The Council for Healthcare Regulatory Excellence

Performance review report 2009/10

Enhancing public protection through improved regulation

July 2010

Annual report volume II

council for healthcare regulatory excellence

The Council for Healthcare Regulatory Excellence

Annual report volume II: Performance review report 2009/2010
Enhancing public protection through improved regulation

(Associated with this document is the *Annual report volume I: Annual report and accounts 2009/2010)*

Presented to Parliament pursuant to schedule 7, paragraph 16(1), paragraph 16(1A) and 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.

Laid before the Scottish Parliament by the Scottish Ministers under the National Health Service Reform and Health Care Professions Act 2002, as amended by the Health and Social Care Act 2008.

Laid before the Northern Ireland Assembly in accordance with the National Health Service Reform and Health Care Professions Act 2002, as amended by the Health and Social Care Act 2008.

Laid before the National Assembly for Wales in accordance with the National Health Service Reform and Health Care Professions Act 2002, as amended by the Health and Social Care Act 2008.

Ordered by the House of Commons to be printed 1 July 2010

HC7-II
SG/2010/87-II

London: The Stationery Office

£27.25
2 volumes not sold separately

council for healthcare regulatory excellence

ISBN: 978 0 10 296423 3

Printed in the UK by The Stationery Office Limited
on behalf of the Controller of Her Majesty's Stationery Office

ID 2361345 07/10 3530

Printed on paper containing 75% recycled fibre content minimum.

About CHRE

The Council for Healthcare Regulatory Excellence promotes the health and well-being of patients and the public in the regulation of health professionals. We scrutinise and oversee the work of the nine regulatory bodies[1] that set standards for training and conduct of health professionals.

We share good practice and knowledge with the regulatory bodies, conduct research and introduce new ideas about regulation to the sector. We monitor policy in the UK and Europe and advise the four UK government health departments on issues relating to the regulation of health professionals. We are an independent body accountable to the UK Parliament.

Our aims

CHRE aims to promote the health, safety and well-being of patients and other members of the public and to be a strong, independent voice for patients in the regulation of health professionals throughout the UK.

Our values and principles

Our values and principles act as a framework for our decision making. They are at the heart of who we are and how we would like to be seen by our stakeholders.

Our values are:

- Patient and public centred
- Independent
- Fair
- Transparent
- Proportionate
- Outcome focused.

Our principles are:

- Proportionality
- Accountability
- Consistency
- Targeting
- Transparency
- Agility.

Right-touch regulation

Right-touch regulation is based on a careful assessment of risk, which is targeted and proportionate, which provides a framework in which professionalism can flourish and organisational excellence can be achieved. Excellence is the consistent performance of good practice combined with continuous improvement.

[1] General Chiropractic Council (GCC), General Dental Council (GDC), General Medical Council (GMC), General Optical Council (GOC), General Osteopathic Council (GOsC), Health Professions Council (HPC), Nursing and Midwifery Council (NMC), Pharmaceutical Society of Northern Ireland (PSNI), Royal Pharmaceutical Society of Great Britain (RPSGB).

Contents

1. Chief Executive's foreword

Patient safety and the protection of the public are at the heart of health professional regulation. In this annual performance review of the nine health professional regulators which we oversee, we are able to report once again that all the regulators take this task seriously and that all continue to improve. Our review highlights areas of excellence as well as identifying weaknesses and aspects of regulation which should be improved. We hope that as well as providing assurance to the public that overall regulators are acting in their interests, the review will provide the regulators with opportunities to learn from each other.

One of the most striking aspects of the regulators' activity is the rapid growth in the number of fitness to practise cases reaching a final determination. The number of cases notified by the regulators to CHRE has grown from just over 200 in 2003/04 to over 1800 in 2009/10.[2] The GMC and other regulators have also identified a continuing increase in the number of concerns and complaints brought to their attention. We need to understand more about why this is; the number of regulated health professionals has of course increased but that is not a sufficient explanation; is there greater awareness of the regulators' role, are we setting higher standards or holding professionals to account more consistently, are we more likely to pursue a regulatory solution when things go wrong? We need to understand more about the underlying causes of this change.

Certainly there is no suggestion that the decisions of the regulators in these cases are unreasonable overall. As the cases have increased the number of determinations causing concern to CHRE has dropped significantly.

In their decisions around fitness to practise, regulators need to be mindful of the need to promote public confidence in regulation. This last year, as before, a small number of controversial decisions have attracted huge media and public attention and provoked criticism and debate. These cases are usually, but by no means always, about doctors. Patients and professionals may disagree vehemently about the findings in each case and sometimes wild claims of witch-hunts, cover-ups, vested interests, and conspiracies abound. Although the language used is often disproportionate we should welcome this attention to the decisions of regulators because it means that regulation matters to both professionals and the public.

Controversy over decisions by the regulators also reminds us that we are dealing with human behaviours and often with the boundaries of good clinical practise. The determination of fitness to practise may be a matter of fine judgment which is why the clearest possible standards and their implementation is of utmost importance. We need to do more to ensure that the public understands that regulation is not for punishment or retribution and that professionals know it is for the public's protection and safety.

We will continue to work with the regulators to develop right touch regulation, to learn from each other and to promote excellence in the interests of people who use health and social care.

Harry Cayton
Chief Executive

[2] See the table on page 16 of Volume 1of this annual report.

2. Executive summary

Introduction

2.1 The primary focus of the professional regulators is patient safety and the protection of the public. Through our review of the nine health professional regulators we are satisfied that the regulators are carrying out their responsibilities in relation to their four statutory functions: standards and guidance, registration, fitness to practise and education and training. We have identified areas of strength in their performance, and in some cases, areas of concerns.

2.2 We have also reviewed key issues and concerns affecting health professional regulation which have the potential to impact on public protection. Through consideration of these issues, we have identified a number of issues for CHRE, the Department of Health and in the case of PSNI, the Department of Health, Social Services and Public Safety Northern Ireland to take forward for further consideration.

Summary of our findings

The key issues and concerns across health professional regulation

2.3 We have discussed a number of issues in this report which have emerged over the last year as well as reviewing progress on a number of developing projects in health professional regulation. These issues are generally focused on three key themes: exchange and transparency of information, involvement of patients and the public in regulation and the mechanisms that ensure that our health professionals are safe and practise effectively.

2.4 Sharing of information between organisations which share an interest in health regulation is important to public protection. As part of our consideration of this issue, we have given some thought to the Independent Safeguarding Authority (ISA), created to help prevent unsuitable people working with children and vulnerable adults. The regulators have a legal responsibility to share relevant information with ISA about individuals who pose a threat to children and vulnerable adults. They have had this duty since October 2009. ISA developed referral guidance and a referral form to enable the regulators to share such information. This has been available on its website since September 2009 but we are aware that the regulators have had some difficulty in interpreting this guidance. We understand that work is continuing with the regulators to develop tools to ensure that there is a clearer understanding of the referral process. We emphasise that it is important to public protection that there continues to be close working between the regulators and ISA to ensure that there is clarity and consistency across the regulators in what cases should be referred, when this should be done and how this should be done.

2.5 We also raise later in the report that there is a risk that the combined responsibilities of ISA and the health professional regulators might create an unnecessary regulatory burden on health professionals.

2.6 We also consider it important for public confidence in regulation that there is more consistent and meaningful data publicly available about the work of the regulators, particularly in relation to timescales for the investigation of fitness to practise cases. We have identified that there is some variation in the data produced by the regulators. We will, therefore, be working with the regulators to develop an agreed data set suitable for publication in future performance reviews. For the first time we have been able to publish some comparative information in this performance review.

2.7 As detailed in paragraphs 2.9 and 2.10 we have seen evidence of the regulators refining their mechanisms to take account of patient and public views in the development of their policies, standards and guidance, in the identification of future work that could be carried out and in regulatory decisions. We have also seen the regulators taking a more active approach to informing patients and the public about the purpose of regulation and what regulation does for them. With such work being carried out, we consider that this is an appropriate time for CHRE to consider what are the most effective methods and mechanisms for engaging patients and the public in the activities of the regulators.

2.8 There were two particularly highly publicised issues in relation to health professional regulation over the last year. These were whistleblowing and language testing of EEA-qualified health professionals. We discuss in the report the regulators' responses to these issues. However, we also highlight the importance of the role of employers, Royal Colleges, professional associations and system regulators in dealing with such matters too. For regulation to work effectively there has to be a joined up approach between all relevant stakeholders.

2.9 An illustration of this, in relation to whistleblowing, is that employers have a role in creating a climate of openness in which staff feel free to raise concerns in a reasonable and responsible way, without fear of victimisation. Royal Colleges and professional associations have a role in supporting those professionals who speak out about poor standards of care and treatment. The professional regulators need to ensure that there are support mechanisms such as specific guidance for whistleblowers to follow and systems regulators need to ensure that action is taken where there have been identified poor standards of care and treatment at NHS bodies.

2.10 An important programme of work that has continued to develop over the review period is revalidation. Revalidation will enable the regulators to regularly review their registrants' knowledge, skills and attitudes. This is a move which is in line with public expectation that their health professional's competence and fitness to practise is regularly reviewed. The regulators' revalidation proposals are at varying stages of development but we consider that it would be useful if there was greater sharing of information between regulators about their proposals and research. We will consider whether we could have a role in helping the regulators share such data.

The performance of the regulators

2.11 We are satisfied that most of the regulators' work is carried out effectively and that their focus has remained on public protection. We have seen many examples of improvements in the regulators' performance. For example, in response to concerns raised last year the GOC has introduced a formal process for identifying and prioritising serious fitness to practise cases and the GOsC has amended its procedures so that there is a presumption that a registrant's response will be shared with the complainant before a fitness to practise case is considered by the investigating committee.

2.12 We have seen the regulators respond to organisational and legislative changes. We have also seen the regulators respond well to unanticipated events. An example of this is the GCC's management of a significant rise in the fitness to practise complaints it receives. In addition to the 40 complaints it normally receives a year, it has received an additional 600 complaints. This appears to be an unexpected consequence of a legal case brought by the British Chiropractic Association against an individual.

2.13 Across the regulators, we have seen evidence that the regulators are refining the mechanisms that they use to achieve direct public and patient involvement in their work. This is illustrated by the work of the NMC during the review of pre-registration nursing education. The NMC engaged with specific patient groups in partnership with organisation such as Mencap and the Alzheimer's Society.

2.14 The regulators are also increasingly taking an active approach to informing patients and the public about regulation. The GDC has developed a patient information leaflet, *Smile*, which gives patients access to clear, jargon free information about the standards that they should expect when they visit the dentist and what action they can take if they are unhappy with the experience. The HPC has also carried out work to identify ways of better meeting expectations of those who raise fitness to practise complaints. It now proposes to provide clearer information to complainants about the purpose of the fitness to practise process, the potential outcomes at each decision of the fitness to practise process and the likely length of time involved at each step.

2.15 Another area where we have seen development by the regulators is in building better relationships with other organisations with a similar interest. The PSNI has developed information sharing arrangements with the Pharmaceutical Society of Ireland. The Societies have co-operated and shared information in relation to a fitness to practise case. The outcomes from the GMC's pilot of GMC affiliates have shown the importance of building rapport with employers. The medical directors perceived that the pilot resulted in better outcomes for doctors and patients and faster resolution of individual complaints with improved linkage between local and national regulation.

2.16 We are pleased with these developments and hope that this report enables the regulators to learn from each others' practices.

2.17 Despite identifying many areas of strengths in the regulators' performance, we have identified some concerns about particular aspects of the some regulators' work. We remain concerned about the PSNI's ability to act as an effective regulator because of its outdated legislative framework. Its current framework does not allow it to take immediate and mandatory action at the commencement of fitness to practise proceedings or to impose lesser sanctions where a registrant is found to have some impairment which does not warrant removal from the register. It also prevents it from having modern and appropriate governance arrangements.

2.18 We also have concerns about the time taken for cases to progress through the GDC's fitness to practise process and the quality of its case management system. Cases are taking on average 18 months to progress from initial receipt of complaint to a final fitness to practise hearing decision and there is a 12 month backlog of cases waiting for a hearing date. The GDC's case management system does not enable reliable management information to be produced which makes it difficult to monitor the progress of cases.

2.19 We also consider that there is still room for improvement by the NMC in relation to their customer focus, the content and use of the standard letters by the fitness to practise department and the consistency and quality of decisions made and recorded by final fitness to practise committees. In addition, we note that it still takes considerable time for cases to be considered and decided upon at the investigating committee stage.

2.20 We note that the regulators are already taking action to address the concerns and we will report on the improvements made in the next performance review.

Recommendations

2.21 We have identified a number of issues for further consideration by CHRE, the Department of Health, in the case of PSNI, the Department of Health, Social Services and Public Safety Northern Ireland and the regulators.

For CHRE

2.22 CHRE will take forward four issues during the review period for 2010/2011:

- How to identify and implement the most effective methods and mechanisms for engaging patients and the public in the activities of the regulators
- Identification of the nature and extent of comparable statistical data about the regulators' activities, for inclusion in a data set for publication in the next performance review. This should help patients and the public to understand more fully how the regulators are meeting their statutory duties

- CHRE's role as a facilitator, to assist the regulators to share information about their revalidation programmes
- CHRE's role as a facilitator to assist the regulators to jointly prepare their own guidance to ensure a consistent approach in the referral of registrants to ISA.

For the Department of Health

2.23 We recommend that the Department of Health should ensure that the regulations arising from the Equality Act 2010 enable all regulators to be subject to the same duties and expectations under all equality and diversity legislation. This should help promote consistency across the regulators in terms of the data that they collate.

For the Department of Health, Social Services and Public Safety Northern Ireland

2.24 We hope that progress continues to be made on our recommendation to the Department that it acts to modernise the framework for regulation of pharmacists in Northern Ireland.

For the regulators

2.25 We expect that the regulators will address any areas of weakness highlighted in the individual regulators' reports. To encourage cross-regulatory learning, we also recommend that they review this document as a whole to consider whether they can learn any lessons from the practices and experiences of the other regulators that will enhance their own overall performance.

3. What does the Council for Healthcare Regulatory Excellence do?

3.1 CHRE promotes the health, safety and well-being of patients and other members of the public through our scrutiny and oversight of the nine health professional regulatory bodies. We do this in six main ways:

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

4. Who are the health professional regulatory bodies?

4.1 The nine health professional regulatory bodies are:

- The General Chiropractic Council (GCC)
- The General Dental Council (GDC)
- The General Medical Council (GMC)
- The General Optical Council (GOC)
- The General Osteopathic Council (GOsC)
- The Health Professions Council (HPC)
- The Nursing and Midwifery Council (NMC)
- The Pharmaceutical Society of Northern Ireland (PSNI)
- The Royal Pharmaceutical Society of Great Britain (RPSGB).

4.2 Details of the professions regulated by each body can be found at Annex A.

4.3 The regulatory bodies have four main functions. They:

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

5. What is the performance review?

5.1 The performance review is our annual check on how effective the regulators have been in protecting the public and promoting confidence in health professionals. We are required to report our findings to Parliament.

5.2 The performance review has two important outcomes:

- It brings about improvements in the work of the regulators as we identify strengths, concerns and recommend changes
- It informs everyone about how well the regulators are protecting the public in their work.

How do we carry out the performance review?

5.3 We use the *Standards of Good Regulation* to judge the regulators' performance. The standards describe what the public expect the regulators to do. To help us to judge the regulators' performance, we:

- Ask the regulators to demonstrate how they meet the standards
- Use the standards to identify the strengths and areas for improvement in each regulator's performance
- use them to identify good practice.

5.4 There are 17 *Standards of Good Regulation*. These are grouped under five functions:

- Standards and guidance
- Registration
- Fitness to practise
- Education and training
- Governance and external relations.

5.5 We do not tell the regulators how they should meet these standards. However, we do consider that in meeting the standards, the regulators should be proportionate, objective, fair and have public protection as their overriding priority. The *Standards of Good Regulation* can be found at Annex B.

The performance review process

5.6 The performance review took place between November 2009 and May 2010. There were seven stages to the performance review:

Stage 1
The regulators provided a written self-assessment of their performance against the *Standards of Good Regulation*.

Stage 2
We examined and tested the regulators' self-assessments using information we had collated from other sources, including our scrutiny of the regulators' fitness to practise decisions and the complaints that we received from members of the public and others.

Stage 3
We wrote to the regulators with our initial assessment of their performance and our requests for additional information or clarification on their initial responses.

Stage 4
We held face-to-face meetings with each of the regulators to discuss our initial assessment.

Stage 5
We considered any additional information provided by the regulators and reached a final view on their performance.

Stage 6
We drafted a report summarising our view on each of the regulators' performance. We shared the report with the regulators and asked for their comments on the factual accuracy of the report.

Stage 7
We considered the comments made by the regulators and finalised each of the regulators' performance review report. We also produced an overarching report which included our views on emerging themes and issues in health professional regulation.

We are grateful for the feedback received from third parties. We found this information very helpful in achieving a more rounded view of the regulators' performance. A full list of third party organisations that provided feedback can be found at Annex C.

Revision of the performance review process and standards

5.7 The current approach to the performance review is now in its third year of operation and we have a good understanding of the regulators' performance. However, we decided that we should review the standards and process to ensure that they were suitably proportionate, risk-based and focused on regulatory outcomes. We also wanted to be sure that the standards drew out information that would allow us to assess whether the regulators are protecting the public, and that they helped the regulators to protect the public.

5.8 As part of the revision process, we met with members of the public, professional representative organisations and the regulators to discuss suggestions and ideas. We also held a 12-week consultation on our proposed revisions to the process and standards between January and April 2010. We received 31 responses to our consultation. We took all the feedback we had received into account before finalising the new performance review process and standards which will be used from 2010/11. The new documents can be found on our website www.chre.org.uk.

6. What are the key issues and concerns across health professional regulation?

Overview

6.1 This year, we have seen that the framework and environment for health professional regulation continues to change. Through this review, we have identified some emerging issues and also reviewed progress on a number of developing projects in health professional regulation which have the potential to impact on public protection. We have collated these issues under the five functions of standards and guidance, registration, fitness to practise, education and training and governance and external relations.

Standards and guidance

6.2 Overall, the regulators' standards and guidance prioritise public protection and patient safety. We consider that the regulators are performing well in the development, production and communication of their standards and guidance. We have identified three areas for further discussion that are currently of particular interest and relevance to CHRE's role in promoting the health, safety and well-being of the public.

The role of patients and the public in the development of standards

6.3 It is important that the needs of patients are met by effective standards and guidance for registrants. As regulators review their standards and guidance, we consider that they should address issues raised by patients, service users and carers, through surveys and other research, as well as new statutory developments. We made this recommendation to regulators in the context of our report on healthcare for people with disabilities.[3]

6.4 We have seen evidence that the regulators are refining the mechanisms that they use to achieve direct public and patient involvement in the development of standards. Some, like the PSNI, have established a Public Forum and ask for members' views and input on a range of issues. Some have also given careful consideration to how they approach relevant and specific patient groups to take account of their views when drafting standards and guidance. As part of its consultation on end of life treatment and care guidance, the GMC went to a care home and spoke to residents and staff and attended a Local Involvement Network meeting for older people. It also commissioned research into the views of patients with terminal illness.

6.5 We have also seen evidence that the regulators are increasingly taking the views of patients and the public into account when identifying potential subject matters for future publications. For example, the GOsC commissioned independent research on public and patient expectations and experience of osteopathic care to inform different areas of its work such as policy-making.

[3] CHRE, 2009. *Healthcare for People with Disabilities*, London: CHRE.

6.6 In addition, the regulators use learning from their fitness to practise cases to inform the standards and guidance available to their registrants. For instance, the GOC asked the College of Optometrists, the Association of Optometrists and the Federation of Ophthalmic and Dispensing Opticians to review their guidance for supervising non-qualified persons following a high profile fitness to practise case. As a result of the GOC's involvement, the professional associations introduced clearer guidance for registrants that made it clear that employers and supervisors must provide the appropriate level of supervision to trainee dispensing opticians and optometrists.

6.7 We consider that ensuring that the development of standards and guidance is informed by public and patient needs enables the final documents to be robust, and targeted to the needs of both the professions and of patients. We talk more about our proposed work on direct public and patient involvement in the regulators' work in paragraph 6.49.

Whistleblowing

6.8 Whistleblowing by health professionals had a significant media profile in 2009, following the decision of a much publicised fitness to practise case heard by the NMC. In response to this case, claims were made in the media that health professional regulators did not protect professionals who raised concerns. Additionally, it was claimed that the possibility of action against staff who did so acted as a disincentive. Consequently there was a perceived potential risk to patient safety and public protection. We note that the regulators refuted these claims citing that through their standards for registrants they demonstrated their strong and clear commitment to support whistleblowers. We are pleased that in the spirit of continuous improvement and in some cases, following feedback from their registrants, many of the regulators are now reviewing or have plans to review their support mechanisms for whistleblowers. This includes developing specific guidance and publishing informative articles in communications with registrants.

6.9 We support these actions as we consider that the regulators should do all they can to support registrants who raise concerns about standards of care, where they do so in a responsible and professional way, as part of their wider duty to act quickly to protect patients and the public from risk of harm. We hope that this work encourages registrants to speak out where necessary and dispels any perception that they will not be supported in doing so.

6.10 However, we note that it is not just the regulators who have a role in creating a climate of 'no fear' for whistleblowers. Employers and system regulators have an important part to play in promoting a climate of openness and dialogue in which staff feel free to raise concerns in a reasonable and responsible way, without fear of victimisation. It is also the case that Royal Colleges and professional associations have a role to play in supporting those professionals who speak out about standards of care in a responsible and professional way. To ensure that whistleblowers

feel able to speak out, all these bodies need to work together to create a climate of support and openness.

Revalidation

6.11 We consider that revalidation is critical piece of work in the wider drive for quality in healthcare. Part of the rationale for revalidation is that it should reassure the public that registered health professionals remain fit to practise and continue to reach the standards required to maintain registration with the regulator. This should be achieved through regular review of the registrant's knowledge, skills and attitudes. Effectively, this is a move from a system that passively records educational achievement and reacts to a professional's impaired practise to an active system of continually recording evidence of competency and fitness to practise. It is a move which is in line with public expectations that their health professional's competence and fitness to practise is regularly reviewed.

6.12 The regulators are at different stages in the development of their proposals. Some of the regulators have a clearer idea of how their revalidation scheme will be structured. The GMC and GOC have recently consulted on proposals for their revalidation scheme, the GDC is taking forward the learning from its pilot and the GOsC is developing a pilot to test and evaluate its draft revalidation scheme during 2011. Others are still in the process of developing their evidence base and information gathering before deciding what, if any, scheme is required. The HPC is gathering evidence of the risks faced by their profession and evidence of how its current processes address these risks. Following this, it is likely that it will then decide whether to develop and introduce an additional process of revalidation, adapt current systems to fill any gaps identified or conclude that no further action is necessary on the basis that its current systems adequately protect the public.

6.13 However, there is commonality in the work that is being carried out. In particular, many of the regulators have commissioned research into the specific risks presented in their registrants' fields of practice including the GCC, GOC, NMC, RPSGB and PSNI. This is to ensure that they develop risk-based revalidation schemes which are targeted and proportionate. Many regulators have also commissioned research on what sources of evidence could be used in revalidation, for example, employer appraisals and patient and colleague feedback. This is to ensure that the schemes are not burdensome and that they are based on fair and objective evidence. Work is also being carried out, including by the GCC, on determining the costs of implementing the various options for revalidation in order that a cost/benefit analysis can be carried out to assess the preferred option. We will continue to monitor the regulators' progress in this area and encourage them to share data from their risk and information gathering exercises between themselves. We will also consider whether we could have a facilitative role in this work.

Registration

6.14 Generally, we consider that the regulators have effective and efficient registration processes. However, we note that there is considerable variation in how the regulators approach their registration function. We have identified five particular areas where we or others have given some thought to how this could be addressed.

Indemnity insurance

6.15 The UK government's policy on professional indemnity insurance is currently under review. The review group will consider whether making it a requirement to have such insurance as a compulsory condition of registration is the most effective and proportionate way of ensuring patients can secure compensation when they suffer harm through negligence on the part of the health professional. At this time, regulators take different approaches to this matter, partly due to differences in their legislation. There is disparity between the regulators in relation to whether indemnity insurance is a condition of registration and whether there is systematic checking of registrants' insurance status. For example, the GOC audits and verifies indemnity insurance information as part of the registration process. However, although the NMC recommends that its registrants have professional indemnity insurance and that they inform their clients and patients where they are unable to obtain adequate insurance, currently no nurses or midwives are required to have insurance as a condition of registration with the NMC.

6.16 The review group has requested that the regulators make no changes to the current approach to indemnity insurance until the outcome of the review. However, the GDC will be making it a condition of registration that all their registrants have indemnity insurance. The NMC will be reviewing its current policy during this year and if it were to make indemnity insurance a requirement of registration, the Nursing and Midwifery Order 2001 would have to be amended to give it the requisite powers. We consider that it is in the public's interest that patients have a mechanism to seek and, where necessary, secure financial redress for a health professional's actions which have caused patient harm. However, we acknowledge that there must be guidance for the regulators on what constitutes appropriate indemnity insurance. Without this, the process will become a bureaucratic check in the registration process, with limited benefit for patients and the public. We look forward to the outcome of this review.

Health requirements

6.17 We were asked by the Department of Health to provide advice on the purpose and use of health requirements in the registration process, the guidance issued by the regulators on this matter and whether removal of the requirement would be detrimental to public protection. This request was in response to the Disability Rights Commission's (now part of the Equality and Human Rights Commission) report *Maintaining Standards:*

Promoting Equality,[4] which identified health requirements for registration as a barrier to people with impairments or long term conditions pursuing careers in a number of regulated professions.

6.18 We found that, as part of the registration process, the regulators consider whether an applicant's health would impact on their ability to practise safely and effectively, even with any necessary adjustments[5]. We consider that this check is necessary for public protection. However, to help prevent any perception or actual discrimination on health grounds in the registration process, we made a number of recommendations. This included using a single test of fitness to practise for registration, in which the health of an applicant would be a relevant factor for consideration. We consider that the health of an applicant should be considered in the registration process only when it relates to the applicant's ability to practise safely and effectively. The health of an applicant should not be considered in isolation.

6.19 We recommended better engagement between regulatory bodies, registrants, applicants and others to ensure that there was a clear message that disclosing information about health would not put an applicant/registrant's career at risk, rather it will only be at risk if they cannot practise safely and effectively. In addition, we recommended that the regulators should consider the most proportionate means of ascertaining whether an applicant is fit to practise. An example of this in practical terms is the GOC's approach in seeking a self declaration from the applicant as to whether they have a health condition which might impair their fitness to practise. The HPC has also recently consulted on a proposal that health references required as part of its registration process should be replaced with a self-declaration that the applicant does not have a health condition which would impact on their ability to practise safely and effectively. We are aware that other regulators are also taking our report and recommendations into account in their work in this area.

Language testing

6.20 Another contentious issue related to the registration process, has been language testing of EEA-qualified health professionals. This has been a high profile issue this year following the death of a patient, David Gray. Mr Gray died as a result of a morphine overdose administered by an EEA-based doctor whose language skills and competence have been called into question. We note that the GMC, in its evidence to the Health Select Committee in April 2010, highlighted its belief that it should be able to language test. There is some debate as to whether the Medical Act 1983 could be amended to allow the GMC to language test EEA applicants to the register within the remit of the EU Directive. We note that the Health Select Committee has recommended that the government seek to make changes to the Professional Qualifications Directive (2005/36/EC), before

[4] Disability Rights Commission, 2007. *Maintaining Standards: Promoting Equality.* London: DRC.

[5] CHRE, 2009. *Health Conditions.* London: CHRE.

it is due to be revised in 2012, to enable the GMC to undertake the systematic testing of language skills of EEA qualified doctors.

6.21 However, it is not just the health professional regulators who have an interest in testing the language skills of EEA registrants who work in the UK. Employers have a responsibility to ensure that prospective health professionals have the suitable skills to meet the needs of patients and the public. We agree with the Health Select Committee that given it will take some time for the EU directive to be amended or the Medical Act 1983 revised, it is essential for public protection that these checks by employers are carried out consistently. There is sufficient ability for employers to make responsible employment decisions. Information sharing amongst employers should also be taking place. This would an important step in ensuring patient safety and public protection.

Misuse of title

6.22 Another aspect of how the regulators protect the public in the registration function is through tackling title misuse. There is a risk of harm and damage to public confidence when unqualified persons present themselves as registered professionals. In our project[6] *Protecting the Public from Unregistered Practitioners*, we considered the risk to the public presented by those who misuse protected titles and the barriers the regulators face when tackling this matter. Our final view was that it was difficult to quantify the risk posed to the public through the misuse of title. Additionally, while we note that the regulators do take different approaches to how they address this issue, we considered that they could be more proactive in tackling it. We made four recommendations on how they could do this. These were: improving public awareness of the importance of registration with a regulator; fostering relationships with other organisations that have a shared interest in preventing title misuse; sending letters to those who misuse the title asking them to stop doing so; and carrying out, where necessary, periodic audits of telephone and web based directories to ensure that only registered professionals are listed. We look forward to seeing what action the regulators have taken in response to this report in the next performance review.

Registers

6.23 The regulators' registers hold information on practitioners who are entitled to practise within a given profession. In the last two performance reviews, we have highlighted that there is great variation in the level of detail provided by the regulators' registers and the way that information is presented. This year we have carried out research into maximising the registers' contribution to public protection.[7]

6.24 Our report made a number of recommendations to improve consistency in presentation and content of the registers which we consider will be

[6] CHRE, 2010. *Protecting the Public from Unregistered Practitioners.* London: CHRE.
[7] CHRE, 2010. *Maximising the Contribution of the Regulators' Registers to Public Protection*. London: CHRE.

beneficial to public protection. For example, as a priority we recommended that the registers should contain all current fitness to practise sanctions including those relating to registrants that are suspended or struck off from the register. Inclusion of this information should assist the public to identify health practitioners who are currently not able to practice. This addition would also remove the misleading impression that, when no matching register entry is found, the user has entered incorrect information during the search, for example by mis-spelling the registrant's name.

6.25 We also looked at the benefits and disadvantages of making information about lapsed fitness to practise sanctions available to the public on the registers. We accept that the purpose of the fitness to practise process is not to punish a health professional, and acknowledge that a professional with an expired sanction has been judged to be fit to practise. However, in line with the principle of transparency, we gave more weight to the rights of patients than those of professionals. We, therefore, recommended that regulators who do not currently publish fitness to practise histories should begin to take a proportionate approach to making this information available against a register entry.

6.26 We note that some of the regulators are already planning to take forward some, if not all, of our recommendations. We look forward to seeing what action all the regulators have taken in response to this report in the next performance review.

Fitness to practise

6.27 The regulators generally meet our standards in this function, however, they still face some challenges. One of these which we have highlighted below is ensuring sufficient transparency of information and information sharing between organisations. Reports on Mid Staffordshire NHS Foundation Trust have illustrated starkly the consequences of poor information sharing and the impact that this can have on patient safety and public confidence in regulation. We have identified four areas for discussion which relate to improving the transparency and sharing of information.

Transparency and consistency of information

6.28 In last year's report, we highlighted the need for regulators to consider how to publish more regular and meaningful information about timescales for the investigation of fitness to practise cases, and their performance against their service standards. We consider it is important that regulators are transparent, not only to ensure that they are publicly accountable, but also to manage expectations around how long a case is likely to take to resolve. We note that in the NMC's new leaflet for employers on fitness to practise, it provides an example timeframe for how long a case could take to be considered through the fitness to practise process.

6.29 As well as improving the transparency of information about timescales for investigation of fitness to practise cases, we also consider that there should be greater consistency in how and when the regulators record information. This would enable greater understanding of what information

published about fitness to practise proceedings represents. There is variation between the regulators around what stage they consider a case has started and on how often case progress is reported on after this point. This is in part due to differences in thresholds and processes. These differences in process also have an impact on whether it is possible to produce comparative data across the regulators which is easy to understand. This is illustrated in the difficulties we have had this year in attempting to provide a figure for the number of cases that have been considered by the investigating committees (or equivalents) and final fitness to practise committees. We intend to carry out some further work on producing an agreed data set for the regulators for publication in future performance reviews. Fitness to practise data will form part of this work.

Sharing a registrant's response with a complainant

6.30 Another area that we highlighted in last year's report was the considerable variation in practice across the regulators in relation to sharing a registrant's response with a complainant prior to the consideration of the case by the investigating committee. We considered that by sharing the registrant's response with the complainant, the investigating committee would have a greater depth of evidence to consider which would be beneficial to public protection.

6.31 Our research supported our initial view on this matter and recommended that there should be a presumption that the registrant's response will be shared in full with the complainant.[8] We noted however that comments of a personal nature not relevant to the case, details that reveal the identity of a whistleblower, or reference to sensitive personal information about the registrant (eg their health or finances), should not be shared. Our other recommendations included that the regulators should provide clear guidance to registrants on what should be included in their response and to complainants on the purpose and potential outcomes of the fitness to practise process.

6.32 We are pleased that following our report, two of the regulators who previously did not share the registrant's responses have changed their position. The GOsC will start to share the registrant's response with the complainant as part of the investigation process shortly and the NMC's fitness to practise committee has agreed in principle to sharing the registrant's response with the complainant. The NMC is currently considering how to implement this change in policy.

The Independent Safeguarding Authority

6.33 The Independent Safeguarding Authority was created as part of the government's Vetting and Barring Scheme to help prevent unsuitable people from working with children and vulnerable adults. Since 12 October 2009, the regulators have had a legal responsibility to notify ISA of relevant information so that individuals who pose a threat can be identified and barred from working with these vulnerable groups. ISA has developed

[8] CHRE, 2009. *Handling Complaints.* London: CHRE.

referral guidance and a referral form which has been available on its website since September 2009. We note that it is currently being updated in light of feedback from users and will be subject to consultation later this year.

6.34 However, due to difficulties in the interpretation of this guidance, the regulators are currently interpreting their legal responsibility to refer matters within the context of their own organisations. While we agree that the regulators need to be actively considering what cases should be referred to ISA, we are concerned about the obvious public protection risks that are associated with allowing such diverse approaches to develop. We understand that work is continuing with the regulators to develop tools to ensure that there is a clearer understanding the referral process. We emphasise that it is important to public protection that there continues to be close working between the regulators and ISA to ensure that there is clarity and consistency across the regulators in what cases should be referred, when this should be done and how this should be done.

6.35 We are also concerned that there is a risk that the combined responsibilities of ISA and the regulators might create an unnecessary regulatory burden on health professionals. We consider that as part of the regulatory framework for people working in health, social care and education, ISA should adhere to the principles of good regulation. We hope that it will demonstrate, in so far as it impacts on health professional regulators, that it is proportionate, targeted, fair, transparent and accountable in its approach.

Duty of co-operation

6.36 The Department of Health is currently consulting on the duty of co-operation set out in section 121 of the Health and Social Care Act 2008. Regulations would require designated bodies, including the regulators, to share information about a health professional's conduct or performance which may be a threat to patient safety at an early stage. This would apply in England and Wales. The purpose of this duty would be to overcome the historical lack of information exchange between bodies carrying out different activities in the health sector.

6.37 We have seen the benefits of increased information sharing between regulatory bodies. For instance, many of the regulators are now using the European Internal Market Information system which allows authorised users to communicate electronically regarding a health practitioner and to share information quickly regarding suitability for registration. The PSNI has developed information sharing arrangements with the Pharmaceutical Society of Ireland. The Societies have co-operated and shared information in relation to a fitness to practise case. We see this work as important in overcoming gaps in regulation across countries. The PSNI has also established information sharing arrangements with other complaint handling bodies in Northern Ireland (the Pharmacy Network Group).

6.38 We have also seen the implications if information is not shared between regulatory bodies on public protection issues, for example, the failures highlighted at Mid Staffordshire NHS Foundation Trust. We support the principle of exchanging relevant information between bodies in the health sector to ensure that there are no gaps in regulation which can impact on public protection.

Education and training

6.39 Public protection and patient safety is at the heart of the work undertaken by the regulators in relation to education and training. However, consideration is being given to if and how information sharing can be enhanced in the education function for the benefit of registrants or potential registrants and public protection. We discuss this matter further below. We also discuss how we consider the public and patients should be involved in the education process.

Continuum of education

6.40 Some of the regulators are beginning to look at the continuum of education, from undergraduate education to revalidation, and to assess the regulator's role and responsibility within it. We agree that clear oversight of the continuum of education provides significant benefits for public protection as it enables consistency in standards and expectations. It also provides the opportunity for consideration to be given to ideas such as whether it is possible to transfer appropriate information about graduates from education providers to employers. This could enhance the level of support and oversight given to individuals to ensure that they remain fit to practise. This is particularly pertinent given research from the USA on doctors' fitness to practise before and after registering with medical regulators which found that those students who had exhibited unprofessional behaviour as a student were more likely to feature within a regulator's fitness to practise process at a later date.

Outcomes of student fitness to practise committees

6.41 Linked to this idea of transferring relevant information through a professional's career, this year we have considered whether the regulators should receive every outcome of student fitness to practise committees. Student fitness to practise committees are normally handled by the education providers, although the GOC has registered students on optometry and optics courses since 2005 and therefore manage the fitness to practise cases against them.

6.42 In our report we noted that the outcome of student fitness to practise committees should be a factor in the regulator's consideration of whether the applicant had good character (or its equivalent) which is a requirement of registration.[9] We considered that there was real value and benefit in terms of public protection in regulators considering student fitness to practise outcomes.

[9] CHRE, 2010. *Student Fitness to Practise – should the regulators receive every outcome*. London: CHRE.

6.43 Therefore, we recommended that students and the education providers should declare information about student fitness to practise sanctions to the regulator. The RPSGB and PSNI are making it a condition of accreditation that universities advise the regulators of the outcomes of their fitness to practise proceedings, and consider that public protection will be enhanced as a result. We recommended that regulators should collect data about student fitness to practise as part of their role in quality assuring the provision of pre-registration education and training. This should be used to improve standards of education and training and to improve the provision of guidance to students about professional conduct and competence. Finally, we recommended that regulators should work with education providers to share good practice in the management of student fitness to practise issues.

Public and patient involvement

6.44 There is still variation in the way that the regulators involve patients and the public in their quality assurance of education providers. We have seen evidence that regulators encourage or require the education providers to take account of the views of patients and the public in the design and delivery of education programmes. For example, the NMC facilitated an event for education providers in which good practice in this area was shared. We have also seen the involvement of patients and the public in the evaluation of courses. For example, the GOC carries out surveys to capture patient perspectives in the quality assurance process. Public members of visit teams are also given specific responsibility for considering the public/patient perspective and have the opportunity to speak to patients during visits. We consider it important that patient involvement is reflected in the design and delivery of education programmes and that any evaluation of the courses has taken the views of patients into account.

Governance and external relations

6.45 The regulators generally have effective governance arrangements in place. We discuss below the impact of the changes to the regulators' governance arrangements and highlight particular challenges that the regulators must address to ensure they continue to protect the public.

6.46 Seven of the nine regulators have worked with their new councils' governance arrangements this year and, in the case of three regulators, new chief executives. The regulators have reported that their new arrangements are generally working well and that they have seen the benefits of these changes. For example, the HPC have said that the smaller number of council members seems to have facilitated greater participation of members, as all committees are comprised of council members. We understand that this has increased the council's overall understanding of the performance of the HPC. We note the positive feedback that we have received in relation to the changes from all the regulators.

Public and patient involvement in regulation

6.47 Over the last year, there has been a focus on regulators taking an active approach to informing the public and patients about regulation. We support this work which empowers patients and the public by providing them with greater information and understanding of what they should expect from a professional and their regulator. An example of this work is the GDC's patient information leaflet *Smile* which gives patients access to clear, jargon- free information about the standards that they should expect when they visit the dentist and what action they can take if they are unhappy with the experience. The GOC has also published a similar patient information leaflet, *How to Complain About an Optician* and another leaflet which explains about the role of the GOC as a regulator called *About Us*.

6.48 In addition to actively informing patients and the public about regulation, we have also seen that some regulators are carrying out work to clarify complainants' expectations of the fitness to practise process. They are doing this to look at ways of better meeting and managing the expectations of those that approach regulators with fitness to practise complaints. We agree that there needs to be greater understanding of the purpose of the fitness to practise process which is not to punish a health professional, but to protect the public by taking action where a professional's fitness to practise is impaired. There also needs to be clearer information about the process itself. The HPC is proposing to address this matter through providing complainants with clearer information on the key points of the fitness to practise process, the potential outcomes at each decision point and the likely length of time involved at each step.

6.49 The regulators now have greater public involvement in their governance arrangements and are actively involving public stakeholders in the design of their work. They are also seeking to overcome the challenges that achieving effective patient and public involvement incurs. It would, therefore, seem an appropriate time for CHRE to consider the most effective mechanisms for engaging patients and the public in the activities of the regulators. This would involve looking at any current barriers to achieving wide representation of views, what mechanisms have worked well so far for the regulators and the impact that effective public and patient involvement can have on the performance of the regulators.

Responding to change

6.50 We consider that agility is an important principle in regulation. This is the regulators' ability to respond to changing circumstances promptly and without any undue interference with their functions. The environment in which the regulators work is constantly changing. The changes may be due to media attention on particular issues or unforeseen consequences of their own or others' actions. This year we have seen many examples where a regulator has had to deal with unexpected events and they have done so effectively. For example, the GCC has so far managed the significant rise in the fitness to practise complaints it received this year. In addition to the normal level of complaints, which is around 40 per year, the GCC received almost 600 further complaints by June 2009. This appears to be

an unexpected consequence of libel action brought against an individual by the British Chiropractic Association.

6.51 The regulators also have to respond to expected changes and we have seen that this takes significant time and resources. For example, the GMC and GOC have both had to manage the arrangements for the transfer of their adjudication functions to the Office of the Health Professions Adjudicator (OHPA) in April 2011 and the GMC has had to do this while also managing the merger of the Postgraduate Medical Education and Training Board. Another example of this is the RPSGB's management of the transition of its regulatory function to the General Pharmaceutical Council (GPhC). Delays in bringing in the full legislative framework for the GPhC have impeded the handover of statutory regulation from the RPSGB to the GPhC.

Equality and diversity

6.52 The regulators are collating equality and diversity statistics but there is some variation, both in the amount of data that has been collected and in those diversity strands against which data is collected. In line with our recommendation in our report on healthcare for people with disabilities,[10] we consider that the Department of Health should ensure that the regulations arising from the Equality Act 2010, should enable all regulators to be subject to the same duties and expectations under all equality and diversity legislation.

[10] CHRE, 2009. *Healthcare for People with Disabilities*. London: CHRE.

7. The regulators in numbers

7.1 In this section, we provide some basic comparable data on each of the health professional regulators. The data provides some context on the size of the regulators in terms of the number of professions and professionals that they regulate and some areas of their workloads.

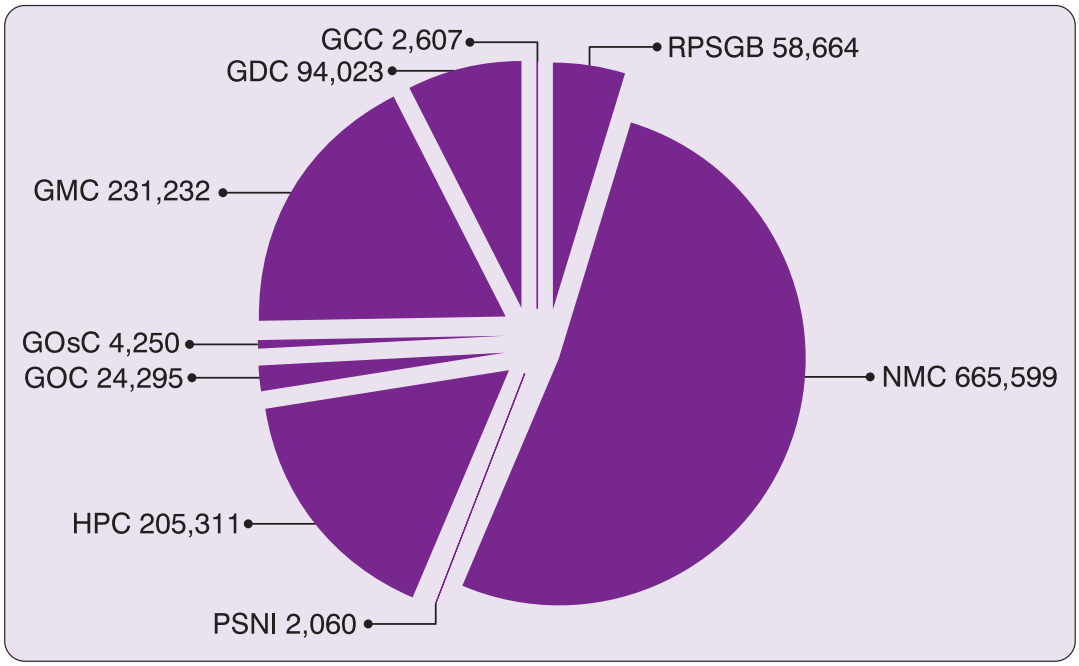
7.2 As discussed in paragraph 6.29 we hope to build on this data in our forthcoming performance reviews. Over the next year, we will work with the regulators to agree a common data set which will be published in our performance reviews. This data should make it easier to understand the similarities and differences in the responsibilities of the regulators and their respective workloads.

Registration information April 2009 – March 2010

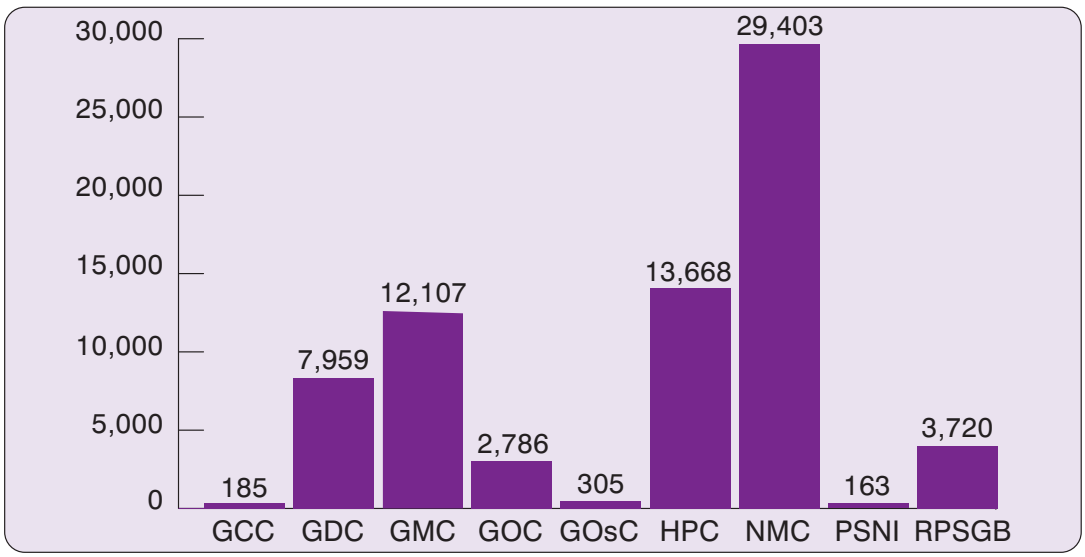
Regulator	No. of professions	Annual retention fee	No. of registrants
GCC	1	£1,000 £100 for non-practising	2,607
GDC	7	£438 for dentists £96 for dental care professionals	94,023
GMC	1	£410 with a licence £145 without a licence	231,232
GOC	2	£219 for registrants £20 for students	24,295
GOsC	1	£350 1st year £500 2nd year £750 thereafter	4,250
HPC	14[12]	£76	205,311
NMC	2	£76	665,599
PSNI	1	£372	2,060
RPSGB	2	£135 pharmacy technician £413 pharmacist £70 pharmacist non-practising	58,664

[11] The HPC regulated 14 professions until 31 March 2010. From 01 April 2010, it has regulated 15 professions.

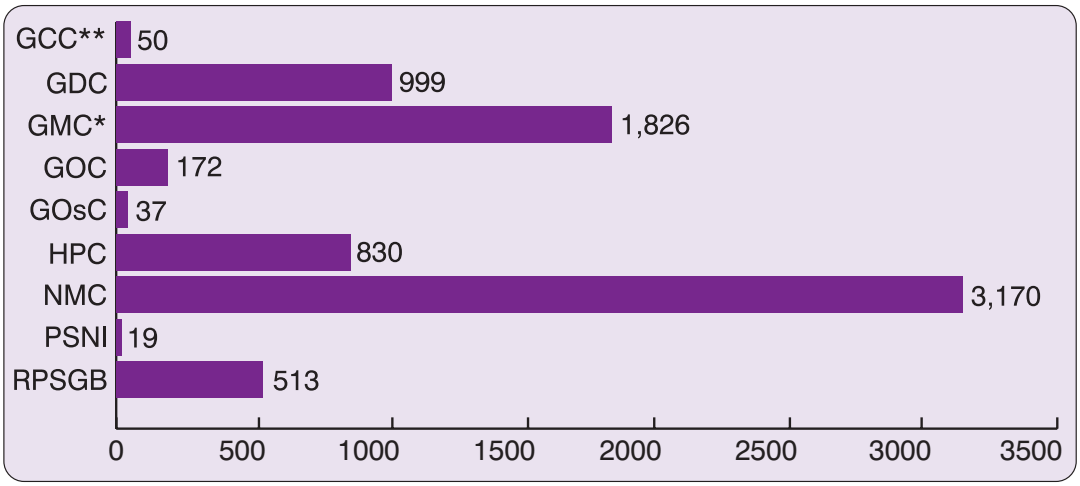
Number of registrants by regulator April 2009 – March 2010



Number of initial registration applications as of 31 March 2010



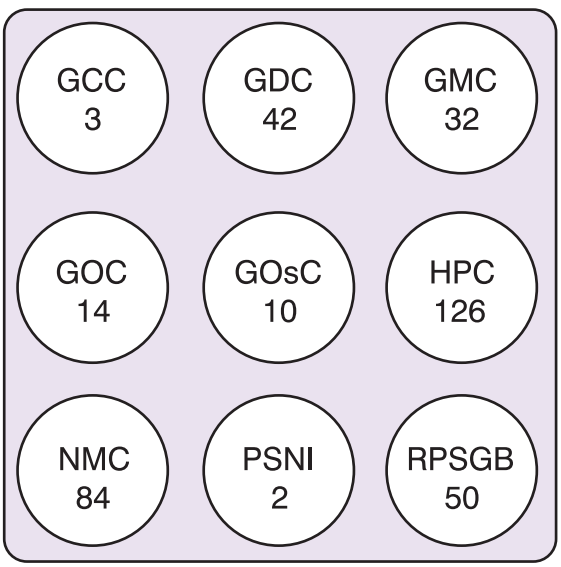
Number of fitness to practise inquiries considered by investigation and final fitness to practise panels April 2009 - March 2010



**GCC – The GCC figures should be read in conjunction with the special circumstances surrounding the nature of the complaints it has received this year, as detailed in the GCC individual report. Further information can be found at paragraphs 9.15 to 9.17.

*GMC – The GMC figure includes cases where a decision was made by case examiners as well as those considered by the investigation and final fitness to practise panels. Figures for the other regulators are the combined total of investigation committee and final panel decisions in the period April 2009 – March 2010. The figures are intended only as a guide to represent the volume of fitness to practise cases dealt with by the regulator's various fitness to practise committees. Direct comparison of the regulators from this data should not be made.

Number of educational institutions accredited per regulator



8. The individual regulator's performance review reports

8.1 We are satisfied that all of the regulators are carrying out their statutory functions but there is variation in the quality of the work undertaken to do this. A number of regulators have made improvements to their performance and some have demonstrated good practice and excellence.

8.2 Our individual performance review reports for the regulators provide our overall assessment of their performance against the five functions. The reports focus on where practices of the regulators have improved since 2008/09, where they have performed well and any new or continuing areas of weakness.

9. The General Chiropractic Council (GCC)

Overall assessment

9.1 The **General Chiropractic Council** regulates **one** profession: chiropractors. It has **2,067** current registrants and received **185** new registration applications in the past year. The GCC has an annual retention fee of **£1,000** for full registration and a fee of **£100** for non-practising chiropractors who wish to remain on the register. The GCC is responsible for the quality assurance of chiropractic training at **three** educational institutions.

9.2 The last year has been a challenging one for the GCC. We note that in addition to the normal level of complaints, which is around 40 per year, the GCC had received almost 600 further complaints by June 2009. This appears to be a consequence of a libel action brought against a science journalist by the British Chiropractic Association. The vast majority of these complaints were made by two individuals and all involved allegations that unsubstantiated claims about the effectiveness of chiropractic treatment for a wide range of medical conditions appeared on registrants' websites. A brief outline of the complaints issue, and the GCC's response, is explained in paragraphs 9.15 to 9.17 of this report. Dealing with these additional complaints continues to put a substantial strain on the GCC's resources.

9.3 However, it has maintained its role as an effective and efficient regulator that focuses on improvement and the protection of the public. The GCC has shown improvement by identifying and developing relationships with a small number of employers of chiropractors, and by providing more detailed letters to all parties following decisions made by GCC fitness to practise committees. It has also shown excellence this year by increasing the availability and transparency of information for the public about how to

make a complaint and how it deals with concerns about registrants' fitness to practise.

9.4 In our previous report we highlighted the following three areas for further consideration. We are pleased to report the following progress this year:

- The GCC's new development and appraisal system for members of fitness to practise committees. The new appraisal process measures members' performance against competencies, and includes self assessment and peer and staff review. We are pleased to note that the new process has already helped to identify and resolve several examples of poor performance, therefore reinforcing the quality of committee decisions and improving public protection
- Further success on the collection of attributable ethnicity and disability data. The GCC has shown improvement in this area as its attributable ethnicity and disability data now covers 81 per cent of GCC registrants, as compared to 71 per cent as reported in our last review
- The outcome of the external analysis of both the investigating and professional conduct committees' reasoning for their decisions. The results of this review were positive and no significant concerns were identified.

9.5 We would like to follow up on the following three areas in next year's performance review:

- Any lessons learned by the GCC in its handling of the exceptional increase in the level of complaints this year. We would be particularly interested in any impact this matter has had on the GCC's regulatory functions, how any ongoing risks were identified and what steps were taken to mitigate these risks to ensure the GCC maintained its public protection role and overall effectiveness as a regulator
- The outcomes of further discussions and the details of any common guidance issued as a result of the GCC's increased engagement with employers of chiropractors
- The outcomes of any pilot involving the use of practice placements including how the GCC identified and managed any associated public protection risks and how it ensured its standards were applied to placements.

Standards and guidance

9.6 We note that this year the GCC met increased demand for its patient information leaflet, *What can I expect when I see a chiropractor?* We welcome the efforts made by the GCC to ensure that information about levels of care the public can expect, and what they can do about any concerns relating to registrants' fitness to practise, is widely available and understood.

9.7 The GCC continues to actively promote and communicate its standards to registrants, potential registrants and other stakeholders. For example, in May 2009 all registrants were sent a copy of the GCC's revised code of practice and standard of proficiency that is effective from June 2010.

In autumn 2009 a UK-wide series of events was attended by various stakeholders including registrants, students and the public and included discussions on the revised code and standard. Feedback from these events indicated that the revised code and standard was patient-friendly and addressed all the issues identified during consultation.

9.8 We welcome the GCC's commissioning of external analysis of all continuing professional development (CPD) activities undertaken by chiropractors in 2008. The objective was to identify any trends in CPD that might inform the GCC's revalidation model. The areas of special interest identified by the research, such as sports and paediatrics, will inform any exploration by the GCC of the need for any specialist chiropractic postgraduate qualifications to ensure that adequate levels of patient care and safety are maintained while the profession is developed.

Registration

9.9 We acknowledge that the GCC continues to process registration applications effectively and has 100 per cent compliance with its service standards for the registration of both UK and international registrants. We recognise this good performance and welcome the fact that the development of an electronic facility for retention of registration applications that do not require any accompanying documentation, as mentioned in the last year's performance review, is on target for implementation in 2010. Such a facility helps to prevent data entry errors and reduces processing times so that resources can be focused on other tasks.

9.10 The GCC has shown improvement in collecting very high levels of attributable ethnicity and disability data in relation to its registrants. We note that audits of registration decisions carried out against the available data indicated there was no bias against any group.

9.11 The GCC is requesting changes to its registration requirements as part of a forthcoming Section 60 order. The changes would give the GCC the power to require initial registration applicants to pass a GCC approved competence test if the application for registration is made more than two years from the date the applicant completed a GCC-recognised degree programme. Similarly, the GCC is seeking the power to require that a competence test must be passed by registrants who have been voluntarily out of practice for two years or more. We support these changes and believe they would strengthen public protection by helping to ensure that all chiropractors' clinical skills and professional knowledge are adequate and up to date before any treatment is offered to patients.

Fitness to practise

9.12 We are pleased to report that the GCC has amended its complaint leaflet, *How to complain about a chiropractor – Telling the General Chiropractic Council about your concerns*, and its standard letters in line with the initial findings of our *Audit of the General Chiropractic Council's initial stages of*

fitness to practise procedures.[12] The revised information leaflet clarifies that, although the GCC is required by legislation to offer complainants the opportunity to make a statement to a solicitor, this is not compulsory for the investigation of the complaint. The GCC also advises complainants that it will refund charges (normally between £7 and £10) in relation to the cost of having a statement witnessed by a solicitor. We consider that the GCC displays excellence by showing consistent performance and continuous improvement in terms of the transparency of the information it provides to complainants.

9.13 The GCC has shown improvement by providing more detailed information in letters to parties following decisions made by its investigating committees and professional conduct committees. As already mentioned in the first section of this report, the results of an external analysis of the GCC's fitness to practise committees' reasoning for their decisions revealed no significant concerns. However as a result of suggestions made to improve transparency and consistency, the GCC has amended all decision letters from fitness to practise committees, which now set out allegations and any evidence considered along with detailed reasons for decisions. These improvements should help to ensure that the public is more fully informed and involved in the GCC's fitness to practise processes.

9.14 Other than those employed by the educational institutions, chiropractors have historically worked together as associates rather than in employer/employee relationships. However, following a survey on this issue conducted last year the GCC has identified five employers of chiropractors and has worked to improve its levels of engagement with them. Specifically, the GCC's work with the employers aimed to help them ensure that the public is properly protected and professional standards maintained by identifying when and how the employers should refer fitness to practise issues to the GCC. A further meeting to discuss information sharing was convened for March 2010. We consider that the GCC has shown improvement in this area and will be interested to know the details of any further progress made.

9.15 As previously mentioned, the GCC received almost 600 unanticipated complaints by June 2009. This appeared to be a consequence of a libel action brought against a science journalist by the British Chiropractic Association. The action taken by the GCC to manage the unprecedented increase in complaint levels included the commissioning and publication of an academic review of the research base for chiropractic care in respect of all the medical conditions identified by the complaints. The GCC considered this to be a proportionate response to managing the unique problems presented by the situation.

9.16 Immediately on receipt of the complaints, the GCC developed and produced likely investigation timelines, staffing requirements, training

[12] CHRE 2010. *Audit of the General Chiropractic Council's initial stages of fitness to practise procedures*. London: CHRE.

programmes and costing for the handling of cases under both existing and proposed legislation. It also sought and obtained legislative change to resolve the anomaly that registrants who were subject to complaints were not required to pay an annual retention fee until such time as a final decision on the complaint had been made. We are pleased that the GCC immediately identified the likely impact of this development on its ability to perform its statutory regulatory functions and quickly formulated a strategy to deal with the situation. Its planning took into account that the GCC's current legislative framework means that a significant number of these complaints are likely to require consideration by the professional conduct committee, as the investigating committee is not allowed to resolve complaints that involve conflicts of evidence. The GCC has for some considerable time been requesting new disposal powers for the investigating committee, an approach that is supported by CHRE.

9.17 Following on from the initial planning stages, we note that the GCC has undertaken significant preparatory work. An analysis of the complaints allowed the investigation and determination stages to be streamlined on the basis that issues identified fell into common themes. The GCC has prepared detailed complaint summaries and reviews of relevant chiropractor web pages to identify any additional matters not highlighted by the complaints. It will also provide the investigating committee with a detailed training session on the relevant consumer protection law and the results of the academic review of relevant research, to aid consistency in the investigating committee's decision making. The GCC aims to complete all of the investigations and to commence professional conduct committee meetings this year.

9.18 We note that the GCC has continued to make the improvements outlined in this report, despite the unexpected and unprecedented rise in the number of complaints received. For next year's review we will be interested to know the details of any impact this issue has had on the GCC's regulatory functions, how any ongoing risks were identified and what steps were taken to mitigate these risks to ensure the GCC maintained its public protection role and overall effectiveness as a regulator.

Education and training

9.19 The GCC's review of the criteria for recognition of chiropractic degree programmes against its revised code of practice and standard of proficiency is on target for completion by May 2010 and includes consideration of criteria set by chiropractic education councils in Europe, Australasia, Canada and the USA. We welcome the consideration of international criteria as this should move forward the programme for consistency in standards of chiropractic education internationally.

9.20 We note that the GCC is currently discussing whether to pilot the use of practice placements with its current education providers. We would be interested to know the outcome of these discussions and, if practice placements are undertaken by students, how the GCC will identify and manage any associated public protection risks and how it will ensure its

standards are applied to any placements. We note the GCC, in parallel with this work and its review of the criteria for recognition, is also exploring with education providers whether any supplementary guidance on the governance of their outpatient clinics would be helpful.

Governance and external relations

9.21 The GCC considers that its new Council is performing well and that it has seen benefits of the new structure such as its focus on the performance of the GCC. The Council will monitor its strategic aims and will measure the performance of the executive against the annual business plans. This should enable clear lines of accountability.

9.22 We commend the speed with which the GCC was able to produce detailed plans to deal with the huge increase in complaints experienced this year and note that despite the major challenges this issue presented to its limited resources, the GCC continued to deliver the totality of its business plan. We consider the GCC's response in developing and evaluating a range of solutions and scenarios to address the problem in the context of both existing and proposed legislative requirements demonstrates that the GCC displays agility, takes proper account of risk in its planning process and illustrates good use of up to date management information.

9.23 We welcome the GCC's recent work with the Inspector Warranted by the Scottish Ministers for the Ionising Radiation (Medical Exposure) Regulations to agree the arrangements for inspections of chiropractic clinics that expose patients to x-rays. The GCC has distributed information about what these inspections involve and what is expected of chiropractors in Scotland for compliance with the regulations. We consider that this is an important contribution to patient safety. We note the difficulties that the GCC has had in organising similar inspection arrangements in England with the Care Quality Commission. We hope that the GCC is able to make progress on this over the next review period.

9.24 The GCC actively maintains international links via its engagement with the European Chiropractors Union and the World Federation of Chiropractic and has exchanged information with and received advice from the Federation in relation to the unusual circumstances it has faced this year. This is important from the viewpoint of ensuring consistency in public protection internationally.

10. The General Dental Council (GDC)

Overall assessment

10.1 The **General Dental Council** regulates **seven** professions: dentists, clinical dental technicians, dental hygienists, dental nurses, dental technicians, dental therapists, and orthodontic therapists. It has **94,023** current registrants and received **7,959** new registration applications in the last year. The GDC has an annual retention fee of **£438** for dentists and **£96** for dental care professionals. The GDC is responsible for the quality assurance of the training of dental professionals at **42** educational institutions.

10.2 The General Dental Council has had a challenging year. It has restructured its fitness to practise and registration departments, has a new Council, an interim chief executive (from 15 December 2009) and begun a major review of its regulatory processes. We consider that the GDC has maintained a steady performance during these changes. However, we are concerned with the time taken for cases to progress through its fitness to practise processes and the quality of its case management system. We consider that these matters need to be addressed as a matter of urgency.

10.3 We note that there are some issues with the GDC's performance. We also note that the interim chief executive and new chair have rapidly identified areas for improvement and proposed changes to address these matters. We have expressed some concern that all decisions should be made through the proper process with the support of Council. We have been assured that this is the case.

10.4 In last year's report we highlighted four areas that we wanted to follow up. We consider that the GDC has made satisfactory progress on these areas:

- The revalidation pilot. The GDC has piloted stage one of the proposed revalidation scheme and work is continuing on the overall proposal
- The implementation of the new education and training standards and its change of approach to quality assurance of education providers. The GDC is continuing with its fundamental review of its education standards and quality assurance process. It has engaged with stakeholders on its draft outcomes
- The revised process for appraisal and assessment of fitness to practise panel members. The GDC is piloting its new appraisal system which is based on self, panel and peer review
- The introduction of mechanisms for measuring and managing performance. The GDC has developed its *Accountability and Performance Framework*. A key element of the framework is the specification and use of success and performance indicators to evaluate organisational success and operational processes. It also clearly links the GDC's strategic aims and operational activity to its key strategic outcome, the protection of the public.

10.5 In next year's review, we would like to see evidence of progress in the following areas:

- The review of the standards function
- The planned changes to the register
- Reduction of delays in fitness to practise case progression
- The review of the GDC's current case management system and action taken to address its shortfalls
- The effectiveness of the fitness to practise function following the recent changes
- The review of the education standards and quality assurance process for undergraduate education.

Standards and guidance

10.6 The GDC has maintained its performance in the development and communication of standards and guidance. However, we note that it is to carry out a strategic review of its standards function this year. The aim is to ensure all its standards continue to prioritise patient safety, that there is a consistent approach to when and how they develop standards and that they have appropriate informal and formal consultation techniques in place to support their development. We look forward to seeing the outcomes of this work.

10.7 We are pleased that the GDC has taken learning from its fitness to practise cases and considered whether it is appropriate to develop guidance to help registrants with particular issues. For example, the GDC has undertaken a substantial research exercise aimed at understanding the opinions of members of the public on issues around advertising. This followed a large number of fitness to practise cases involving misleading advertising. The GDC will use the outcomes of this research to inform new guidance.

10.8 Alongside developing new supplementary guidance, we are pleased that the GDC has implemented its registrant learning plan. It has drawn lessons from its fitness to practise cases, registrant queries, and complaints from the Dental Complaints Service to provide valuable case studies and feedback to registrants on matters pertaining to professional standards. We consider that this work should improve registrants' practice for the benefit of public protection.

10.9 The GDC has also produced a patient information leaflet, *Smile*, which has been distributed to dental surgeries. We are pleased that patients have access to clear, jargon-free information about the standards that they should expect when they visit the dentist and what action they can take if they are unhappy with the experience.

Registration

10.10 The GDC's registrant population has changed significantly. It previously looked after one register of dentists but now also holds a register for dental care professionals. This has significantly increased the number of

its registrants. To manage the change in registrant population, the GDC underwent a restructure in April 2009 to enable it to work more efficiently in dealing with registration applications and in the maintenance of the register. The teams who undertake this work now have a specialist focus. However, cross-team training means in peak periods, such as in summer 2009, it is able to move staff between teams and ensure targets for registration applications were met. We consider this to be a sensible approach to a function where there are anticipated peaks and troughs in the workload.

10.11 As well as restructuring the registration department, the GDC has sought to learn from and improve its activities. It does this through feedback from its customer advisory and information team and its audits of completed applications. It is also reviewing its database to ensure that all aspects of its registration activity are recorded. These tasks should improve the quality of the registration processes and ensure that candidates' enquiries can be dealt with quickly and accurately by those accessing the database.

10.12 The GDC has been registering dental care professionals for two years. It has registered 43,726 professionals. After the transitional period, the GDC audited its register and found three potentially fraudulent applications and 26 erroneous applications. It has taken action to address these matters. We consider that the GDC took prudent action to maintain the integrity of its register following the transitional period and quickly addressed the small number of errors identified.

10.13 In last year's report we highlighted the work undertaken by the GDC to consult on changes it could make to its register. The GDC now has agreed plans to make a number of changes which include publishing all current fitness to practise sanctions (private conditions will only be indicated), renewal dates, clear explanations about sanctions and improving the register's search functionality. These should be in place by the end of 2010. We are pleased with this development, which we consider should enhance public protection.

Fitness to practise

10.14 The GDC's fitness to practise department has undergone a significant restructure. The purpose was to reduce the time taken for cases to progress through the fitness to practise process. The restructure created a prosecutions team comprised of in-house lawyers. They are responsible for managing the external legal service and taking control of the prosecutions process from initial receipt of complaint through to final disposal. The restructure also introduced the idea that a caseworker and an in-house lawyer will work in partnership on the consideration of cases. The GDC hopes that this will improve consistency and ensure that cases are closed at the right point in the process without any undue delay. We would like to see these benefits realised. However, we are anxious that the process could become overly legalistic if there is involvement of lawyers at every stage. We note, though, that the GDC is confident that it will be in a position to validate its approach in next year's review when the changes have resulted in significant improvements in case management.

10.15 The GDC saw an unexpected 40 per cent increase in its fitness to practise workload since 2008/09. It currently takes an average of 18 months for a case to progress from receipt of complaint to a final fitness to practise hearing decision. However, the GDC also has a 12 month backlog of cases waiting for a hearing date. This means that cases will take longer to be resolved. As well as the restructure noted above, the GDC is considering a number of options to address this problem such as increasing the number of concurrent hearings, overscheduling hearings and an increase in staffing levels. We consider that delays impact on the fairness of the process as well as the GDC's ability to promptly protect the public by efficiently progressing appropriate cases to a final fitness to practise hearing. We note that the planned changes will not be implemented instantly but will want to see that steps have been taken to reduce the delays in our next review.

10.16 The GDC completed the migration of its fitness to practise data to the CARE database. However, this has highlighted that the database cannot produce reliable management information. This is partly due to the system itself and partly due to caseworkers having to interpret what data should be put into the system and when this should occur. Staff are currently having to manually check the data produced which is not an effective way of working. In addition, it makes it difficult for case managers to ensure their staff members' cases are progressing sufficiently. The GDC is currently reviewing the CARE system to ascertain whether it is fit for purpose. We consider that this work should be a priority for the GDC and will want to see evidence of progress made on this matter in the next review.

10.17 As part of the restructure the GDC has also reviewed and replaced its operating guidance and disclosure policy. The new standard operating procedures should ensure a shared understanding and consistency of approach. It has also brought in a new approach to referring cases for an interim order. The GDC considers that as the referral is overseen by an in-house lawyer, cases should be dealt with quickly and only appropriate cases should be taken forward. We welcome any changes that enhance public protection but again express anxiety about a potential over reliance on in-house lawyers in decision making as opposed to their important role of providing advice.

10.18 As well as reviewing its process, the GDC is also looking at cases closed during the initial stages of the fitness to practise process. It is analysing the reasons for case closures to see if there is any learning which could impact on policy or operational guidance and to provide constructive feedback to staff and panel members. We agree that this is a sensible approach with obvious public protection benefits.

10.19 This year the GDC has recruited panelists for the investigating committee against competencies and trained them to undertake the role. As part of this work, it has developed a new appraisal process for all panelists that sit on fitness to practise committees. The process is based on self, panel and

peer review. It is currently being piloted. This is a valuable tool for driving up panelists' skills. We look forward to seeing the outcomes of this work.

10.20 While the focus in fitness to practise has been on reviewing its structure, processes, policy and decisions, we are pleased that the GDC has also produced a leaflet for employers. This gives details on when and how to refer cases to the fitness to practise department, the importance of checking the register, and encouraging employees to undertake continuing professional development. We note that this leaflet is going to be supported by a series of events for employers.

Education

10.21 The GDC has continued the revision of its standards for education and training for students and education providers. It has consulted with registrants and tested the draft outcome based standards in a series of seven consultative events for dentists, dental care professional educators and trainers. It has also consulted with deans of schools. As the standards have been well received, the GDC has begun to draft accompanying guidance.

10.22 As reported last year, the GDC is also reviewing its approach to quality assurance. It wants to ensure that its processes are fit for purpose, targeted on risks and efficient. Progress will be made on this once the standards are nearer to finalisation. As part of this work, it will be considering how to maximise the benefits of public involvement. Currently, the GDC has a public visitor on each panel and checks to see whether education providers have incorporated patients' views into the design and delivery of the courses. However, it feels that these processes could be strengthened. We do consider that it is appropriate that patient involvement is reflected in the design and delivery of education programmes and that any evaluation of courses takes the views of patients into account. We therefore look forward to seeing the outcomes of the GDC's work in this area.

10.23 We are pleased that the GDC is looking at the continuum of education from undergraduate to revalidation and reflecting on what this means for its role as a regulator. It is considering the idea that trainees keep a portfolio of information about their education and performance throughout their career. We agree that this continuum provides significant benefits for public protection and that consideration should be given to how these benefits can be realised.

10.24 We note that there were delays in the publication of the GDC's guidance on student fitness to practise. The GDC's initial public consultation on the document used a new technique which drew limited responses. The GDC therefore felt it was appropriate to consult again on the guidance using its standard methods. The GDC has a communications strategy in place to ensure that all students and education providers are aware of the guidance. It has also changed its annual monitoring form to ask education providers to provide patient feedback on the use of student fitness to practise panels. While we are disappointed with the slow progress, we

are pleased that this guidance has now been published. It is important to embed professionalism at the first stage of a dental care professional's career and for appropriate action to be taken where it is felt that a student's performance is below standard.

Governance and external relations

10.25 In addition to the restructuring in the registration and fitness to practise department, the GDC is undertaking a review of its regulatory processes to highlight further areas for improvements and integration. It has also already developed an improvement action plan and several senior members of staff have left the organisation. We have been assured that all decisions have been through the proper processes and that they have the support of the Council. Good governance requires that the Council has access to well thought out and costed proposals and has the time to review, consider and agree them.

10.26 The GDC's reconstituted Council took office on 1 October 2009. The Council has parity of public and professional membership. The four chief dental officers act as associate members with no voting powers. We note that work is continuing on reviewing the GDC's governance arrangements to ensure that they are fit for purpose for the new Council. For example, the GDC is reviewing its code of conduct and appraisal system for Council members, developing a scheme of delegation and reviewing its risk register. It has also undertaken significant work, including consultative events, to develop its corporate strategy. Alongside this work, it has developed an *Accountability and Performance Framework*. This demonstrates the centrality of the corporate strategy in ensuring that the GDC is clear about its strategic aims and that its operations are designed to deliver strategic outcomes that protect the public. We consider this cohesive approach to its work will have clear benefits for the organisation and for public protection.

10.27 As well as facilitating a major review and implementing changes, the GDC has sought to learn from the experience of the Director for Scotland's first year in operation. Acknowledging the differences between the four UK countries is particularly important to the GDC, as the provision of dental services across the UK is carried out by different bodies. It is, therefore, important that the GDC has a close working relationship with the systems regulators to ensure that information is shared. We consider that this level of co-operation has significant benefits to public protection in relation to addressing any fitness to practise concerns.

10.28 The GDC has revised its corporate customer complaints procedure to improve the accessibility of the process, the consistency of complaint handling and to ensure it is focused on the complainant's needs. The GDC wants the complaints process to provide insight into its processes, systems and staff to enable it to continuously improve. We welcome this revised approach. It is important to public confidence that a regulator manages its complaints effectively, efficiently and with a focus on customers' needs.

11. The General Medical Council (GMC)

Overall assessment

11.1 The **General Medical Council** regulates **one** profession: doctors. It has **231,232** current registrants and received **12,107** new registration applications in the past year. The GMC has an annual retention fee of **£410** with a licence to practice (**£420** from 1 April 2010), and **£145** without a licence. The GMC is responsible for the quality assurance of the training of doctors at **32** educational institutions. From 1 April 2010, the GMC became responsible for all stages of medical education and training, which includes the quality assurance in relation to **21** postgraduate deaneries.

11.2 The GMC has continued to perform well, demonstrating excellence in several areas across its functions in a year of significant change. It is impressive that the GMC has maintained its commitment to continuous improvement, even in areas where it was already performing to a good standard, and to addressing challenges in medical regulation. We note that it has made good progress on a number of projects. These include, but are not limited to, the merger of the Postgraduate Medical Education and Training Board (PMETB) with the GMC, the introduction of a licence to practise and changes to its fitness to practise rules.

11.3 In last year's review, we noted three areas of the GMC's performance on which we wished to monitor progress. We are pleased with the progress made, which is as follows:

- Outcomes of the use of its ethnicity and diversity data in its research programme. The research has been completed and communicated to relevant stakeholders. Council members, the health professional regulators and other interested parties have had the opportunity to hear and discuss the findings. The GMC is currently considering the impact of this research on policy and operational matters
- Enhancement of management information and assessment of organisational performance. The GMC has used its evaluation framework to focus on outcomes and the impact of its work as it relates to protecting the public. It has identified outcomes for each of the strategic aims and for each activity in its business plan. The GMC will monitor and report to Council every six months on the progress made
- Enhanced engagement with key interest groups. The GMC has devised a communications plan to ensure that it is targeting key stakeholders with the right information
- Establishment of a Reference Community. The Reference Community is comprised of 27 members of the public and 27 doctors. The GMC has consulted with the community on a variety of operational and policy issues. It has taken account of the feedback received and made a number of changes to documents. The GMC says that its early indications are that the group is having a positive impact on its work.

11.4 In next year's review, we will look at the progress that has been made on the:

- Two stage programme of work on continuing professional development (CPD)
- The outcome of the GMC affiliates pilot
- Impact of an increased caseload on the timeliness of the fitness to practise process
- Outcome of the vulnerable witness support pilot
- The merger of PMETB with the GMC
- Patient involvement in the quality assurance of education providers
- The impact of the research, which took account of the GMC's ethnicity and diversity data, on policy and operational matters.

Standards and guidance

11.5 The GMC has continued to demonstrate excellence in the development and communication of its standards and guidance. It has published guidance on confidentiality and undertaken consultations on key challenges that doctors face in practice today, such as end of life treatment and care, research methods and audio and visual recordings of patients. This level of agility should ensure that the GMC is in step with the key issues its registrants face and that the public is protected.

11.6 The GMC has also maintained its commitment to ensure widespread engagement and discussion on its consultations, in particular with those who are most affected by the draft standards or guidance. During the GMC consultation on end of life treatment and care guidance, it met with all its key stakeholders. It went to a care home and spoke to residents and staff and attended a Local Involvement Network meeting for older people. The GMC also designed a specific consultation questionnaire for members of the public and commissioned research into the views of patients with terminal illnesses. We consider that this process should ensure that the guidance is robust and focused on the needs of the relevant stakeholders.

11.7 We are pleased that the GMC has also continued to ensure that its work is accessible to registrants and students who need to use the standards and guidance in their practice. It has published eight new scenarios on its '*Good Medical Practice In Action*' web pages to ensure this reflects all of the GMC's recently published guidance. The revised website includes an A to Z of guidance which makes it easier for registrants to find the relevant guidance and increases their understanding of how the guidance links together. The GMC has also developed a student website which contains information on all of its work and a podcast on professionalism.

11.8 CPD is not a requirement for entry or retention on the GMC's register. However, evidence of participation in CPD will form part of the registrant's evidence to show that they are fit to practise as part of revalidation. As part of this work, the GMC has agreed a two stage programme. It will consult on the Royal Colleges' specialty standards (of which CPD is a component) and on the key principles of CPD that should inform revalidation and it will

conduct a fundamental review of the role of the regulator in CPD. We look forward to seeing the outcomes of this work.

11.9 This year the GMC has reached its first milestone towards revalidation; it introduced the licence to practise. We acknowledge the significant amount of work undertaken by the GMC to ensure all its key stakeholders understood the implications of the introduction of the licence, including changes to its register. It managed a communications campaign to engage with doctors, developed a new guide for patients on doctors' registration and held a series of briefing events across the UK aimed at organisations which employ, contract with or provide the services of doctors.

Registration

11.10 The GMC has continued to demonstrate excellence through its focus on improving its registration process. The GMC seeks to learn from its quality assurance programme, complaints and analysis of registration application form errors. For example, as a result of reviewing online registration applications it has identified that the recording of a doctor's employment history is a common area of error and is taking steps to amend its online system. As well as learning from errors, the GMC has undertaken a number of initiatives to further enhance the consistency of its decision making. It has held workshops for staff to review different types of applications to ensure that policies are being applied consistently. It also worked with colleagues in the fitness to practise directorate to ensure that the test of fitness to practise is consistently applied.

11.11 We are pleased that the GMC has achieved a good response rate from its registrants in terms of accessibility of its registration information and the registration application form. We are also encouraged that the GMC has not become complacent in light of this good response rate and declining procedural error rate. It is about to undertake a post implementation review of its new registration framework to assess the impact and effectiveness of its policies and procedures.

11.12 The GMC has worked to improve the usefulness of the register particularly for employers. Following consultation with employers, it has enhanced functionality so that users can search for up to 10 doctors at one time, and the register now includes details of registrants' retention fee renewal dates. This is a positive step given the implications for public protection of those doctors who continue to work when unregistered. The GMC has also extended the download of its register service to the Scotland Workforce Information Standard System, to Connecting to Health's Primary Care Information System, and arrangements are being finalised for the service to be extended to Welsh Primary Care and Northern Ireland Health Boards. When this work is completed, there will be daily updates of registrants' status for all doctors in the NHS in the UK. We consider that having up to date information available to the main employer of doctors in the UK is beneficial to public protection.

11.13 We also note that the GMC is reviewing whether expired warnings and interim orders where there has been no subsequent finding of impairment

should remain on the register. We would encourage the GMC to consider our recent report on registers[13] when undertaking this review.

11.14 The GMC has completed its ethnicity census and has data for 74 per cent of its registrants. We welcome the GMC's commitment to sharing this data as part of its wider programme of sharing statistical information on its register. We consider this level of transparency may encourage a better understanding of the demographic profile of doctors.

Fitness to practise

11.15 Following a review of its fitness to practise procedures, the GMC introduced a number of changes to its rules. The changes include new powers to filter out vexatious complaints at initial assessment and powers to undertake an investigation to establish whether it is in the public interest to proceed with a case against a doctor which is more than five years old. It also includes enhanced powers for the Registrar to review decisions taken at the investigation stage to see whether there have been administrative or judgement errors which require the case to be looked at again. We consider that these changes should ensure that the fitness to practise process is focused on appropriate cases and that the GMC is able to make decisions which are in the interests of public protection.

11.16 As part of its commitment to continuous improvement and with a transfer of its adjudication responsibilities to the Office of the Health Professions Adjudicator in mind, we note that the GMC is undertaking a review of its case management systems. This programme of work has a variety of strands which have been informed by feedback from stakeholders. The strands include drafting and, where possible, streamlining of charges, more active pre-hearing case management and a review of methods of estimating the length of hearings. The GMC is also undertaking a fundamental review of its investigation manual and guidance. We support this focus on continuous improvement and the inclusive approach taken to the consideration of these matters.

11.17 We are pleased with the GMC's work with employers in Scotland to agree a model of engagement which includes training sessions and access to advice. We are also pleased with the outcomes from the GMC's pilot of GMC affiliates which has shown the importance of building rapport with employers. The medical directors perceived that the pilot resulted in better outcomes for doctors and patients and faster resolution of individual complaints with improved linkage between local and national regulation. The GMC has agreed further piloting as part of the Department of Health's Revalidation Pathfinder Pilots and to extend the pilot in Scotland. We look forward to the outcomes of these pilots which we consider could be very important to public protection.

[13] CHRE, 2010. *Maximising the Contribution of the Regulators' Registers to Public Protection*. London: CHRE.

11.18 An unintended consequence of the work on GMC affiliates appears to have been an increase in more serious fitness to practise concerns being referred to the GMC. The GMC is considering its options on how to manage this increase in volume to ensure that it does not adversely impact on the timeliness of its case progression. It has also highlighted the need to understand the reasons for the increase and to consider how revalidation may also impact on the fitness to practise directorate's workload. We will monitor developments in this area in next year's review.

11.19 We are disappointed that the GMC continues only to share a registrant's response with a complainant where there is significant dispute between the parties' understanding of events. We consider that there should be a presumption to share the response with the complainant, although comments of a personal nature not relevant to the case, details that reveal the identity of a whistleblower, or reference to sensitive personal information about the registrant (eg their health or finances), should not be shared. We consider that this information can prevent complaints progressing unnecessarily and does enhance the case examiner's decision making to ensure that decisions are focused on public protection.

11.20 However, we note that the GMC has responded to CHRE on this matter and explained its reasons for disagreeing with our recommendation. The GMC has said that its current practice is to share a doctor's comments with the complainant where the only allegation that the doctor is facing was raised in the original complaint and there is a significant dispute between the parties as to the relevant events. As the GMC's process includes seeking representations from employers, in a significant amount of cases, the nature of the concern about the doctor is extended beyond the original complaint. The GMC do not consider that it would be appropriate to disclose these details to the original complainant.

11.21 The GMC launched its vulnerable witness support pilot in November 2009 in partnership with Victim Support. The pilot comprises independent volunteers providing pre-hearing orientation visits, and one-to-one support on the day of the hearing. The GMC has also developed a virtual online hearing room which is available on its website to allow witnesses to orientate themselves prior to giving evidence. We are supportive of this work as witnesses are very important in the resolution of fitness to practise cases. We would be interested to see the outcomes of the pilot in next year's review.

Education and training

11.22 The GMC has published its standards and outcomes for undergraduate medical education, *Tomorrow's Doctors*. We consider that these standards are an example of good practice. They are clear, comprehensive, focused on patient safety and have benefitted from wide engagement and discussion with stakeholders.

11.23 Following the merger of PMETB with the GMC, the GMC is now responsible for managing the education of doctors throughout their careers. We agree with the GMC that this continuum provides significant

benefits for public protection. A single point of responsibility should ensure consistency in standards and expectations. This in turn will allow a clear message of patient safety and patient-focused care to be embedded at each stage of learning. We are pleased that the GMC's approach to this merger is not just to integrate postgraduate medical education within its remit, but also to use the opportunity to drive higher standards at all stages of the education process. It commissioned the Patel review[14] to look at the future of regulation of medical education and training. This report has been published and the findings are informing the GMC's views and discussion on its role in regulating education and training.

11.24 The GMC has established a working group to review the fitness to practise arrangements for both students and foundation year one trainees. The group has identified that the transition between undergraduate education and first year of training is when proper support and oversight is essential. It is, therefore, looking at ways to enhance the current arrangements. This includes establishing any evidence that newly qualified doctors are not prepared for practice, and taking appropriate action to address any areas identified. It also includes determining how to transfer appropriate information about graduates from medical schools to employers and foundation year one educational supervisors. We consider that this is an example of risk based regulation which is focused on improving patient safety and professionalism.

11.25 This year the GMC had to manage a high profile adverse incident when it was incorrectly informed that four students had graduated. All four students were provisionally registered and working in Wales. We understand that that there were no incidents of patient harm during this time. We are pleased with the GMC's response following notification of this error. It moved quickly to revoke the registration of those individuals and remove them from the register to ensure the public was protected. It also sought to learn from the event and requested that the Cardiff Medical School undertake an investigation into the errors and that it shared the learning from this incident with other medical schools. The GMC has also agreed with the school that it should be able to take account of the circumstances when developing supplementary guidance on assessment.

11.26 In light of the merger of PMETB with the GMC and the publication of *Tomorrow's Doctors* the GMC's quality assurance programme for education providers will focus on sharing good practice and supporting schools to implement the revised standards. We consider this plan to be sensible. We consider that it is appropriate that patient involvement is reflected in the design and delivery of education programmes and that any evaluation of the courses has taken the views of patients into account. We note that the GMC does have both forms of patient involvement in its quality assurance process. It has also held a visitors day in November 2009 which was designed to explore ways of improving the process including from the public perspective.

[14] GMC, 2010. *Report of the Medical Education and Training Regulation Policy Review.* London: GMC.

Governance and external relations

11.27 The GMC said that the change in the structure and membership of the Council has been managed well and that there are good levels of trust between the Council and the executive. In 2009 the GMC produced a new *Governance Handbook* which is designed to ensure that there are clear lines of accountability and developed a *Corporate Strategy* which sets out what the Council aims to achieve over the next four years.

11.28 We consider that the GMC has a real and transparent commitment to evidence based policy development. This commitment is underpinned by a variety of research and engagement activities. These include independently commissioned academic projects, collaborative research initiatives, surveys of doctors, public and discussion forums and listening to the views of its stakeholders gathered informally and formally during the course of its work. The outcomes of this work are shared by the GMC internally to ensure that the learning is taken into account in its work and externally to enhance public accountability.

11.29 The GMC has maintained its good performance in working with other organisations that share common interests in the UK and in Europe. Active co-operation with groups which have a key interest in their work is embedded through membership of co-opted members on fixed issue working groups. As well as co-operating with others to manage specific issues, the GMC has joined the National Collaborative Group and plans to participate in five planned collaborative reviews. These are designed to ensure patient safety and to reduce regulatory burden through better use of time and resources of a number of regulators.

11.30 It also continued its engagement in the development of European regulation and has had an active and successful role in a number of important public protection matters. This includes achieving the successful adoption of a GMC tabled amendment in the patients' rights directive. This states that there should be a legal duty on member states to share information immediately and proactively about health providers or health professionals who have had action taken against their registration or their right to provide services. The GMC has also improved its facilities in Belfast and Cardiff to enable a wider range of activities to take place so that it can remain sensitive to the local context and healthcare delivery systems.

11.31 The GMC has also undertaken a significant amount of work to embed equality and diversity principles in its work. It established a work programme following an independent review of its policies, practices and attitudes to equality and diversity issues. The programme included the creation of an internal equality and diversity champions network and hosting a seminar to engage with black and ethnic minority doctors. The GMC has also appointed a head of diversity. We note that the GMC is also currently considering the outcomes of its research programme which included looking at why doctors from some backgrounds are more likely to be referred forward to the final stages of the GMC's fitness to practise procedures than doctors from other backgrounds. We are pleased with the GMC's commitment to seeking to ensure that its procedures are free from discrimination.

12. The General Optical Council (GOC)

Overall assessment

12.1 The **General Optical Council** regulates **two** professions: optometrists and dispensing opticians (including student opticians and optical businesses). It has **24,295** current registrants and received **2,786** new registration applications in the review period. The GOC has an annual retention fee of **£219** for registrants and **£20** for students. The GOC is responsible for the quality assurance of the training of optical professionals at **14** educational institutions.

12.2 The previous review period was a difficult one for the General Optical Council due to a period of transition involving changes in leadership, Council membership and senior staff. Our performance review for 2008/09 recognised that the GOC had undertaken a significant amount of work to address areas of improvement identified by us and by the GOC itself. However we also expressed concern at the rate of progress made on some matters. In comparison, this year we consider that the GOC has achieved notable improvements in most areas.

12.3 We consider that the GOC has responded positively to issues raised in the last review and has made significant progress in several areas this year. It has performed well by:

- Preparing a Registration toolkit for registrants, which will be available from spring 2010
- Introducing a formal process for identifying and prioritising serious fitness to practise cases to ensure that interim action is considered where appropriate
- Introducing processes to mitigate against the risks of not having a fully functional IT based case management system
- Developing service standards along with mechanisms to monitor performance against those standards
- Introducing a policy to publish summary assessment reports on education providers on the GOC website
- Introducing governance changes in line with the Dickson report[15]
- Applying equality, diversity and human rights impact assessments to all new policies and procedures and introducing mechanisms to permit the collection and analysis of equality and diversity data to help identify any trends in fitness to practise investigations.

12.4 We would like to follow up on the three areas below in next year's performance review:

- Implementation of the GOC's project plan, particularly to improve registrant and employer understanding of fitness to practise issues and to develop witness/complainant support

[15] Department of Health, 2008. *Implementing the White Paper Trust, Assurance and Safety: enhancing confidence in healthcare professional regulation*. London: Department of Health.

- Any progress made by the GOC on issues surrounding the public accessibility of fitness to practise information on its public registers
- Any progress made by the GOC on the implementation of internal audits of decisions taken that look at, amongst other things, equality and diversity issues.

Standards and guidance

12.5 The GOC took account of the views of its stakeholders in its recent amendments to its codes of conduct for individual registrants and for business registrants. A number of important changes were made to further ensure patient safety and protect patient interests. These included the provision of clearer advice to registrants on when and how to raise matters relating to both their own fitness to practise and that of colleagues so that quick and effective action to protect patients can be taken. Changes were also introduced to ensure that temporary and occasional registrants from other European Economic Area states have adequate and appropriate indemnity insurance to remain on the register. The GOC also successfully influenced the outcome of the consultation on the code of conduct of the European Council for Optometry and Optics (ECOO) to ensure that the standards prioritised patient safety and interests and reflected those within the GOC's own code of conduct. The ECOO code is now used as a framework for all ECOO organisations when devising their own codes of conduct.

12.6 The GOC continued to ensure that learning points from fitness to practise cases impact upon the guidance available to registrants. For example, the GOC asked the College of Optometrists, the Association of British Dispensing Opticians, the Association of Optometrists and the Federation of Ophthalmic and Dispensing Opticians to review their guidance for supervising non-qualified persons following a high profile fitness to practise case, where this was the key issue. As a result of the GOC's involvement, the professional bodies introduced clearer guidance for registrants that made it clear that employers and supervisors must provide the appropriate level of supervision to trainee dispensing opticians and optometrists.

12.7 The GOC has shown improvement in its level of engagement with the public around its standards. For example, it has produced new booklets aimed at patients and entitled *How to Complain About an Optician* and *About Us*. These explain the action that patients can take if standards are not met. The GOC has also worked with the British Contact Lens Association to produce a consumer leaflet in response to concerns raised about the online purchasing of contact lenses, often from overseas retailers who do not comply with legal requirements. The GOC promoted the leaflet at events aimed at patients and the public and through the media. Similarly, the GOC is currently developing a booklet, *What Can You Expect From Your Optician?* which aims to provide the public with a jargon free, plain English explanation of the standards of optical care they should expect from opticians.

12.8 Another example of engagement with the public is the best practice booklet for registrants which forms part of the registration toolkit being developed by the GOC. This will provide guidance for registrants on how best to highlight their GOC registration, such as use of a downloadable GOC-registered logo on stationery and websites and the wearing of a badge showing their GOC registration number. A booklet aimed at patients explains what the logo means, what it means to be treated by a GOC-registered practitioner and what patients should do if they have concerns about the care they receive. These booklets will be widely distributed, for example they will be sent to all full registrants and available from Citizens Advice Bureaux and patient groups.

Registration

12.9 Following last year's review, the GOC has completed the first phase of its online retention project. This provides registrants with an online facility to track the status of retention applications and to download receipts and retention confirmations, allowing them to provide this information to employers much more quickly and efficiently while reducing any administrative burden on the GOC.

12.10 In our previous report, we said that in 2009/10 we would like to see what progress the GOC could make towards the introduction of organisation-wide service standards. We are pleased to report that the GOC has shown improvement through the development of service standards for the processing of registration and restoration applications. It has been monitoring its performance against the new standards since August 2009. We also note the GOC has performed well against its service standards and that this information is made available to the public on the GOC website.

12.11 Since our last review, the GOC has held consultations with its stakeholders on what fitness to practise information should be displayed on its public registers. This included whether details of suspended registrants and those who have been removed from the register should be publicly available. We are pleased to note that, subject to the results of further consultation on this issue and further discussion with us, the GOC has agreed that its public registers will provide this information to enhance transparency for patients and the public.

12.12 We are encouraged by the significant work done by the GOC to publicise the importance of checking that a professional is registered. The GOC's registration toolkit will be available to registrants in spring 2010.

Fitness to practise

12.13 The GOC has developed a new public information leaflet about its complaint process – *How to Complain About an Optician*. The leaflet sets out information about the types of complaint that can be dealt with by the GOC, explains the GOC's process for dealing with complaints and identifies alternative organisations that the public can contact if the complaint does not relate to fitness to practise issues.

12.14 Since last year's review, the GOC has shown improvement by introducing processes to mitigate against the risks of not having a fully functional IT based case management system. Measures include the development of a detailed spreadsheet to record data in relation to timeframes for completion of key stages of the fitness to practise process and a formal review process whereby cases awaiting consideration by the investigation committee are reviewed by GOC's director of legal and fitness to practise to ensure optimum progress is maintained. Additional new processes have been introduced to ensure that all cases are formally assessed at an early stage by a senior member of the fitness to practise team to identify any need for an interim order application.

12.15 We also consider that the GOC has shown progress in the introduction of new fitness to practise service standards for progressing cases for consideration by the investigation and fitness to practise committees. The details of performance against these service standards will be published in the GOC's annual fitness to practise report.

12.16 We recognise that following comments in the 2008/09 review and a public consultation, the GOC has prioritised the development of draft referral guidance for use by its new investigation committee to encourage consistent decision making. The GOC expects to publish the new guidance in April or early May 2010. We are also pleased to note the action taken by the GOC to ensure that the investigation committee gives sufficient reasons for every decision and that these are conveyed to all parties.

12.17 In addition, we note that the GOC has undertaken extensive work on a project to formulate processes for the internal audit of decisions made by the investigation committee to assess the adequacy of the investigation. To a more limited extent, it will also assess the decision making of the fitness to practise committee (for example whether it had sufficient information, whether it followed GOC policy and guidance and whether proper account was taken of equality and diversity). The GOC expects the appropriate mechanisms will be approved by its audit committee and Council in 2010.

Education and training

12.18 In line with ongoing annual reviews of educational handbooks, the GOC intends to update its optometry dispensing and contact lens handbooks to include the revised GOC core competencies which are currently being finalised following consultation. The updated handbooks are due to be published in May 2010.

12.19 The GOC has shown improvement by ensuring that patients' views are taken into account as part of the GOC's evaluation of education and training providers. Surveys are now used to capture patient, employer and supervisor perspectives in the quality assurance process. Public members of visit teams are given specific responsibility for considering the public/patient perspective and have the opportunity to speak to patients during visits. The GOC's education quality assurance process and all visit reports, including the new annual reports, are published on the GOC website.

12.20 The GOC has also shown improvement by implementing its annual monitoring scheme of education and training providers, as mentioned in last year's performance review. The GOC states that annual monitoring is appropriately focused on areas of risk and assessment of GOC core competencies. The new scheme was introduced to provide an overview between five-yearly visits, maintain a more timely awareness of any programme changes and to provide a more effective mechanism to track progress against any conditions or recommendations arising from GOC educational or training visit reports.

Governance and external relations

12.21 The GOC has said that the move to a smaller, board-like council has allowed the Council to be more clearly focused on setting strategy. The Council's emphasis is on stakeholder engagement and holding the executive to account for the delivery of its strategy. The GOC's statutory committees include a wide range of stakeholders and this ensures the Council takes a range of views into account and provides a greater sense of accountability.

12.22 The GOC uses evidence gathered from other areas of its work and external information in policy development. This is demonstrated by co-operation between the GOC and the professional bodies as detailed above, when a fitness to practise issue raised as the result of a patient complaint highlighted an issue in relation to professional body guidance.

12.23 We also note that the GOC made amendments to registration leaflets for publication in spring 2010. These were intended to clarify the GOC's role in taking action in respect of misuse of professional titles or illegal practice, following our report *Protecting the Public from Unregistered Practitioners: tackling misuse of protected title.*[16]

12.24 The GOC takes account of the differences between the four countries when devising policies and processes and engaging with stakeholders. The GOC is taking existing processes into account and using information that is already available across the four countries. For example, in Scotland, commissioning bodies are already retesting clinical skills required to provide optical NHS treatment and the GOC will examine these results as part of revalidation, rather than develop new tests.

[16] CHRE 2010. *Protecting the Public from Unregistered Practitioners: tackling misuse of protected title*. London; CHRE.

13. The General Osteopathic Council (GOsC)

Overall assessment

13.1 The **General Osteopathic Council** regulates **one** profession: osteopaths. It has **4,250** current registrants and received **305** new registration applications during the last year. The GOsC has an annual retention fee of **£350** for first-time registrants, **£500** for the second year and **£750** thereafter. The GOsC is responsible for the quality assurance of the training at **10** educational institutions.

13.2 The General Osteopathic Council continues to be a forward and outward looking regulator that retains a focus on improvement. This is illustrated by the GOsC's implementation of changes in its fitness to practise processes and procedures to enhance public protection and in the improved access to information about regulation and registration for patients and registrants through a revised website. The GOsC has also commissioned significant research projects into the evaluation of risk in osteopathic practice and the development of a national audit tool aimed at identifying improvements in patient care and establishing consistent national standards.

13.3 We consider that the GOsC has responded positively to issues raised in the last review and has performed well by:

- Amending its procedures so that, with appropriate safeguards and written guidelines for staff, the presumption is that a registrant's response will be shared with a complainant before a fitness to practise case is considered by the investigating committee. We consider that this information can prevent complaints progressing unnecessarily and does enhance the investigating committee's decision making to ensure that decisions are focused on public protection
- Introducing a new performance appraisal scheme for fitness to practise committee members to ensure that members have the appropriate knowledge and skills to perform the role
- Commissioning independent research on patients' and the public's experiences of osteopathic care across the UK. The results of this work are due to be published by the middle of 2010 and are expected to inform future policy making, improve the GOsC's ability to issue timely, targeted guidance to the profession, and assist with the production of guidance information for patients and the public.

13.4 We would like to follow up on the three areas below in next year's performance review:

- The outcomes of the GOsC's patient expectations research and the subsequent action taken in light of the findings
- The impact of the measures taken by the GOsC to improve the timeliness of fitness to practise cases

- The results of the GOsC's preliminary quality assurance review in relation to the accreditation of the Osteopathic Educational Institutions (OEIs), as described in later in this report.

Standards and guidance

13.5 During the review period, the GOsC launched and promoted an extensively redeveloped website to enhance accessibility of its information to the public, patients and registrants, and to provide more information about the standards expected of osteopaths on the register.

13.6 The GOsC has this year funded significant ongoing research into the evaluation of potential risks in osteopathy. It expects to use the results to provide registrants, the public and other stakeholders with a better understanding of the potential risks associated with osteopathic care and therefore allow more informed patient choice in relation to osteopathic treatment.

13.7 The GOsC has also commissioned research into the development of a national audit tool for osteopathic practice. This will be a mechanism for identifying improvements in practice, helping to reduce patient complaints and developing local and national protocols. It is expected to contribute to patient safety by improving registrants' performance and helping to establish consistent national standards.

13.8 The GOsC continues to maintain good engagement with registrants. As part of the current review of its Code of Practice, the GOsC has engaged with registrants and professional associations through a series of six regional meetings across the UK. The aim was to explore the strengths and weaknesses of the code as identified by practitioners and to identify registrant perspectives on aspects that needed amendment. Feedback has been channeled through a GOsC working party which is currently revising the Code for re-issue in 2011.

Registration

13.9 The GOsC publishes requirements for registration, including the appeals process, both online and in paper format. A new public website has improved the accessibility of registration information for all users. Over the next two years the GOsC expects to further develop its online services to enable registrants to renew their registration online. This should provide registrants with a more efficient registration process while reducing the administrative burden on the GOsC.

13.10 The GOsC continues to ensure that registration applications are processed in line with registration service standards. The GOsC expects that its new database management system, introduced to replace a number of separate databases, will help it to continue to monitor and review its performance. The new system enhances information security, retrieval of key management data and performance monitoring. At the same time it provides a single point for the entry and retrieval of data and eliminates the risk associated with the use of separate databases.

13.11 This year the GOsC has promoted the need for the public to check that a professional is registered through distribution of the UK regulators' leaflet *Who regulates health professionals?* at all stakeholder engagement events. It also promoted the importance of checking registration status in press releases and through the GOsC Osteopathic Information (telephone) service, and has encouraged stakeholder organisations and practices to link their own websites to that of the GOsC. As a visible confirmation of registration, the GOsC provides registrants with a registration certification mark that can be used on literature and signage. The GOsC also supplies annually renewable certificates for display in practices and ID cards for identification when registrants undertake home visits or are working out of multiple practices.

13.12 We believe that the GOsC continues to protect the public by operating an effective system of monitoring and prosecuting individuals who may be using the title of osteopath unlawfully. One such individual was prosecuted in 2009. The GOsC has also recently lodged a petition for interdict in Scotland to prohibit an individual from holding himself out as entitled to practise as an osteopath.

Fitness to practise

13.13 The GOsC provides information to prospective complainants in various ways including by email, through its website, by telephone, by letter and in person. Last year, it began a customer satisfaction survey of complainants and registrants who had been through the GOsC's fitness to practise procedures. It expects that analysis of the results will help identify any necessary changes to the complaints process. We welcome this work and acknowledge that, given the low number of complaints involved, it will take some time before there is a sufficient number of responses that will allow meaningful analysis. However, we do consider that these responses should be regularly revisited to ensure that any issues requiring immediate attention can be addressed.

13.14 We welcome the GOsC's decision to amend its procedures so that, with reference to appropriate safeguards and written guidelines for staff, the presumption is that a registrant's response will be shared with a complainant prior to consideration by the investigating committee. We consider that this provides the committee with greater depth of evidence, that it enhances their decision making and should help ensure that decisions are focused on public protection.

13.15 We acknowledge that last year's introduction of a new fitness to practise infrastructure had unforeseen effects on the length of time taken to deal with fitness to practise cases. No hearings were listed towards the end of previous panelists' tenure, followed by a period when new panelists were being trained and were not immediately available. The reduction in panel size from five to three members allowed hearings to be convened more easily and additional hearings were scheduled for the first half of 2010. The GOsC will continue to monitor the flow of cases through the system to

ensure that further delays to cases are avoided. The GOsC expects to meet the service standard by August 2010.

13.16 We note that following last year's performance review and as part of a Section 60 request, the GOsC has taken steps to remove the role of independent screener from its fitness to practise processes. We had also recommended this in our recent report, *Audit of the General Osteopathic Council's initial stages of fitness to practise procedures.*[17] We believe this role could be fulfilled by the GOsC's fitness to practise team staff, and that such a change would reduce the time taken to conclude fitness to practise cases.

13.17 The GOsC has shown improvement by introducing an assessment and appraisal scheme for fitness to practise panel members that includes peer review. We note the introduction of feedback forms used by panel chairs to assess the performance of legal advisors. We believe these measures should help ensure that panelists are performing to the required standard and that their decision making is sound, proportionate and provides the necessary level of public protection.

Education and training

13.18 We consider that the GOsC has good levels of engagement with students and Osteopathic Educational Institutions (OEIs). For example, it gives presentations to students at various points in their training. These presentations are used to reinforce the importance of patient safety through the use of case studies based on themes identified in fitness to practise cases.

13.19 As stated in last year's report, the GOsC does not have a separate code of practice for students, who are expected to comply with the code of practice developed for registrants. However, we note that the GOsC has considered this matter in 2009/10. It worked with the GMC on a student fitness to practise seminar for OEI representatives. The aim was to identify areas of respective responsibility for student fitness to practise and how these might be jointly addressed by the GOsC and the OEIs. Later in 2010, the GOsC and the OEIs will give further consideration to the development of specific student fitness to practise guidance in the light of the seminar. The objective is to enhance public protection and safety by ensuring that fitness to practise issues are appropriately addressed prior to student entry onto the GOsC registers.

13.20 We note that the GOsC has asked for a change in legislation to allow accreditation of educational institutions, as well as individual courses. It believes that this would encourage OEIs to employ effective quality management systems in order to comply with the GOsC's accreditation requirements, and would also allow the GOsC greater flexibility to apply the appropriate scrutiny measures. We understand that the major review is

[17] CHRE 2010, *Audit of the General Osteopathic Council's initial stages of fitness to practise procedures*. London: CHRE.

due to start in April 2011, in accordance with the GOsC'S corporate plan. However, we also acknowledge that the GOsC is currently undertaking a preliminary quality assurance review which is considering improvements that do not require statutory change. This includes; a review and update of the GOsC'S policy and the aims of the quality assurance process; a review and streamlining of operational processes to ensure GOsC aims are delivered; a review and improvement of the requirements of the annual OEI report, and a review of the competencies and training of visitors that conduct quality assurance reviews. All streams include the need to incorporate patient involvement and views.

13.21 We acknowledge that as part of its quality assurance process, the GOsC considers patient feedback gathered by OEIs, and that visiting teams explore the processes that OEIs have in place to gather and respond to patients' views. We acknowledge the GOsC's consideration of more extensive and direct ways of incorporating patient perspectives into quality assurance processes regarding student education, as referred to in the previous paragraph. We consider that it is appropriate that patient involvement is reflected in the design and delivery of education programmes and that any evaluation of courses takes the views of patients into account.

Governance and external relations

13.22 The GOsC has continued to respond constructively to regulatory reform. It believes that, to date, the changes in structure and membership of the Council implemented in April 2009 appear to be working well. A key advantage is that the new members have a diverse skills base to draw upon in areas such as clinical, financial and consumer affairs, which should enable more rounded decision making. Agendas and minutes of Council meetings are published on the GOsC website, while a summary of decisions taken is published in *The Osteopath* on a bi-monthly basis.

13.23 The GOsC co-operates readily with other regulators and stakeholders in the UK and abroad. In the past year, the GOsC has used its influence in the Forum for Osteopathic Regulation in Europe (FORE) to strengthen ties with the European Federation of Osteopaths. This culminated in the signing of a Memorandum of Understanding in September 2009, which outlines each organisation's commitment to work with the other to promote the regulation of osteopathy throughout Europe. The GOsC's current work with FORE centres around the possible development of pan-European standards of osteopathy. The aim is to ensure that any agreed European standards prioritise patient safety and interests and reflect those of the GOsC.

13.24 The GOsC has engaged a specialist consultant to assist in a review of its equality scheme. As part of this work, it recently held two disability involvement forums for osteopaths, students and patients. The aim was to highlight any areas where the equality scheme might need strengthening in relation to the GOsC's disability equality duties. We are encouraged by this approach and look forward to seeing the outcomes of this work.

14. The Health Professions Council (HPC)

Overall assessment

14.1 The **Health Professions Council** regulates **15** professions: arts therapists, biomedical scientists, chiropodists/podiatrists, clinical scientists, dieticians, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, prosthetists/orthotists, radiographers, speech and language therapists and practitioner psychologists. It has **205,311** current registrants and received **13,668** new registration applications since the last performance review. The HPC has an annual retention fee of **£76**.The HPC is responsible for the quality assurance of the training of health professionals at **126** educational institutions. The HPC became the health regulator for a fifthteenth profession – hearing aid dispensers – from 1 April 2010.

14.2 The Health Professions Council is a well organised, efficient and cost-effective regulator. This has helped it maintain a good performance during a year that saw it assume responsibility for two further professions – practitioner psychologists and private hearing aid dispensers. We acknowledge the significant amount of work that the HPC has undertaken to ensure a smooth transition to statutory regulation for these professions including its communications with:

- Applicants about the need to register with the HPC and the standards that they have to meet
- Employers and patients about the importance of checking that a professional is registered.

14.3 In last year's report we highlighted three areas where we wished to consider progress:

- The outcomes of the research into complainants' expectations. We are pleased with the plans that the HPC has developed in light of the findings of this research. This includes providing complainants with clearer information on the key points of the fitness to practise process, the potential outcomes at each decision point and the likely length of time each step will take
- Sharing a registrant's response with a complainant prior to consideration of the case by the investigating committee. We are disappointed with the HPC's fitness to practise committee's decision to continue not to share a registrant's response with a complainant unless there are exceptional circumstances. Our view that there should be a presumption to share the response with the complainant was supported in the research the HPC commissioned on complainants' expectations. We consider that this information can prevent complaints progressing unnecessarily and does enhance the investigating committee's decision making to ensure that decisions are focused on public protection
- Patient involvement in the assessments of education providers. We are pleased that the HPC undertook research on whether patients and students should be on its visitor panels and whether its current approach of encouraging education providers to provide evidence of

how they have involved service users in their work should be made compulsory. The outcomes of this research and ways in which it could be taken forward are currently being considered by the HPC's education committee.

14.4 In next year's review, we would like to see progress in the following areas:

- Patient involvement in the assessments of education providers
- Implementing improvements to the fitness to practise process as a result of research into complainants' expectations.

Standards and guidance

14.5 The HPC has assumed responsibility for practitioner psychologists and private hearing aid dispensers this year. We acknowledge the work that has been undertaken in communicating the standards that registrants have to meet to individual professionals and employers.

14.6 We note that the regulation of these professions has increased the diversity of settings in which the HPC's registrants practise. The HPC has confirmed that it is aware of the need to meet the ongoing challenge of communicating with a broad range of registrants, some of whom do not work in traditional health settings nor consider themselves to be health professionals (eg sports and exercise psychologists). It will do this in a variety of ways including engagement with employers and attending registrant events. We note that this challenge may be compounded as the HPC has consulted on assuming responsibility for the statutory regulation of a further three professions – dance movement therapists, psychotherapists and counsellors – which will extend the diversity of settings further. We consider it important for public protection that the HPC meets this challenge.

14.7 The HPC has developed a dedicated area on its website for students, trainees and those working on approved programmes. The area includes information on applying for registration and an audio visual presentation on the role of the HPC, information on regulation and details of how to apply and stay registered with the HPC. Powerpoint slides and handouts have been produced to allow the education providers to deliver the information in their own style. We consider this development to be a sensible and pragmatic way to disseminate information to a wide range of students across 237 approved programmes.

14.8 The HPC has established arrangements to learn from its audits of continuing professional development (CPD) profiles. It has, based on statistical advice, reduced the audit sample size from five per cent to two and a half per cent. Statistical consultants were recruited to help it identify areas of potential CPD non-compliance and how the CPD audits might be changed to address these areas. The HPC is also gathering learning directly from registrants in a variety of ways.

14.9 Through the audits, the HPC also identified a small number of registrants who had used a third party to write their CPD profile on their behalf. As a

result, it consulted and made a minor change to its CPD standards. The change to standard five ensures that registrants participate in audits in good faith, prioritising public protection. We consider that this, and the arrangements set out above, demonstrates that the HPC is taking an agile, risk-based and proportionate approach to CPD.

Registration

14.10 The HPC has continued to improve its performance in this function in many ways. It has distributed letters to registrants and information and posters through professional body networks to remind registrants about the importance of renewal. It has also implemented processes to ensure it has tried to contact registrants in a variety of ways including through their employers to remind them of the need to renew their registration. The HPC has seen a record number of registrants successfully renew their registration. We are pleased with the success of this work because of the implications for public safety if a registrant allows their registration to lapse but continues to treat patients.

14.11 As well as improving registrant renewal rates, we are pleased that the HPC has looked to improve the integrity of its register. It is about to conduct a fraud management exercise to validate the qualifications declared on the register. Through this, the HPC should be able to identify any cases of fraud as well as opportunities to reduce the risk of fraudulent applications. We agree with the HPC that this is important work to ensure fraudulent entries to the register are prevented or identified and appropriately dealt with. Furthermore, the HPC's online registration renewals process is now in place. This should reduce the risk for erroneous entries to the register.

14.12 The HPC has consulted on the removal of a health reference as a requirement for registration. This is line with our recommendation[18] that regulators consider the most proportionate means of ascertaining the information that they need to determine whether those seeking entry to the register are fit to practise. We are pleased with this development which could help prevent people with disabilities or long term conditions being deterred from pursuing a career in a regulated health profession.

14.13 As the HPC has initiated a number of improvements to its registration process, it has commissioned research to gain an in-depth insight into the overall customer service experience from a registrant's viewpoint. We would be interested to see the results of this research.

14.14 The HPC has reviewed and refreshed its public information leaflet using feedback from the communications disability network Connect and the Plain English Campaign. The leaflet outlines the importance of using a registered health professional and checking the register. The leaflet has been widely distributed. The HPC has also undertaken a consumer media campaign to raise awareness of the opening of the register to practitioner

[18] CHRE, 2009. *Health Conditions: report to the four UK health departments*. London: CHRE. [page 16]

psychologists. We see this work as important for public protection, particularly given the diverse nature of the HPC's registrants.

Fitness to practise

14.15 We are pleased with the HPC's plans to enhance communications with complainants. These include providing complainants with clearer information on the key points of the fitness to practise process, the potential outcomes at each decision point and the likely length of time involved at each step. It has also appointed a case and witness liaison manager who is the dedicated contact for witnesses. This role is important for public protection, as witnesses are very important in the resolution of fitness to practise cases.

14.16 As well as looking to improve its communications with complainants, the HPC has also continued to engage effectively with employers this year. For example, it has held employer events across the four UK countries and developed relationships with employers of practitioner psychologists, particularly with the National Offender Management Service, the largest employer of forensic psychologists.

14.17 In addition to developing new processes, the HPC has undertaken a number of improvement programmes this year. It has reviewed those fitness to practise cases that result in 'no case to answer' or 'not well founded' decisions to identify learning, it has updated its practice notes and indicative sanctions policy, it is planning to improve its literature for witnesses and has continued to implement a new case management system. We are pleased with the HPC's focus on continuous improvement.

14.18 However, we are disappointed that the HPC's fitness to practise committee decided, against our published advice,[19] to continue not to share a registrant's response with a complainant unless there are exceptional circumstances. We consider that there should be a presumption to share the response with the complainant although comments of a personal nature not relevant to the case, details that reveal the identity of a whistleblower, or reference to sensitive personal information about the registrant (eg their health or finances), should not be shared. This view was supported in the research commissioned by the HPC on complainant expectations. We consider that this information can prevent complaints progressing unnecessarily and does enhance the investigating committee's decision making to ensure that decisions are focused on public protection.

14.19 The HPC has proposed mechanisms to audit its fitness to practise panels' decisions. Decisions will be reviewed for adherence to the applicable law and to HPC policy in a given area. As such, it is an audit of decision making within the reasonable range of decisions open to panels, rather than of the quality of the decision. Any concerns will be raised with the

[19] CHRE, 2009. *Handling Complaints: sharing a registrant's response with a complainant*. London: CHRE.

panels concerned, and may be taken into account through the appraisal process or covered in training sessions or through the quarterly fitness to practise newsletter to panel members. We recognise that the HPC avoids any action that may appear to influence its panels. However, we consider that decision-making would be improved if the quality of the decision was also audited. This would have obvious benefits for public protection.

Education and training

14.20 The HPC's revised standards of education and training became effective in the 2009/10 academic year. We welcome these changes, which strengthen the standards' focus on patient safety; the standards are more clearly linked to the requirements for entry to the register, positively support the importance of independent and inter-professional working and require processes to be in place to manage a student's poor conduct. These changes have been communicated to education providers in a variety of ways.

14.21 The HPC has published its *Guidance on Conduct and Ethics for Students*. The guidance has been designed to set out students' personal responsibility for their own behaviour. It also provides education providers with guidance on admissions and on dealing with the poor conduct of students. Management of students' fitness to practise is now mandatory for education providers. We are pleased with this development which highlights the importance of professionalism at the earliest stage of a student's career.

14.22 As the HPC assumed responsibility for practitioner psychologists it had to agree an approach for the approval process for pre-registration education programmes. It has decided to take a risk based approach which involves all programmes having an approval visit within the next three years, with those that were in the process of being assessed by the British Psychological Society considered immediately. This seems to be a proportionate response.

14.23 Following last year's review, we note that the HPC undertook research on whether its visitor panels should include patients and students and whether its current approach of encouraging education providers to provide evidence of how they have involved service users in their work should be made compulsory. The outcomes of this research and ways in which this work could be taken forward are currently being considered by the HPC's education committee. We consider that it is appropriate that patient involvement is reflected in the design and delivery of education programmes and that any evaluation of courses takes the views of patients into account.

Governance and external relations

14.24 The HPC has undertaken a collective review of its new Council's performance. The impact of the change to a smaller, more board-like Council has been reported as positive both by members and the executive. The smaller number of Council members seems to have facilitated greater

participation of members, as all committees are comprised of Council members. We understand that this has increased the Council's overall understanding of the performance of the HPC and as the HPC retained 60 per cent of its former Council membership there has been no great loss of corporate memory. We are encouraged by this feedback.

14.25 We recognise that the HPC has continued to learn from its own activities and from external information. Following the publication of our report to the Secretary of State on the General Social Care Council[20] in September 2009, the HPC considered its own position in relation to the issues raised in the report and considered whether it needed to take any action. It has also learnt from the complaints it receives. For example, the introduction of an online renewal system was a result of complaints about the reliance of the renewals process on the postal system.

14.26 The HPC has co-operated with organisations with a common interest. It is looking to work with the British Psychological Society to raise awareness of the regulation of sports and exercise psychologists. We are supportive of this work as there are potential public protection risks related to unqualified psychologists working in this area. It is also currently discussing arrangements for the exchange of information about fitness to practise cases with the Isle of Man government. We consider that there are clear public protection benefits to these arrangements being finalised.

15. The Nursing and Midwifery Council (NMC)

Overall assessment

15.1 The **Nursing and Midwifery Council** regulates **two** professions: nurses and midwives. It has **665,599** current registrants and received **29,403** new registration applications during the review period. The NMC has an annual retention fee of **£76**. The NMC is responsible for the quality assurance of nursing and midwifery training at **84** educational institutions.

15.2 The Nursing and Midwifery Council continues to maintain good performance across a number of its functions including the development and communication of its standards and the efficient processing of registration applications. We consider it continues to make progress in those areas of weakness identified in our *Special Report for the Minister of State for Health Services*[21] particularly in relation to case progression. However, we remain concerned about the customer service provided by the fitness to practise department and the quality and consistency

[20] CHRE, 2009. *Report and Recommendations to the Secretary of State for Health on the Conduct Function of the General Social Care Council*. London: CHRE.

[21] CHRE, 2008. *Special Report to the Minister of State for Health Services on the Nursing and Midwifery Council*. London: CHRE.

of decisions made and recorded by fitness to practise panels. We also comment on some details of governance within this report.

15.3 In last year's review we highlighted eight areas where we wished to see progress. We are satisfied with the progress made in the following areas:

- The collection of ethnicity and diversity data. A data collection exercise has commenced and all existing nurses and midwives will have been asked to complete a questionnaire by July 2010
- A further reduction in the time taken to process fitness to practise cases, particularly those which had been awaiting a hearing for over nine months. Although we have some concerns regarding the timeliness of cases considered at the investigation committee stage, we have seen significant reductions in the time taken for cases to progress through the fitness to practise process and in the number of cases waiting more than nine months for a hearing
- The complete implementation of an IT based case management system. The system was implemented in December 2009, after considerable delay. We note that the NMC did keep its stakeholders informed of this delay and took steps to progress the implementation as quickly as it could. The new system appears to meet the NMC's requirements and we now expect that the NMC will be able to make significant progress in its fitness to practise casework
- The development of an internal quality assurance team in the fitness to practise department. A quality assurance manager and a head of service improvement were appointed earlier this year. We look forward to seeing the outcomes of their work
- The publication of a fitness to practise disclosure policy. The NMC has now published a fitness to practise disclosure policy
- Further improvement to stakeholder engagement. As set out in this report, we have seen that the NMC has extensively engaged with its stakeholders across a wide range of its activities.

15.4 We consider that there is still room for improvement in the following areas and we will want to see progress next year:

- An improvement in the consistency and quality of decisions made and recorded by final fitness to practise committees. We note that the NMC is reviewing its current recruitment processes and has implemented a new appraisal process to ensure that it engages panelists with the right skills and abilities. It has also commissioned a baseline assessment of its hearings process which is looking at the consistency and quality of its case presentation, legal assessment and panel decision making processes
- Further improvements in the culture of customer focus and in the content and use of standard letters by the fitness to practise department. The NMC acknowledges that it has not made the progress it would have liked on improving its customer focus in terms of the quality of its correspondence or the responsiveness of staff. We note that the NMC has established a review all of its fitness to practise correspondence. It is also considering how to understand its current

performance in relation to customer service and how to manage ongoing customer satisfaction.

15.5 We would also like to see evidence of progress in the following areas:

- The outcomes of the internal audits and reviews of the NMC's fitness to practise hearing processes and fitness to practise decisions
- Progress on wider public involvement in the quality assurance of education providers
- Implementation of a complaint process across the organisation
- Implementation of information governance and assurance arrangements to protect personal data.

Standards and guidance

15.6 The development and communication of standards continues to be an area of strength for the NMC. It has undertaken significant work this year on developing new or revised advice sheets, publishing updated guidance on matters such as record keeping and reviewing its standards and rules relating to midwives. It has also looked to build on the success of its *Guidance for the Care of Older People* by exploring how it can guide nurses and midwives in their approach to the care of other patient groups. We are pleased with the wide-ranging programme of work which looks to ensure that nurses and midwives are adequately supported in their practice and are able to protect the public.

15.7 In the development and revision of standards, the NMC has actively engaged with its stakeholders. We consider that this should make the standards more robust and focused on the needs of the relevant stakeholders. On the revision of the *Midwives rules and standards*, the NMC has informally consulted on how the rules and standards currently work, held a telephone survey of midwives, met with a variety of women's groups, established a user group of interested parties and an advisory group of professionals to advise on practice related issues.

15.8 The NMC has maintained its strong commitment to communicating its standards in a variety of ways. For example, it has established a page on Facebook which provides a discussion forum for registrants, held roadshows on the revised *Code – standards of conduct for performance and ethics for nurses and midwives*, which were designed to raise awareness of the code and help nurses and midwives to embed it in practice, launched a new quarterly publication for its registrants and worked with a variety of partners to disseminate its leaflet *Support for Parents: how supervision and supervisors of midwives can help you*. We consider that this work should enable the NMC to reach a wide audience and ensure the registrants and the public are aware of the standards.

15.9 We are pleased that the NMC has also evaluated the effectiveness of its work in this area. We consider it is important for regulators to check the quality of their work with registrants to ensure user confidence and the usability of the standards and guidance. As an example of this work, an

on-line evaluation on the *Standards for Medicines Management* found that the standards were easy to understand and that it was helpful to have the information in one document. The NMC has also undertaken work to gauge awareness of its revised code; it has used polls on its website and invited nurses and midwives to tell it about how the code has affected their practice.

15.10 The NMC has undertaken a review of its framework for Local Supervising Authorities (LSAs) to drive up the quality of the oversight of midwives. There has been improvement in the LSAs' reporting of significant incidents and other management data to the NMC, which should ensure that the NMC can respond more quickly to issues where appropriate. It also improves the transparency and consistency of approach, amongst LSAs that are investigating serious incidents in the maternity services, in identifying how midwives can be supported to improve their practice or, where necessary, speedily referring them to the NMC. We consider this work is important to ensure the safety of women and families who use maternity services.

15.11 The NMC does not audit registrants' continuing professional development (CPD) portfolios. It believes that the most effective way to improve public protection is to focus its resources on establishing a system of revalidation. As part of its revalidation work, it is looking at what evidence would be required to audit outcome based CPD in terms of professional development value rather than auditing what professional development has been undertaken. We agree with this approach to auditing CPD portfolios as public protection is only enhanced if the learning undertaken actually helps the registrant to improve their ability to practise safely and effectively.

Registration

15.12 The NMC has maintained good performance in its registration department in terms of processing and checking registration applications. There were some difficulties as a result of the postal strike but the NMC did take steps to address the implications of this disruption. It has continued to detect fraudulent applications and is confident that using the European Internal Market Information system has contributed to reducing the risk of fraudulent applications. This system allows authorised users to communicate electronically regarding a health practitioner and to share information quickly regarding suitability for registration. We are pleased with this development as it appears to have had a real impact on helping the NMC protect the public.

15.13 Alongside using a system to improve information exchange across Europe, the NMC is looking to share its registration status information directly with the NHS in England and Wales through the electronic staff record system. This should be in place by the end of 2010. We agree that this will be beneficial to employers in the NHS who regularly need to check the status of large numbers of nurses and midwives. We also consider that it enhances public protection because employers have immediate and quick access through their own systems to this information.

15.14 The NMC has focused its resources on publicising to employers the importance of checking the register. It has done this through its fitness to practise roadshows, conferences and other events. At these events the NMC raised awareness of the need for employers to use its confirmation service as a routine part of their employment practices. The NMC will ensure that the register checking facility is made a prominent part of its new website and will also remind independent midwives to ensure that they are transparent about the need for their clients to check their registration status. We agree with the NMC's approach on this matter which should address the needs of its stakeholders and ensure that the public is protected.

15.15 We are pleased that the NMC has progressed its programme on diversity data collection, which began in July 2009. By July 2010, it will have contacted all existing nurses and midwives to ask them to complete a diversity questionnaire. The NMC will report on this work later this year and we look forward to seeing the results of this exercise. This should help the NMC to assure itself that its procedures demonstrate best equality and diversity practice.

Fitness to practise

15.16 Last year, we reported that we were satisfied with the rate of progress made by the NMC to address the issues identified in our special report. It had moved to new purpose-built premises, was able to produce more accurate management data, was developing an IT based case management system, had made some improvements to the efficiency of case progression and was working towards a more customer-focused culture.

15.17 This year we consider that the NMC has continued to make progress on improving the areas of administrative weakness but we are disappointed on the progress made in terms of its customer focus and the quality and consistency of the decisions made and recorded by final fitness to practise committees.

15.18 The NMC's IT based case management system was originally scheduled to be integrated into the fitness to practise department by June 2009. However, delays occurred and the NMC sent a team to work with the suppliers to progress the implementation of the system as quickly as it could. The NMC kept CHRE and its other stakeholders updated on progress. Following extensive testing, the system was finally implemented on 14 December 2009. The system manages cases from initial receipt through to substantive hearings. We would expect the NMC to be able to demonstrate a substantive improvement in quality and process compliance now the system has been successfully implemented. We acknowledge that this delay has impacted on the NMC's ability to improve its customer service.

15.19 The NMC has made great progress on improving the overall efficiency of its case progression. Although it has missed its target to conclude 75 per

cent of cases within 15 months of receipt by the end of 2009/10, we are pleased with the improvement shown in that 66.4 per cent of cases were concluded within that timeframe and that on average it takes 15 months to conclude a case (figures from April to December). We would expect the percentage of cases to be concluded within 15 months to rise with the implementation of its case management system. We note that those cases waiting for over nine months for a hearing has also reduced from 137 to 10. We recognise that the NMC has implemented a number of initiatives to enable this improvement, such as increasing the number of panelists and holding management and staff review meetings.

15.20 However, we do have some concerns that while delays between referral and hearing have reduced, there has not be a similar improvement in those cases being considered and decided upon at the investigating committee stage. We acknowledge that the NMC is working with its external legal advisers to manage this part of the process better and has doubled the number of investigating committee meetings held since January 2010. We consider that it is important to improve the efficiency of this stage to ensure fairness to all parties and to enhance public protection by progressing appropriate cases to a final fitness to practise hearing promptly.

15.21 The NMC acknowledges that it has not made the progress it would have liked on improving its customer focus in terms of the quality of its correspondence or the responsiveness of staff. It notes that redirection of staff to test and train on its case management system had an adverse effect on its responsiveness to letters and telephone calls from parties to fitness to practise cases. However, as it has improved case efficiency and implemented its case management system, it will now focus on customer service. We hope that the NMC will be able to effectively manage efficient case progression and improve customer service as a joint enterprise over this year.

15.22 We note that staff have been trained in plain English and external letter writing skills and that letters to fitness to practise parties at each stage of the process now indicate how long each stage will take. We are pleased that in addition the NMC has established a review all of its fitness to practise correspondence. We hope that this will enhance the tone, quality and clarity of its correspondence.

15.23 We are also pleased that the NMC is considering how to understand its current performance in relation to customer service and how to manage ongoing customer satisfaction. It must be recognised that good customer service instils confidence in the system as a whole. The NMC is developing customer service standards and will consult on these with relevant stakeholders to ensure that they are meaningful. It is also considering recording telephone calls for the purpose of monitoring, training and development. Whilst we would not discourage the NMC from using these sophisticated options, we note that customer service can be improved purely by responding appropriately to correspondence and telephone calls.

15.24 The NMC has undertaken work to understand the needs of employers, witnesses and the public. It commissioned research to understand the views of those who had recently been through the fitness to practise process. It has also held employer roadshows and a workshop for representatives from complaints services and patient helplines. These had two purposes: to enable the NMC to understand the needs of stakeholders and to disseminate information on how and when to refer cases and what happens following a referral. This work was one of a number of triggers that resulted in the NMC inviting every head of human resources, director of nursing and director of midwifery to a learning event designed to provide them with an overview of key areas of interest, including fitness to practise. It also resulted in a new leaflet being drafted for employers and three for witnesses. We consider that these leaflets are a helpful way to communicate with key stakeholders and to provide useful information such as timeframes of case progression. However, we have some concerns about the leaflet for employers which we consider could discourage referrals and place the onus of investigation on the employers themselves. We consider that this could damage public protection.

15.25 The NMC does take account of the feedback that it receives on its work. We are pleased with its responses to a number of issues. In response to our audit of initial stages of fitness to practise it is reviewing its triage process to make a number of improvements. These include improved guidelines for staff to use when making decisions about what matters should be not referred to the investigating committee, use of clinical assessors in this decision making and improving its advice on when to refer cases for consideration for an interim order. It has also addressed the perception issue reported to us by registrant representatives of the set up of the hearings room. It has separated the council officer and legal assessor from the panel members to ensure it is clear that they do not work together. We are also pleased that the NMC's fitness to practise committee has agreed, in principle, that the registrant's response should be shared with the complainant. We understand that the NMC is currently considering how to implement this change in policy.

15.26 We are supportive of the NMC's active approach to potential fitness to practise cases. It does not want to continue to rely on cases being brought to its attention and has begun exploring processes to capture, record and use intelligence to intervene in future cases of systematic failure such as that seen at Mid Staffordshire NHS Foundation Trust.

15.27 We have concerns about the quality of the NMC's decision making and recorded decisions. We note that the NMC is reviewing its current recruitment processes to ensure that it engages panelists with the right skills and abilities. It is implementing a new appraisal system which should enable areas in need of improvement to be addressed. It is also producing a drafting tool to help panelists draft consistent and clear reasons for their decisions. We consider this work to be important to maintaining public confidence in the NMC as an effective regulator and look forward to seeing the outcomes next year.

15.28 As well as improving its panelists, we are pleased that the NMC is looking to review the quality of its decisions through other means. It has commissioned a baseline assessment of its hearings process which is looking at the consistency and quality of its case presentation, legal assessment and panel decision making processes. The quality assurance manager is also reviewing cases that have been closed, at the initial stage, within the last year to identify further improvements and any emerging issues. Finally, the NMC has implemented arrangements to record, analyse and report on critical events. The quality assurance manager will undertake a cause and effect analysis of the events and identify any action/learning points to reduce the risk of recurrence. We consider that this work is vital in enhancing the quality of the NMC's work and process compliance. We will look to see progress on this area next year.

Education and training

15.29 We acknowledge that the NMC has continued its significant work programme on the revision of its pre-registration nursing education. Amongst other things, the NMC has developed a new competency framework for pre-registration nursing. This sets out the knowledge, skills and attitudes that all nurses need to demonstrate at the point of registration. It is also developing new teaching, learning and assessment requirements for pre-registraton nursing education programmes. Ultimately, this work should result in improved outcomes for nursing education which will benefit patients.

15.30 We are pleased with the extensive stakeholder engagement during the review of pre-registration nursing education. We consider that this should ensure that the standards are comprehensive and focused on patient centred care. The engagement has been achieved in many ways including through project groups with stakeholder representation and an e-portal to facilitate participation in the development of this work. The NMC has engaged with specific patient groups (adult, children, mental health and learning disabilities) in partnership with organisations such as Mencap and the Alzheimer's Society. It has held focus groups and designed surveys specifically for patients and their carers within the four patient groups.

15.31 The NMC held a launch event in Liverpool on its *Guidance on professional conduct for nursing and midwifery students*. The launch was supported by an article in *NMC News* and the establishment of a website page specifically for students. The guidance was also circulated to all education providers and to students through the new student magazine *&YOU* which gave case studies and explanations about how the guidance should be used. We consider that engagement with students about the significance of professionalism is key to ensuring that they are aware of its importance. Alongside this, we are pleased that the NMC has monitored the use of student fitness to practise panels and is satisfied that they are well established, functioning effectively and protecting the public.

15.32 The NMC managed an adverse incident this year, following reports of poor standards of care and treatment being provided at a teaching hospital,

Basildon and Thurrock University Hospitals NHS Foundation Trust. We note that the NMC took an active approach to this issue. It visited the hospital and reviewed arrangements in place for practice based learning. The NMC found that the Trust had already put in place a number of measures since the adverse reports and that generally student nurses and midwives were not at risk of being exposed to poor practice. The report on this review was published in March 2010.[22]

15.33 The NMC still takes a different approach than other regulators to the quality assurance of pre-registration education providers. The NMC considers that this has driven up standards and that it is a proportionate and risk based process but we remain concerned about whether it is necessary to achieve the outcome of nurses leaving training fit for registration. We are pleased that the NMC has facilitated the sharing of good practice regarding patient involvement in the design and delivery of education programmes.

Governance and external relations

15.34 The NMC is carrying out a review of its governance structure. It is looking at the nature, format and frequency of its Council and committee meetings. In relation to observer involvement, it has decided not to allow the public the opportunity to ask questions at its meetings. As an alternative it is looking at how it can gather their feedback on papers through a dedicated question and answer session after meetings and a dedicated email service. While we acknowledge that the NMC believes that it is not appropriate for observers to raise matters at Council meetings, we consider that this could lead to a perception that it is not a transparent organisation and not willing to be held to account in a minuted meeting.

15.35 We are pleased that the NMC has generally continued to improve its stakeholder engagement. This includes ensuring stakeholder involvement in the development and revision of standards, meetings being held with individual stakeholders such as a workshop for members of the traveller community, and events at which the NMC both imparted information and sought to gain learning from its stakeholders. In 2009, the NMC also established its devolved dialogue programme. The main purpose of this is to gather intelligence about changing priorities within the devolved administrations, how these differ in each country and to develop better relationships to ensure that the NMC is discharging its duties appropriately across the UK. We consider that this work will enhance the ability of the NMC to work as an effective regulator.

15.36 The NMC commissioned market research with registrants, the public, employers and educators to find out about their perceptions of NMC and its role. The NMC will take the learning from this research and use it to inform its communications and marketing strategy. It is also establishing a formal structure to evaluate its stakeholder engagement work to ascertain

[22] NMC, 2009. *Nursing and Midwifery Council Report on the Extraordinary Review of Pre-registration Nursing (Adult) Education and the Maternity Services at Basildon and Thurrock University Hospitals NHS Foundation Trust*. London: NMC.

its benefits and the impact of the involvement. We would be interested to see the outcome of this work.

15.37 The NMC has implemented its new procedure for dealing with complaints and feedback about its services. As a first step it is tracking the complaints received by the office of the chief executive and chair. The NMC has recorded over 108 complaints so far (from April to December 2009) and is responding to over 75 per cent of the complaints within 20 working days. It is currently considering how to broaden its approach to ensure that feedback and complaints received across the organisation are appropriately recorded, dealt with and, where necessary, learnt from. From feedback we received from complainants about difficulties in accessing a formal complaints process and delays in receiving responses, particularly in relation to complaints raised within the fitness to practise department, we consider that these arrangements should be put in place as a matter of urgency to ensure that public confidence in the NMC is maintained.

15.38 An internal audit of the NMC's personal data security described the assurance level as 'adequate in most respects but needing further refinement to fully safeguard the NMC'. In response to this, the NMC has begun work on the revision of its information governance and security arrangements. We would support the need for the prompt undertaking of this work as we have received feedback about confidential papers being mislaid or sent to the wrong parties.

16. The Pharmaceutical Society of Northern Ireland (PSNI)

Overall assessment

16.1 The **Pharmaceutical Society of Northern Ireland** regulates **one** profession: pharmacists in Northern Ireland. It has **2,060** current registrants and received **163** new registration applications since the last review. The PSNI has an annual retention fee of **£372**. The PSNI is responsible for the quality assurance of pharmaceutical training at **two** educational institutions.

16.2 The Pharmaceutical Society of Northern Ireland has continued to perform well in the last year even though legislative constraints still limit its ability to meet some of our minimum requirements. In particular, we consider it has responded positively to the issues raised in the previous performance review. It has:

- Improved its communication with its stakeholders on the importance of checking a professional is registered. For example, it has written directly to employers and produced and disseminated a public information leaflet

- Increased the use of its Public Forum. The Forum has participated in standards development, the drafting of new legislation and improving the usability of PSNI's register
- Published assessment reports on the education providers and the accreditation process for education institutions on its website
- Published 'frequently asked questions' about its disclosure policy and a specific disclosure policy for complainants and registrants on its website
- Maintained a satisfactory level of equality and diversity data collection
- Achieved significant progress in the separation of its regulatory and professional functions through the creation of a professional forum. The PSNI will take account of advice from its professional and public forum whilst having a Council that is focused solely on public protection.

16.3 The PSNI is still hindered in its ability to act as an effective regulator by its outdated legislative framework. Whilst progress has been made in drafting improvements to the legislation since May 2008, when support was given by the Northern Ireland Assembly for the PSNI's legislation to be updated, an agreed draft of the legislation has yet to be laid before the Assembly. We note, however, that primary legislation is necessary to achieve all the changes that are required.

16.4 Furthermore the PSNI is now the only remaining regulator to retain both professional and regulatory responsibilities for its profession, since the establishment of the General Pharmaceutical Council (GPhC) which will assume its statutory responsibilities in summer 2010 (replacing the Royal Pharmaceutical Society of Great Britain's (RPSGB's) regulatory role). We continue to consider that the regulatory framework for pharmacists in Northern Ireland needs to be modernised.

16.5 We would like to follow up on the following three areas next year:
- The continued progress on the separation of the PSNI's regulatory and professional functions
- The PSNI's approach to managing its education function after the establishment of the GPhC
- The progress made on modernising the PSNI's regulatory framework.

Standards and guidance

16.6 The PSNI has produced its own guidance this year as well as that developed in conjunction with the RPSGB. The motivation for the development of the standards and guidance documents has been patient safety. For example, the work with RPSGB to develop a student code of conduct and fitness to practise guidance was taken forward to ensure fitness to practise issues were appropriately addressed prior to entry onto the regulators' registers.

16.7 In the development of the standards and guidance, the PSNI has achieved a good level of involvement with its Public Forum. For example, when drafting the standards supporting the Responsible Pharmacists

regulations, members contributed useful patient perceptions about the difficulty in understanding the different qualifications of those working in a pharmacy (counter assistants, technicians, pharmacists and responsible pharmacists). These comments will also inform ongoing standards development.

16.8 We are pleased that the PSNI has now endorsed our guidance, *Clear Sexual Boundaries Between Healthcare Professionals and Patients: responsibilities of healthcare professionals*, and has developed a supplementary note to help pharmacists apply the guidance in the context of pharmacy practice. It is clearly important that pharmacists understand that it is their responsibility to maintain professional relationships with patients for the purposes of public protection, particularly in light of the growing clinical role of the profession.

16.9 In last year's report we highlighted that we wanted to see the progress the PSNI had made on its stakeholder engagement. We consider it is important that PSNI ensures its work meets the needs of its stakeholders and that the stakeholders are aware of the standards that pharmacists in Northern Ireland should meet. We are pleased with the efforts the PSNI has made over the last year. It has worked hard to develop relationships with public advocacy groups. It has met with a number of groups to discuss and take views on pharmacy regulation. Through the Pharmacy Network Group it is also able to have similar discussions with a large section of the pharmacist employers including the Regional Health Board. It has also published its revised *Code of Ethics* and accompanying standards and guidance. The documents were launched at a public event which was attended by the Northern Ireland Health Minister and a wide number of public bodies and achieved significant media coverage.

16.10 The PSNI has continued to improve the public protection focus of its continuing professional development (CPD) system. It now requires all registrants to reflect and record how they believe their documented CPD cycle has improved their ability to protect the public. The PSNI's CPD system will be a significant component of its revalidation process. With this aim in mind, we note that the PSNI provides both descriptive and numerical assessments on each CPD profile to help its registrants understand how they are performing.

Registration

16.11 The PSNI has maintained its performance in managing an efficient, well defined and accessible registration process. It has seen a reduction in the number of errors in submitted registration forms and a reduction in calls and enquiries about the process. It is also continuing to reduce the time taken to process the registration forms.

16.12 We are pleased that the PSNI has enhanced the fairness of its registration process. It has removed the mandatory requirement for those who did not qualify in Northern Ireland to attend a meeting with the regulator. It is arguably unfair to enforce such a meeting when a similar arrangement is

not in place for those who qualified in Northern Ireland but wish to register with the RPSGB. This is particularly true when the issues the meeting addresses can be dealt with through other registration processes.

16.13 As part of its process to prevent fraudulent applications, we note that the PSNI is taking steps to extend the requirement for photographic identification to pre-registration trainees. We consider this to be a sensible step to take. It is also considering introducing identity cards for pre-registration trainees and pharmacists. It is hoped these would help identify the differences between those working in pharmacies and enable the public to direct questions about their health to the most appropriate individual.

16.14 Alongside managing an effective registration process, the PSNI has shown improvement in its communication with stakeholders on the importance of checking that a professional is registered. The PSNI has written to every pharmacy employer, it has produced and disseminated a public information leaflet and it has developed links with other information sources such as the Department of Health, Social Services and Public Safety website. An analysis of the PSNI's website shows that the 'Search the Register' page is the most popular section of the website.

16.15 The PSNI's communication with employers, through the Pharmacy Network Group (previously known as the Complaints Allocation Panel), has also resulted in two cases being reported to the PSNI of registrants continuing to practise despite being removed from the register for non payment of fees. Action has been taken by the regulator to address the concerns about the two individuals.

Fitness to practise

16.16 The PSNI manages a small number of fitness to practise cases. However, it has worked hard to maximise the effectiveness of its work in this function and to introduce mechanisms to reduce the risks associated with its outdated legislation.

16.17 The Pharmacy Network Group is now operational. The PSNI has seen the benefits of its improved and formalised information gathering and exchange arrangements with the inspectorate and employers. Previously, some complaints could be opened, investigated and closed without reference to the regulator where this could have been necessary. The Pharmacy Network Group enables a complaint to be considered in context (inclusive of service provision, conduct, professionalism and criminality) and for an agreement to be reached on who should lead on the investigation. This approach ensures that there is an integrated approach to the resolution of complaints with public protection at its core.

16.18 As well as improving the way in which complaints are initially considered, the PSNI has enhanced the way learning from fitness to practise cases is shared. The PSNI detailed the outcomes of its fitness to practise cases in

its annual report and included a learning points section highlighting the lessons from the cases.

16.19 We are also pleased with the action taken by the PSNI to improve communication with all parties to a fitness to practise complaint. It has introduced templates to ensure that scrutiny committee decisions are consistent and transparently documented. It has also devised a specific disclosure policy for the complainants and registrants so that they have a clear understanding of what information will and will not be released during the process.

16.20 However, while the PSNI performs well it is constrained by its legislation. The PSNI still does not have statutory powers to impose interim orders or a proper range of fitness to practise sanctions. As we stated last year, we are pleased that the PSNI has introduced voluntary undertakings. This is where registrants can voluntarily agree not to practise until the resolution of fitness to practise proceedings. However, we consider that there is a real risk to the public through the PSNI's inability to take immediate and mandatory action at the commencement of fitness to practise proceedings and to impose a lesser sanction where registrants are found to have some impairment which does not warrant removal from the register.

16.21 We also remain concerned that the PSNI still does not have the powers to set up health procedures within their fitness to practise process, that it has a restriction on having a pool of chairs and panelists and has a chair of the statutory committee who is not independently appointed and has disproportionate powers. We recognise that the PSNI has established a scrutiny committee to mitigate against the risk of the chair of the statutory committee misusing their power to decide whether a case should be referred to a final fitness to practise hearing. To mitigate against the risk of the chair of the statutory committee using their power of veto against a pharmacist's removal from the register, the PSNI has also appointed appropriately qualified statutory committee panel members. However, we consider that the outdated legislation causes a potential conflict of interest and impacts on public confidence in the regulator to act fairly and independently.

Education and training

16.22 As a consequence of the establishment of the GPhC, the standards for education in pharmacy schools in Northern Ireland are under review. The PSNI has participated in the review and consultation of the standards. We are encouraged that it continues to recognise the importance of consistency in education across the UK in terms of public protection.

16.23 The PSNI continues to engage actively with undergraduate students and pre-registration trainees. It delivers lectures on fitness to practise matters, the *Code of Ethics* and the importance of personal responsibility. The importance of personal responsibility is embedded further in pharmacy education through the new *Student Code of Conduct* developed in conjunction with the RPSGB. The code sets out the PSNI's expectations

of its students in terms of personal responsibility for their own practice and inter-professional learning. We are supportive of this action as by embedding professionalism at the first stage of a pharmacist's career, fitness to practise concerns may either be avoided or dealt with appropriately at the earliest possible point.

16.24 The PSNI carries out accreditation of education institutions in partnership with the RPSGB. Discussions are ongoing on how this relationship will continue once the GPhC is fully operational. In the meantime, the PSNI has reviewed its quality assurance processes for accrediting schools of pharmacy and recruited a new accreditation panel which has both public and professional representation. It is expected that their expertise will aid in the discussions with the GPhC. We hope that these discussions will also consider how to ensure patients' views are reflected in the design and delivery of education programmes and that any evaluation of courses takes the views of patients into account.

16.25 Following on from last year's review, we are pleased that the PSNI has published the accreditation process for, and assessment reports of, its two education institutions.

Governance and external relations

16.26 The PSNI is now the only health professional regulator without parity of public and professional representation on its Council. Its members are also not independently appointed against competencies. We acknowledge that the PSNI has appointed two non-registrant Council members and that the Council now has the greatest number of public members that it can achieve under its current legislative framework. We also recognise that the PSNI has introduced a process whereby candidates for Council must self-certify against competencies. However, we do not see this as an alternative to modernised legislation which we consider must be progressed promptly. It is important that all regulators have appropriate governance arrangements in place to work effectively.

16.27 We note that the PSNI continues to work towards the separation of its professional and regulatory functions. It has consulted on the operation and development of the professional forum. The proposals were well received and the arrangements for the appointments and formal constitution of the forum are being advanced. We are pleased with the PSNI's plans for the Council to have no responsibility for professional leadership. The intended focus is instead on regulation and public safety, utilising support and advice from its public and professional forum.

16.28 The PSNI has developed its information sharing arrangements with the Pharmaceutical Society of Ireland. The Societies have co-operated and shared information in relation to a fitness to practise case and panelists' training, as well as CPD and revalidation. We see this work as important in encouraging consistency in regulation across land borders and overcoming gaps in regulation across countries.

17. The Royal Pharmaceutical Society of Great Britain (RPSGB)

Overall assessment

17.1 The **Royal Pharmaceutical Society of Great Britain** regulates **two** professions: pharmacists and pharmacy technicians. It has **58,664** current registrants and received **3,720** new registration applications since last year's performance review. The RPSGB has an annual retention fee of **£413** for pharmacists, **£135** for pharmacy technicians and **£70** for non-practising pharmacists. The RPSGB is responsible for the quality assurance of the training of pharmaceutical professionals at **50** educational institutions.

17.2 The Royal Pharmaceutical Society of Great Britain continues to experience major organisational changes during a transitional phase, in which the responsibility for regulating the profession will move to the General Pharmaceutical Council (GPhC). The GPhC will commence its regulatory role in 2010, Parliamentary timetable permitting. Once this occurs, we will oversee the GPhC rather than the RPSGB. We note that the extent of the changes made necessary by this has placed significant demands on the RPSGB's management and staff, and feel that it is important to acknowledge that the current regulator has continued to fulfil its statutory functions and perform to the standards expected during a challenging period.

17.3 We welcome the improvements made in several areas since the last review. We acknowledge the significant challenges resulting from organisational changes. Delays in bringing in the full legislative framework for the GPhC have impeded the handover of statutory regulation from the RPSGB to the GPhC. We note that managing the slipping timeframe for the establishment of the GPhC has been difficult, and that with the GPhC Council now in position there is a requirement for them to have policies in place. While the delays have affected implementation, they have also provided an opportunity for revisions to be made to draft standards and to provide more time for collaboration between the GPhC and the Society.

17.4 We consider that the RPSGB has responded positively to the other issues raised in the last review. For example, it has performed well by:

- Implementing an enhanced IT case management system. The RPSGB's new case management system was launched in June 2009 and now provides management with the facility to record and audit the fitness to practise cases transferred to the system, from beginning to end. We note that an internal audit of the new system will be undertaken in the first part of 2010. We also note that the RPSGB has now transferred most of the remaining cases from its previous case management system but that work is progressing on the migration of a number of cases from an even earlier case management system. Development of a separate tool to extract and manipulate reporting data is currently underway

- Developing a new witness guidance document for witnesses who appear before the RPSGB's fitness to practise committees and revising the content of letters sent to complainants to enhance clarity. These improvements were made by incorporating public feedback from RPSGB's customer satisfaction survey
- Providing all registrants with a 'Responsible Pharmacist' toolkit which included a notice that must be displayed in pharmacies in response to the planned introduction of new regulations. The RPSGB has also set up a dedicated page on its website to provide guidance and information on this subject.

Standards and guidance

17.5 The RPSGB is in a transitional period during which new standards are being developed for its successor, the GPhC. A consultation on the draft GPhC standards has taken place; we hosted the consultation and presented a summary and recommendations to the GPhC. In our 2008 *Advice to the Department of Health and the Pharmacy Regulation and Leadership Oversight Group on Aspects of the Establishment of the General Pharmaceutical Council,*[23] we anticipated modern and forward looking standards; however those developed were not as progressive as we had hoped. We hope that the GPhC improves these standards so that they are fit for purpose for a regulator in the twenty first century. Society staff have contributed to the development of the new GPhC standards, which are being modelled on the principles of the Society's code of ethics.

17.6 As well as continuing to review, amend and communicate existing standards, in 2009, after public consultation, the RPSGB provided all registrants with new professional standards guidance; *Professional Standards and Guidance for Continuing Professional Development* and *Professional Standards and Guidance for Responsible Pharmacists*.

17.7 The RPSGB has also put considerable effort into communicating its standards. It has regularly published articles relevant to practice in magazines aimed at pharmacy professionals. In addition, it has directed further communications to the profession in relation to key areas such as the call and review process for continuing professional development (CPD) and the introduction of mandatory registration for pharmacy technicians. The RPSGB's inspectorate delivers a programme to pre-registration trainee pharmacists which introduces and explains the regulator's role and what happens should a student be subject to an investigation. We welcome the RPSGB's continued use of varied communication methods to ensure that standards and guidance are accessible, up to date and widely disseminated to all pharmaceutical professionals. This should aid registrant awareness and compliance with standards and guidance during this transitional phase. In turn, this should help to ensure that public protection is properly maintained.

[23] CHRE 2008. *Advice to the Department of Health and the Pharmacy Regulation and Leadership Oversight Group on Aspects of the Establishment of the General Pharmaceutical Council.* London: CHRE.

17.8 The RPSGB has now issued its multi-lingual information leaflet, *Protecting the Public*, which outlines the code of ethics, how to check the register, the complaints process and how to make a complaint. The leaflet is available online and copies have been distributed widely to pharmacies, Local Involvement Networks and the NHS. We note that the RPSGB has identified the promotion of standards to the public and other stakeholders as an area for future development.

17.9 The RPSGB implemented quantitative and qualitative monitoring of registrants' CPD records in July 2009. This encourages registrants to reflect on individual requirements and formulate a CPD plan which they evaluate once completed. Registrants who persistently refuse to engage with the CPD scheme are referred to the Inspectorate. They are asked to admit a breach of the code of ethics by failure to submit their CPD record, and to accept a letter of advice from the chief inspector. Failure to do so leads ultimately to a referral to the fitness to practise department. We believe this will improve efficiency and should help ensure that only appropriate cases are subject to the fitness to practise processes.

Registration

17.10 We acknowledge that the statutory regulation of pharmacy technicians came into force on 1 July 2009 and that there will be a further two years of transitional arrangements until registration becomes mandatory in July 2011. The RPSGB estimates that there will be a further 8,000 technicians who will need to register before that deadline, 5,000 of whom work in hospital pharmacy. We note that these applications are being processed at a steady rate and in line with service standards. We welcome the recent internal audit of the RPSGB's registration processes, which found that controls were adequate overall and rigorous for overseas applications.

17.11 We are pleased to report that following last year's performance review the RPSGB has reviewed its annual notification. It has also provided all pharmacists with a 'Responsible Pharmacist' toolkit. This includes the amended format of the notice to be displayed in pharmacies and more explicit guidance about legal and regulatory requirements and fitness to practise, as well as guidance on the imminent split of the RPSGB's regulatory and professional functions. The RPSGB has also set up a dedicated page on its website to provide guidance and information on being a Responsible Pharmacist.

17.12 We consider that the RPSGB has shown improvement by providing additional information and guidance for stakeholders on internet pharmacy on its website. We believe that this reinforces the importance of checking that a pharmacy is registered. As the safety and quality of products being sold by unqualified internet suppliers cannot be guaranteed, we consider that this is an important and necessary contribution towards maintaining public protection.

Fitness to practise

17.13 We consider that the RPSGB has shown improvement this year by collaborating with the National Clinical Assessment Service to ensure that employers are fully informed of the options available when making decisions on matters related to registrant performance or fitness to practise. Similarly, the Society's inspectorate has strengthened its links with primary care organisations with the aim of tackling concerns locally and responding effectively to matters affecting patient risk and public confidence. We welcome this work and believe that it will help ensure that employers better understand what issues should be referred to the RPSGB and when to report them. This should help to ensure that the fitness to practise process is focused on appropriate cases and that the RPSGB is able to make decisions which are in the interests of public protection.

17.14 We are pleased to report that the RPSGB's new case management system was launched in June 2009. It now gives management the facility to record and audit all fitness to practise cases, transferred to that system, from beginning to end and can provide key information on timescales at each stage of the fitness to practise process. We note that an internal audit of the new system will be undertaken in the first part of 2010. We also note that the RPSGB has now transferred most of the remaining cases from its previous case management system but that work is progressing on the migration of a number of cases from an even earlier case management system. Development of a separate tool to extract and manipulate reporting data is currently underway.

17.15 The Society has said that decisions to share registrant responses with complainants are taken on a case by case basis and that, unless there are reasons as to why information should not be disclosed, information is shared with the registrant and the complainant. The decision to disclose is made in accordance with the principles of fairness and requires an assessment as to whether disclosure could contaminate the complainant's evidence (or that of another witness to the investigation), which may inappropriately broaden or refocus the investigation. In addition, if a complaint is handled through the Society's non referral process the registrant's response to the complaint is routinely shared with the complainant and is included in the letter sent to the complainant from the chief inspector. The Society has said that this translates to approximately two thirds of the complaints investigated not proceeding to the investigating committee, and that cumulatively this substantially minimises (if not prevents) instances where cases proceed unnecessarily to the investigating committee in circumstances where it was determined not to share the registrant's response with the complainant.

17.16 While we acknowledge that the Society's position on disclosure may cover most circumstances, we take the view that registrant responses should be shared with complainants in all cases although comments of a personal nature not relevant to the case, details that reveal the identity of a whistleblower, or reference to sensitive personal information about the registrant (for example their health or finances), should not be shared. For

the most serious cases that will almost certainly progress to a final hearing, or where there is no disagreement about events, waiting for a response from the complainant should not be allowed to delay the process.

17.17 We are pleased to note a steady increase in the capacity of the investigating committee which has led to a reduction in the number of cases to be dealt with, and the recent shortening of the time taken to refer cases from the statutory committees' secretariat to the final fitness to practise committee. We acknowledge that the RPSGB is currently developing new reporting tools following the introduction of its new case management system, and that it has taken this opportunity to revise its service standards for fitness to practise. We welcome the undertaking of an internal audit to identify causes of delay and look forward to the findings which are due later this year. We would, however, encourage the RPSGB to publish its performance levels against its service standards as we believe that it is reasonable that the public should have access to this information.

17.18 We acknowledge that the RPSGB currently reviews the decisions of its fitness to practise committees and identifies issues and learning points that in turn influence policy, guidance and practice. We welcome the RPSGB's consideration of a more formal process for auditing its own decisions. We also note that it uses the equality and diversity data it collects to monitor its fitness to practise function and to identify areas of improvement, and that this information is included in its annual review.

Education and training

17.19 We acknowledge the involvement of students and trainees in the quality assurance of pharmacy education provision and note that although patients are not involved in routine quality assurance in this area, their views were used extensively in consultations on new education standards and in drafting the RPSGB's new *Code of Conduct for Pharmacy Students* and its *Guidance on Fitness to Practise in Schools of Pharmacy*. We welcome the inclusion of patient views and perspectives gathered as part of any consultations. However, we consider that it is appropriate that patient involvement is reflected in the design and delivery of education programmes and that any evaluation of the courses has taken the views of patients into account.

17.20 As part of its quality assurance process, the RPSGB monitors pass rates of students who sit the registration examination at all schools of pharmacy. In late 2009, the RPSGB identified that pass rates for students at one of the three new schools fell significantly below the usual range. We welcome the immediate action taken by the RPSGB to manage the issue by advising that an independent enquiry should be set up to establish the cause. The enquiry reported that a number of factors could have contributed to the low pass rate, including curriculum design and delivery, inadequate on-course preparation for the examination and student misconceptions of pharmacy leading to a generally poor performance in pre-registration. The RPSGB has therefore requested that the school develops measures to evaluate what would be an acceptable improvement and will reassess more data

in June, following the summer 2010 registration examination. We consider that this demonstrates that the RPSGB takes account of risk while focusing on maintaining and improving standards and protecting patient safety.

17.21 The RPSGB carries out accreditation of education institutions in Northern Ireland in partnership with the Pharmaceutical Society of Northern Ireland (PSNI). Discussions are ongoing on how this relationship will continue once the GPhC is fully operational.

Governance and external relations

17.22 As reported last year, the Department of Health decided that, due the establishment of the GPhC, the RPSGB should not move to a smaller, fully appointed Council with at least 50 per cent public membership. The RPSGB has said that the focus has been on plans for the transfer of regulation, which are currently on track for 2010, Parliamentary timetables permitting. However, we acknowledge that there have been some difficulties in managing the slipping timeframe. In addition to the requirement to maintain the normal functions of the RPSGB, its staff have been involved in contributing to the GPhC's work.

17.23 We note the RPSGB's recognition of differences in the three GB countries and its efforts to address these this year. For example, membership of the Public Liaison Group includes representatives from Scottish and Welsh Community Health Councils, and the contributions of national pharmacy boards in England, Scotland and Wales were included when the RPSGB developed the professional standards and guidance for responsible pharmacists (the PSNI was also involved).The RPSGB has also held Council meetings and stakeholder events in Cardiff, Edinburgh and York.

17.24 We are pleased to note the RPSGB's work with the Medicines and Healthcare products Regulatory Agency and others to produce a leaflet on counterfeit medicines that was sent to all pharmacies. The RPSGB has also worked with the Department of Health and a range of stakeholders to develop guidance for the implementation of the Responsible Pharmacist legislation. We welcome these examples of the RPSGB's continued co-operation with other organisations to protect and improve public safety and protection.

18. Conclusions and recommendations

Conclusion

18.1 The performance review has identified that the regulators are fulfilling their statutory responsibilities and are focused on public protection. We are pleased to have seen a number of improvements across the regulators performance and a real desire to continuously improve. In addition, we are heartened that the regulators have managed changes in the framework and environment of health professional regulation and the anticipated and unexpected consequences of their own and others' actions.

18.2 We have also identified particular concerns with some of the regulators' work but are satisfied that work is generally already underway to ensure that improvements are made. We will be following up on the progress made by the regulators in the next performance review.

18.3 In relation to the key issues and concerns affecting health professional regulation, we have identified matters where we consider that the regulators can enhance how they protect the public and promote patient safety. We will look to see what action has been taken in relation to these areas in the next review. We have also highlighted the importance of joined up working in health regulation. We emphasise that patient safety is not just the responsibility of the health professional regulators but that for effective regulation there needs to be joint working with employers, professional associations, Royal Colleges and system regulators.

18.4 We have also identified a number of issues for CHRE and others to take forward to ensure that public protection and patient safety remain at the heart of health professional regulation. We will report on progress on these issues in the next performance review.

Recommendations

18.5 We have identified a number of issues which require further consideration by CHRE, the Department of Health and in the case of PSNI, the Department of Health, Social Services and Public Safety.

For CHRE

18.6 We will take forward the following four issues for further consideration:

- What are the most effective mechanisms for engaging patients and the public in the activities of the regulators
- What information should be included in a data set for publication in the performance review
- What role CHRE can play in facilitating the sharing of information between the regulators about their revalidation programmes
- CHRE's role as a facilitator to assist the regulators to jointly prepare their own guidance to ensure a consistent approach in the referral of registrants to the Independent Safeguarding Authority.

For the Department of Health

18.7 We recommend that the Department of Health should ensure that the regulations arising from the Equality Act 2010 will enable all regulators to be subject to the same duties and expectations under all equality and diversity legislation.

For the Department of Health, Social Services and Public Safety

18.8 We hope that progress continues to be made on our recommendation to the Department that it acts to modernise the framework for regulation of pharmacists in Northern Ireland.

For the regulators

18.9 In addition to addressing the highlighted areas of weakness identified in the individual regulators reports, we recommend that the regulators review this document as a whole and consider whether they can learn and improve from the practices of the other regulators.

19. Annex A: Index of regulated health professions

Health profession regulator	Regulated health profession
General Chiropractic Council	Chiropractors
General Dental Council	Dentists Dental hygienists Dental therapists Clinical dental technicians Orthodontic therapists Dental nurses Dental technicians
General Medical Council	Doctors
General Optical Council	Dispensing opticians Optometrists
General Osteopathic Council	Osteopaths
Health Professions Council	Arts therapists Biomedical scientists Chiropodists Clinical scientists Dieticians Hearing Aid Dispensers* Occupational therapists Operating department practitioners Orthoptists Orthotists Paramedics Physiotherapists Podiatrists Practitioner psychologists Prosthetists Radiographers Speech and language therapists
Nursing and Midwifery Council	Nurses Midwives
Pharmaceutical Society of Northern Ireland	Pharmacists
Royal Pharmaceutical Society of Great Britain (England, Scotland and Wales)	Pharmacists Pharmacy technicians**

*From 1 April 2010, HPC also regulated Hearing Aid Dispensers.

**Pharmacy technicians are registered with the RPSGB on a voluntary basis currently. On 1 July 2011 registration will become mandatory.

20. Annex B: The Standards of Good Regulation

Introduction

There are 17 standards spanning five regulatory functions: standards and guidance; registration; fitness to practise; education and training; and governance and external relations.

Definitions

Standards are the basis of the performance review process. They describe what the public should expect from regulators. We use the standards in two ways. First, we ask the regulators to show how they meet the standards. Secondly, we use the standards to identify each regulator's strengths and areas for improvement as well as to compare the performance of each of the regulators.

All **minimum requirements** must be met to meet the standards. However, the regulators can also show that they meet the standards in other ways. Minimum requirements sometimes describe current duties, give examples of current practice, or indicate good practice.

Supporting information

We ask the regulators to provide information against each of the standards and minimum requirements. We ask the regulators to provide sufficient information whether in summary or in supporting documentation to justify what has been stated in their response. Where the regulators are unsure, we ask them to discuss their questions with us. Where we consider that there is insufficient information, we will raise this with the regulator before the performance review meeting.

1 First function: standards and guidance

Standards

1.1 The regulator publishes standards of competence and conduct,[24] which prioritise patient[25] safety and interests and reflect up-to-date practice.

Minimum requirements

i) Standards prioritise patient safety and patient interests.
ii) Core standards are formulated as general principles, which apply to all situations and areas of practice.
iii) The core standards are easy to understand for registrants and clearly outline registrants' personal responsibility for their practice.
iv) Where appropriate, supplementary guidance is produced to help registrants apply the core standards about specialist or specific issues.
v) The regulator regularly reviews its standards to ensure that they are up-to-date, and, where appropriate, they are revised with input from stakeholders.

1.2 The regulator actively makes its standards available and accessible to registrants and potential registrants in the UK, and informs them of their current or future responsibility to meet these standards.

Minimum requirements

i) Standards are available in different formats.
ii) The regulator has a communications strategy to promote the standards which is targeted to the needs of registrants and potential registrants.

1.3 The regulator informs the public of the standards that registrants should meet and the action that they can take if these standards are not met.

Minimum requirements

i) Standards are available in different formats.
ii) The regulator has a communications strategy to promote the standards which is targeted to the needs of the public, employers and other stakeholders.

[24] There is a variety of terminology for standards of conduct and standards of competence across regulators. Standards of conduct govern professional behaviour, whereas standards of competence (standards of proficiency or standards of practice) can include clinical and management skills, knowledge, and how to apply these. The focus, amount of details and presentation of standards vary. Extracted from *Regulation of the Health Professions: a scoping exercise carried out on behalf of CRHP*, 2004.

[25] We use the word 'patients' to include all those to whom health professionals provide healthcare services, including clients, customers or service users. The concept also includes members of the public.

1.4 The regulator requires registrants to maintain standards through a process of continuing professional development or equivalent systems and is working towards a system of revalidation.[26]

Minimum requirements

i) The regulator regularly audits their registrant's CPD profiles to ensure that the CPD is targeted to the specific learning needs of individual registrants and that public protection is prioritised.

ii) The regulator works with others (including public and patient groups) towards a system of revalidation carried out on a periodic basis and with intensity proportionate to risk for each registrant and with targeted remedial action.

[26] Revalidation is the process by which a registrant will have to show the regulator on a periodic basis that they are fit to practise and meet the regulator's standards of competence and conduct.

2 Second function: registration

Standards

2.1 The regulator has efficient, fair and transparent processes for entry to the register and periodic renewal of registration.

Minimum requirements

i) The registration process including how to appeal a registration decision is well-defined and details are accessible.
ii) All applicants are treated fairly and assessed against a well-defined set of criteria that are linked to the standards of competence and conduct.
iii) All applications are processed efficiently and the regulator's performance is monitored against its service standards or equivalent measures.
iv) The regulator takes steps to ensure against fraudulent or erroneous entry to the register.

2.2 Registers are accessible to the public and include all relevant information about registrants.

Minimum requirements

i) The regulator makes its registers available to the public.
ii) The public and employers are easily able to find a specific registrant and identify if there are restrictions on their practice.
iii) A registrant's fitness to practise history and any sanctions are available on the register.

2.3 The regulator takes action to prevent non-registrants fraudulently using a protected title or undertaking a protected act.

Minimum requirements

i) The regulator publicises the importance of checking that a professional is registered.
ii) The regulator has procedures for dealing with a person found to be fraudulently using a protected title, or undertaking a protected act (where this applies) and uses the procedures to stop them from doing so.

3 Third function: fitness to practise

Standards

3.1 The regulator has an accessible process through which patients, the public, employers and others can raise concerns about registrants. The regulator provides information to those raising concerns about how the matter will be dealt with.

Minimum requirements

i) The regulator has a process to receive concerns against registrants that is publicly available, and easy to understand and use.
ii) The regulator provides information in different ways to those raising concerns about how the matter will be dealt with.
iii) The regulator works with employers to help them understand which cases should be referred to them and when this should occur.

3.2 The regulator keeps all parties informed of progress during fitness to practise cases.

Minimum requirements

i) All parties are informed of progress at the following stages at least:
   a) initial consideration;
   b) referral to a fitness to practise panel;
   c) final outcome;
   and preferably on a six to eight week basis.
ii) The regulator complies with its publicly available disclosure policy, which sets out what information is available and at what stage it will be shared.
iii) The regulator publishes the outcomes of final fitness to practise hearings, apart from health cases.

3.3 Fitness to practise cases are dealt with in a timely manner at all stages.

Minimum requirements

i) The regulator has a case management system.
ii) There are ways to identify and prioritise serious cases so that they can be referred to a panel to consider whether it is necessary to impose an interim order.
iii) There are systems and guidance to identify cases that have become delayed so that action is taken.
iv) Cases are listed and heard in a timely manner by fitness to practise panels after referral.
v) The regulator has service standards or equivalent measures for each key milestone of the fitness to practise process and performance is monitored against them. This information is accessible to its stakeholders.

3.4 There are processes for the appointment, assessment and training of fitness to practise panel members.

Minimum requirements

i) The regulator uses competences which reflect the skills and knowledge needed for the role of panellist/chair when recruiting panel members.
ii) There is an assessment and appraisal process for fitness to practise panel members.
iii) Members receive feedback from the regulator and CHRE in relation to the cases they have considered and are aware of any learning from relevant court outcomes.
iv) There is a training programme for panel members that amongst other things covers equality and diversity issues.

3.5 Decisions made at the initial stages of the fitness to practise process (pre-fitness to practise panel stage) and at final fitness to practise panels are well reasoned and focused on the protection of the public.

Minimum requirements

i) Staff and panels involved in taking decisions at all stages receive training and guidance on how to carry out their work.
ii) The regulator has guidance on criteria for referral from the initial stages of the fitness to practise process to the final panel hearing which is focused on protection of the public.
iii) The regulator has comprehensive indicative sanctions guidance that facilitates consistent decision making focused on the protection of the public.
iv) There are internal audits of decisions taken that look at amongst other things equality and diversity issues.

4 Fourth function: education and training

Standards

4.1 The regulator ensures that its standards for education and training to be met by students/trainees prioritise patient safety and interests and reflect up-to-date practice.

Minimum requirements

i) Standards for education and training prioritise patient safety and patient interests and link in with the standards of competence and conduct for registrants.
ii) The regulator ensures that standards are applicable to the different stages of training and education. Standards outline students'/trainees' future personal responsibility for their own practice as well as for inter-professional working.
iii) The regulator regularly reviews its standards to ensure that they are up-to-date. The regulator revises standards or produces supplementary guidance as required and in consultation with stakeholders.

4.2 The regulator ensures that its standards for the delivery of education and training prioritise patient safety and interests and reflect up-to-date practice.

Minimum requirements

i) Standards for the delivery of education and training prioritise patient safety and interests and link in with the standards of competence and conduct for registrants.
ii) The regulator ensures that standards are applicable to all situations, including placements.
iii) The regulator regularly reviews its standards to ensure that they are up-to-date. The regulator revises standards or produces supplementary guidance as required and in consultation with stakeholders.

4.3 The regulator has a transparent and proportionate system of quality assurance for education and training providers.

Minimum requirements

i) The regulator assesses education and training providers, including arrangements for placements, at appropriate intervals, which may vary between establishments proportionally to risk.
ii) Students'/trainees' and patients' perspectives are taken into account as part of the evaluation.
iii) Educational and training providers that meet the required standards are approved, and steps are taken where a provider falls short of the standards.
iv) Information on the assessment process and details of the final assessments are accessible to all stakeholders.

5 Fifth function: governance and external relations

Standards

5.1 The regulator's Council conducts business transparently and accountably.

Minimum requirements

i) The regulator has a clearly defined aim and a strategy which is regularly reviewed and published.
ii) It has a Code of Conduct for Council members.
iii) The Council includes expertise from a range of stakeholders and has at least parity of professional and public members.
iv) The Council has a defined process for dealing with complaints/ concerns about Council members.
v) Individuals are appointed against competencies[27] which reflect the skills and knowledge required for the role of Council member.
vi) Council and the executive have clear lines of accountability.

5.2 The regulator seeks continuously to improve and decisions are based on up-to-date management information[28] and are directed to protecting, promoting and maintaining the health, safety and well-being of the public.

Minimum requirements

i) The regulator gathers evidence from its activities including audits[29] and external information including recommendations from CHRE. The regulator disseminates it throughout the organisation. This evidence informs policy development.
ii) The regulator has a planning process, which ensures that functions are sufficiently resourced and takes account of risks.
iii) The regulator takes into account the differences between England, Scotland, Wales and Northern Ireland when devising its policies and processes and in engaging with stakeholders.
iv) The regulator is committed to promoting the principles of the Human Rights Act and respect for equality and diversity. It ensures that all activities are free from discrimination.
v) The regulator has an accessible, effective and efficient complaints procedure for dealing with complaints about itself. Learning from the complaints is disseminated to the complainant, throughout the organisation, informs policy development and improves practices.

---

[27] Until all Council members are appointed, this is likely to apply to public members only.
[28] This is the information that an organisation requires to run its business properly, this will include risk information, metrics, performance indicators, resource implications and where appropriate stakeholder views.
[29] The use of the term 'audit' in the performance review standards refers to quality audits of services, functions, work stream, rather than financial audits.

vi) The regulator co-operates with other organisations with a common interest. It develops strategic alliances, co-ordinates goals and project planning.
vii) The regulator engages in the development of international regulation.
viii) The regulator meets its statutory responsibilities in sharing information and in seeking, retaining and destroying personal and sensitive information.

21. Annex C: Third party feedback

As part of this year's performance review, we wrote to a wide range of organisations who we considered had an interest in how the regulators performed against the *Standards of Good Regulation* and our public stakeholder network. We invited them to share their views with us on the regulators' performance in relation to the standards. We explained that we would use the information provided to challenge the regulators' self-assessments to ensure that we had a more rounded view of the regulators' performance. We also placed a general invite to provide views on the regulators' performance on our website.

Below is a list of the third party organisation feedback that we took into account:

- Action against Medical Accidents
- Association of Radical Midwives
- British Osteopathic Association
- Council of Deans for Health
- Dental Schools Council
- Dignified Revolution
- Independent Midwives
- Medical Defence Union
- Medical Protection Society
- North Glasgow Community Health and Care Partnership
- Royal College of Midwives
- Royal College of Nursing
- Royal College of Paediatrics and Child Health
- Royal College of Physicians
- Royal College of Surgeons of England
- Unison
- West Kent Primary Care Trust

Published by TSO (The Stationery Office) and available from:

Online
www.tsoshop.co.uk

Mail, telephone, fax and email
TSO
PO Box 29, Norwich NR3 1GN
Telephone orders/general enquiries: 0870 600 5522
Order through the Parliamentary Hotline Lo-Call 0845 7 023474
Fax orders: 0870 600 5533
Email: customer.services@tso.co.uk
Textphone: 0870 240 3701

The Parliamentary Bookshop
12 Bridge Street, Parliament Square,
London SW1A 2JX
Telephone orders/general enquiries: 020 7219 3890
Fax orders: 020 7219 3866
Email: bookshop@parliament.uk
Internet: http://www.bookshop.parliament.uk

TSO@Blackwell and other accredited agents

Customers can also order publications from:
TSO Ireland
16 Arthur Street, Belfast BT1 4GD
Telephone orders/general enquiries: 028 9023 8451
Fax orders: 028 9023 5401

ISBN 978-0-10-296423-3

9 780102 964233