This built on our 2015 publication *Rethinking*

regulation, in which we explained why the current arrangements for regulation are no longer fit for purpose and set out our vision for the future. In *Regulation rethought* we propose how the ideas that we had previously set out could be put into practice. This includes a shared purpose across the regulatory system, a renewed focus on core functions, and a greater focus on cost-effectiveness and efficiency in pursuing those functions. We propose a shared, public register and a system of licensing, overseen by a single assurance body; a greater emphasis on regulators using their insights and data to work in partnership to identify problems at an early stage; and shorter, less costly and more consensual ways to close fitness to practise cases. We recommend a review of arrangements for the quality assurance of higher education courses. We also discuss the application of our methodology set out in *Right-touch assurance: a methodology for assessing and assuring occupational risk of harm* (2016).

1.69 *Right-touch assurance* is an innovative tool for assessing the risk of harm presented by different health and care occupations. This tool indicates the form of assurance needed to manage the risk of harm to patients and service users arising from the practice of an occupation. It is intended to help governments in making objective and transparent decisions on whether new roles should be regulated or what alternative action should be taken, such as an accredited register, credentialing or employer-led controls. In the longer term the methodology could be used or adapted to aid decisions on whether specialties should be regulated, if there should be annotations on registers, as well as reviewing the need for provisional and student registration.

1.70 We responded to 18 public consultations in 2016/17. These included policy consultations by the regulators we oversee; the House of Lords call for evidence on the long-term sustainability of the NHS; the Department of Health's Safe Spaces consultation; the European Commission's consultation on national action plans for reviewing regulation of professionals and 'proportionality test' for regulation; and the Irish government's consultation on the proposed regulation of counsellors and psychotherapists. Our consultation responses are published on our website.

1.71 We presented at the Scottish Regulation Conference this year and liaised with regulators and government officials in Northern Ireland, Wales and England. We contributed to several conferences including international regulatory conferences. We were represented at Department of Health working groups including the Cavendish Governance Board and the Health and Social Care Strategy Workforce Forum. We developed a new version of our Welsh website to improve the information provided.

1.72 We published our review of the literature on professional identity and its links with regulation. This is a topic that is pertinent to many of the current discussions about both the possible merging of regulators and the development of new groups of practitioners in healthcare, such as nursing and physician associates. A number of factors appear to influence professional identity, and although it is possible to identify characteristics common to professions, it is a deeply personal and individual notion shaped by a person's own experiences and interactions. The little evidence we found relating to regulation suggests that there may be some, possibly minimal, role played by regulation in professional identity. At the time of writing, we are awaiting the final report of an independent researcher, whom we commissioned to undertake qualitative research with healthcare practitioners on their perceptions of professional identity and regulation, to fill the gap we identified in the literature.

Legislative reform

1.73 The Authority provided timely advice and briefings to officials, Peers and MPs on proposals for a new regulator for social workers, during the passage of the Children and Social Work Bill through Parliament. This ultimately resulted in positive changes to the Bill making the new regulator, Social Work England, independent from Government and bringing it under the statutory oversight of the Authority which will help to ensure transparency and a clear focus on public protection. We continue to be part of and provide advice to the working group establishing the new regulator.

1.74 At the time of writing we still await the publication of the four-country consultation on reforming the health and care professional regulators. In anticipation of that consultation we have undertaken preparatory work on education and training, fitness to practise, registration and how regulation can be more preventative in focus, building on our publication *Regulation rethought*.

1.75 It remains our view that reform of the sector is both necessary and urgent. Reformed regulatory arrangements are necessary to support the delivery of health and care services in the future in a flexible and innovative way.

Accredited Registers

1.76 The Health and Social Care Act 2012 has given the Authority the power to accredit registers that meet our standards in the interests of service users and the public. The accredited registers programme, launched in 2013, applies to the health and care sector in the UK. It was established to provide assurance that registers are well run.

1.77 Being accredited means that an organisation has satisfied the Authority that it meets its high standards. It is a mark of quality. Accredited registers are entitled to use the Authority's accreditation mark (shown below) so that they can be distinguished easily.

1.78 The programme is financed by a combination of accreditation fees and a subvention from the Department of Health. The programme is not yet self-financing and continues to require a subvention. We were pleased to receive agreement for renewal of the subvention, however we have experienced delay in obtaining funds from the Department of Health due to its procurement processes. We will be consulting on a new fee model in 2017/18.

1.79 We have accredited 23 registers to date, covering 30 occupations and 80,000 practitioners. Accreditation is reviewed annually. By the end of the financial year, we had accredited four new registers and renewed accreditation of 17. Two annual assessments have carried over into the new financial year.

1.80 From 1 April 2016, we introduced an additional element to our education and training standard to increase transparency and inform the public when choosing

practitioners from an accredited register. The first assessment against this took place in June 2016. Fourteen registers have been assessed against that new standard. Assessment against this standard will take place in the upcoming annual reviews for the remaining registers.

1.81 In February 2017, we provided guidance to supplement our standard that requires registers to recognise professional conduct decisions made by other accredited registers and regulators. This followed the outcome of a judicial review involving two accredited registers in December 2016, which ruled that where two or more accredited registers cover the same occupations and have effectively the same code of ethics, a registrant could not be put through professional conduct procedures by different registers.

1.82 To encourage learning and improvement, we held a seminar for registers on handling complaints. We also ran webinars for organisations planning or preparing to apply for accreditation with us.

1.83 We worked in partnership with the Royal Society for Public Health to explore how the accredited registers workforce can contribute further to Public Health England's initiatives to improve the nation's public health. The report will be presented at our conference in May 2017. We also began a pilot with a GP commissioning consortia in the South West of England to examine how GPs can work in partnership with accredited registers to support patient-centred care. We worked with NHS England to help them establish a credentialing register for workers in the life sciences industries who work within NHS trusts and routinely interact with directly with patients and/or NHS front-line staff. Two non-surgical cosmetic practice registers, Save Face and Treatment You Can Trust were accredited, as recommended by Professor Sir Bruce Keogh's Review of the Regulation of Cosmetic Interventions.

1.84 During the year, we received and considered 21 queries about accredited registers. As a result of our focus on complaints-handling, we decided from March 2017 to include in our assessments for annual renewal of accreditation an audit of complaints cases. We will report on the results of this next year.

1.85 We have continued to work to raise awareness of the accredited registers programme and the importance of using registrants on them. This includes attending GP conferences, working with the Local Government Association, NHS Choices and Healthwatch, among others. However, awareness of the programme remains insufficient for it to deliver full benefit to the public. We have been disappointed that opportunities for the government to promote the programme, which is implementing government policy, have been missed. We are liaising with the Department of Health to ask for increased recognition of the value of the programme.

1.86 We have also asked the Department to assist with securing changes to the Rehabilitation of Offenders Act and the Safeguarding Vulnerable Groups Act to strengthen the protection accredited registers can offer. At present, their exclusion from those Acts constrains their ability to respond to some complaints due to data protection issues.

1.87 We delivered presentations about the programme at different events and met with several stakeholders during the year. We also responded to consultations relevant to the programme and to accredited registers.

Commissions from Government(s)

1.88 In August 2016, the Department of Health asked the Authority for advice on the appropriate level of oversight for the emerging role of the Nursing Associate. We were unable to provide definitive advice as the scope of the role had not been sufficiently determined to apply the methodology reliably. We recommended registration rather than regulation of Nursing Associates as an interim measure until a full assessment could be made. Nevertheless, the Department of Health subsequently announced that it intended to proceed with regulating the role in England and asked the Nursing and Midwifery Council to fulfil this function, to which the NMC's Council agreed in January 2017.

1.89 In December 2016, we published advice to Government on an initial evaluation of the feasibility of prohibition order schemes for unregulated health and care workers in the UK. This commission examined prohibition order schemes currently in place, drew out common features across the schemes and highlighted potential implications of establishing prohibition orders in the health and care sector.

Advice to other organisations

1.90 We published the report of our performance review of the College of Registered Nurses of British Columbia. We had adapted our Standards of Good Regulation and added a set of standards on governance, against which to assess the College's performance and produce a substantial report. The report was welcomed by the College which is implementing the recommendations in it.

1.91 We hosted an intern for the Hong Kong government who was studying our accredited registers programme. Following our previous work with the Chinese University of Hong Kong, the Hong Kong government announced that it will launch its own accredited registers programme. We are continuing to advise on its development.

1.92 We are working with the Department for Education on the creation of Social Work England.

1.93 We have seconded a member of staff to the National College of Policing.

Financial summary

1.94 Our funding for 2016/17 comprised £3.86 million fees paid by the regulators and £0.2 million from the Department of Health. In 2015/16 our funding was £2.7 million fees raised from the regulators, £1.4 million from Department of Health and £0.038 million from the devolved administrations.

1.95 At 31 March 2017, we carried forward reserves of £1.87 million (2015/16: £1.81 million) after net operating costs of £0.11 million (2015/16: £0.69 million). Net operating costs for 2016/17 are calculated net of fees received from the regulators, which is recorded as an income in accordance with IAS 18.

1.96 During the year ending 31 March 2017, we generated a surplus that increased our reserve position by £0.06 million.

1.97 An analysis of accounting policies is shown in note 1 to the accounts. There have been no significant changes to these during the year.

Transparency

1.98 The Authority is committed to the provision of information to the public.

1.99 Our creditor payment policy is maintained in accordance with the government's Better Payment Policy, which currently provides for payment of suppliers within five working days of receipt of invoice, except where there may be a query or dispute regarding an invoice.

1.100 This target is challenging, especially for a small organization like ours, and could only be achieved if we employed more staff. Accordingly, we aim to pay 60 per cent of undisputed invoices within five days and 100 per cent within 10 days.

1.101 During the 2016/17 financial year, 100 per cent of invoices were paid in 10 days and 66 per cent (by number of invoices) and 65 per cent (by total invoice value) within five days. Details of our payment record can be found on our website.[29]

1.102 No interest was paid under the Late Payment of Commercial Debts (Interest) Act 1998.

1.103 The balance owed to trade payables as at 31 March 2017 was £17,086 (2015/16: £11,445). As a proportion of the total amount invoiced by suppliers in the year, this is equivalent to 3.20 days (2015/16: 2.13 days).

1.104 Other information that can be found in the government disclosure and transparency sections of our website include:

- Expenditure over £25,000
- Board member expenses
- Executive team expenses
- Hospitality.

Sustainability

1.105 Due to our size, we are not required to provide a sustainability report. We nevertheless do seek to minimise the impact of our activities on the environment.

1.106 Our office was refurbished, before we became tenants, in accordance with the BREEAM environmental assessment standard, which looks at heating, lighting, recycling and other matters, and has an 'excellent' rating.

1.107 We occupy 2.58 per cent of the building, part of which is occupied by our own tenants.

1.108 Rainwater is collected and used to supply the sanitary facilities, reducing our clean water consumption.

1.109 Our offices have facilities to separate waste for recycling, and to encourage staff to do this, no waste is collected from bins at desks. Waste is separated into glass, recyclable, non-recyclable and food waste. A contractor separates the mixed recyclables. No waste goes to landfill. Waste that cannot be recycled is incinerated. In 2016/17 98 per cent of waste, within the building, was recycled and 2 per cent was incinerated. The cost of all waste disposal is included in our building service charges.

[29] www.professionalstandards.org.uk/about-us/ask-us-for-information/government-disclosure/payment-statistics

1.110 Our gas and water consumption is calculated as 2.58 per cent of the total. Our electricity is separately monitored and the consumption for the space rented from the landlord is known. This does not, however, include the consumption by our tenants. Our consumption for 2016/17 and the previous year is set out below.

	2016/2017	2015/2016
Gas	7,672kWh	6,253kWh
Electricity	65,031kWh	64,882kWh
Water	146.64m^3	155.77m^3
Waste removed	2.76 tonnes	3.33 tonnes

1.111 The installation of waste compactors has reduced the frequency of collections from daily to fortnightly, reducing vehicle emissions.

1.112 We seek to minimise the impact of our own activities on the environment. When equipment is purchased, consideration is given to energy consumption. We use recycled materials where such alternatives are available and provide value for money.

1.113 We continue to seek to reduce the use of paper by maximising the use of our intranet and website for the dissemination of information. We are also using electronic versions of meeting papers where technically practical. Where paper is used, we look to reduce its consumption through the active management of printers requiring double-sided printing.

1.114 We use 'off-white recycled paper' for our day-to-day needs. We used 71 cases of paper in 2016/17 (69 cases in 2015/16).

1.115 When travel is necessary, we use public transport as much as possible and have increased our use of telephone and video conferencing to avoid the need to travel. When appropriate journeys within the UK and Europe are made by train.

1.116 We have continued to collect environmental information regarding journeys made by Board and staff members.

Mode of travel	2016/2017		2015/2016	
	CO^2/kg Total	CO^2/kg Average per full-time equivalent*	CO^2/kg Total	CO^2/kg Average per full-time equivalent*
Air*	153	4	4,268	125
Rail	633	17	762	22

* This information only relates to flights booked through our central supplier. Some international flights booked separately, often by commissioning organisations, are not included

Risk

1.117 Details of this can be found in paragraphs 2.65-2.71.

Approved by the Board

Harry Cayton CBE
Accounting Officer
9 June 2017

2. Accountability Report

Corporate governance report

Directors' report

2.1 We have an executive team as shown below, covering our three areas of work: governance and operations; scrutiny and quality; and policy and standards.

2.2 A register of senior managers' interests is available on our website.[30]

2.3 Directors are members of staff and are paid in accordance with staff policies.

Harry Cayton	Chief Executive
John McDermott	Director of Governance and Operations
Mark Stobbs	Director of Scrutiny and Quality
Christine Braithwaite	Director of Policy and Standards

Public appointments

2.4 Public appointments are generally made for an initial term of four years, which can be extended for a second term. The total time served should not exceed eight years.

2.5 Schedule 7 of the National Health Service Reform and Health Care Professions Act 2002, as amended by the Health and Social Care Act 2008 and by the Health and Social Care Act 2012, provides directions for the appointment of members to the Authority.

2.6 In the autumn of 2016, the tenure of four of our Board members came to an end; The Chair of the Audit and Risk Committee and Board members from Scotland, Wales and Northern Ireland.

2.7 Following a public recruitment process, the Privy Council appointed Frances Done CBE as the Chair of the Audit and Risk Committee for a period of four years, effective from 1 January 2017.

2.8 The devolved administrations also each made appointments to our Board, with Moiram Ali, Thomas Frawley CBE and Marcus Longley appointed from Scotland, Northern Ireland and Wales respectively for the same length of time.

2.9 Details of all Board appointments and who makes them are shown in the table below.

2.10 Details of the directorships and significant interests held by the board are contained within the register of interests held on our website.[31]

[30] www.professionalstandards.org.uk/docs/default-source/board/management-team-register-of- interests-2016.pdf?sfvrsn=0

[31] www.professionalstandards.org.uk/docs/default-source/board/board-register-of-interests.pdf

Board members

Board member	Appointed by
George Jenkins OBE (Chair)	Privy Council
Renata Drinkwater	Privy Council
Ian Hamer OBE***	Welsh Ministers
Andrew Hind CB*	Secretary of State
Frances Done CBE**	Privy Council
Stuart MacDonnell*	Department of Health Northern Ireland
Thomas Frawley CBE**	Department of Health Northern Ireland
Jayne Scott*	Scottish Ministers
Moiram Ali**	Scottish Ministers
Antony Townsend	Privy Council
Harry Cayton CBE	Authority's Board

* Up to 31 December 2016
** From 1 January 2017
*** Continuing until new Board member starts in May 2017

2.11 Details of the attendance of Board members can be found in the governance statement.

The Board and Accounting Officer's Statement of responsibilities

2.12 Under the Cabinet Office's Guidance on Codes of Best Practice for Board Members of Public Bodies, we are responsible for ensuring propriety in its use of public funds and for the proper accounting of their use. Under Schedule 7, Paragraph 16 (2) of the National Health Service Reform and Health Care Professions Act 2002, as amended by the Health and Social Care Act 2008, we are required to prepare a statement of accounts in respect of each financial year in the form and on the basis directed by the Secretary of State for the Department of Health, with the consent of HM Treasury. The accounts are to be prepared on an accruals basis and must give a true and fair view of the Authority's state of affairs at the year end and of its income and expenditure, total changes in taxpayers' equity and cash flows for the financial year.

2.13 In preparing the accounts, we are required to:

- Observe the accounts direction issued by the Secretary of State, with the consent of HM Treasury, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards have been followed, and disclose and explain any material departures in the financial statements
- Prepare the statements on the going concern basis unless it is inappropriate to presume that we will continue in operation.

2.14 Following the change in our funding arrangements the Board has appointed the Chief Executive as our Accounting Officer. His relevant responsibilities as the Accounting Officer, include his responsibility for the propriety and regularity of the public finances for which he is answerable and for the keeping of proper records. Although we are not a Non-Departmental Public Body he observes the requirements set out in the Non-Departmental Public Bodies' Accounting Officers' Memorandum issued by HM Treasury and published in Managing Public Money.

Further explanation

2.15 The Health and Social Care Act 2012 changed the name of CHRE to the Professional Standards Authority for Health and Social Care and provided a power for the Authority to accredit voluntary registers of health and care occupations. The Act also changed the basis on which the Authority was funded to a system of fees and charges on the bodies it oversees or provides services to. The fee regulations came into effect in August 2015, after which time the authority no longer receives grant in aid from either the Department of Health in England or the devolved governments of the UK. The 2012 Act includes a provision for the Accounts Direction to the Authority to be issued by the Privy Council. This provision has not yet been enacted so for the purpose of these accounts the Authority continues to follow the Accounts Direction issued in 2013-14 by the Department of Health.

Data handling

2.16 Details of this can be found in paragraphs 2.72-2.78.

Governance statement

2.17 Our Board has corporate responsibility for ensuring that the Authority fulfils its statutory duties and for promoting the efficient, economic and effective use of its resources.

2.18 The Authority's Board comprises seven non-executive members and one executive member. All non-executive members of our Board have been appointed from the public so that we are completely independent of the health and social care professions and regulators that we oversee.

Chair of the Board

2.19 The Chair has a particular leadership responsibility on the following matters:

- Leading the Board in formulating our strategy
- Ensuring that the Board, in reaching decisions, takes proper account of any relevant guidance
- Promoting the efficient, economic, and effective use of resources, including staff
- Encouraging high standards of propriety
- Ensuring that the Board meets at regular intervals throughout the year and that the minutes of meetings accurately record the decisions made and, where appropriate, the views of individual members
- Ensuring that the work of the Authority is reported annually to Parliament.

Attendance at Board meetings held in public

2.20 There were six Board meetings held in public between 1 April 2016 and 31 March 2017.

2.21 Members' attendance at Board meetings during 2016/17 was as follows:

Board member	Number of meetings attended	Possible
George Jenkins OBE (Chair)	6	6
Renata Drinkwater	6	6
Ian Hamer OBE***	6	6
Andrew Hind CB*	4	4
Frances Done CBE**	2	2
Stuart MacDonnell*	3	4
Thomas Frawley CBE**	2	2
Jayne Scott*	3	4
Moiram Ali**	2	2
Antony Townsend	6	6
Harry Cayton CBE	6	6

* Up to 31 December 2016
**From 1 January 2017
***Continuing until new member starts May 2017

2.22 During the year under review, the Board was active in ensuring that our statutory functions were maintained and that the threats we were encountering were being addressed and that the opportunities were recognised. It achieved this by effective use and monitoring of the risk register and assurance framework and by remaining vigilant about the quality of our outputs.

2.23 The Board is confident that it continues to receive appropriate, complete and relevant reports from the executive to ensure that it can fulfil its strategic role and can hold the executive to account. Quality assurance is provided by both the Scrutiny Committee and the Audit and Risk Committee, which report to the Board. The Board also reviews all key policy papers and reports before publication to ensure they meet the high standards it expects. The Board also receives finance reports at every meeting and reviews the risk register twice a year.

2.24 The Board pays particular attention to the conduct of the Authority's investigations and special reviews and carefully assures itself of the quality of the final reports.

2.25 The Board plays an important role in establishing the strategic direction for the Authority and considers this and related issues at its annual planning day.

2.26 The Board also reviews its own performance as part of its strategic planning.

2.27 The Board has paid particular attention to the selection and induction of new members in order to acquire a good mix of skills and ensure an effective transition. The Board considers that it is functioning effectively.

2.28 Maintaining the quality of our work is an important consideration for the Board. It contributes to publications and reports prior to publication and takes a close interest in research and policy development. Board members attend the Authority's annual research conference and Symposium.

2.29 The Board also reviews information it receives about the Authority's performance from external parties including the statutory regulators, the accredited registers and the Departments of Health in England, Scotland, Wales and Northern Ireland.

2.30 All members of the Board are appraised annually by the Chair and are able to comment on the performance of both the Chair and the Chief Executive.

2.31 The detail of quality assurance is delegated to the Scrutiny Committee and to the Audit and Risk Committee. We report on their activities separately. The Terms of Reference for the two committees are reviewed annually.

Committees and working groups of the Board

Audit and Risk Committee

2.32 The Board has an Audit and Risk Committee to support it in its responsibilities for risk control and governance. The committee reviews the comprehensiveness of assurances in meeting the Board's and Accounting Officer's assurance needs and reviewing the reliability and integrity of these assurances.

2.33 Four Audit and Risk Committee meetings were held between 1 April 2016 and 31 March 2017.

2.34 Members' attendance at committee meetings during 2016/17 was as follows:

Committee member	Number of meetings attended	Possible
Andrew Hind CB*	4	4
Frances Done CBE**	N/A	N/A
Stuart MacDonnell*	4	4
Jayne Scott*	3	4
Moiram Ali**	N/A	N/A

* Up to 31 December 2016
**From 1 January 2017

2.35 The minutes of the committee's meetings are formally reported to the Board, as is the committee's opinion on the risk register and the changes made to it.

2.36 The committee reviews its Terms of Reference and work programme annually and reports any changes that it proposes to the Board. Each year, it formally reports to the Board on:

- Its work during the previous financial year
- The assessment of information governance arrangements
- The internal audit reports submitted to it
- The views and opinions of the auditors.

2.37 The committee sets its own work programme for the coming year and this influences the work programme set by the internal auditors.

Regulators internal audit hub

2.38 We have chosen to be within the Government Regulators Internal Audit Hub. The Hub's current internal auditors, Grant Thornton (GT), were our internal auditors for 2016/17.

2.39 The internal audit work this year focused on:

- Key financial controls
- Follow up on previous recommendations
- Adherence to our business principles and reserves policy.

Key financial controls

2.40 The review considered the adequacy of design and operating effectiveness of the key financial controls, including policies and procedures, reconciliations, invoicing, payroll, purchase to pay and management reporting.

2.41 The review, which identified one action that merited attention for the Authority to consider, concluded:

'…the Authority has well designed corporate process for the key financial systems included in the scope of this review and that these were operating effectively based on sample testing.'

Follow up on previous recommendations

2.42 The review considered the Authority's actions associated with various previous recommendations, including accredited registers, consultations and key financial controls.

2.43 The review, which identified that of the eight recommendations, four had been completed, one was in progress, two were overdue and one was not due yet, concluded:

'Management is making good progress in implementing previously agreed internal audit recommendations…'

Adherence to our business principles and reserves policy

2.44 This review looked at whether the Authority was acting in accordance with its own business principles and reserves policy which are set out above.

2.45 The review, which identified three actions that merited attention for the Authority to consider, concluded:

'In the period April 2016 – March 2017, based on the work performed to date, and subject to the completion of the outstanding work, we found the Authority has adhered to the set of business principles and reserves policy it has set out… Our work did not identify any fundamental or significant errors in relation to the application of the principles or reserves policy, based on the work carried out.'

Risk register

2.46 The Directors Group reviews the risk register quarterly. Every six months, the updated report is considered by the Audit and Risk Committee and thereafter by the Board. Risks are added, updated or deleted outside of this process when the need arises.

2.47 During the year, the committee reviewed the risk register maintained by the executive. The main risks discussed, some of which are covered in detail in the strategic report, related to the timing of funding arrangements and opportunities to improve our support services.

Assurance framework

2.48 During 2014/15 the committee considered how the Board members could be assured about the operation of the Authority and how this could be documented. In doing so, the committee sought to identify a format that was proportionate and informative and so produced an Assurance Framework.

2.49 This Assurance Framework was used in 2016/17 to record and inform Board members of the evidence they can rely on to provide assurance to them in relation to the running of the Authority and the mitigation of risks.

2.50 The document is linked to the risk register and is regularly updated.

Scrutiny Committee

2.51 The Scrutiny Committee receives reports on the operation of our scrutiny and oversight of the nine health and care professional regulatory bodies and provides quality assurance of Section 29 decisions and the accredited registers programme.

2.52 Three Scrutiny Committee meetings were held between 1 April 2016 and 31 March 2017.

2.53 Members' attendance at committee meetings during 2016/17 was as follows:

Committee member	Number of meetings attended	Possible
Ian Hamer*	2	2
Antony Townsend	3	3
Renata Drinkwater	3	3
Tom Frawley**	1	1

* Up to 31 December 2016
**From 1 January 2017

Appointments to regulators' councils

2.54 At all three meetings, the Scrutiny Committee considered reports on recent activity, as well as information provided about the Authority's internal processes and its relationship with external stakeholders including the Privy Council in relation to this area of its work.

Review of final fitness to practise decisions (the Authority's Section 29 jurisdiction)

2.55 At all three meetings, the Scrutiny Committee reviewed decisions taken to refer to Court/not to refer to Court individual regulators' final fitness to practise panel decisions that had been taken at Section 29 case meetings. At each meeting, the Committee reviewed a sample of these decisions taken throughout the year and confirmed that it was satisfied as to the processes followed. In February 2017, the Board also reviewed decisions on whether cases should have been referred to case meetings. It was satisfied with the processes followed.

2.56 In 2016, the Committee and, subsequently, the Board, approved a pilot of a structured test that could in future be used to decide whether or not a Section 29 case meeting should be held. The pilot while useful gave rise to a number of concerns. The Committee (and, subsequently, the Board) agreed that the test should be dropped and a revised approach will be incorporated within an updated version of the Authority's Section 29 Process and Guidelines document. This has been done.

Annual performance review of regulators

2.57 The Scrutiny Committee has received regular reports on the progress of the Performance Review process and, in particular, any concerns that have arisen in the first year of the new process. The Committee has been content with that process. It will review how the process as gone in the next financial year after the final reviews have been completed.

Standards of Good Regulation

2.58 The Scrutiny Committee has been involved in work to review the Standards of Good Regulation. These are the Standards that the Authority uses to assess regulators' performance and are now over 10 years old. The Authority is reviewing the Standards and the Committee has been involved in commenting on the process and on the key issues that have arisen. It will continue to do so in 2017.

Accredited Registers

2.59 The Scrutiny Committee carried out its scrutiny of the accredited registers programme. It received progress updates on applications going through initial assessment, annual reviews of accreditation and notifications of change.

2.60 The committee was also kept informed about the communications activities and engagement with stakeholders to raise awareness of the programme.

Pension scheme regulations

2.61 As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments to the scheme are in accordance with the rules and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

2.62 The protection of data held by us and requests for its disclosure continue to be important considerations for us.

2.63 As a small employer not within the NHS, the Authority does not have online access to the NHS Pension Authority (NHSPA). We submit paper documentation to the NHSPA in order that they would update our staff records and other data.

2.64 We have continued to try to make arrangements to have online access so that the records, especially staff records, can be updated in real time.

Risk and uncertainty

Approach

2.65 During 2016/17 we subjected our risk management practices to a detailed gap analysis against the industry best practice Management of Risk methodology.

2.66 Both the approach (process and matrix scoring system) and risk register were scrutinised, and we decided to update our process to align to best practice around neutral language and to update our risk register to include missing fields.

2.67 In reality these actions amount to incremental improvements rather than wholesale changes to the Authority's risk management practices, and in practical terms resulted in the register also capturing the full range of risks – i.e. opportunities as well as threats, as well as the appetite or necessary response to the risk.

Specific items during 2016/17

2.68 The timetable for the determination and collection of our fee income remained a concern to us during 2016/17.

2.69 The steps outlined in the Fees Regulations are such that there will always be a tight timetable for both the Authority and the Privy Council. We were pleased that the cycle was completed ahead of schedule and because the regulators paid promptly it meant that we ended the 2016/17 financial year in receipt of our income for 2017/18 as required.

2.70 Our Board remain conscious of the risks to our cash flow should there be any delay to the receipt of the fees and amended its reserves policy in our 2017/18 consultation document. This policy is set out on the notes to the accounts.

2.71 During 2016/17 we have identified various opportunities to improve our operations and as such have embarked on comprehensive programmes of work to redevelop our support services, review our grading and pay structures and ensure that we are prepared for the forthcoming General Data Protection Regulation.

Data handling

2.72 Our system of internal control is based on the HMG Security Policy Framework and we continue to monitor and review our compliance with them.

2.73 We hold little personal information. The main data we hold relates to our own staff. Where we require access to personal data held by others, this is generally undertaken at the premises of the data holder. Staff undertaking audits as part of performance reviews are required to work through remote access to our server whenever possible. Since this is not always possible, the laptops used by the auditors have been encrypted to provide another layer of security.

2.74 Staff continue to undertake the government's 'Protecting Information' online training. The training is split into three levels and is assessment-based.

2.75 All staff are required to complete the level appropriate to their level of responsibility for data-handling. All members of staff successfully passed the assessment in 2016/17.

2.76 The Audit and Risk Committee Chair has provided a statement that she was satisfied that we have appropriate policies for staff to adhere to, as far as they apply to the Authority, and that suitable processes are in place to mitigate risks to our information.

2.77 This statement has been prepared following consideration of the Authority's Annual Assessment of Information Risk Management for 2016/17 and the assurance provided by it.

2.78 We have no personal data incidents to report.

Accounting Officer's responsibilities

Scope of responsibility

2.79 As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Authority's policies, aims and objectives, while safeguarding the funds and organisational assets for which I am personally responsible. I follow the guidance set out in Managing Public Money.

2.80 The Authority reports to the UK Parliament and works closely with the devolved administrations in Northern Ireland, Scotland and Wales, and with the Department of Health in England, to deliver our statutory obligations and the key objectives of our business plan. This includes identifying and responding appropriately to both internal and external risks.

The purpose of the system of internal control

2.81 The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

2.82 The system of internal control is designed to identify and prioritise the risks to the achievement of organisational policies, aims and objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

2.83 Our system of internal control has been in place for the year ended 31 March 2017 and up to the date of approval of the annual report and accounts, and accords with HM Treasury guidance. The key elements of the system of internal control include:

- Financial procedures detailing financial controls for responsibilities of, and authorities delegated to, the management team
- Business planning processes setting out the objectives of the Authority supported by details of annual income, expenditure, capital and cash flow budgets
- Regular reviews of performance along with variance reporting, scenario planning and reforecasting.

Review of effectiveness

2.84 As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed by the work of the internal auditors, the Directors Group, which has responsibility for the maintenance of the internal controls, and comments made by the external auditors in their management letter and other reports. The Audit and Risk Committee and Board have advised me on the implications of the result of my review on the system of internal control. The Scrutiny Committee has this year considered in detail our performance against our own standards of our statutory functions.

2.85 The effectiveness of the system of internal control was maintained and reviewed through:

- The Board of the Authority, which met six times
- The Audit and Risk Committee, which consists of three members of the Board. I also attended the Audit and Risk Committee meetings together with the Director of Governance and Operations, the Head of Finance and representatives from the National Audit Office and our internal auditors
- Risk management arrangements as described, under which key risks that could affect the achievement of our objectives have been managed actively, with progress being reported to the Audit and Risk Committee and, through it, to the Board of the Authority
- Our annual assessment of information risk management undertaken in accordance with the Cabinet Office's guidance
- Regular reports from the internal auditors, Grant Thornton, complying with the government's Internal Audit Standards
- Comments made by external auditors in their management letter and other reports.

2.86 Grant Thornton, internal auditors to the Regulators Hub have been our internal auditors for the year under review. The Head of Internal Audit in his report for 2016/17 stated that:

'…..…None of the audits highlighted any fundamental or significant issues…Based specifically on the scope of reviews undertaken and specific testing/evaluation we performed during 2016/17, we have concluded that controls we tested were suitably designed and operating effectively in the areas of corporate governance, risk management and internal controls in the two areas reviewed this year.'

2.87 I do not consider that we have any significant weaknesses in our system of internal controls. A programme of continuous monitoring exists, in consultation with the Audit and Risk Committee, internal auditors and external auditors, to ensure that we meet best practice standards in all areas of our operations.

2.88 Our Assurance Framework is monitored along with the risk register by the Directors Group, the Audit and Risk Committee and the Board. External and internal influences are considered and any potentially significant risks are discussed with key stakeholders as soon as they become apparent.

2.89 I am satisfied that the annual assessment of information risk management adequately reflects the information risks we have managed and that we have considered future risks. I consider that we have taken the actions necessary to

manage information risks effectively. I am confident that staff are aware of their responsibility to store, share and destroy information securely. I am satisfied that the minor information risk incidents which occurred this year were managed appropriately, that corrective action was taken and that no sensitive information was disclosed or lost.

2.90 This report has been prepared in accordance with the 2016 - 2017 Government Financial Reporting Manual (FReM) issued by HM Treasury.

2.91 Our accounts have been prepared in accordance with Schedule 7, Paragraph 15 of the National Health Service Reform and Health Care Professions Act 2002, as amended by the Health and Social Care Act 2008 and the Health and Social Care Act 2012.

2.92 Details about the NHS Pension Scheme and the treatment of pension liabilities in the accounts are set out in accounting policies within the notes to the accounts (note 1).

2.93 I confirm that:

- The assessment of information risk management has been completed satisfactorily and that the information can be used for our Annual Governance Statement
- This report and accounts as a whole are fair, balanced and understandable
- We have complied with the Code of Corporate Governance as detailed in DAO(GEN)02/12 – Governance Statements in so far as it applicable to us
- So far as I am aware, there is no relevant audit information of which the auditors are unaware, and that I have taken all the steps to make myself aware of any relevant audit information and to establish that the auditors are aware of that information
- I take personal responsibility for the report and the judgements required for determining that it is fair, balanced and understandable.

Harry Cayton
Accounting Officer

9 June 2017

3. Remuneration and staff report

Remuneration policy

Remuneration Committee

3.1 The Remuneration Committee typically meets once a year, or more frequently if necessary, to deal with remuneration issues if they arise.

3.2 The Authority does not have a Nominations Committee. The Remuneration Committee would undertake this role should the need arise.

3.3 One Remuneration Committee meeting was held between 1 April 2016 and 31 March 2017. Members' attendance is shown below.

Board member	Number of meetings attended	Possible
George Jenkins OBE	1	1
Ian Hamer OBE***	1	1
Andrew Hind CB*	1	1
Frances Done CBE**	0	0
Thomas Frawley CBE**	0	0

* Up to 31 December 2016
**From 1 January 2017
***Continuing until new member starts May 2017

3.4 Under previous arrangements with the Department of Health, recruitment and retention of staff were for some years been restricted by instructions with regard to our pay. As part of this we were prevented from paying the annual increments and had an annual uplift to reflect a cost of living increase determined for us.

3.5 Following financial impendence from the Department of Health, during 2016/17 the Remuneration Committee agreed a 1 per cent cost of living increase but also committed to fundamentally review the staff grades and pay bands so as to reflect their true market value. This review has been undertaken and will be actioned in 2017/18.

3.6 Contracts are generally offered on a permanent basis. If they are offered on a fixed-term basis, this is to reflect the nature and context of the work involved. The notice period required is determined by the position of the post holder. We treat termination payments and provisions for compensation for termination on a case-by-case basis in consultation with our advisers.

Senior managers' contracts

Name	Title	Date of contract	Unexpired term	Notice period
Harry Cayton	Chief Executive	1 August 2007	Permanent contract	6 months
John McDermott	Director of Governance and Operations	5 September 2016	Permanent contract	3 months
Mark Stobbs	Director of Scrutiny and Quality	3 May 2016	Permanent contract	3 months
Christine Braithwaite	Director of Standards and Policy	17 May 2010	Permanent contract	3 months

Senior managers' salaries

Name	Salary 2016/2017 £'000	Expenses payments (taxable)	Performance pay and bonuses £000	Long-term performance pay & bonuses £'000	All pension-related benefits £'000	TOTAL 2016/2017 £'000
Harry Cayton	150-155	0	0	0	35-40	190-195
John McDermott	55-60***	0	0	0	10-15	65-70
Mark Stobbs	85-90***	0	0	0	20-25	105-110
Christine Braithwaite	95-100	0	0	0	20-25	115-120
Linda Allan	45-50****	0	0	0	15-20	60-65
Rosalyn Hayles	15-20****	0	0	0	10-15	30-35

Name	Salary 2015/2016 £'000	Expenses payments (taxable)	Performance pay and bonuses £'000	Long-term performance pay & bonuses £'000	All pension-related benefits £'000	TOTAL 2015/2016 £'000
Harry Cayton	150-155	0	0	0	45-50	200-205
Linda Allan	90-95	0	0	0	20-25	115-120
Rosalyn Hayles	95-100**	0	0	0	25-30	120-125
Christine Braithwaite	90-95	0	0	0	25-30	120-125

All Salary figures include a 5% retention allowance
**Includes payment in respect of annual leave not taken
***Lower figures due to mid-year start dates
**** Lower figures due to mid-year leaving dates

3.7 This table has been audited by the Comptroller and Auditor General.

3.8 All senior managers in the year were members of the NHS Pension Scheme.

3.9 Total remuneration includes salary and all pension-related benefits calculated in accordance with the NHS Pensions guidance,[32] which seeks to quantify the increase in pension benefits in the year by comparing the overall pension benefits at the beginning of the year with those at the end of the year. There were no non-consolidated performance-related pay, benefits-in-kind or severance payments in 2016/17 or 2015/16.

[32] Disclosure of Senior Managers' Remuneration (Greenbury) 2015

Pensions

Name	Title	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 as at 31 March 2017 (bands of £5,000)	Lump sum at age 60 related to accrued pension as at 31 March 2017 (bands of £5,000)	Cash Equivalent Transfer Value as at 1 April 2016 (to the nearest £1,000)**	Cash Equivalent Transfer Value as at 31 March 2017 (to the nearest £1,000)**	Real increase in the Cash Equivalent Transfer Value during the reporting year (to the nearest £1,000)**
Harry Cayton	Chief Executive	2.5-5	0-2.5	30-35	20-25	517	558	41
John McDermott ***	Director of Governance and Operations	0-2.5	N/A*	0-5	N/A*	0	7	7
Mark Stobbs***	Director of Scrutiny and Quality	0-2.5	N/A*	0-5	N/A*	0	20	20
Christine Braithwaite	Director of Standards and Policy	0-2.5	2.5-5	15-20	50-55	359	410	51
Linda Allan **	Director of Governance and Operations	0-2.5	N/A*	10-15	N/A*	154	178	24
Rosalyn Hayles*****	Director of Scrutiny and Quality	0-2.5	N/A*	5-10	N/A*	86	101	15

* Not applicable in the 2008 scheme
** Up to 15 September 2016
*** From 3 May 2016
**** From 5 September 2016
***** Up to 25 May 2016

3.10 This table has been audited by the Comptroller and Auditor General.

Cash Equivalent Transfer Value
A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the members' accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another scheme or arrangement when the member leaves a scheme and chooses to transfer the benefit accrued in the former scheme. The pension figures shown relate to the benefits that the individual

has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figure – and from 2005-2006, the other pension details – include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS Pension Scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. A CETV is calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase/(decrease) in CETV
This reflects the increase/(decrease) in CETV. It takes account of the increase in accrued pension due to inflation, contributions paid by the employer and employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

3.11 No compensation has been paid to former senior managers, or payments made to third parties for the services of a senior manager.

3.12 This information has been audited by the Comptroller and Auditor General.

3.13 No senior manager had expenses subject to UK tax.

Authority members' remuneration

3.14 Since 1 August 2016 remuneration for the Chair and Board members is subject to superannuation.

3.15 The payments made to the Board are also subject to Cabinet Office guidance and have not increased since 2009/10. The Chair receives remuneration of £33,688 pa (2015/16: £33,688 pa); members receive annual remuneration of £7,881 (2015/16: £7,881) and the Audit and Risk Committee Chair receives annual remuneration of £13,135 (2015/16: £13,135). Members' remuneration during the year amounted to £91,515 (2015/16: £90,450) including social security and superannuation costs.

3.16 Members' remuneration is subject to tax and national insurance through PAYE.

3.17 In addition, expenses amounting to £14,002 (2015/16: £10,942) were reimbursed to Board members. Travel expenses related to travel to the Authority's offices are subject to tax which is paid by the Authority on their behalf, by agreement with HMRC.

3.18 Members' remuneration has been audited by the Comptroller and Auditor General.

3.19 Payments to individual members are disclosed below.

Payments made to the Authority's Board members during 2016/17

	2016/2017 Salary (bands of £5,000)	2016/2017 Travel expenses (bands of £5,000)	2015/2016 Salary (bands of £5,000	2015/2016 Travel expenses (bands of £5,000))
Chair				
George Jenkins OBE	30-35	0-5	5-10	0-5
Members				
Renata Drinkwater	5–10	0-5	5–10	0-5

Ian Hamer OBE***	5–10	5-10	5–10	0-5
Andrew Hind CB* (Audit and Risk Chair)	5-10	0-5	10–15	0-5
Frances Done CBE** (Audit and Risk Chair)	0-5	0-5	N/A	N/A
Stuart MacDonnell*	5–10	0-5	5–10	0-5
Thomas Frawley CBE**	0-5	0-5	N/A	N/A
Jayne Scott*	5–10	0-5	5–10	0-5
Moiram Ali**	0-5	0-5	N/A	N/A
Antony Townsend	5–10	0-5	5–10	0-5

* Up to 31 December 2016
** From 1 January 2017
*** Continuing until new Board member starts in May 2017

3.20 During 2016/17 two Board members were members of the NHS Pension Scheme. The amount contributed by the Authority and the members were as follows (bands of £5,000):

- Andrew Hind 0–5
- Moiram Ali 0–5

3.21 Full pension details as required by FReM for Board members will be disclosed from next year.

Staff report

3.22 We are committed to enabling all employees to achieve their full potential in an environment characterised by dignity and mutual respect. Our employment policies seek to create a workplace in which all employees can give their best, and can contribute to our and their own success. These are reviewed and updated with external specialists in order to ensure compliance with legislation.

3.23 We retain the services of Right Corecare and our staff have access to assistance and counselling if required.

3.24 We recognise the business benefits of having a diverse workforce and are committed to maintaining a culture in which diversity and equality are actively promoted and where discrimination is not tolerated. We operate a fair and open selection policy relating to applications for employment and internal promotion.

3.25 Further information about the senior management team can be found in the Remuneration section of this report.

3.26 Our staff turnover while less than last year, was still a cause for concern given the loss of expertise, knowledge and skills. However, the retention payment linked to

increased notice periods has assisted with knowledge transfer, facilitating handovers and reducing the time that posts are vacant.

3.27 As part of our corporate social responsibility we encourage our staff to support charities and other community organisations. Members of staff are currently involved with Comic Relief and a research ethics committee. Staff are active in fundraising for a number of good causes.

Fair pay disclosures

3.28 The Authority is required to disclose the relationship between the remuneration of the highest paid director (in our case, the Chief Executive) and the median remuneration of the Authority workforce.

3.29 The remuneration of the Chief Executive in the financial year 2016/17 was £154,000 This was 3.28 times the median remuneration of the workforce, which was £46,902.

3.30 The remuneration of the Chief Executive in the financial year 2015/16 was £152,500. This was 3.28 times the median remuneration of the workforce, which was £46,438

3.31 No employee received remuneration in excess of the Chief Executive in 2016/17 or 2015/16. Remuneration ranged from £24,000 to £154,000 (2015/16: £26,000 to £153,000).

3.32 In 2016/17, three members of the senior management team were female (50%) (2015/16 3 persons, 75%) while overall, 33 employees were female (64%) (2015/16 73%, 29 employees).

3.33 This information has been audited by the Comptroller and Auditor General.

Sick absence

3.34 A total of 224 days (2015/16, 264 days) were lost due to sick absence in the year. This equates to 4.6 days (2015/16, 6 days) per person.

Policies relating to disability

3.35 We are committed to applying our equal opportunities policy at all stages of recruitment and selection.

3.36 We work to ensure that:

- The most suitable applicant is appointed to each post, having regard to the real needs of the job
- That the process is open, fair and honest
- We make reasonable adjustments to overcome barriers during the course of interviews and employment
- Equal opportunities are provided for all applicants
- Both internal and external candidates are assessed based on the same selection criteria
- Discrimination and bias is eliminated from the process
- Legal objectives are met, and good employment practices followed

- Our application form provides a section for potential candidates to confirm whether or not they consider themselves to have a disability.

3.37 If identified on the application form all candidates who meet the minimum selection criteria of a vacancy will be interviewed under the Guaranteed Interview Scheme.

3.38 Whilst we are committed to the Guaranteed Interview Scheme, this requirement does not extend to the appointment decision, whereby the best person for the job will be appointed in line with equality legislation.

Staff numbers and related costs

Average number of persons employed

3.39 The average number of full-time and part-time staff employed (including temporary staff) during the year is as follows:

	Permanently employed	Other	Total 2016/17	Permanently employed	Other	Total 2015/16
Total	39.71	0.26	**39.97**	32.4	0.7	**33.1**

3.40 There were no staff engaged on capital projects in the period to 31 March 2017.

Costs of persons employed

	Permanently employed	Other	Total 2016/17	Permanently employed	Other	Total 2015/16
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Salaries	2,094	-	2,094	1,717	-	1,717
Social security costs	229	-	229	153	-	153
Superannuation costs	253	-	253	180	-	180
Agency/ temporary costs	-	16	16	-	47	47
	2,576	**16**	**2,592**	**2,050**	**47**	**2,097**

3.41 This table has been audited by the Comptroller and Auditor General.

Reporting of Civil Service and other compensation schemes: exit packages

3.42 No redundancy or other departure costs were incurred in the year.

3.43 No persons were employed off payroll or on a consultancy basis during the year.

3.44 This information has been audited by the Comptroller and Auditor General.

4. Parliamentary accountability and audit report

Clarifications

Losses and special payments

4.1 Losses and special payments were individually and in total below the reporting threshold of £300k.

Regularity of expenditure

4.2 The Authority operates with four distinct work streams which are reflected in the segmentation of our accounts:

- Regulatory and standards setting work – paid for through fees raised from the Regulatory bodies
- Accredited Registers – self-funding with support of DH subvention
- Commissions from Government(s) – paid for by the commissioning body
- Advice to other organisations – earned through fees.

4.3 The income and expenditure for each segment is accounted for separately and we work to ensure that there is no cross-subsidy.

4.4 As reported elsewhere our internal auditors undertake an annual review of the management of our finances in relation to our published business principles which are in paragraphs 1.30-1.33.

4.5 This information has been audited by the Comptroller and Auditor General.

Fees and charges

4.6 The Health and Social Care Act 2012 provided for the Authority to be funded by the regulatory bodies that it oversees.

4.7 The Act enabled the Privy Council to make regulations requiring each of the regulatory bodies that regulate health and social care professionals to pay fees to the Professional Standards Authority in relation to the functions undertaken by the Authority as specified in the regulations. This secondary legislation, The Professional Standards Authority for Health and Social Care (Fees) Regulations 2015 (the Fee Regulations) was laid in Parliament on 27 February 2015 and came into force on 1 April 2015.

4.8 The first fees were collected in November 2015 for the period 1 August 2015 to 31 March 2016. The Department of Health provided funding for the period 1 April 2015 to 31 July 2015.

4.9 The functions within the scope of the Fees Regulations are those within our first work stream; that is the regulatory oversight and improvement work undertaken in relation to the statutory regulated health professional bodies.

4.10 2016/17 was the first full year that the Authority has been funded primarily through fees. The fee period for 2017/18 will be from April to March covering the same period as the Authority's financial year.

4.11 Details of the related operating costs for our regulatory and standards setting function are shown below.

31 March 2017	Regulatory and standards setting work	Commissions from Government(s)
	£'000	£'000
Operating costs	4,137	17
Operating income	(4,176)	(17)
Net operating costs	**(39)**	**-**

4.12 This information has been audited by the Comptroller and Auditor General.

Long-term expenditure trends

4.13 The main drivers that will influence our future budgetary needs are:

- Changes to the volume of work that we have to undertake in particular the number of Fitness to Practise cases reviewed
- Changes to legislation that either place new duties upon us or require us to utilise more resources in undertaking our existing work as a consequence of changes to processes and procedures
- Changes to legislation that we as a business or employer are required to comply with
- Changes that we introduce
- Changes to our costs arising from inflation etc
- Changes to the income and expenditure of the accredited registers programme.

Section 29 cases

4.14 This is the area of our work that can significantly fluctuate and is accordingly difficult to predict. Many cases take a long time from the date a complaint is made to when they come to the Authority, hence it is not just the volume received by a regulator but the time they take to process them that influences the Authority's workload.

4.15 This year we experienced an increase in the total number of determinations received from the panels of the nine regulatory bodies that we oversee (4,285 determinations received in 2016/17, compared with 3,756 determinations received in 2015/16). We undertook detailed case reviews in 200 cases this year, compared to 157 performed in 2015/16.

4.16 While staff can absorb a degree of change, the fact that we need to meet statutory deadlines means that we may need to engage temporary staff should the numbers rapidly rise. During the period under review, we engaged a temporary member of staff to ensure that statutory deadlines continued to be met, whilst a member of the Scrutiny team was on maternity leave. In the event that the number of cases continue to rise, and at particularly busy times, we have in place on-call

arrangements with our external legal providers to ensure that our statutory deadlines continue to be met.

Changes to our legislation

4.17 There is the prospect that changes to legislation directly or indirectly may impact on our work. The introduction of proposed changes to legislation either for us or for the regulators would require analysis and consideration. There are proposals for changes to the regulation of health and social care professionals, but these are not yet developed to a state that would enable the Authority to consider the impact on our work or expenditure.

4.18 Assuming that our workload remains consistent with the current year we would not anticipate significate changes to our expenditure.

Harry Cayton CBE

Accounting Officer

9 June 2017

5. The Certificate and Report of the Comptroller and Auditor General to the Houses of Parliament, the Scottish Parliament and the Northern Ireland Assembly

I certify that I have audited the financial statements of the Professional Standards Authority for Health and Social Care for the year ended 31 March 2017 under the National Health Service Reform and Health Care Professions Act 2002 as amended by the Health and Social Care Act 2008 and the Health and Social Care Act 2012. The financial statements comprise: the Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity; and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration and Staff Report and the Parliamentary Accountability Disclosures that is described in that report as having been audited.

Respective responsibilities of the Board, Accounting Officer and auditor

As explained more fully in the Statement of Board and Accounting Officer's Responsibilities, the Board and the Accounting Officer are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit, certify and report on the financial statements in accordance with the National Health Service Reform and Health Care Professions Act 2002 as amended by the Health and Social Care Act 2008 and the Health and Social Care Act 2012. I conducted my audit in accordance with International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors. In applying the Ethical Standards I identified a business relationship between the National Audit Office and the Professional Standards Authority for Health and Social Care. Further details are disclosed with in Note 4. The revenue received is immaterial to the National Audit Office, and I consider that appropriate safeguards have been implemented to protect my and the NAO team's objectivity throughout the audit.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Professional Standards Authority for Health and Social Care's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by Professional Standards Authority for Health and Social Care; and the overall presentation of the financial statements. In addition I read all the financial and non-financial information in the Review of Professional Regulation and Registration with Annual Report and Accounts to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially

incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my certificate.

I am required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Opinion on regularity

In my opinion, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Opinion on financial statements

In my opinion:

- the financial statements give a true and fair view of the state of the Professional Standards Authority for Health and Social Care's affairs as at 31 March 2017 and of the Professional Standards Authority for Health and Social Care's net operating cost for the year then ended; and

- the financial statements have been properly prepared in accordance with the National Health Service Reform and Health Care Professions Act 2002 as amended by the Health and Social Care Act 2008 and the Health and Social Care Act 2012 and Secretary of State for Health directions issued thereunder.

Opinion on other matters

In my opinion:

- the parts of the Remuneration and Staff Report and the Parliamentary Accountability disclosures to be audited have been properly prepared in accordance with Secretary of State for Health directions made under the National Health Service Reform and Health care Professions Act 2002 as amended by the Health and Social Care Act 2008 and the Health and Social Care Act 2012; and
- the information given in Performance Report and Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- adequate accounting records have not been kept or returns adequate for my audit have not been received from branches not visited by my staff; or

- the financial statements and the parts of the Remuneration and Staff Report and the Parliamentary Accountability disclosures to be audited are not in agreement with the accounting records and returns; or
- I have not received all of the information and explanations I require for my audit; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

Report

I have no observations to make on these financial statements.

Sir Amyas C E Morse **Date 20 June 2017**
Comptroller and Auditor General

National Audit Office
157-197 Buckingham Palace Road
Victoria
London
SW1W 9SP

6. Financial statements – financial position as at 31 March 2017

		March 2017		March 2016	
	Note	£'000	£'000	£'000	£'000
Non-current assets					
Intangible assets	7	235		274	
Property, plant and equipment	8	115		87	
Total non-current assets			***350***		***361***
Current assets					
Trade and other receivables	9	253		1,022	
Cash and cash equivalents	10	5,425		4,579	
Total current assets			***5,678***		***5,601***
Total Assets			**6,028**		**5,962**
Current liabilities					
Trade and other payables	11	(4,147)		(4,142)	
Provisions	12	(7)		(7)	
Total current liabilities			***(4,154)***		***(4,149)***
Assets less liabilities			**1,874**		**1,813**
Reserves					
General reserves			**1,874**		**1,813**

The notes on pages 80 to 94 form part of these accounts.

Harry Cayton CBE
Accounting Officer
9 June 2017

7. Financial statements – comprehensive net expenditure for the year ended 31 March 2017

			March 2017 £'000		March 2016 £'000
Expenditure					
Staff costs	3		2,592		2,097
Other administrative costs	4		1,928		1,873
Income					
Fees Income	5		(3,855)		(2,690)
Operating income	6		(555)		(595)
Net operating cost			**110**		**685**

The notes on pages 80 to 94 form part of these accounts.

Other comprehensive net expenditure

7.1 There was no other comprehensive net expenditure in the year ended 31 March 2017 (none in the year ended 31 March 2016)

8. Financial statements – cash flows for the period ended 31 March 2017

	Note	March 2017	March 2016
		£'000	£'000
Cash flows from operating activities			
Net operating costs for the year		(110)	(685)
Adjustment for non-cash transactions	4	95	89
Decrease in trade and other receivables	9	769	(685)
Increase in trade and other payables	11	5	3,812
Increase/(Decrease) in provisions	12	-	(1)
Net cash inflow/(outflow) from operating activities		***759***	***2,530***
Cash flow from investment activities			
Purchase of property, plant and equipment	8	(84)	(63)
Net cash outflow from investment activities		***(84)***	***(63)***
Cash flow from financing activities			
Grant in aid from the Department of Health:			
Revenue		171	1,396
Capital		-	20
Credit Facility received from Department of Health			
Revenue – cash drawn down		-	200
Revenue – cash repaid		-	(200)
Devolved Administration funding:			
Scotland		-	15
Wales		-	9
Northern Ireland		-	14
Net cash flow from financing activities		***171***	***1,454***
Net financing			
Net increase in cash and cash equivalents	10	846	3,921
Cash and cash equivalents at the beginning of the financial year	10	4,579	658
Cash and cash equivalents at the end of the financial period	10	**5,425**	**4,579**

The notes on pages 80 to 94 form part of these accounts.

9. Financial statements – changes in taxpayer's equity for the year ended 31 March 2017

		General reserve
		£'000
Balance as at 31 March 2015		**1,044**
Changes in reserves in the year ended 31 March 2016		
Net operating costs		(685)
Grant in aid from the Department of Health:		
Revenue		1,396
Capital		20
Funding from the devolved administrations:		
Scotland		15
Wales		9
Northern Ireland		14
Balance as at 31 March 2016		**1,813**
Changes in reserves in the year to 31 March 2017		
Net operating costs		(110)
Grant in aid from the Department of Health:		
Revenue		171
Capital		-
Funding from the devolved administrations:		
Scotland		-
Wales		-
Northern Ireland		-
Balance as at 31 March 2017		**1,874**

The notes on pages 80 to 94 form part of these accounts.

10. Notes to the accounts

1. Accounting policies

Basis of preparation

10.1 These financial statements have been prepared in accordance with the 2016/17 Government Financial Reporting Manual (FReM) issued by HM Treasury.

10.2 The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the UK public sector context.

10.3 Where the FReM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Authority for the purpose of giving a true and fair view has been selected.

10.4 The particular policies adopted by the Authority for the reportable period are described below. They have been applied consistently in dealing with items that are considered material to the accounts.

Critical accounting judgements and key sources of estimation uncertainty

10.5 In the application of the Authority's accounting policies, management is required to make judgements, estimates and assumptions about carrying amounts of assets and liabilities that are not readily apparent from other sources.

10.6 The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant.

10.7 Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed.

10.8 Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

10.9 During the year no significant accounting judgements or estimates were made.

Intangible assets

Internally generated intangible assets

10.10 An internally generated intangible asset arising from the Authority's activities and expenditure is recognised where all of the following conditions are met:

- An asset is created that can be identified (such as bespoke software)
- It is probable that the asset created will generate future economic benefits
- The development cost of the asset can be measured reliably.

10.11 Intangible fixed assets are measured at cost and valued using depreciated replacement cost that is deemed a suitable proxy for fair value. For intangible assets with finite useful lives, amortisation is calculated so as to write off the cost of an asset, less its estimated residual value, over its useful economic life.

10.12 Database amortisation had been charged from the date the asset is brought into use and is amortised on a straight line basis over 10 years.

Non-current assets

Property, plant and equipment

10.13 Non-current assets other than computer software are capitalised as property, plant and equipment as follows:

- Equipment with an individual value of £1,000 or more
- Grouped assets of a similar nature with a combined value of £1,000 or more
- Refurbishment costs valued at £1,000 or more.

10.14 The Authority has adopted IFRS 13 and in accordance with the FReM has deemed that depreciated historical cost is a suitable proxy to current value in existing use or fair value where the asset has a short useful economic life or is of low value. Indexation has not been applied since 31 March 2008 as this would not be material. Asset valuations are reviewed on an annual basis, at each statement of financial position date, to ensure that the carrying value fairly reflects current cost.

10.15 Depreciation is provided on a straight-line basis, calculated on the revalued amount to write off assets, less any estimated residual balance, over their remaining estimated useful life.

10.16 The useful lives of non-current assets have been estimated as follows:

- Furniture and fittings over the remaining accommodation lease term
- Computer equipment—three years.

These provide a realistic reflection of the lives of the assets.

Depreciation is charged from the month in which the asset is acquired.

Cash at bank and in hand

10.17 Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours.

Grant in aid and general reserve

10.18 From 31 July 2015 the Authority was no longer primarily financed by grant-in-aid from the Department of Health.

10.19 Revenue grant in aid received from the Department of Health, was used to finance activities and expenditure which supported the statutory and other objectives of the Authority, was treated as contributions from a controlling party giving rise to a financial interest in the residual interest in the Authority, and therefore accounted for as financing by crediting them directly to the general reserve on a cash received basis.

10.20 In the year to 31 March 2017 the Authority received funding from the Department of Health that was used to part-finance the accredited registers programme.

10.21 This funding was classified as grant in aid and was accounted for as financing by crediting this directly to the general reserve, accounting treatment required by FReM.

Reserves policy

10.22 The timing of the determination of the fees is not fully within the control of the Authority and should there be a delay in the receipt of the fee income the Authority will face cash flow problems and could have difficulty in meeting its expenditure requirements and statutory duties.

10.23 The cash flow issues are linked to the receipt of the fee income. If the consultation process is not concluded by the Privy Council in time for the determination to be made by the beginning of March, then the Authority will face the prospect of having no income at the start of the financial year.

10.24 The Authority may also have to address financial shortfalls arising during the fiscal year. The budget for any given year has to be estimated prior to the commencement of the consultation exercise, which being lengthy has to commence early in the preceding year, thus there could be occasions when the Authority has to address unexpected expenditure during the year after the fee has been determined – for example costs arising from an increase in its workload, the need to undertake an investigation or changes to legislation.

10.25 While the Authority has the power to consult on an additional fee during the year, the time that this would take makes it an impractical means of addressing such issues. Seeking additional fees also means that the regulatory bodies would be asked to provide funding that they had not budgeted for, resulting in fluctuations in their own budgets.

10.26 To accommodate unexpected expenditure peaks and cash flow deficiencies, and to reduce the prospect of needing to seek additional fees, the Board agreed that the Authority should keep an agreed level of financial reserves, sufficient to ensure that its statutory functions can continue to operate.

10.27 Having reserves that can be called upon will also eliminate the need to pay arrangement fees and interest on any monies borrowed.

10.28 The policy is set out below:

- The Authority has agreed to hold reserves of three months' total operating costs of circa £1 million, within which it draws a distinction between
- A restricted element associated with regulatory and standards work
- An unrestricted element associated with all the Authority's work
- The intention is that over time the restricted element will amount to two months' total operating costs
- The present make-up of the reserves does not conform to this two thirds/one third split due to the opening position being largely made up of historical Grant in Aid funding from the Department of Health
- The level and make-up of our reserves will be reported through our Annual Report
- Any money taken from reserves during the year will need to be replaced in the following year(s)
- Should there be a need to draw upon the restricted element of the reserves we will report this to the regulatory bodies at an appropriate point.

Fees income

10.29 From 1 August 2015 Authority has primarily been financed through fees paid by the regulatory bodies. This is in accordance with the Health and Social Care Act 2012 and The Professional Standards Authority for Health and Social Care (Fees) Regulations 2015.

10.30 Receipts from the fees from the regulatory bodies are classified as income and recognised over the period agreed in Fee Regulations. Any surplus arising will be taken into account when calculating future fee rates to the extent that this is not required to maintain an appropriate level of reserves in accordance with the Authority's reserves policy.

Operating income

10.31 Operating income includes: Section 29 case cost recoveries; premises income received from subtenants; fees received from the provision of services to other members of the health regulation community; and accreditation fees received from register applicants wishing to be accredited.

10.32 Accredited registers' revenue consists of non-refundable fixed accreditation fees, payable when application documents have been submitted to the Authority, and renewal fees, payable on the anniversary of the accreditation date. Income from both initial and renewal fees is recognised in the operating cost statement in accordance with the completion of the Authority's work in relation to these.

Comparative costs and restatements

Section 29 costs and recoveries

10.33 Under its Section 29 powers, the Authority can appeal to the High Court against a regulatory body's disciplinary decisions. Costs incurred by the Authority in bringing Section 29 appeals are charged to the comprehensive net expenditure statement on an accruals basis.

10.34 As a result of judgments made by the courts, costs may be awarded to the Authority if the case is successful or costs may be awarded against the Authority if the case is lost. Where costs are awarded to, or against, the Authority, these may be subsequently revoked or reduced as a result of a successful appeal either by the defendant or by the Authority. Therefore, in bringing either income or expenditure to account, the Authority considers the likely outcome of each case on a case-by-case basis.

10.35 In the case of costs awarded to the Authority, the income is not brought to account unless there is a final uncontested judgment in the Authority's favour or an agreement between parties of the proportion of costs that will be paid and submitted to the courts. When a case has been won but the final outcome is still subject to appeal, and it is highly probable that the case will be won on appeal and costs will be awarded to the Authority, a contingent asset is disclosed.

10.36 In the case of costs awarded against the Authority, expenditure is recognised in the income and expenditure where there is a final uncontested judgment against the Authority. In addition, where a case has been lost, but the final outcome is still subject to appeal, and it is probable that costs will be awarded against the Authority, a provision is recognised in the accounts. Where it is possible but not probable that

the case will be lost on appeal and that costs may be incurred by the Authority, or where a sufficiently reliable estimate of the amount payable cannot be made, a contingent liability is disclosed.

Value added tax

10.37 Value added tax (VAT) on purchases is not recoverable, hence is charged to the comprehensive net expenditure statement and included under the heading relevant to the type of expenditure, or capitalised if it relates to an asset.

Retirement benefit costs

10.38 Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

10.39 Therefore, the scheme is accounted for as if it were a defined contribution scheme; the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

10.40 For early retirements, other than those due to ill health, the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the income statement at the time the Authority commits itself to the retirement, regardless of the method of payment.

Operating leases

10.41 Rentals payable under operating leases are charged to the comprehensive net expenditure statement on an accruals basis.

International Financial Reporting Standards (IFRSs), amendments and interpretations in issue but not yet effective or adopted

10.42 International Accounting Standard (IAS8), accounting policies, changes in accounting estimates and errors require disclosures in respect of new IFRSs, amendments and interpretations that are, or will be, applicable after the accounting period. There are a number of IFRSs, amendments and interpretations issued by the International Accounting Standards Board that are effective for financial statements after this accounting period. The following have not been adopted early by the Authority:

- IFRS 15 – Revenue from contracts with customers
- IFRS 9 – Financial instruments
- IFRS 16 – Leases
- IAS12 – Income taxes
- IAS 7 – Statement of cashflows
- IFRS 2 – Share based payments.

10.43 None of these new or amended standards and interpretations are likely to be applicable or are anticipated to have future material impact on the financial statements of the Authority.

Accounting standards issued that have been adopted early

10.44 The Authority has not adopted any IFRSs, amendments or interpretations early.

2. Analysis of net operating costs by segment

Segmental analysis

10.45 Net operating costs were incurred by the Authority's four main expenditure streams as follows. The Authority does not maintain separate statements of financial position for these streams. There were no inter-segment transactions in the year.

31 March 2017	Regulatory and Standards setting work	Accredited registers	Commissions from Government(s)	Advice to other organisations	Total
	£'000	£'000	£'000	£'000	£'000
Operating costs	4,137	355	17	11	**4,520**
Operating income	(4,176)	(215)	(17)	(2)	**(4,410)**
Net operating costs	**(39)**	**140**	**-**	**9**	**110**
31 March 2016	**Regulatory and Standards setting work**	**Accredited registers**	**Commissions from Government(s)**	**Advice to other organisations**	**Total**
	£'000	£'000	£'000	£'000	£'000
Operating costs	3,507	364	24	75	**3,970**
Operating income	(2,914)	(247)	(25)	(99)	**(3,285)**
Net operating costs	**593**	**117**	**(1)**	**(24)**	**685**

10.46 The work of these operating segments is described in performance report.

3. Staff numbers and related costs

Costs of persons employed

	Permanently employed	Other	Total 2016/17	Permanently employed	Other	Total 2015/16
	£'000	£'000	£'000	£'000	£'000	£'000
Salaries	2,094	-	2,094	1,717	-	1,717
Social security costs	229	-	229	153	-	153
Superannuation costs	253	-	253	180	-	180
Agency/ temporary costs	-	16	16	-	47	47
	2,576	**16**	**2,592**	**2,050**	**47**	**2,097**

10.47 Full details regarding these matters are on pages 67 to 69 in the Staff Report.

4. Other administrative costs

	Notes	31 March 2017	31 March 2016
		£'000	£'000
Members' remuneration		92	90
Legal and professional fees		800	662
Premises and fixed plant		549	575
Training and recruitment		140	98
PR, communications and conferences		71	172
Establishment expenses		85	95
External audit fee		19	19
Other costs		77	73
Non cash expenditure:			
Amortisation	7	39	39
Depreciation	8	56	50
Total administrative costs		**1,928**	**1,873**

* The Authority made payments of £308,683 (£283,654 in 2015/16) to the National Audit Office for non-audit work in respect of accommodation costs of the Authority for use of office space at 157-197 Buckingham Palace Road, London.

5. Fee Income

	31 March 2017	31 March 2016
	£'000	£'000
Fee Income from Regulators	3,855	2,690
Total	**3,855**	**2,690**

10.48 Fee income received from GMC (£690k), NMC (1,743k) and HCPC (£859k) amounted to more than 10 per cent of the total PSA's revenue individually. The fees are paid accordance with the Health and Social Care Act 2012 and The Professional Standards Authority for Health and Social Care (Fees) Regulations 2015.

6. Operating Income

	31 March 2017	31 March 2016
	£'000	£'000
Section 29 cost recoveries	152	78
Accredited registers' income	215	197
Fees from external customers	2	99
Subtenancy income	132	143
Other operating income	37	3
Income from DH Commissions	17	25
Accredited registers Grant from DH	0	50
Total operating Income	**555**	**595**

7. Intangible assets

31 March 2017	**Section 29 database**
	£'000
Valuation	
At 1 April 2016	393
Amortisation	
At 1 April 2016	119
Charge for the period	39
At 31 March 2017	158
Net book value	
At 31 March 2017	235
At 31 March 2016	274
31 March 2016	**Section 29**

	database
	£'000
Valuation	
At 1 April 2015	393
Amortisation	
At 1 April 2015	80
Charge for the period	39
At 31 March 2016	119
Net book value	
At 31 March 2016	274
At 31 March 2015	313

8. Non-current assets

Property, plant and equipment

31 March 2017	Furniture, fixtures and fittings	IT equipment	Total
	£'000	£'000	£'000
Valuation			
At 1 April 2016	151	351	502
Additions	2	82	84
Disposals	(4)	(1)	(5)
At 31 March 2017	149	432	581
Depreciation			
At 1 April 2016	127	288	415
Charge in period	9	47	56
Disposals	(4)	(1)	(5)
At 31 March 2017	132	334	466
Net book value			
At 31 March 2017	**17**	**98**	**115**
At 31 March 2016	**24**	**63**	**87**

10.49 All assets above are wholly owned by the Authority without any related financial liabilities.

31 March 2016	Furniture, fixtures and fittings	IT equipment	Total
	£'000	£'000	£'000
Valuation			
At 1 April 2015	128	344	472
Additions	23	40	63
Disposals	-	(33)	(33)
At 31 March 2016	151	351	502
Depreciation			
At 1 April 2015	116	282	398
Charge in period	11	39	50
Disposals	-	(33)	(33)
At 31 March 2016	127	288	415
Net book value			
At 31 March 2016	**24**	**63**	**87**
At 31 March 2015	**12**	**62**	**74**

9. Trade receivables and other current assets

10.50 Amounts falling due within one year:

	31 March 2017	31 March 2016
	£'000	£'000
Trade and other receivables	54	844
Prepayments	199	178
Total trade and other receivables	***253***	***1,022***

10.51 There are no trade receivables and other current assets falling due after more than one year.

Intra government balances

10.52 Intra government balances within the totals for trade receivables and other current assets are as follows:

	31 March 2017	31 March 2016
	£'000	£'000
Balances with other central government bodies	20	23
Balances with local authorities	134	137
Total intra government balances	**154**	**160**

Balances with bodies external to government	99	862
Total trade and other receivables	***253***	***1,022***

10. Cash and cash equivalents

	31 March 2017	31 March 2016
	£'000	£'000
Balance at 1 April 2016	4,579	658
Net changes in cash and cash equivalent balances	846	3,921
Balance at 31 March 2017	**5,425**	**4,579**
The following balances were held at:		
Government Banking Service	239	133
Commercial banks and cash in hand	5,186	4,446
Balance at 31 March 2017	**5,425**	**4,579**

11. Trade payables and other current liabilities

10.53 Amounts falling due within one year:

	31 March 2017	31 March 2016
	£'000	£'000
Trade and other payables	17	11
Taxation and social security	64	50
Accruals and deferred income	4,066	4,081
Total trade and other payables	***4,147***	***4,142***

10.54 There were no trade payables and other current liabilities falling due after more than one year.

Intra government balances

10.55 Intra government balances within the totals for trade payables and other current liabilities are as follows:

	31 March 2017	31 March 2016
	£'000	£'000
Balances with other central government bodies	79	53
Balances with NHS bodies	0	0
Total intra government balances	**79**	**53**
Balances with bodies external to government	4,068	4,089
Total trade and other payables	***4,147***	***4,142***

12. Provisions for liabilities and charges

	HMRC provision
	£'000
Balance at 31 March 2016	7
Arising during the period	61
Provision used	(61)
Balance at 31 March 2017	**7**

10.56 The HMRC provision as at 31 March 2017 represents the Authority's estimated liability for income tax and National Insurance Contributions in relation to Board members' travel and subsistence expenses.

13. Additional general reserves note

	Unrestricted Element All work (Regulatory and standards setting / Accredited Registers / Commissions from Government(s) / Advice to other organisations)	**Restricted Element** (Regulatory and standards setting work)	**Total**
	£'000	**£'000**	**£'000**
Balance as at 31 March 2016	951	862*	1,813
Changes in reserves in the year ended 31 March 2017			
Regulatory and Standards setting work		39	39
Accredited registers	(140)		(140)
Commissions from Government(s)		-	-
Advice to other organisations	(9)		(9)
Other accounting adjustments			
Grant in Aid from DH	171	-	171
Fund transfer for Board members' recruitment	(54)	54	-
Balance as at 31 March 2017	**919**	**955**	**1,874**

*This includes both cash and non-cash elements

14. Contingent assets and liabilities

Assets

10.57 There were no contingent assets as at 31 March 2017 (none as at 31 March 2016).

Liabilities

10.58 Eight High Court cases under the Authority's Section 29 powers were undecided as at 31 March 2017. There was therefore uncertainty, as at that date, as to the related financial consequences, pending a final judgment.

10.59 Judgment by the High Court may permit recovery of these Authority costs or, alternatively, issue a charge to the Authority of the costs of the regulatory body and its registrant.

10.60 Based on current agreement with the Department of Health £312k of the old Grant in Aid Funding is retained by the Authority to be spent as agreed with the Department on an ongoing basis, as a result in the future circumstances could arise in which a proportion of this amount could potentially be payable to the Department of Health.

15. Capital commitments

10.61 The Authority had no capital commitments as at the statement of financial position dates.

16. Commitments under leases

Operating leases

10.62 The Authority’s expenses include rent and service charge payments under operating lease rentals.

10.63 The Authority had the following obligations under non-cancellable operating leases:

Buildings	**31 March 2017**	**31 March 2016**
	£'000	**£'000**
Not later than one year	297	297
Later than one year and not later than five years	297	594
Total commitments under operating leases	**594**	**891**

10.64 An amount of £297k has been recognised as lease payment in Income and Expenditure Statement.

10.65 The Authority sub-leases its premises to two subtenants and recognises rent and service charge sub-lease receipts as income. An amount of £83K in respect of these charges has been recognised as income in Income and Expenditure Statement.

10.66 Total future minimum lease receipts due to the Authority under operating leases are given in the table below:

Future minimum sub-lease receipts	31 March 2017	31 March 2016
	£'000	£'000
Not later than one year	83	83
Later than one year and not later than five years	36	71
Total minimum sub-lease receipts	**119**	**154**

Finance leases

10.67 The Authority did not have any finance leases in the period to 31 March 2017 and 31 March 2016.

17. Related parties

10.68 The Authority is accountable to the UK Parliament.

10.69 The Authority is an unclassified public body. It was funded and sponsored by the Department of Health to 1 August 2015. The Department also provided funding to support the accredited registers scheme and to pay for advice commissioned from the Authority. The Department of Health is regarded as a related party.

10.70 During the period to 31 March 2017, the Department of Health provided total grant in aid of £0.17m (2015/16: £1.41m). In addition to this, during the period to 31 March 2017 the Authority has received £17K from the Department of Health in respect of commissioned work (2015/16: £25K).

10.71 The Authority received no funding contributions towards its activities from the devolved administrations in Northern Ireland, Scotland, and Wales. In 2015/16, the Authority received £14K from Northern Ireland, £15K from Scotland and £8K from Wales that related to previous year.

10.72 The Health and Care Professions Council belongs to the Department of Health group and regarded as a related party. During the period to 31 March 2017 the Authority has received £0.88m in respect of 2017/18 fee income (2015/16 £0.86 million in respect of 2016/17 fee income) from HCPC. In addition to this Authority has received £41k from HCPC in respect of four High Court cases under the Authority's Section 29 power.

10.73 The Authority maintains a register of interests for the Chair and Board members, which is available on the website. The register is updated on a periodic basis by the Executive Secretary to reflect any change in Board members' interests. During the period ending 31 March 2017, no Council member undertook any related party transactions with the Authority (other than the standard remuneration detailed above in the Remuneration Report).

10.74 The senior management team is also asked to disclose any related party transactions. During 2016/17, there were no related party transactions to disclose (other than the standard remuneration detailed above in the Remuneration Report).

18. Losses and special payments

10.75 Losses and special payments were individually and in total well below the reporting threshold of £300k.

19. Post statement of financial position events

10.76 These accounts were authorised for issue on 20 June 2017 by the Accounting Officer.

10.77 Following the result of the general election the Authority has considered what if any impact the decision might have on its operations. Given the nature of our work we do not believe that there will be any significant impact.

20. Financial Instruments

Financial risk management

10.78 Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

10.79 Given the way the authority is financed, and that it has limited powers to borrow or invest surplus funds, and that its financial assets and liabilities are generated by day to day operational activities, the Authority's exposure to financial risks is reduced.

10.80 Debtors and creditors that are due to mature or become payable within 12 months from the statement of financial position date have been omitted from all disclosures.

Currency risk

10.81 The Authority is a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling-based. The Authority has no overseas operations. Therefore, the Authority has low exposure to currency rate fluctuations.

Interest rate risk

10.82 The Authority had no borrowing and the fees from the regulatory bodies were received in 2015/16 and early 2016/17 so the Authority's exposure to this risk was very low. As at 31 March 2017, the Authority had a non-interest bearing cash balance of £5,424,583.74.

Credit risk

10.83 Because the majority of the Authority's income comes from statutory fees payable by regulatory bodies the credit risk that the Authority is exposed to is low. However, the timing of the receipt of this income could potential result in short-term cash flow issues. The Authority is mitigating this risk by maintaining a reasonable level of reserves.

Liquidity risk

10.84 The Authority relies primarily on fee income with statutory fees payable at the commencement of financial year therefore, the Authority has low exposure to liquidity risk.

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