Professional Standards Authority for Health and Social Care

Annual Report and Accounts and Performance Review Report 2013-14

Volume I
Annual Report and Accounts 2013-14

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Volume I: Annual Report and Accounts 2013-14

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1. Chair's introduction

During the last year, we fully established ourselves as the Professional Standards Authority for Health and Social Care and have implemented successfully all the new responsibilities given to us in the Health & Social Care Act 2012.

The health and well-being of patients and other members of the public are at the heart of what we do; although regulatory oversight may at times seem remote and technical, our real purpose is to improve regulation in the public interest.

The Authority has maintained its statutory responsibilities for the oversight of nine regulators. We published our audit reports between September 2013 and March 2014 and our performance review report for 2014 accompanies this report.

The regulators have continued to see a rise in complaints and this has a direct impact on our work. We have reviewed 3,566 cases in the 12 months covered by this report.

To protect the public, we have lodged more appeals to the High Court against the decisions of the regulator's fitness to practise panels than in most previous years. However, we do not think that any conclusion about the overall quality of decision-making by panels can be drawn from this increase in appeals, as they represent a tiny fraction of the whole.

Our new Accredited Voluntary Registers Scheme has accredited 10 registers covering 24 occupations and 47,000 individual registrants. It is proving attractive to register holders and their registrants as well as to the members of the public and employers who use their services.

We also continue to contribute to regulatory policy. We advised the Secretary of State on Duty of Candour, and gave evidence to the Cavendish Review of Health Care Assistants as well as the Caldicott Review of Information Governance. We have responded to numerous consultations by the regulators and others including the Welsh Assembly Government's White Paper *The Future of Regulation and Inspection of Care and Support in Wales.* We have worked closely with the Law Commission on the review of the regulation of health and care professionals.

In July, we were called to give evidence to the Health Select Committee and are pleased to have a continuing role advising the Committee about regulation in health and social care.

Our international work has continued to grow with reviews completed for the Royal College of Dental Surgeons of Ontario and the Irish Nursing and Midwifery Board. Our staff regularly contribute to national and international conferences.

This has been a challenging and significant year for the Authority and I am indebted to our small team of committed and skilful staff for the way in which they have embraced new developments while maintaining extremely high standards, under the excellent leadership of our Chief Executive, Harry Cayton.

Our Board, which has been together for six years, will face changes this year as three members complete their terms and retire. I am hugely grateful to the Board for their service, their wisdom and for their strategic guidance, which has been invaluable in enabling the Authority to look to the future with confidence.

Baroness Jill Pitkeathley OBE
Chair

2. Strategic report

About the Professional Standards Authority

Who we are

2.1 The Professional Standards Authority for Health and Social Care (the Authority) was established on 1 December 2012. Its role and duties are set out in the Health and Social Care Act 2012.[1]

2.2 The Authority continues the work of the Council for Health Care Regulatory Excellence (CHRE), which was constituted by the Health and Social Care Act 2008[2] and was a transformation of the Council for the Regulation of Health Professionals set up in April 2003 by the National Health Service Reform and Health Care Professions Act 2002.[3]

2.3 The Authority has a Board comprising seven non-executive members and one executive member, the Chief Executive, who is appointed by the Board.

2.4 The non-executive members are appointed by the Privy Council, the Secretary of State for Health, the Scottish and Welsh ministers and the Department of Health, Social Services and Public Safety in Northern Ireland.

2.5 The Authority is an unclassified public body, funded through the Department of Health in England and by the devolved administrations in Northern Ireland, Scotland and Wales.

Our role and what it entails

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

2.7 We have duties and powers in relation to:

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

[1] Available at www.legislation.gov.uk/ukpga/2012/7/contents/enacted
[2] Available at www.legislation.gov.uk/ukpga/2008/14/contents
[3] Available at www.legislation.gov.uk/ukpga/2002/17/contents

What we do

Oversight of the regulators

2.8 The Authority has powers to:

- Audit the initial stages of fitness to practise cases and report on our findings in relation to each regulator
- Review the outcome of final fitness to practise cases and to refer them to court if we consider that the outcome is unduly lenient and fails to protect the public
- Investigate, compare and report on the performance of each regulatory body. We are specifically required to report to Parliament on how far each regulatory body has complied with any duty imposed on it to promote the health, safety and well-being of patients, service users and the public
- Give directions requiring a regulatory body to make rules under any power the body has to do so.

2.9 We promote the health and well-being of patients, service users and the public in the regulation of health and social care professionals. To do this, we listen to people's views and concerns and consider them when developing our work. We have an active programme of engagement with patients, service users and members of the public.

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

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

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

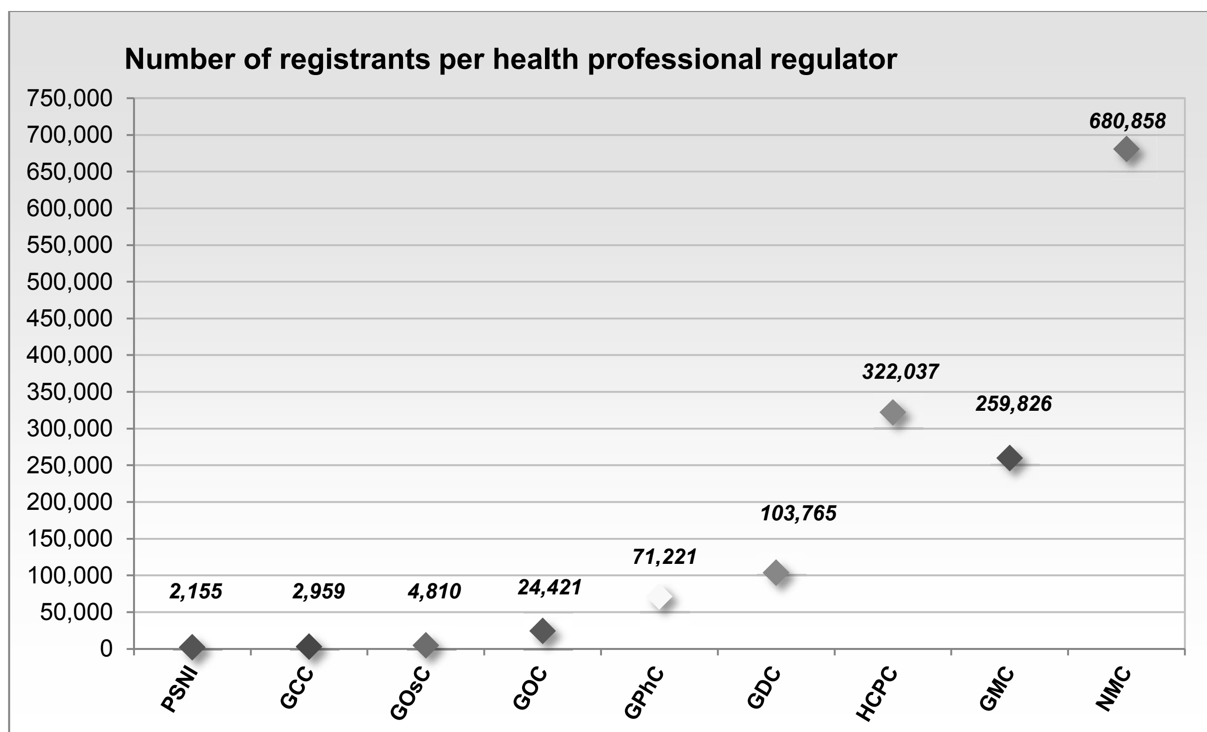
2.13 We share good practice and knowledge with the regulatory bodies, conduct research and introduce new ideas about regulation to the sector. We work closely with, and advise, the four UK government health departments on issues relating to the regulation of health and care professionals. In addition,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

2.14 The regulatory bodies are the:

- **General Chiropractic Council** (GCC) which regulates chiropractors in the UK
- **General Dental Council** (GDC) which regulates dentists, dental nurses, dental technicians, dental hygienists, dental therapists, clinical dental technicians and orthodontic therapists in the UK
- **General Medical Council** (GMC) which regulates doctors in the UK

- **General Optical Council** (GOC) which regulates optometrists, dispensing opticians, student opticians and optical businesses in the UK
- **General Osteopathic Council** (GOsC) which regulates osteopaths in the UK
- **General Pharmaceutical Council** (GPhC) which regulates pharmacists and pharmacy technicians in England, Wales and Scotland
- **Health and Care Professions Council** (HCPC) which regulates arts therapists, biomedical scientists, chiropodists/podiatrists, clinical scientists, dieticians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists and orthotists, radiographers and speech and language therapists in the UK, and social workers in England
- **Nursing and Midwifery Council** (NMC) which regulates nurses and midwives in the UK
- **Pharmaceutical Society of Northern Ireland** (PSNI) which regulates pharmacists in Northern Ireland.

2.15 Details of the number of registrants in each health and social care professional regulator we oversee (as at 31 March 2014) are shown below.



Advice and investigations for governments

UK-wide regulation; working with all four governments

2.16 We support the work of the Secretary of State, the National Assembly for Wales, Scottish Ministers and the Department of Health, Social Services and Public Safety in Northern Ireland on issues affecting the regulation of health and social care professionals and any matter connected with a health or care profession.

Advising health ministers

2.17 The Secretary of State and Health Ministers in Scotland, Wales and Northern Ireland may request advice from us about the regulation of health and/or social care professionals or request that we investigate matters of concern.

2.18 The Health and Social Care Act 2012 states that when the levy is in place and the Authority is independent, the Department of Health and devolved administrations will pay a fee to be determined by the Authority for this work.

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

Accreditation of voluntary registers

2.20 The Authority has a role in strengthening quality and patient safety by setting standards for voluntary registers and accrediting them.

2.21 The purpose of the voluntary scheme is to encourage the development of professional conduct, ethical practice and high standards of performance in groups associated with, or affiliated to, the delivery of health and social care where the occupation is not statutorily regulated.

2.22 We provide information about the accreditation scheme on our website and work with interested groups to encourage their participation in the scheme and their preparation for accreditation.

Advice provided to other organisations

2.23 Our legislation permits us to provide advice or auditing services to regulatory bodies and to others that have similar functions to those of a regulatory body whether or not their function relates to health or social care. The recipient must pay the Authority for the advice or audits provided.

2.24 In February 2013, we were commissioned to conduct a review for the Royal College of Dental Surgeons of Ontario. At their request, we reviewed and reported on their performance in relation to the standards of good regulation as adapted for their jurisdiction. This proved a fruitful experience for both the College and the Authority and has resulted in a continuing exchange of ideas and people. The report is published on our website.

2.25 We were commissioned by the Irish Nursing and Midwifery Board to review their fitness to practise processes in the light of changes to its legislation. We submitted our report in March 2014 and it will be published in due course.

2.26 During the year, we have continued to advise the Hong Kong Food and Health Administration through the JC School of Public Heath of the Chinese University of Hong Kong on its reform of health professional regulation in Hong Kong.

2.27 We have contributed to international conferences and seminars, including the International Society for Quality in Healthcare, the National Network of Canadian Regulatory Authorities, the World Health Executive Forum, the European Health Forum Gastein, the General Assembly of the European Council of Liberal Professions, the International Sociological Association (Sociology of Professional Groups) Interim Conference, and the IQ Congress 2014.

Our values

2.28 Our values 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 partners. We are committed to being:

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

2.29 Our values will be explicit in: the way that we work; how we approach our oversight of the registration and regulation of those who work in health and social care; how we develop policy advice; and how we engage with all our partners. We will be consistent in the application of our values to what we do.

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

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

2.32 We promote and support right-touch regulation.[4] This is regulation that is based on an assessment of risk, which is targeted and proportionate, providing a framework in which professionalism can flourish and organisational excellence can be achieved.[5] We will apply the principles of right-touch regulation to our own work.

2.33

Our aim

2.34 The Professional Standards Authority works to raise standards and encourage improvements in the registration and regulation of people who work in health and

[4] Professional Standards Authority. 2010. Right-Touch regulation. Available at http://www.professionalstandards.org.uk/policy-and-research/right-touch-regulation

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

social care. We do this in order to promote the health, safety and well-being of patients, service users and other members of the public.

Strategic objectives

2.35 Our strategic objectives for 2013/15 are set out below. The ways in which we have met them during 2013/14 are discussed in the Chief Executive’s report.

2.36 Our strategic objectives are that we will:

1 – Contribute to the improvement of occupational standards and practice in health and social care by ensuring the Professional Standards Authority is an independent, authoritative, effective, value-for-money organisation acting in the public interest.

We do this through:

- Consistent application of our values
- Dialogue with patients and service users, the public and their representative organisations
- Being committed to inclusion, equality, diversity and human rights
- Promoting regulation's proper role in public safety
- Being clear and positive in our relationships with regulatory bodies and organisations holding voluntary occupational registers
- Active engagement with regulators and others, both within and outside the health and social care sector
- Efficient business practices and cost-effective working
- Publishing annually our business plan and annual report and accounts.

2 – Report clearly and openly on the effectiveness of regulatory bodies in the regulation of health and social care professionals in the interests of patients and the public.

We do this by:

- Working with the health and social care professional regulators we oversee (see Chapter 4) to deliver evidence-based, reliable assessment and robust oversight of their performance
- Reporting annually on the regulators' responses to our performance reviews and audits and on their implementation of our recommendations
- Using our statutory powers to audit and review fitness to practise cases appropriately, including the statutory right of appeal
- Responding appropriately to concerns and complaints raised with us and investigating and reporting openly when necessary
- Being proportionate and focused on outcomes

- Enabling good practice and learning to be shared
- Transparent, resolute and fair public reporting.

3 – Enhance public confidence in unregulated health and care occupations by creating a reliable and effective accreditation scheme for voluntary occupational registers, promoting quality in education and training, registration and standards of conduct.

We do this by:

- Having clearly defined standards of entry to our voluntary registers accreditation scheme
- Ensuring that all holders of voluntary registers which we accredit continue to meet our standards
- Supporting and encouraging the holders of voluntary registers to meet the standards of the accreditation scheme and enabling them to join
- Promoting communication and co-operation between the holders of voluntary registers to share best practice
- Clarifying for and communicating to the public the difference between statutory regulation and voluntary registration
- Enabling the public and patients to make informed choices about the provision of health and social care
- Taking action against those holders of voluntary registers which fail to meet our standards
- Reviewing the effectiveness and efficiency of the scheme
- Ensuring that the scheme is value for money.

4 – Build evidence and promote debate in order to identify best practice in health and care professional regulation and registration and to influence the wider field of regulatory policy.

We do this by:

- Research and analysis of policy in regulation, health and social care both in the UK and overseas
- Responding to commissions for advice from the Secretary of State for Health and the ministers in devolved administrations
- Identifying problems from our performance reviews and recommending solutions
- Publishing research, advice and guidance

- Promoting discussion, debate and learning through seminars and conferences
- Understanding the wider context of regulation including internationally
- Responding with agility to changes in the health and social care context
- Facilitating co-operation and collaboration between regulatory bodies and others.

2.37 We consider how we have achieved these strategic objectives in this report.

The year under review

Risk and uncertainty

2.38 During the year, we continued to face issues arising from our interim status and uncertainty regarding the implementation of our new funding arrangements.

2.39 The 2012 Act introduced the means for funding of the Authority's regulatory work to be changed from Grant in Aid to a fee/levy to be paid by the regulatory bodies. Enabling legislation needs to be commenced in order for the fees to be collected. The Authority continues to work with the Department of Health and others to implement the legislation and related processes.

2.40 During 2013/14, detailed discussions have been held with the Department of Health and HM Treasury and we are hopeful that the necessary legislation will be forthcoming in 2014/15 enabling the new arrangements to commence in the next financial year.

2.41 Since 2013, the Authority has been operating with segmented accounts in preparation for this significant change. We continue to operate as a going concern and have a letter from the Department of Health which guarantees our funding until such time that we become self-funding.

2.42 While the long lead in time has allowed us to focus on other changes, including the introduction of the accreditation of voluntary registers (AVR) scheme, it has meant that work previously undertaken in anticipation of the change may need to be repeated. It has also meant that, from a strategic point of view, we have not known what funding we might have for future years, limiting our long-term planning.

2.43 Our status was considered during the initial discussions about the levy. Although we had been included in the Arm's Length Body review, we were not actually a non-departmental public body and we have been formally reclassified as an 'unclassified public body' pending changes to our funding arrangements. This has had advantages as well as disadvantages. While we have to make fewer contributions to centralised Department of Health reports, as we are not regarded as being a full member of the group, we can at times find that information we require is not immediately available since it is not always apparent that it is relevant to us. During the year, we have maintained close communication with our sponsor unit in order to minimise these issues.

Volume of work

2.44 During 2012/13, we noticed that the number of fitness to practise cases we were receiving had noticeably increased. This trend has continued with a 30 per cent increase in cases during the past year. Full details of this aspect of our work can be found in the Scrutiny and Quality report.

2.45 In addition to an increase in the volume of work, the number of cases that we have appealed or have been subject to other legal action has also markedly increased during the last 12 months.

2.46 Alongside the increase in the volume and complexity of cases, we have had to implement new ways of working as a consequence of changes to the way in which we source external legal advice. We have recruited legally qualified staff to undertake much of the work previously undertaken by secondees from legal firms, reducing our costs and external contracts while giving us greater continuity.

Law Commission Review of the Regulation of Health Professionals

2.47 The Law Commission's review into the legal framework of health and care professional regulation was published on 2 April 2014. We welcomed the prospect of a single legislative framework, and the potential advantages this offers in terms of consistency and efficiency in the delivery of professional regulation and for the Authority's oversight of the sector.

2.48 Based on our initial analysis, we do have concerns that if passed into law, the proposed bill, as it currently stands, may not provide a good statutory basis for the simplification or improvement of public protection.

2.49 We have concerns that some of the changes proposed will make it harder to protect patients and limit the Authority's powers. We have made our views about the provisions in the proposed bill known to the Department of Health.[6]

Key performance indicators

2.50 In our annual business plan, we set out key performance indicators (KPIs)for our work. Our performance against them is discussed regularly with our sponsor unit at the Department of Health.

2.51 Our performance against the KPIs during 2013/14 can be seen in the table below.

Work stream	KPI	Performance
Section 29 decisions	All (100%) relevant decisions to be considered within statutory deadlines	>99.9%
Complaints about Regulatory bodies	All (100%) complaints acknowledged within five working days	93%
DPA & FOI enquiries	All (100%) FOIA and DPA requests dealt with within statutory deadlines	100%

[6] Our full response can be found at http://www.professionalstandards.org.uk/library/document-detail?id=6eff589e-2ce2-6f4b-9ceb-ff0000b2236b

Finance	To pay undisputed invoices: 60% in five days; 100% in 10 days	53% 100%
HR	Sickness no more than 2.5% Staff turnover less than 10%	1.2% 1.8%
Complaints about the Authority	100% of complaints acknowledged in five days Complaints to be completed within 28 days	100% 100%
Accredited voluntary registers (AVRs)	First checkpoint within 15 working days from confirmation of the payment to Authority Applications will be put before the accreditation panel within 21 days of receipt of all information/documentation required	66% 100%

Employees

2.52 The Authority is committed to enabling all employees to achieve their full potential in an environment characterised by dignity and mutual respect. Our employment policies seek to create a workplace in which all employees can give their best, and can contribute to the Authority's, and their own, success.

2.53 We retain the services of Right Corecare and our staff have access to assistance and counselling if required. Details of staff sickness rates can be found in the Remuneration report.

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

2.55 In 2013/14, 75 per cent of our senior management team was female; overall 65 per cent of the workforce was female. Further information about the senior management team can be found in the Remuneration section of this report and in the notes to the accounts.

2.56 The Authority is committed to keeping its staff informed about its performance, development and progress, and encourages staff involvement. During the year under review, a team manager's forum was established, with direct linkage to the Directors group.

2.57 No disclosures have been received in relation to incidents of whistle blowing or bullying.

Training and skills

2.58 We have assessed the competences and key training requirements for all staff and are working to ensure that recruited staff either have or acquire the training required. We intend to use this information in the development of corporate training plans.

Sustainability

2.59 Due to our size, the Authority is not required to provide a sustainability report. We do seek to minimise the impact of our activities on the environment.

2.60 Our office was refurbished before we became tenants, in accordance with the BREEAM environmental assessment standard, which looks at heating, lighting, recycling and other matters; it has an 'excellent' rating. The Authority occupies 2.58 per cent of the building, part of which is occupied by the Authority's tenants.

2.61 Our gas and water consumption is calculated as 2.58 per cent of the total. Our electricity is separately monitored and the consumption for the space rented from the landlord is known. This does not, however, include the consumption by the Authority's tenants. Our consumption for 2013/14 and the previous year is set out below.

	2013/14	2012/13
Gas	4,982kWh	6,297kWh
Electricity	72,406kWh	64,461kWh
Water	162.62 m^3	130 m^3
Waste removed	3.17tonnes	3.23 tonnes

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

2.63 Our offices have facilities to separate waste for recycling; to encourage staff to do this, no waste is collected from bins at desks. Waste is separated into glass, recyclable, non-recyclable and food waste. A contractor separates the mixed recyclables. No waste goes to landfill. Waste that cannot be recycled is incinerated. The food waste is used to produce compost for the landscaped areas around the building.

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

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

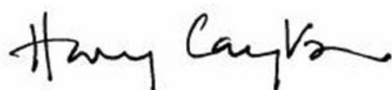
2.66 We continue to seek to reduce the use of paper by maximising the use of our intranet and website for the dissemination of information. We are also using electronic versions of meeting papers where technically practical. Where paper is used, we are looking to reduce its consumption through the active management of printers requiring double-sided printing. We use 'off-white recyled paper' for our day-to-day needs. We used 142 cases of paper in 2013/14 (329 cases in 2012/13).

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

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

Mode of travel	2013/14		2012/13	
	CO^2/kg Total	CO^2/kg Average per full-time equivalent*	CO^2/kg Total	CO^2/kg Average per full-time equivalent*
Air	11,078	320	5,238	206
Rail	760	22	460	18

Approved by the Board.



Harry Cayton
Accounting Officer

9 June 2014

3. Chief Executive's report

Introduction

3.1 I make this report on behalf of the Senior Management team of the Authority. The team includes myself and the three directors. Full details can be found in the Remuneration section. Information about our non-executive board members can be found in the Governance section.

3.2 The purpose of the Professional Standards Authority for Health and Social Care is to promote the health, safety and well-being of patients, service users and other members of the public. We are committed to fulfilling that aim within our statutory powers and duties.

3.3 The primary means by which we achieve that aim is through the exercise of our statutory powers of oversight of the regulators, scrutiny of their fitness to practise cases, and reporting on their performance to the Parliaments and Assemblies of the UK and by the accreditation of voluntary occupational registers of unregulated professions.

3.4 Our oversight of the appointment of members to the Councils of the regulators is now established and we have provided advice to the Privy Council on 10 occasions during the year.

3.5 We also promote consumer confidence, protection and choice though Accredited Voluntary Registers. This scheme accredits the organisations that hold registers of people working in unregulated health and care occupations, such as counsellors and psychotherapists, acupuncturists, sports rehabilitators and public health practitioners. Launched in February 2013, the scheme already includes 11 registers, covering 24 occupations.

3.6 We also promote the public interest in regulation by our work on standards and policy. We provided advice to the Department of Health during the year, including advice relating directly or indirectly to the Mid Staffs Enquiry Report. This included advice on a duty of candour, a fit and proper persons test for managers, and the management and dismissal of poorly performing care workers. We also published papers on alternatives to fitness to practise hearings and lapsing from registers, and we carried out a rapid review of approaches to international registrations for the Parliamentary Under Secretary of State for Health. All advice provided can be found on our website. In addition, we responded to consultation documents issued by the Department of Health and other organisations.[7]

3.7 Building our knowledge of regulation through research, international comparison, seminars and conferences remains an important part of our commitment to quality.

3.8 Our annual Symposium has become an established and highly regarded opportunity for health and care regulators in the UK and elsewhere to meet and exchange ideas and good practice. We think it important to create a space where those charged with the daily delivery of regulation also have time to reflect and think.

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[7] Details of the responses made to consultations can be found at http://www.professionalstandards.org.uk/policy-and-research/policy-advice/consultation-responses

3.9 An important development for us this year has been in our relationship with the House of Commons Health Committee. The Committee intends to hold an evidence session with the Authority annually: both to hold us to account for our work and to seek our perspective on the health and care regulators and registers we oversee. This, in turn, will inform the Committee's own programme of work. Our first evidence session before the Committee took place in July 2013.

3.10 We completed a commissioned review for the Royal College of Dental Surgeons of Ontario and another for the Nursing and Midwifery Board of Ireland. We also continued to provide advice and support to colleagues in Hong Kong as they review health professional regulation there.

3.11 We recognise the importance of maintaining a UK-wide perspective. During the year, the Board reviewed our external relations and communications needs; our objective is to be better aware of developments in the health systems in Scotland, Wales and Northern Ireland, as well as England, and to maintain good working relationships with colleagues across the UK.

3.12 All these activities are reported in more detail below.

Oversight of the regulators

Scrutiny and quality

3.13 The principal aim of our scrutiny of final fitness to practise cases is to improve the standard of the decisions made by the regulators' panels and committees. This can usually be achieved by feeding back learning points to the regulators, rather than by referring cases to court. We usually do this in writing, or sometimes in feedback meetings. The feedback we provide to the regulators may assist them in focusing the training they provide to their fitness to practise panel members, and/or staff. During 2013/14, we have continued to contribute to such training if asked to do so by the regulators.

3.14 This work supports our second and fourth strategic objectives:

> **2 - Reporting clearly and openly on the effectiveness of regulatory bodies in the regulation of health and social care professionals in the interests of patients and the public**
>
> **4 - Building evidence and promoting debate in order to identify best practice in health and care professional regulationo and registration and to influence the wider field of regulatory policy.**

3.15 This year we have again seen an increase in the number of fitness to practise cases notified to us by the regulators, from 2,738 in 2012/13 to 3,566 in 2013/14. This continues the trend of increases year on year in the number of cases, which we noted in last year's report.

3.16 Of the 3,566 cases we received in 2013/14, 2,220 were closed with no requirement for more information. We sought and considered additional information in 429 cases. In 632 of all cases received, we identified learning points to feed back to the regulators. By comparison, in 2012/13 we identified learning points in 328 cases, which represents an increase in the number of learning points we have fed back, even accounting for the overall increase in case numbers.

3.17 We have a range of powers to scrutinise the regulators to ensure that patient safety and public protection are central to their work. Under Section 29 of the National Health Service Reform and Health Care Professions Act 2002, we can refer final fitness to practise decisions made by the nine regulatory bodies to court. We do this if we consider that a decision is unduly lenient (within the meaning of that phrase, as set out in case law) and that a referral is necessary in the interest of public protection. We have continued to use these important powers where necessary for the protection of the public. While the number of fitness to practise cases being managed by the regulators has risen significantly, there continues to be only a small number of cases where the criteria for a court referral are met (see Table 2). It is worthy of note that we have referred to court one in 300 cases during 2013/14, compared to one in 600 during 2012/13: i.e. our rate of referrals has doubled. We believe that may reflect a downward trend in the consistency of good decision making across the regulators, which is a trend we will continue to monitor.

3.18 During 2013/14, we considered 29 cases at case meetings, compared to 10 cases during 2012/13, and we referred 12 cases to court (in 2012/13 we referred four cases to court). In 15 cases, we did not make a referral to court and instead fed back learning points to the regulators; and in the remaining two cases, we took no further action.

3.19 Examples of three cases that we referred to court are set out on pages 18 to 21.

3.20 During 2013/14, we carried out audits of a sample of the cases closed at the initial stages of the fitness to practise process by five of the nine regulators that we oversee. During 2013/14, we audited the handling of cases closed at the initial stages of the fitness to practise process by the following regulators: GMC, HCPC, GDC, PSNI and NMC. The reports of our audit findings are available from our website.

3.21 The evidence that we obtained during the audits in 2013/14 has been used to inform our assessment of risks for the purposes of deciding which regulators to audit in 2014/15.

Performance review

3.22 We carried out our annual performance review of the nine regulators for 2013/14 using the same standards and process as last year. We have continued to use the revised approach to evidence gathering that we initiated in 2011/12 as well as continuing with the revised, briefer reporting structure initiated in 2011/12.

3.23 For the performance review of the health professional regulators in 2013/14, please refer to volume II of this annual report.

Fitness to practise

3.24 There has been a 30 per cent increase in the number of fitness to practise cases notified to us by the nine regulators compared to the previous year. To a large extent, this reflects the increase in the volume of cases being heard by the NMC each day (during 2013/14, it increased the number of hearings per day to 22).

3.25 We have generally reviewed all cases within our statutory deadline, although we note that has proved challenging in some cases where the regulators have not been able to provide us with the hearing transcripts and evidence promptly. In

three cases, we were unable to carry out our review before the expiry of the deadline for an appeal – we have fed back our concerns about this to the relevant regulator who has assured us the problem will be resolved quickly.

3.26 We acknowledge that the number of fitness to practise allegations is increasing significantly for some regulators, and we welcome the attempts being made by regulators to understand the reasons for this increase, in addition to putting more resource into the fitness to practise function to deal with referrals promptly.

3.27 The number of our own appeals has also increased; however, these remain a very small percentage of the total and we do not think general conclusions can be drawn from such small numbers or from one year's data. We will continue to keep these numbers under review.

3.28 Further information about the performance of the regulators and their fitness to practise processes appears in Volume II of this report.

Case study 1: Responsibility of senior nurse for front-line patient care

The Authority referred this case to the High Court in November 2013.

This case was one in which the Nursing and Midwifery Council's (NMC's) Conduct and Competence Committee (CCC) had found that the registrant had failed in respect of her role as the Director of Nursing/Chief Nurse at an NHS Trust. The CCC found that the registrant had exposed patients to risk, and in one instance “danger”. The key findings by the CCC were that the registrant had:

- Not ensured adequate staffing levels and skills mix of staff on particular wards, that staffing levels were her responsibility, that in her position she knew or ought to have known that staffing levels were inadequate and that she should have addressed these issues appropriately
- Not ensured that record keeping was conducted to the appropriate standards on particular wards
- Not ensured that nutrition and fluids were provided to an appropriate standard on the Emergency Assessment Unit (EAU)
- Not ensured that patient dignity and privacy had been adequately maintained on the EAU
- Spoken inappropriately to one member of staff
- As a result of the failure to ensure adequate staffing levels or an appropriate mix of skills, allowed a situation to arise where patients were exposed to risk on one Ward, on A&E, on the EAU and also to danger in A&E.

The CCC found that the registrant was expected to act as the foremost nurse at the Trust; ensure a high level of nursing provision; and act as an example to, and a voice for, other nurses at the Trust. The CCC also found that the registrant had a responsibility to raise issues that included inadequate staffing levels, skills mix and provision of nursing care across the Trust with the Board. While the CCC took into account that the Trust had been under significant financial pressure and turmoil at the time, it found that the registrant had lost sight of what was required in that role. The CCC found that the registrant had disregarded direct operational

responsibilities and limited herself to a strategic role, and so the registrant had, in failing to ensure adequate nursing provision at the Trust, placed patients in danger.

The CCC found that the registrant had shown no insight into her previous conduct and therefore it could not rule out that the registrant would act in the same way again. However, in imposing the sanction, the CCC differentiated between the seriousness of failings in administration and those of a clinical nature. The CCC imposed a caution order which would be noted on the register, but which would not have any restrictive effect, thereby allowing the registrant to return to full practice.

The Authority referred this decision to the High Court on the following grounds: (a) the CCC's finding at the sanction stage was inconsistent with its finding at the impairment stage that the registrant was liable to put patients at risk; (b) the CCC was wrong to distinguish between misconduct in administration and misconduct in care; (c) the CCC failed to apply or consider the NMC's Indicative Sanctions Guidance; (d) the sanction imposed did not pay sufficient regard to public interest considerations.

The Authority was also concerned that the NMC had failed to put all relevant evidence before the CCC. A number of the allegations at the NMC hearing were not found proved because the CCC concluded that the NMC had not gathered enough evidence. While the Authority included this as a ground of appeal, it was withdrawn before the hearing in order to facilitate resolution between the parties.

The High Court approved a consent order between the Authority, the NMC and the registrant in January 2014 allowing the appeal, quashing the decision of the CCC and substituting a decision of erasure.

In this case, the Authority was also required to apply to the High Court for interim relief requiring the NMC to hold the registrant on its register until the outcome of the appeal. Under Section 29 of the National Health Service Reform and Health Care Professions Act 2002 (as amended), the Authority has 40 days in which to review a determination by a regulator and to lodge an appeal. While some of the regulators the Authority oversees have the legal power to hold a registrant on their register until any Court appeal that the Authority decides to lodge has been concluded, this is not the situation in relation to the NMC. The NMC's legal framework means that once the NMC's own fitness to practise hearing is concluded, the nurse may 'lapse' from the NMC's register if they have not complied with the requirements for renewing their NMC registration. In this case, the registrant had not renewed her registration with the NMC and was not subject to either a conditions of practice order or suspension order, and therefore her registration would have lapsed before the appeal was heard by the Court had the Authority not asked the Court to intervene to prevent that from happening. This was the second time during 2013/14 that the Authority had to ask the Court to intervene in this way. On both occasions, the Court held that allowing the registrant to lapse from the register would frustrate the Authority's ability to take action under its Section 29 powers, and accordingly the Court ordered the NMC to hold the registrant on the register until the appeal had been concluded.

Case study 2: Dishonest communication with patients is serious misconduct

The Authority referred this case to the High Court in September 2013.

This case was one in which the General Dental Council's (GDC's) Professional Conduct Committee (PCC) had found that the registrant had provided deficient care to a patient at two consultations in late 2011. The key aspect of the patient's complaint was that the registrant had extracted the wrong tooth.

The PCC found that there had been various clinical failings during the course of the consultations, including: the unnecessary and inappropriate removal of the tooth; poor record-keeping practices; and inappropriate prescribing of antibiotics. The PCC also found that the registrant had written two letters in response to the complaint in which the registrant had falsely and dishonestly claimed that the patient had pointed to the lower part of her mouth as the source of the pain; rejected the offer of antibiotics; and specifically asked for the wrong tooth to be extracted.

The PCC found that the registrant's clinical practice raised no current concerns; however, the PCC found that, given the allegations in relation to the registrant's dishonest behaviour, as well as his limited appreciation of the seriousness of the matter, a finding of impairment was required on public interest grounds. The PCC imposed a reprimand on the basis that it was highly unlikely that there would be a repetition of the dishonesty and that the registrant had not been motivated by financial gain but had acted “out of a misguided sense of self-preservation”.

The Authority referred this case to the High Court on grounds that included: (a) the sanction was manifestly wrong in that it failed to reflect the seriousness of the misconduct; (b) the PCC had failed to have any, or any adequate regard to the GDC's Guidance for the Professional Conduct Committee; (c) the PCC's reasons for finding that a reprimand was sufficient sanction were irrational, inconsistent and insufficient; and (d) the terms of the reprimand were inappropriate in that they failed to make any reference to the proved dishonesty.

The High Court approved a consent order between the Authority, the GDC and the registrant in March 2014 allowing the appeal and substituting a decision of three months' suspension with a review hearing before the expiry of the suspension order to take effect from April 2014.

Case study 3: Social worker's failure to visit or keep proper records

The Authority referred this case to the High Court in February 2014.

The case was one in which the Health and Care Professions Council's (HCPC's) Conduct and Competence Committee (CCC) had found that the fitness to practise of the registrant (a social worker) was impaired in relation to a number of matters relating to case management and record keeping while the registrant worked within the Children's Services division of a County Council. The County Council received a complaint about the registrant that triggered a limited audit of her work. When concerns were raised about the standard of the record keeping, the registrant was given an opportunity to update the records, and then told managers that she had done so. On re-checking the files, the reviewing manager noted little if any change, and so a wider investigation commenced. During the course of the internal investigation, the registrant claimed that she had undertaken visits that were not supported by the records.

The allegations made by the HCPC related to concerns linked to five families, all of whom had children who were the subject of child protection plans or other child protection measures. The allegations were in connection with: record keeping; failures to visit children and to hold meetings with families and relevant professionals at a 'safe frequency'; and, in relation to family A, that the registrant had misrepresented the outcome of two home visits in a child protection review conference report, stating on one occasion that a child had been seen, when in fact no one was home, and on another, stating that the child was “ok” when the registrant had not attended the home.

The Authority referred this case to the High Court on the grounds that: (a) the HCPC had failed to allege that the registrant's actions in relation to family A were dishonest and, had an allegation been found proved, it was likely that a more severe sanction would have been imposed; (b) when considering sanction, the CCC did not properly consider the registrant's lack of insight and the seriousness of the registrant's conduct in providing false information to the child review panel, the risks to the relevant families and the HCPC's Indicative Sanctions Guidance; (c) the CCC did not explain how the decision to impose a conditions of practice order was appropriate, taking into account the HCPC's Indicative Sanctions Guidance, the public interest, and also that the terms of the conditions themselves were inadequate. In particular, the conditions did not require any supervision or any adequate monitoring of the registrant's practice.

The Authority lodged the appeal in February 2014 and then stayed the proceedings, having been informed that the HCPC intended to request that another CCC review the decision (the HCPC has the power to do this under its legal framework). At a hearing in March 2014, the CCC considered an application for voluntary erasure that had been made by the registrant. The application was granted and the registrant was removed from the HCPC's register of social workers. The registrant will not be entitled to apply for restoration to the register for five years and if she does apply for restoration at that time, her application will be treated in the same way as if she had been struck off the register at the CCC hearing.

Table 1

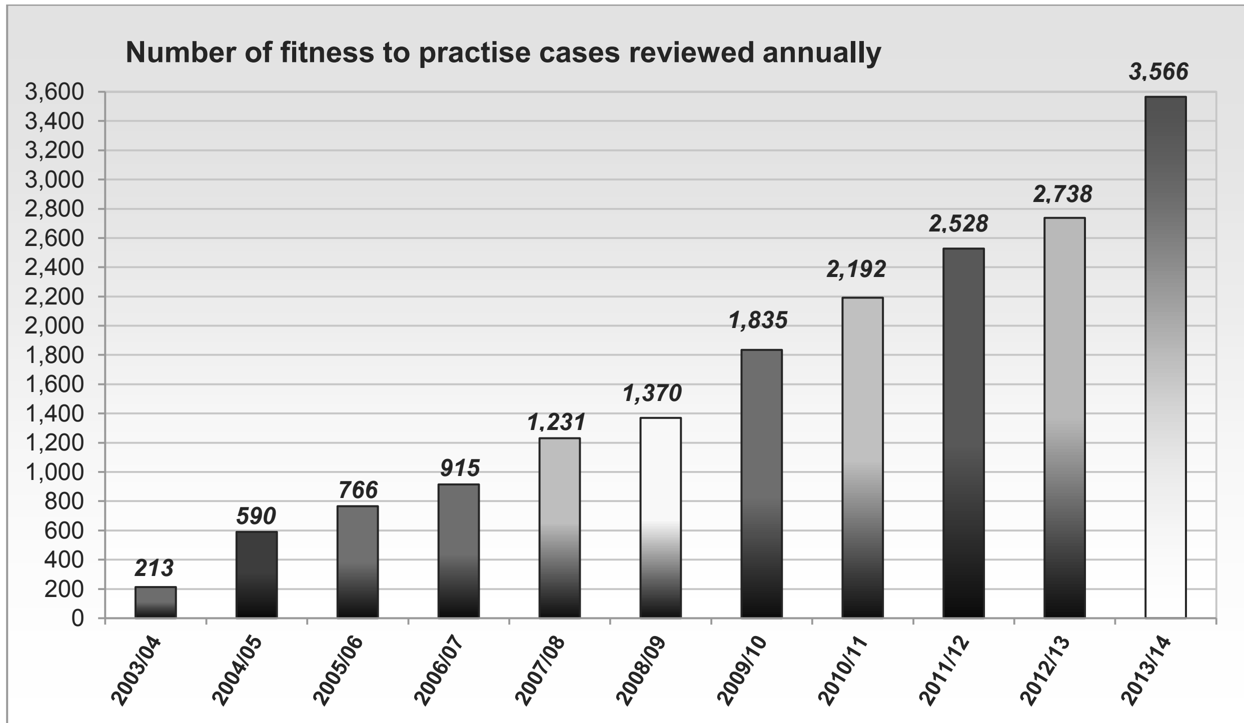
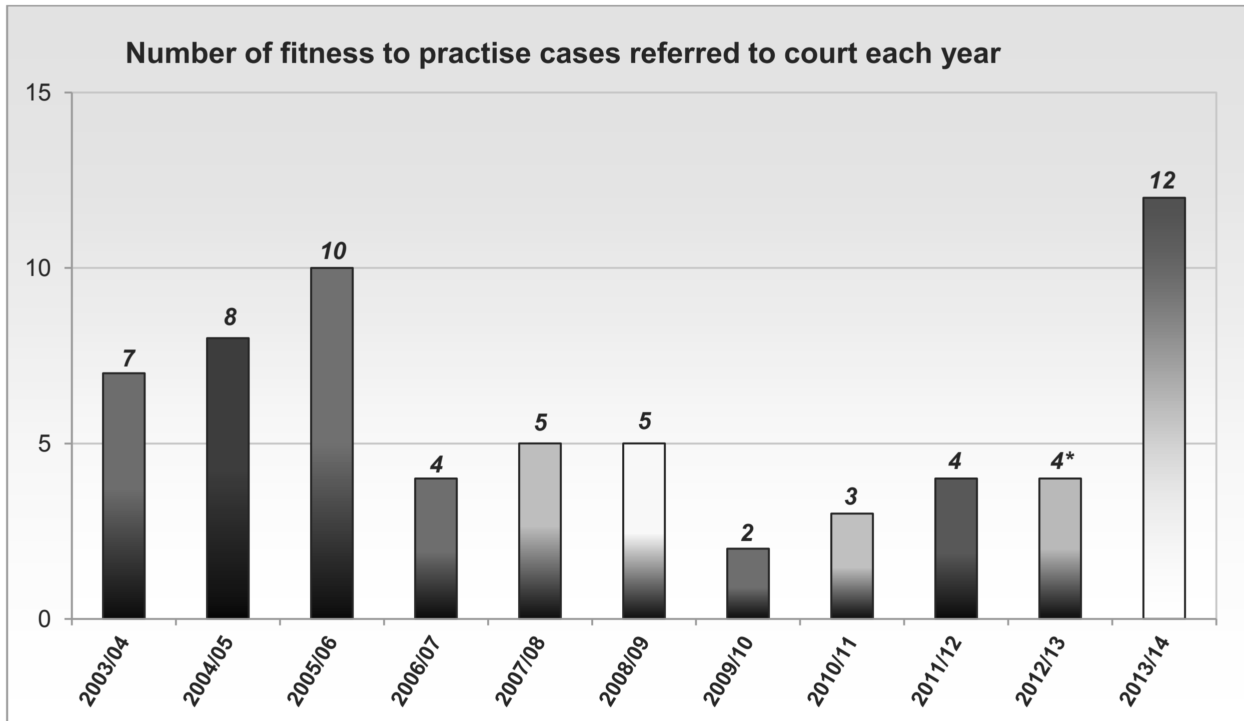


Table 2



** In 2012/13, four cases in total were referred to court, with one case withdrawn by CHRE/the Authority.*

Scrutiny of regulators' council appointments processes

3.29 Since 1 July 2012, the Authority has assisted the Privy Council with appointments to the regulatory councils (excluding the PSNI). We acquired this role with the commencement of Section 227 of the Health and Social Care Act 2012. Since August 2012 we have provided advice to the Privy Council in relation to all processes to make appointments to regulators' councils.

3.30 Under these provisions, the Privy Council has the power to make the appointments, but can make arrangements with others, including the Authority and the regulators, to assist it with this function. In practice, this means each regulator is responsible for all aspects of the recruitment/selection process up to the point it has decided which candidates it considers should be appointed. The regulator then recommends the candidates to the Privy Council. If the Privy Council accepts the recommendation, it makes the appointments, informed by the Authority's advice about the process the regulator has used.

3.31 We scrutinise each appointments process and assess whether it adheres to the principles of appointment on merit, fairness, transparency and openness, and the extent to which it inspires confidence. Once we have scrutinised evidence provided by the regulator at the point they recommend candidates to the Privy Council, if we are satisfied that a process has adhered to all these principles, we advise the Privy Council that it can have confidence in the process.

3.32 The scope of our assistance to the Privy Council is limited to scrutinising the process the regulator has used to select candidates to recommend for appointment. We take no view on the suitability of individuals for particular roles; wherever possible, we avoid knowing the identities of recommended candidates. We also do not prescribe the process regulators must use, in line with a right-touch approach. As long as a regulator can demonstrate that its process adheres to the four principles, it may implement a process which best suits its own needs and resources.

3.33 The nature of the Authority's assistance to the Privy Council, which is not specified in the Act, is the subject of a memorandum of understanding concluded between the Privy Council and the Authority in February 2013. We agreed that we will provide advice to the Privy Council in relation to all open competitions and reappointments processes and, if the Privy Council requests it, in relation to any other aspect of the Privy Council's appointments function. We have published two documents detailing our approach, describing the scrutiny process we use and providing good practice guidance on making council appointments. Revised and updated versions of these documents were published in January 2014, after a comprehensive review of our process following its first year of operation.

3.34 In 2013/14, we provided advice to the Privy Council in relation to 10 processes run by six regulators. Nine of these processes related to appointments via open competition, covering 42 vacancies including two chair roles. We advised the Privy Council that it could have confidence in these processes. The tenth instance in which we provided advice was in relation to the extension of the term of office of the Chair of the NMC. We advised the Privy Council that this process did not fully adhere to our principles of a good appointments process, principally because there had been no transparent, competitive selection process either in relation to the NMC Chair's initial appointment or the extension of the term. Other

considerations at the time meant that the Privy Council did extend the NMC Chair's term by nine months. However, it did so on the basis that no further extensions would be made, meaning that the next Chair would need to be appointed following a full open competition.

3.35 In the course of our scrutiny, we have identified areas for improvement as well as instances of good practice. We have sought to share learning among the regulators, and for this purpose held a seminar in July 2013 which the eight regulators and the Privy Council Office attended. The seminar also provided an opportunity to gain feedback from attendees to inform our review of our process. During the review, we also sought input from health departments in all four countries and others active in the wider field of public appointments, including the Office of the Commissioner for Public Appointments. The revised guidance documents we published in January 2014 reflect the outcome of the review, and incorporate many of the lessons learnt since 2012. We will continue to seek to promote good practice in this area, and will publish further guidance as required.

Standards and policy

Advice on matters related to the regulation of health and care professionals

3.36 The Standards and Policy team work to improve the regulation of people working in health and social care. In doing so, it keeps the regulators informed about developments in other regulatory areas and how these could be transferred to health and social care sector. The team responds to consultations undertaken by the regulators and others. It is also responsible for the promotion of the work of the organisation and its relationship with the public and patients.

3.37 This work underpins and supports our second and fourth strategic objectives:

> **2 - Reporting clearly and openly on the effectiveness of regulatory bodies in the regulation of health and social care professionals in the interests of patients and the public**
>
> **4 - Building evidence and promoting debate in order to identify best practice in health and care professional regulation and registration and to influence the wider field of regulatory policy.**

3.38 In August 2013, we published good practice advice on lapsing registration. This work was prompted by findings in our 2011/12 Performance Review that indicated a wide variation in approaches to the lapsing of registration across the regulators. Our report found that there could be some benefit to harmonising the approaches to renewal across the regulators to provide greater clarity for employers. We also recommended that regulators consider what practical measures they could implement to support registrants to meet the renewal requirements.

3.39 We have responded to 15 consultations over the year, including the GMC's consultation on English language requirements, the NMC's consultation on revalidation and several relating to indemnity insurance requirements.

3.40 Our accountability and relationship with the Health Committee was enhanced this year following a recommendation in the Francis Report (2013).[8]

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[8] Available at http://www.publications.parliament.uk/pa/cm201314/cmselect/cmhealth/657/65704.htm#a4

3.41 The Committee wrote in its report, 'After Francis':

> *'Robert Francis recommended that the Committee, through its arrangements for regular accountability hearings with professional and system regulators and otherwise, should monitor the implementation of his recommendations and the development of the cultural change in the NHS which he considers vital. The Committee agrees with Robert Francis' recommendation for its role in monitoring implementation of his recommendations. The Committee therefore proposes to enhance its scrutiny of regulation of healthcare professionals by taking public evidence each year from the Professional Standards Authority for Health and Social Care (the PSA, formerly the Council for Healthcare Regulatory Excellence) on the regulatory environment and the performance of each professional regulator, based on the PSA's own annual report. The Committee held an initial evidence session on 9 July 2013 with representatives of the PSA to examine its annual report and performance review for 2012/13.*[9]
>
> *The Committee plans to draw on the views expressed by the PSA in its reports and in these sessions in preparing for its regular accountability hearings with the GMC and the NMC. It will also examine the case for inviting other professional regulators under the PSA's remit to appear before it from time to time, in the light of the views expressed about their performance by the PSA.*
>
> *The Francis Report demonstrated that failure of professional responsibility was a key factor that contributed to failures of care at the Mid Staffordshire NHS Trust. The Committee has also consistently emphasised the importance of an open and accountable professional culture in its own reports during this Parliament. It welcomes Robert Francis' recommendation that there should be enhanced parliamentary oversight of the quality of professional regulation, and it intends to develop its relationship with the PSA to make this oversight as effective as possible.'*

3.42 Our support for the Committee's scrutiny takes a range of forms:

- The performance review report, and audit reports as they are published
- Our annual meeting with the committee following the publication of our performance review
- Written evidence ahead of each individual meeting with the regulators, including section 29 data where appropriate
- Additional briefings on topics identified by the Committee—for example, we were asked to provide information on the transfer of the social work register to HCPC ahead of the accountability meeting in January.

[9] Available at [13 http://www.publications.parliament.uk/pa/cm201314/cmselect/cmhealth/657/65704.htm#note13

Our relationship with the public, regulators, and other stakeholders

3.43 We commissioned advice on our approach to consulting and involving patients and service users in England, Northern Ireland, Wales and Scotland to take account of our expanded responsibilities including the operation of our accreditation scheme for voluntary registers. This will inform our new engagement plan to be developed in 2014/2015.

3.44 We have continued to publish our quarterly e-newsletter, which is circulated to members of our three networks: the public stakeholder network, professional stakeholder network and the Accredited Voluntary Registers network. We have also scoped work to enhance our web and online publications to ensure that the information we provide is as accessible and useful to our stakeholders as it can be.

3.45 We have had continuing dialogue with the Law Commissions as they developed their proposals for the Health and Care Professions Bill. We have supported the Department of Health led system response to Francis, contributed to the duty of candour review (Williams and Dalton), contributed to the Parliamentary and Health Service Ombudsman's report on midwifery, and supported a number of working groups, including the Cavendish Governance Board.

Promoting research, discussion and debate

3.46 We have continued to promote discussion and debate in the sector, to encourage the sharing of ideas, promote learning from good practice and ensure that the interests of the public are at the centre of regulatory policy development.

3.47 We have continued to build our network of academics interested in different aspects of professional regulation. The Authority held its first academic conference on 28 March 2014 at Cumberland Lodge, Windsor Great Park, in collaboration with the International Care Ethics Observatory, University of Surrey. The theme of the one-day conference was 'Improving Professional Regulation: Interprofessional Insights'. 25 presentations through the day set out research into different aspects of regulation that was either complete or underway. 75 people attended, including academics from 18 different institutions and a wide range of academic disciplines. Guests from outside the UK came from the Netherlands, Canada, the US and Turkey.

3.48 The themes of the conference included regulators' engagement with the public, how regulators influence registrants, continuing fitness to practise, understanding risk, regulatory design, professionalism, and culture and behaviour. Dr Jean Moore from the State University of New York and Professor Ivy Lynn Bourgeault from the Institute of Population Health at the University of Ottawa closed the day with a discussion on the relationship between the professions, workforce planning, and the state in regards to regulation.

3.49 We held a seminar on the regulators' current research priorities jointly with the Department of Health on 3 December 2013. Regulators presented on current research being pursued, future priorities, and resources. Representatives from health and social care regulators attended, including eight professional regulators, two system regulators, and the Parliamentary and Health Services Ombudsman. In addition, academics with a background in regulatory research and representatives from HealthWatch attended.

3.50 The Authority held its annual symposium at Cumberland Lodge, Windsor Great Park, on 20–21 February 2014. The focus of discussion was the government's response to the Francis Report and the final report and draft Bill from the Law Commission. The event was attended by 58 people including Chief Executives and Chairs of the regulators we oversee, the regulators of social workers in Scotland, Wales and Northern Ireland, government officials, the commissioner for Public Law and members of the public law team, systems regulators, senior regulatory lawyers, public representatives, academics, the Scottish Public Services Ombudsman, and the Chair of the Ontario Health Professions Regulatory Advisory Council.

3.51 The Chief Executive and the Research and Knowledge Manager co-authored a paper for the Health Foundation, 'Asymmetry of Influence', which was published in October 2013. This thought paper discusses the relationship between regulators and those they regulate—be they people, places or products—and the impact this can have on patient safety. It proposes that regulators should work together to create a regulatory system which minimises the multiplicity of different sources of guidance and direction, which is consistent and clear, and which can be seen to be a single regulatory force with different elements. By working together to create conditions which promote engagement with professional responsibility and identity, regulators can create a consistent regulatory system within which safe care can flourish.

3.52 In response to growing interest from the regulators in alternatives to hearings at the final fitness to practise panel stage, we commissioned independent research from Research Works, a specialist research company, on public responses to these alternatives. We found that there was strong support for these different methods, because hearings were seen as very stressful experience for complainants and witnesses. However, there were also concerns that these alternatives could lead to less thorough investigations, overly lenient sanctions, a lack of transparency, and the loss of the complainant's voice in the process.

3.53 Plans to carry out three research projects this year were paused when the Department of Health informed the Authority and other bodies that only business-critical work should be completed that year. While we consider these projects to be necessary, we decided that we could delay them until the next financial year. These projects are two consumer research projects related to social work to aid our work in this area and a collaboration with Surrey University to assess the usability of data we hold relating to fitness to practise cases to support thematic research.

Strengthening relationships across the UK, in Europe and worldwide

3.54 We continue to monitor developments in regulation internationally, retain our membership of international organisations and seek opportunities to share good practice and promote ideas and debate. In this, we are increasingly supported by our growing international review work.

3.55 We held a seminar with Professor Ron Paterson, New Zealand Parliamentary Ombudsman entitled Reforming Professional Regulation; an international perspective. The Chief Executive of the Authority interviewed Professor Paterson about his views on regulatory reform, his insights into international developments

in regulation, and his reflections for the UK following the final report of the Francis Inquiry.

3.56 We have given presentations at several research conferences nationally and internationally. In November, we spoke at the Annual Regulation Conference in Scotland and in March at the Care Council for Wales's regulatory conference about the scope to use fitness to practise data to reduce misconduct in the future. Other engagements included: a social care ethics conference, University of Surrey; CEPLIS General Assembly; Madrid, International Sociological Association (Professions), Lisbon 28–30 November; and IQ Kongress Berlin 4–5 February.

Advice to, and investigations for, governments

3.57 Our legislation enables UK health ministers to request our advice on any matters connected with healthcare professions or to investigate and report on matters relating to our functions. In 2012, the remit of this advice was extended to accommodate changes to the regulation of social workers in England, and the introduction of accredited voluntary registers by the Health and Social Care Act 2012. In all instances, the Authority must comply with the request.

3.58 Recommendations about candour, openness and transparency in the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry prompted two separate requests for advice. In July 2014, we advised the Secretary of State for Health on Robert Francis' recommendations to introduce a statutory duty of candour between regulated professionals and their employers and make it a criminal offence for registered professionals to obstruct candour or make misleading or untruthful statements. In September 2014, we advised how professional regulation could encourage professionals to be more candid with patients and service users when healthcare or social work goes wrong. Our advice[10] identified a number of areas where professional regulation could be improved to encourage more candour and advised the Secretary of State how he could support these improvements. To inform this advice, we conducted a rapid literature review[11] which explored the factors that encourage and discourage professionals from disclosing mistakes and reporting safety concerns, and considered what this could mean for professional regulation.

3.59 In response to the Cavendish Review, the Secretary of State for Health asked us for advice on how health and social care employers could be more effective in dismissing underperforming staff. We recommended that if the Department of Health wishes to develop further guidance and support for employers, it should communicate the benefits of investing in performance management and direct employers to existing ACAS guidance and support as well as related sector-specific guidance.

3.60 We received a commissioning letter from the Department of Health on 1 August 2013 asking us to review the processes used by the nine regulators whom we oversee for registering international applicants: that is, those trained and applying

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[10] Available at http://www.professionalstandards.org.uk/docs/default-source/psa-library/candour-advice-to-secretary-of-state---final.pdf?sfvrsn=0

[11] Available at http://www.professionalstandards.org.uk/docs/default-source/psa-library/candour-research-paper---final.pdf?sfvrsn=0

from outside the European Economic Area, (EEA). In this rapid review, we set out the range of approaches adopted by the regulators, and gave examples of how they assure themselves of the applicant's language ability, identity, academic qualifications, registration, and experience. We also reviewed training or adaptation requirements, and identified some points of interest and notable practice. Our report was published in October 2013.

3.61 In January 2014, we commenced work on a commission on implied consent, which stemmed from a recommendation in the Caldicott review of Information governance published in March 2013. This commission is ongoing.

Accreditation of voluntary registers

3.62 This work supports our third strategic objective:

> **3 - Enhancing public confidence in unregulated health and care occupations by creating a reliable and effective accreditation scheme for voluntary occupational registers, promoting quality in education and training, registration and standards of conduct.**

3.63 The Health and Social Care Act 2012 has given the Authority the power to accredit voluntary registers that meet our standards in the interests of service users and the public. The Accredited Voluntary Registers scheme, launched in 2013, applies to the health and care sector in the UK. It was established to provide assurance that voluntary registers are well run and achieve the Authority's 11 standards, including:

- Governance
- Setting standards for registrants
- Education and training
- Managing the register
- Complaints and information.

3.64 Being accredited means that an organisation has satisfied the Authority that it meets its high standards. It is a mark of quality. Accredited registers are entitled to use the Professional Standards Authority's accreditation mark (see picture 1 below) so that they can be distinguished easily. The quality mark will give extra peace of mind for anyone looking for a practitioner, letting them know that anyone who holds the mark has committed to the high standards of personal behaviour, technical competence and business practice (where applicable) of the organisation holding an accredited voluntary register.

3.65 Since the scheme launched, we have accredited 11 registers, covering 24 occupations and approximately 47,000 practitioners. Accreditation is renewable annually. The first two registers accredited, the British Association of Counselling and Psychotherapy and the British Acupuncture Council, applied to renew and have been successful. By the end of the financial year, six organisations were undergoing assessment.

3.66 The following organisations have been accredited:

- British Association for Counselling and Psychotherapy
- Play Therapy UK
- National Counselling Society

- National Hypnotherapy Society
- British Acupuncture Council
- United Kingdom Council for Psychotherapy
- Alliance of Private Sector Practitioners
- Complementary and Natural Healthcare Council
- British Association of Sport Rehabilitators and Trainers
- Federation of Holistic Therapists
- UK Public Health Register.

3.67 To encourage learning and improvement, we held a seminar for AVRs in October 2014 and our first annual good practice conference took place in March. We also held a seminar in Scotland to raise awareness of the scheme. In addition, we ran four workshops for organisations planning or preparing to apply.

3.68 During the year, we have met with senior stakeholders to inform them about the scheme and its benefits including: NHS England, NHS Employers, Ofsted, Health Education England, QAA, Ofqual, NHS Blood and Transplant, Advertising Standards Authority, HMRC, private health providers and insurers. We also spoke at a number of events. Information about the scheme is now available on several online portals used by patients and service users such as NHS Choices in England and NHS Inform in Scotland. It is also recognised by the Any Qualified Providers scheme and information about the scheme is included regularly in Clinical Commissioning Group bulletins, and bulletins issued by NHS Employers.

3.69 We noted that all of the organisations who applied to have their registers accredited willingly made a number of improvements in preparing for their application and during the assessment process in order to meet our standards.

3.70 We received and considered 20 concerns and complaints about AVRs. All of the issues raised have been resolved.

Advice provided to other organisations

3.71 Our legislation permits us to provide advice or auditing services to regulatory bodies and to others that have similar functions to those of a regulatory body, whether or not their function relates to health or social care. The recipient must pay the Authority for the advice or audits provided.

3.72 In February 2013, we were commissioned to conduct a review for the Royal College of Dental Surgeons of Ontario. At their request, we reviewed and reported on their performance in relation to the standards of good regulation as adapted for their jurisdiction. This proved a fruitful experience for both the College and the Authority and has resulted in a continuing exchange of ideas and people. The report is published on our website.

3.73 We were also commissioned by the Irish Nursing and Midwifery Board to review their fitness to practise processes in the light of changes to their legislation. We submitted our report in March 2014 and it will be published in due course.

3.74 During the year, we have continued to advise the Hong Kong Food and Health Administration through the JC School of Public Heath of the Chinese University of Hong Kong on their reform of health professional regulation in Hong Kong.

3.75 We have also contributed to a number of international conferences and seminars including: the International Society for Quality in Healthcare; The National

Network of Canadian Regulatory Authorities; the World Health Executive Forum; the European Health Forum Gastein; the General Assembly of the European Council of Liberal Professions; the International Sociological Association (Sociology of Professional Groups) Interim Conference; and the IQ Congress 2014.

Governance and operations

3.76 This work underpins our first strategic objective:

> **1 - Contributing to the improvement of occupational standards and practice in health and social care by ensuring the Professional Standards Authority is an independent, authoritative, effective, value for money organisation acting in the public interest.**

Accounts and audit

3.77 Our accounts have been prepared according to Determinations by the Secretary of State pursuant to Schedule 7, Paragraph 15 of the National Health Service Reform and Health Care Professions Act 2002, as amended by the Health and Social Care Act 2008 and the Health and Social Care Act 2012.

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

3.79 Our external auditor is the Comptroller and Auditor General. PricewaterhouseCoopers were contracted to undertake the internal audit function via the Department of Health Internal Audit framework arrangement.

3.80 This report has been prepared in accordance with the 2013/14 government Financial Reporting Manual (FReM) issued by HM Treasury.

3.81 As far as we are aware, there is no relevant audit information of which the auditors are unaware, and we have taken all the steps to make ourselves aware of any relevant audit information and to establish that the auditors are aware of that information.

Financial summary

3.82 Grant in aid funding for 2013/14 comprised £2.8m (2012/13: £3.30m) from the Department of Health and £0.33m (2012/13: £0.38m) from the devolved administrations. As at 31 March 2014, we had reserves carried forward of £0.80m (2012/13: £0.80m) after net operating costs of £3.20m (2012/13: £3.20m).

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

Transparency

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

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

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

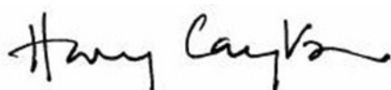
3.87 During the 2013/14 financial year, 100 per cent of invoices were paid within 10 days and 53 per cent (by number of invoices) and 46 per cent (by total invoice value) were paid within five days. Details of our payment record can be found on our website.[12]

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

3.89 The balance owed to trade creditors as at 31 March 2014 was £73,000 (2012/13: £47,000). As a proportion of the total amount invoiced by suppliers in the year, this is equivalent to 15 days (2012/13: seven days). The increase in the number of days arises from the significant fall in the amount invoiced by suppliers in the year, particularly in relation to legal and professional fees as shown in note 4 to the accounts.

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

- Expenditure over £25,000
- Council member expenses
- Management team expenses
- Hospitality
- Staff salaries
- Staff organogram.



Harry Cayton

Accounting Officer

9 June 2014

[12] www.professionalstandards.org.uk/about-us/disclosure-and-transparency/government-disclosure/payment-statistics

4. Remuneration report

4.1 Our pay policy incorporates a band structure within which staff can progress along incremental points within a given band alongside a performance appraisal process. No performance-related pay bonuses are paid. Normal practice would be for the Remuneration Committee to consider an annual uplift to reflect a cost of living increase payable from October. In line with the pay guidance for government employees issued by the Cabinet Office in 2010, the uplift has been centrally determined.

4.2 Progression through the pay band increments is subject to meeting certain performance standards, as defined in the policy. All staff receive an annual appraisal in April and, where performance has reached the agreed standard, progression within their band takes place in April.

4.3 We were instructed by the Department of Health in 2010/11 that as the annual increments were not contractual, the Cabinet Office guidelines prohibited us from paying them. Accordingly, 2013/14 was the fourth consecutive year that the staff received no increments.

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

4.5 A total of 97 days (2012/13: 74 days) were lost due to sickness absence in the year. This equates to 2.3 days (2012/13: 2.3 days) per person.

Senior managers' contracts

Name	Title	Date of contract	Unexpired term	Notice period
Linda Allan	Director of Governance and Operations	15 March 2010	Permanent contract	3 months
Christine Braithwaite	Director of Standards and Policy	17 May 2010	Permanent contract	3 months
Harry Cayton	Chief Executive	1 August 2007	Permanent contract	6 months
Rosalyn Hayles	Director of Scrutiny and Quality	15 August 2010	Permanent contract	3 months

Senior managers' salaries

Name	Salary 2013/14 (£'000)	Salary 2012/13 (£'000	Real increase/ (decrease) in pension at age 60 (£'000)	Total accrued pension at 31 March 2014 (£'000)
Linda Allan	80–85	80–85	0–2.5	5–7.5
Christine Braithwaite	80–85	80–85	0–2.5	10–12.5
Harry Cayton	140–145	140–145	0–2.5	20–22.5
Rosalyn Hayles	75–80	75–80	0–2.5	2.5–5

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

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

4.7 A register of senior managers' interests is available on our website.

4.8 Under the government's *Financial Reporting Manual*, the Authority is required to disclose the relationship between the salary of the most highly paid director (the Chief Executive) and the median earnings of the overall Authority workforce.

4.9 The baseline salary of the Chief Executive in the financial year 2013/14 was £142,000. This was 3.47 times the median salary of the workforce, which was £41,000.

4.10 The salary of the Chief Executive in the financial year 2012/13 was £141,000. This was 3.47 times the median salary of the workforce, which was £41,000.

4.11 No employees received remuneration[13] in excess of the Chief Executive in 2013/14 or 2012/13. Remuneration ranged from £20,000 to £142,000 (2012/13: £20,000 to £141,000).

[13] Other than the disclosed package in note 3, total remuneration includes salary only and there were no non-consolidated performance-related pay, benefits-in-kind or severance payments in 2013/14 or 2012/13. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Pensions

Name	Title	Value of accrued pension (£'000) at 31.3.2014	Accrued elated lump sum (£'000) at 31.3 2014	Real increase/(decrease) in related lump sum (£'000)	Cash Equivalent Transfer Value as at 1 April 2013 (to nearest £1,000)	Cash Equivalent Transfer Value as at 31 March 2014 (to nearest £1,000)	Real increase in the Cash Equivalent Transfer Value during the reporting year (to nearest £1,000)
Linda Allan	Director of Governance and Operations	5–7.5	N/A*	N/A	62	86	23
Christine Braithwaite	Director of Policy and External Relations	10–12.5	35–37.5	2.5–5	229	259	27
Harry Cayton	Chief Executive	20–22.5	20–22.5	-2.5–0	352	409	51
Rosalyn Hayles	Director of Scrutiny and Quality	2.5–5	N/A*	N/A	31	44	13

* Not applicable in 2008 scheme

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

Cash Equivalent Transfer Value
A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the members' accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another scheme or arrangement when the member leaves a scheme and chooses to transfer the benefit accrued in the former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figure, and from 2005/06 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS Pension Scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETV are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

4.12 No compensation has been paid to former senior managers, nor payments made to third parties for the services of a senior manager.

Authority members' remuneration

4.13 Remuneration for the Chair and Board members is not subject to superannuation.

4.14 Payments made to the Board are also subject to Cabinet Office guidance and have not increased since 2009/10. The Chair receives remuneration of £33,688 pa (2012/13: £33,688); members receive annual remuneration of £7,881 (2012/13: £7,881) and the Audit and Risk Committee Chair receives annual remuneration of £13,135 (2012/13: £13,135). Members' remuneration during the year amounted to £90,696 (2012/13: £90,901) including social security costs.

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

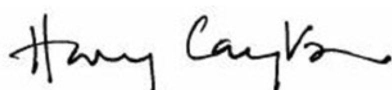
4.16 In addition, expenses amounting to £12,056 (2012/13: £12,703) were reimbursed to Board members. Travel expenses related to travel to the Authority's offices are subject to tax.

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

4.18 Payments to individual members are disclosed below.

Payments made to Authority Board members during 2013/14

	2013/14 Salary (bands of £5,000)	2012/13 Salary (bands of £5,000)
Chair		
Jill Pitkeathley	30–35	30–35
Members		
Ann Curno	5–10	5–10
Ian Hamer	5–10	5–10
Andrew Hind (Audit and Risk Committee Chair)	10–15	10–15
Sally Irvine	5–10	5–10
Stuart MacDonnell	5–10	5–10
Jayne Scott	5–10	5–10



Harry Cayton
Accounting Officer

9 June 2014

5. Statement of the Board's and the Accounting Officer's responsibilities

The Board's responsibilities

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

5.2 In preparing the accounts, the Authority is required to:

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

The Accounting Officer's responsibilities

5.3 The Accounting Officer for the Department of Health has appointed the Chief Executive as the Authority's Accounting Officer. His relevant responsibilities as the Accounting Officer, including his responsibility for the propriety and regularity of the public finances for which he is answerable and for the keeping of proper records, are set out in the Non-Departmental Public Bodies' Accounting Officers' Memorandum issued by HM Treasury and published in Managing Public Money.

6. Governance statement

The Authority's Board

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

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

6.3 We have a small executive team covering our three areas of work: scrutiny and quality; policy and standards; and our governance and operations.

Chair of the Board

6.4 The Chair is responsible to the Secretary of State for the Department of Health for England and to the devolved administrations. The Chair has a particular leadership responsibility on the following matters:

- Formulating the Authority's strategy
- Ensuring that the Board, in reaching decisions, takes proper account of any relevant guidance provided by the ministers or the sponsor departments
- Promoting the efficient, economic, and effective use of resources including staff
- Encouraging high standards of propriety
- Ensuring that the Board meets at regular intervals throughout the year and that the minutes of meetings accurately record the decisions made and, where appropriate, the views of individual members.

Board members

Board member	Appointed by
Jill Pitkeathley (Chair)	Privy Council
Ann Curno	Secretary of State for Health
Ian Hamer	Welsh ministers
Andrew Hind	Secretary of State for Health
Sally Irvine	Secretary of State for Health
Stuart MacDonnell	Department of Health, Social Services and Public Safety in Northern Ireland
Jayne Scott	Scottish ministers
Harry Cayton	Authority Board

6.5 Schedule 7 of the National Health Service Reform and Health Care Professions Act 2002, as amended by the Health and Social Care Act 2008 and by the Health and Social care Act 2012, provides directions for the appointment of members to the Authority.[14]

6.6 A register of interests for each member is available on our website.[15]

Reappointments

6.7 Public appointments are generally made for an initial term of four years, which can be extended for a second term. The total time served should not exceed eight years. When CHRE was established, the Council members were appointed for varying initial terms in order to facilitate future continuity.

6.8 The 2012 Act made provision for changes to the governance of the Authority, including changes to the arrangements for appointments to the Board of the Authority. The regulations to implement this section have yet to be produced. We do, however, understand that they will be forthcoming during 2014 and that we will be able to follow their requirements for appointments and re-appointments in the coming year.

6.9 No appointments were made during 2013/14

Attendance at Board meetings held in public

6.10 There were six Board meetings held in public between 1 April 2013 and 31 March 2014.

Board member	Number of meetings attended
Jill Pitkeathley (Chair)	6
Ann Curno	6
Ian Hamer	6
Andrew Hind	5
Sally Irvine	5
Stuart MacDonnell	5
Jayne Scott	5
Harry Cayton	6

6.11 During the year, the Board has been active in ensuring that the Authority's existing statutory functions were maintained and that the risks the Authority was encountering were being addressed. It achieved this by effective use and monitoring of the risk register and by remaining vigilant about the quality of our outputs.

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

[14] Available at www.legislation.gov.uk/ukpga/2002/17/contents
[15] Available at www.professionalstandards.org.uk/docs/board-related-documents/2012-council-register-of-interests.pdf?sfvrsn=0

reports and receives assurance from the Audit and Risk and Scrutiny Committees.

6.13 During the year, the Audit and Risk committee have been working to produce an assurance framework document and this will provide further assurance for the Board.

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

6.15 The Board also reviews its own performance as part of its strategic planning. It discussed the way in which board appraisals are undertaken and the Chairs of the Audit and Risk Committee and Scrutiny Committee now provide comment to the Chair before appraisals are held. The Board considers that it is functioning effectively.

6.16 Being mindful of its role the Board has paid proper attention to succession planning by requesting that the Department of Health takes steps to implement the legislation required in order that new members can be appointed in a timely manner.

6.17 Maintaining the quality of our work is an important consideration for the Board. It reviews important publications and reports prior to publication and takes a close interest in research and in policy development.

6.18 The Board also reviews information it receives about the Authority's performance from external parties including the statutory regulators, the voluntary registers and the Departments of Health in England, Scotland, Wales and Northern Ireland. In July 2103, the Authority presented evidence to the Health Select Committee and the Board was able to read and consider the committee's comments on our work.

6.19 All members of the Board are appraised annually by the Chair and are able to comment on the performance of both the Chair and the Chief Executive. The Chair is appraised by a senior civil servant in the Department of Health.

6.20 The detail of quality assurance is delegated to the Scrutiny Committee and to the Audit and Risk Committee. We report on their activities separately.

6.21 The Board also receives finance reports and receives assurance from the Audit and Risk and Scrutiny Committees.

Committees and working groups of the Council

Audit and Risk Committee

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

6.23 There were four Audit and Risk Committee meetings held between 1 April 2013 and 31 March 2014.

6.24 Members' attendance at committee meetings during 2013/14 was as follows:

Committee member	Number of meetings attended
Andrew Hind (Chair)	4
Stuart MacDonnell	3
Jayne Scott	3

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

6.26 The committee reviews its terms of reference and work programme annually and reports any changes that it proposes should be made to the Board. Each year it formally reports to the Board on:

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

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

6.28 The committee sets its own work programme for the coming year at its December meeting and this influences the work programme set for internal audit.

6.29 The internal audit reports were considered by the Committee:

- Financial controls
- Accredited voluntary registers scheme
- Information governance.

6.30 PricewaterhouseCoopers (PwC) on behalf of the Department of Health was our internal auditor during the 2013/14 financial year.

Financial Controls internal audit report

6.31 The Committee received a report from PwC on the Authority's financial controls. While a number of medium findings were identified, the report had resulted in a satisfactory rating and had concluded that the financial controls were working well, particularly taking account of the constraints around resources.

AVR Scheme internal audit report

6.32 The Committee also received the internal audit report on the AVR scheme. Only one medium-rated finding, along with some low-rated findings were reported and a satisfactory overall rating was achieved.

Information governance internal audit report

6.33 Controls around the scheme had been running well and no significant issues had been reported.

Risk register

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

6.35 During the year, the committee reviewed the risk register maintained by the executive. The main risks were discussed, some of which are covered in detail in the Strategic report, relating to the timing of new funding arrangements, the cost of legal advice and the increasing number of cases.

Move to regulators internal audit hub

6.36 The Department of Health had alerted the Authority to the existence of an audit hub as it thought the Authority might like to consider moving to it given its role and prospective funding arrangements. Other bodies involved in the hub had a clear function within the work of government but did not sit clearly within a particular department.

6.37 The focus of the internal auditor contracted to work with the hub would be on dealing with regulatory issues and related risk, especially reputational risks, which the hub regarded as being equally important risks as financial ones.

6.38 The Committee also considered that moving would allow for more opportunity for shared learning with other similar organisations.

6.39 The Authority attended hub meetings during the year and decided to move to be part of the hub for 2014/15. The Authority participated in the procurement of internal auditors for the hub.

Procurement policy

6.40 The Committee reviewed the revised procurement policy to provide greater clarity about procurement levels and more focus around value for money.

HMT Audit and risk assurance committee handbook

6.41 The Committee considered the updated Audit and Risk Assurance handbook from the Treasury. A checklist was produced in order that it could identify which guidelines it complied with and which matters might need further consideration.

6.42 It was agreed that to improve relationships and communication, formal meetings with the internal and external auditors should be timetabled into the Committee work programme to enable them to be officially recorded in the minutes.

6.43 It was agreed that the Committee would formally report any declarations of interest of Committee members and this would be a standing item on committee agendas in addition to the existing practice on Board agendas.

6.44 The Committee acknowledged it was important to formally review the effectiveness of its work. It was suggested that as the Chair of the Authority appraised each member annually, it would be helpful to include a section in this session to assess their effectiveness in terms of their membership on the Committee. To assist this, the Chair of the Audit and Risk Committee should have the opportunity to provide feedback on members to the Chair of the

Authority in preparation for the appraisals. The Authority Chair should provide feedback to the Committee Chair on any issues raised by the members.

Scrutiny Committee

6.45 The Scrutiny Committee reviews, monitors and reports on the operation of the Authority's scrutiny and oversight of the nine health and care professional regulatory bodies. This year, for the first time, it extended its remit to include scrutiny of the Authority's AVR scheme.

6.46 During 2013/14 each of the Scrutiny Committee's meetings have concentrated on one of the three principal areas of the Scrutiny and Quality Team's work: the review of final fitness to practise decisions (under Section 29 of the 2002 Act), the initial stages audits and the annual performance review.

6.47 There were three Scrutiny Committee meetings held between 1 April 2013 and 31 March 2014. Members' attendance is shown below.

Committee member	Number of meetings attended
Sally Irvine (Chair)	3
Ann Curno	3
Ian Hamer	3

6.48 At its meeting in December 2013, the Committee decided that updates on various areas of work should be included as standing items on each agenda. The relevant areas of work are: the Authority's scrutiny of the appointments processes used by eight of the regulators in respect of their Council members; the exercise by the Authority of its 'Section 29' right to refer 'unduly lenient' decisions made by the regulators' fitness to practise panels to court; concerns about the regulators received by the Authority; audit and performance review; and the Accredited Voluntary Registers scheme.

Initial stages audits

6.49 At the Scrutiny Committee's meeting in March 2014, the committee reviewed the audit reports from the 2013 audit cycle and confirmed it was content with the quality of those reports (at that time one report had not yet been published).

6.50 At its meeting in December 2013, the committee agreed on the regulators to be audited during 2014 based on an assessment of the relevant risks.

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

6.51 At its meetings in December 2013 and March 2014, the Scrutiny Committee reviewed decisions taken to refer to court/not to refer to court individual regulators' fitness to practise panel decisions that had been taken at Section 29 case meetings. At the December meeting, the Committee reviewed all such decisions taken during the previous year, and at the March meeting it reviewed the decisions taken in the period since the December meeting. At each meeting, the Committee also reviewed a small sample of cases that had not been referred

forwards for Section 29 case meetings. The Committee agreed that the executive had reached appropriate decisions in each case.

6.52 At its meeting in September 2013, the Committee considered a report from the Authority's external auditor into potential options for maximising the efficiency of the Authority's process for reviewing final fitness to practise decisions. Following their suggestion, it was agreed that the Authority's staff would carry out some pilot work.

Annual performance review of the regulators

6.53 At its meeting in September 2013, the Committee discussed proposals to review the performance review process with the aim of maximising the value of the data which the Authority collects across its Scrutiny and Quality functions within an integrated annual report about each regulator, as well as future-proofing the process to take into account anticipated changes in the external environment. These proposals were also discussed at the Authority's Board meetings in July and September 2013.

Other work

6.54 The Committee has regularly reviewed the Authority's handling of concerns about the regulators and has received regular updates on the progress of individual Section 29 appeals and the Authority's scrutiny of the processes that the regulators use in relation to the appointment of Council members.

6.55 At its meeting in December 2013, the Committee approved draft changes to its terms of reference to incorporate a new role in scrutinising the Authority's (AVR) scheme. The Committee also added an update about the AVR scheme to a list of standing items to be reviewed at each meeting, going forwards. The amendments to the Committee's Terms of References were approved subsequently at a Board meeting.

Remuneration Committee

Role

6.56 The Remuneration Committee meets once a year, or more frequently if necessary, to agree the annual cost of living increase for staff and to deal with other remuneration issues if they arise.

6.57 There were two Remuneration Committee meetings held between 1 April 2013 and 31 March 2014. Members' attendance is shown below.

Committee member	Number of meetings attended
Jill Pitkeathley (Chair)	2
Ian Hamer	2
Andrew Hind	2
Harry Cayton (in attendance)	1
Linda Allan (in attendance)	2

6.58 Since the organisation continued to be subject to the ongoing pay restrictions set by the Cabinet Office, the committee was not required to consider any pay award for the staff in 2013/14.

6.59 The Committee considered the potential impact that changes to the pension contributions could have on staff. It noted that changes implemented in April 2013 resulted in the take home pay of some staff decreasing. It was, however, noted that the implementation of the 1 per cent salary pay rise effective as of 1 April would not result in staff having to make greater contributions. The Committee agreed that these issues would continue to be monitored.

6.60 The Committee considered and agreed the addition of a new pay band within the Authority's existing pay structure. The need for this arose as a consequence of the need to appoint a senior solicitor to undertake work that had previously been done by secondees from external legal firms.

6.61 During 2013, the senior management team's job descriptions, which had not been reviewed since 2010, were independently reviewed and evaluated using the Department of Health's senior salary format.

6.62 The resulting report indicated that should any Director leave, the salary for the new appointment should be, and would need to be, significantly higher. The committee was also aware of the prospective risk of equality claims should the Directors’ salaries cease to be equitable following an appointment to the new format.

6.63 The Remuneration Committee therefore proposed that discussions be held with the Department regarding the prospect of a recruitment and retention payment for the directors.

6.64 Having noted the number of staff that had been on maternity leave, the Committee considered the issue of paternity leave and considered the Authority's policy in relation to that of other public sector bodies. The Committee agreed that staff should be able to take up to two weeks of paid paternity leave.

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

Pension scheme regulations

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

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

Data handling

6.68 Our system of internal control is based on the Cabinet Office minimum mandatory requirements and we continue to monitor and review our compliance with them.

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

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

6.71 All staff are required to complete the level appropriate to their level of responsibility for data handling. All members of staff who have completed the training to date have successfully passed the assessment.

6.72 As we have had several new permanent staff and a number of temporary staff working with us, during 2013/14 we organised internal information governance training. This was particularly focused on our internal information security policies and procedures.

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

Scope of responsibility

6.74 As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Authority's policies, aims and objectives, while safeguarding the public funds and organisational assets, for which I am personally responsible, in accordance with the responsibilities assigned to me in *Managing Public Money*.

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

The purpose of the system of internal control

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

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

6.78 Our system of internal control has been in place for the year ended 31 March 2014 and up to the date of approval of the annual report and accounts, and accords with HM Treasury guidance. The key elements of the system of internal control include:

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

Review of effectiveness

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

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

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

6.81 The Department of Health framework agreement through which we obtained our internal audit services ceased on 31 March 2013. PwC became our internal auditor on 1 April 2014 and provided the Head of Internal Audit report at the end of the year. The reported stated:

> *'My overall opinion is that I can give satisfactory assurance to the Accounting Officer that the Professional Standards Authority has had adequate and effective systems of control, governance and risk management in place for the reporting year 2013/14.'*

6.82 The Authority will be moving from the Department of Health internal audit hub to the regulatory internal audit hub from 1 April 2014. The Internal Auditor for the regulator's hub is Grant Thornton.

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

6.84 During 2013/14, the Audit committee worked to consider the means of assurance that they and the Board could have with respect to the work of the Authority. This work has resulted in the production of an assurance framework document.

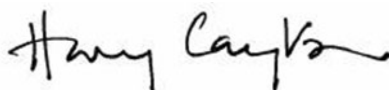
6.85 External and internal influences are considered and any potentially significant risks are discussed with key stakeholders as soon as they become apparent.

6.86 We continue to keep our arrangements under review in response to external developments.

6.87 I am satisfied that this report reflects adequately the information risks we have faced and will face in the future, as well as the actions that we take to manage the information risks effectively. I am satisfied that any information risk issues were managed appropriately. I am confident that the Authority's staff are aware of their responsibility to store, share and destroy information securely.

6.88 I confirm that the assessment of information risk management has been completed satisfactorily and that the information can be used for our annual governance statement.

6.89 I confirm we have complied with the Code of Corporate Governance as detailed in DAO(GEN)02/12 – Governance Statements, insofar as it is applicable to us.



Harry Cayton
Accounting Officer
9 June 2014

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

I certify that I have audited the financial statements of the Professional Standards Authority for Health and Social Care for the year ended 31 March 2014 under the National Health Service Reform and Health Care Professions Act 2002 as amended by the Health and Social Care Act 2008 and Health and Social Care Act 2012. The financial statements comprise: the Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity; and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report that is described in that report as having been audited.

Respective responsibilities of the Accounting Officer and auditor

As explained more fully in the Statement of the Board's and the Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit, certify and report on the financial statements in accordance with the National Health Service Reform and Health Care Professions Act 2002 as amended by the Health and Social Care Act 2008 and Health and Social Care Act 2012. I conducted my audit in accordance with International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Professional Standards Authority for Health and Social Care's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by Professional Standards Authority for Health and Social Care; and the overall presentation of the financial statements. In addition I read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my certificate.

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

Opinion on regularity

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

Opinion on financial statements

In my opinion:

- the financial statements give a true and fair view of the state of the Professional Standards Authority for Health and Social Care's affairs as at 31 March 2014 and of the net operating cost for the year then ended; and
- the financial statements have been properly prepared in accordance with the National Health Service Reform and Health Care Professions Act 2002 as amended by the Health and Social Care Act 2008 and Health and Social Care Act 2012 and Secretary of State directions issued thereunder.

Opinion on other matters

In my opinion:

- the part of the Remuneration Report to be audited has been properly prepared in accordance with Secretary of State directions made under the National Health Service Reform and Health Care Professions Act 2002 as amended by the Health and Social Care Act 2008 and Health and Social Care Act 2012; and
- the information given in the Chief Executive's Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

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

- adequate accounting records have not been kept or returns adequate for my audit have not been received from branches not visited by my staff; or
- the financial statements and the part of the Remuneration Report to be audited are not in agreement with the accounting records and returns; or
- I have not received all of the information and explanations I require for my audit; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

Report

I have no observations to make on these financial statements.

Amyas C E Morse
Comptroller and Auditor General
National Audit Office
157-197 Buckingham Palace Road
Victoria
London
SW1W 9SP

16 June 2014

8. Statement of comprehensive net expenditure for the year ended 31 March 2014

			March 2014 £'000		March 2013 £'000
Expenditure					
Staff costs	3		1,878		1,492
Other administrative costs	4		1,722		2,026
Income					
Operating income	5		(398)		(323)
Net operating cost			**3,202**		**3,195**

The notes on pages 55 to 70 form part of these accounts.

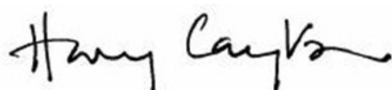
Other comprehensive net expenditure

There was no other comprehensive net expenditure in the year ended 31st March 2014.

9. Statement of financial position as at 31 March 2014

		March 2014		March 2013	
	Note	£'000	£'000	£'000	£'000
Non-current assets					
Intangible assets	6	353		390	
Property, plant and equipment	7	113		114	
Total non-current assets			***466***		***504***
Current assets					
Trade and other receivables	8	278		291	
Cash and cash equivalents	9	256		206	
Total current assets			***534***		***497***
Total Assets			**1,000**		**1,001**
Current liabilities					
Trade and other payables	10	(253)		(222)	
Provisions	11	(6)		(6)	
Total current liabilities			***(259)***		***(228)***
Non-current assets less net current assets/(liabilities)			**741**		**773**
Assets less liabilities			**741**		**773**
Reserves					
General reserves			**741**		**773**

The notes on pages 55 to 70 form part of these accounts.



Harry Cayton
Accounting Officer
9 June 2014

10. Statement of cash flows for the period ended 31 March 2014

	Note	March 2014	March 2013
		£'000	**£'000**
Cash flows from operating activities			
Net operating costs for the year		(3,202)	(3,195)
Adjustment for non-cash transactions	4	108	62
Decrease/(increase) in trade and other receivables	8	13	(31)
Increase/(decrease) in trade and other payables	10	31	(63)
(Decrease)/increase in provisions	11	-	3
Net cash outflow from operating activities		***(3,050)***	***(3,224)***
Cash flow from investment activities			
Purchase of property, plant and equipment	7	(67)	(14)
Purchase of intangible assets	6	(3)	(390)
Net cash outflow from investment activities		***(70)***	***(404)***
Cash flow from financing activities			
Grant in aid from the Department of Health:			
Revenue		2,765	2,896
Capital		69	404
Devolved Administration funding:			
Scotland		180	200
Wales		103	115
Northern Ireland		53	64
Net cash flow from financing activities		***3,170***	***3,679***
Net financing			
Net increase in cash and cash equivalents	9	50	51
Cash and cash equivalents at the beginning of the financial year	9	206	155
Cash and cash equivalents at the end of the financial period	9	**256**	**206**

The notes on pages 55 to 70 form part of these accounts.

11. Statement of changes in taxpayer's equity for the year ended 31 March 2014

		General reserve
		£'000
Balance as at 31 March 2012		**289**
Changes in reserves in the year ended 31 March 2013		
Net operating costs		(3,195)
Revenue		2,896
Capital		404
Scotland		200
Wales		115
Northern Ireland		64
Balance as at 31 March 2013		**773**
Changes in reserves in the year to 31 March 2014		
Net operating costs		(3,202)
Grant in aid from the Department of Health:		
Revenue		2,765
Capital		69
Funding from the devolved administrations:		
Scotland		180
Wales		103
Northern Ireland		53
Balance as at 31 March 2014		**741**

The notes on pages 55 to 70 form part of these accounts.

12. Notes to the accounts

1. Accounting policies

Basis of preparation

These financial statements have been prepared in accordance with the 2013/14 Government Financial Reporting Manual (FReM) issued by HM Treasury. The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the UK public sector context. Where the FReM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Authority for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Authority for the reportable period are described below. They have been applied consistently in dealing with items that are considered material to the accounts.

Critical accounting judgments and key sources of estimation uncertainty

In the application of the Authority's accounting policies, management is required to make judgements, estimates and assumptions about carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

Non-current assets

Intangible assets

Internally generated intangible assets

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

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

Intangible fixed assets are measured at cost.

For intangible assets with finite useful lives, amortisation is calculated so as to write off the cost of an asset, less its estimated residual value, over its useful economic life.

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

Property plant and equipment

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

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

Under the principles of modified historical cost accounting, depreciated historical cost is deemed a suitable proxy where the asset has a short useful economic life or is of low value. Indexation has not been applied since 31 March 2008 as this would not be material. Asset valuations are reviewed on an annual basis, at each statement of financial position date, to ensure that the carrying value fairly reflects current cost.

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

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

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

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

Cash at bank and in hand

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

In the statement of cash flows, cash is shown net of bank overdrafts held with the Government Banking Service (GBS) that form an integral part of the Authority's cash management and over which the Authority has a right of set off against other GBS accounts in credit.

Grant in aid and general reserve

The Authority is financed by grant in aid from the Department of Health.

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

Financial contributions to the activities of the Authority from the devolved administrations are also accounted for as financing by crediting them directly to the general reserve on a cash received basis.

Operating income

Operating income includes: Section 29 case cost recoveries; premises income received from subtenants; fees received from carrying out an independent performance review of the Royal College of Dental Surgeons of Ontario; an independent review of fitness to practise of the Nursing and Midwifery Board of Ireland; a report for the Health Foundation; and accreditation fees received from voluntary register applicants wishing to be accredited.

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

Comparative costs and restatements

Section 29 costs and recoveries

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

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

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

In the case of costs awarded against the Authority, expenditure is recognised in the income and expenditure where there is a final uncontested judgement against the Authority. In addition, where a case has been lost, but the final outcome is still subject to appeal, and it is probable that costs will be awarded against the Authority, a provision is recognised in the accounts. Where it is possible but not probable that the case will be lost on appeal and that costs may be incurred by the Authority, or where a sufficiently reliable estimate of the amount payable cannot be made, a contingent liability is disclosed.

Value added tax

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

Short-term employee benefits

Salaries are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the year is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs

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

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

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

Operating leases

Rentals payable under operating leases are charged to the operating cost statement on an accruals basis.

Foreign exchange

Transactions which are denominated in a foreign currency are translated into sterling at the exchange rate ruling on the date of each transaction, except where rates do not fluctuate significantly, in which case an average rate for a period is used. Resulting exchange gains and losses are taken to the operating cost statement.

Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature, they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings including losses which would have been made good through insurance cover had the Authority not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). The Authority does not generally hold insurance but had specific cover in respect of travel and business continuity.

Financial instruments

As required by the FReM, the Authority has accounted for financial instruments and made disclosures relating to those financial instruments, in accordance with International Accounting Standards 32 and 39 and International Financial Reporting Standard 7.

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

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

- IAS 32 Offsetting Financial Assets and Financial Liabilities
- IAS 36 Recoverable Amount Disclosure for Non-Financial Assets
- IFRS 9 Financial Instruments
- IAS 9 Novation of Derivatives and Continuation of Hedge Accounting
- Investment Entities (amendments to IFRS 10, IFRS 12 and IAS 27).

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

Accounting standards issued that have been adopted early

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

2. Analysis of net operating costs by segment

Segmental analysis

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

Year ended 31 March 2014	Standards and regulations	Government commissions	Chargeable activities	Voluntary registers	Total
	£'000	£'000	£'000	£'000	£'000
Operating costs	3,277	9	9	305	**3,600**
Operating income	(244)	-	(38)	(116)	**(398)**
Net operating costs	**3,033**	**9**	**(29)**	**189**	**3,202**
Year ended 31 March 2013	**Standards and regulations**	**Government commissions**	**Chargeable activities**	**Voluntary registers**	**Total**
	£'000	£'000	£'000	£'000	£'000
Operating costs	3,026	-	318	174	**3,518**
Operating income	(268)	-	-	(55)	**(323)**
Net operating costs	**2,758**	**-**	**318**	**119**	**3,195**

3. Staff numbers and related costs

Average number of persons employed

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

	Permanently employed	Other	Total 2013/14	Permanently employed	Other	Total 2012/13
Total	33.66	0.91	**34.57**	**24.59**	0.78	**25.37**

There were no staff engaged on capital projects in the period to 31 March 2014.

Costs of persons employed

Staff costs increased in 2014 in response to the significant increase in fitness to practise cases notified to us and the higher proportion of cases requiring our input in feeding back learning points to the regulators, holding case meetings and making court referrals.

	Permanently employed	Other	Total 2013/14	Permanently employed	Other	Total 2012/13
	£'000	£'000	£'000	£'000	£'000	£'000
Salaries	1,492	-	1,492	1,179	-	1,179
Social security costs	138	-	138	92	-	92
Superannuation costs	179	-	179	150	-	150
Agency/ temporary costs	-	69	69	-	71	71
	1,809	**69**	**1,878**	**1,421**	**71**	**1,492**

Reporting of Civil Service and other compensation schemes: exit packages

Redundancy and other departure costs have been paid in accordance with Department of Health guidelines and employment law, and are accounted for in the year of departure.

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	1	0	1
Total number of exit packages	1	0	1

4. Other administrative costs

	Notes	31 March 2014	31 March 2013
		£'000	**£'000**
Members' remuneration		91	91
Legal and professional fees		656	1,145
Premises and fixed plant		562	519
Training and recruitment		97	56
PR, communications and conferences		58	14
Establishment expenses		84	79
External audit fee (**)		21	23
Other costs		45	37
Non cash expenditure:			
Loss on disposal of fixed assets		-	-
Amortisation	6	40	-
Depreciation	7	68	62
Total administrative costs		**1,722**	**2,026**

* The Authority made payments of £248,000 to the National Audit Office for non-audit work in respect of accommodation costs of the Authority for use of office space at 157–197 Buckingham Palace Road, London.

5. Operating income

	31 March 2014	31 March 2013
	£'000	**£'000**
Section 29 cost recoveries	60	36
Accredited voluntary registers' income	116	55
Fees from external customers	38	25
Subtenancy income	175	207
Other operating income	9	-
Total operating Income	**398**	**323**

6. Intangible assets

31 March 2014	Section 29 database
	£'000
Valuation	
At 1 April 2013	390
Additions	3
At 31 March 2014	393
Amortisation	
At 1 April 2013	0
Charge for the period	40
At 31 March 2014	40
Net book value	
At 31 March 2014	353
At 31 March 2013	390

31 March 2013	Section 29 database
	£'000
Valuation	
At 1 April 2012	0
Additions	390
At 31 March 2013	390
Amortisation	
At 1 April 2012	0
Charge for the period	0
At 31 March 2013	0
Net book value	
At 31 March 2013	390

7. Non-current assets

Property, plant and equipment

31 March 2014	Furniture, fixtures and fittings	IT equipment	Total
	£'000	£'000	£'000
Valuation			
At 1 April 2013	117	252	369
Additions	9	58	67
At 31 March 2014	126	310	436
Depreciation			
At 1 April 2013	78	177	255
Charge in period	18	50	68
At 31 March 2014	96	227	323
Net book value			
At 31 March 2014	**30**	**83**	**113**
At 31 March 2013	**39**	**75**	**114**

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

31 March 2013	Furniture, fixtures and fittings	IT equipment	Total
	£'000	£'000	£'000
Valuation			
At 1 April 2012	117	238	355
Additions	-	14	14
Disposals	-	-	-
At 31 March 2013	117	252	369
Depreciation			
At 1 April 2012	62	131	193
Charge in year	16	46	62
Disposals	-	-	-
At 31 March 2013	78	177	255
Net book value			
At 31 March 2013	**39**	**75**	**114**
At 31 March 2012	55	107	162

8. Trade receivables and other current assets

Amounts falling due within one year:

	31 March 2014	31 March 2013
	£'000	£'000
Trade and other receivables	85	102
Prepayments	193	189
Total trade and other receivables	***278***	**291**

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

Intra government balances

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

	31 March 2014	31 March 2013
	£'000	£'000
Balances with other central government bodies	3	21
Balances with local authorities	145	141
Total intra government balances	**148**	**162**
Balances with bodies external to government	130	129
Total trade and other receivables	***278***	**291**

9. Cash and cash equivalents

	31 March 2014	31 March 2013
	£'000	£'000
Balance at 1 April 2013	206	155
Net changes in cash and cash equivalent balances	50	51
Balance at 31 March 2014	**256**	**206**
The following balances were held at:		
Government Banking Service	253	205
Commercial banks and cash in hand	3	1
Balance at 31 March 2014	**256**	**206**

10. Trade payables and other current liabilities

Amounts falling due with one year:

	31 March 2014	31 March 2013
	£'000	£'000
Trade and other payables	73	47
Taxation and social security	52	41
Accruals and deferred income	128	134
Total trade and other payables	***253***	***222***

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

Intra government balances

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

	31 March 2014	31 March 2013
	£'000	£'000
Balances with other central government bodies	53	49
Balances with NHS bodies	-	4
Total intra government balances	**53**	**53**
Balances with bodies external to government	200	169
Total trade and other payables	***253***	***222***

11. Provisions for liabilities and charges

	HMRC provision
	£'000
Balance at 31 March 2013	6
Arising during the period	6
Provision used	(6)
Balance at 31 March 2014	**6**

The HMRC provision as at 31 March 2014 represents the Authority's estimated liability for income tax and National Insurance Contributions in relation to Board members' travel and subsistence expenses.

12. Contingent assets and liabilities

Assets

One High Court case had been decided in the Authority's favour as at 31 March 2014; however, the exact quantum of settlement has not been decided at that date.

Liabilities

Eleven High Court cases under the Authority's Section 29 powers were undecided as at 31 March 2013. There was therefore uncertainty, as at that date, as to the related financial consequences, pending a final judgement.

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

13. Capital commitments

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

14. Commitments under leases

Operating leases

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

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

Buildings	31 March 2014	31 March 2013
	£'000	£'000
Not later than one year	267	267
Later than one year and not later than five years	156	423
Total commitments under operating leases	**423**	**690**

The Authority subleases its premises to two subtenants and recognises rent and service charge sublease receipts as income.

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

Future minimum sub-lease receipts	31 March 2014	31 March 2013
	£'000	£'000
Not later than one year	93	112
Later than one year and not later than five years	54	177
Total minimum sub-lease receipts	**147**	**289**

Finance leases

The Authority did not have any finance leases in the period to 31 March 2014.

15. Related parties

The Authority has ultimate accountability to the UK Parliament.

The Authority is an unclassified public body. While it continues to be funded by the Department of Health, it remains sponsored by the Department.

The Department of Health is regarded as a related party. During the year to 31 March 2014, the Department of Health provided total grant in aid of £2.83m (2012/13: £3.30m).

The Authority received funding contributions towards its activities in the year from the devolved administrations in Northern Ireland (£0.05m), Scotland (£0.18m), and Wales (£0.10m). In 2012/13, the Authority received £0.06m from Northern Ireland, £0.20m from Scotland and £0.11m from Wales.

The Authority maintains a register of interests for the Chair and Board members, which is available on the website. The register is updated on a periodic basis by the Executive Secretary to reflect any change in Board members' interests. During the year ending 31 March 2014, no Council member undertook any related party transactions with the Authority.

The senior management team is also asked to disclose any related party transactions. During 2013/14, there were no disclosures.

16. Losses and special payments

There were no material losses and special payments in the period.

17. Post statement of financial position events

- The Queens speech of 4 June contained no provision for the enactment of legislation appertaining to the regulation of health professionals
- The commencement order to bring section 226(2)(a) of the 2012 Act into force, enabling the Authority to appoint to its own Board was published on 6 June
- At the time of publication the legislation necessary for the commencement of the new fee arrangements had not been published.

These accounts were authorised for issue on 16 June by the Accounting Officer

18. Financial Instruments

Financial risk management

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

The relationship that the Authority has with the Department of Health, and the way it is financed, means that its exposure is reduced. In addition, the Authority has limited powers to borrow or invest surplus funds and its financial assets and liabilities are generated by day-to-day operational activities; thus the effect of the financial instruments on changing the risk is again reduced.

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

Currency risk

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

Interest rate risk

The Authority has no borrowing and relies primarily on grant in aid from the Department of Health and financial contributions from the devolved administrations. Therefore, the Authority has low exposure to interest rate fluctuations.

As at 31 December 2014, the Authority had a non-interest bearing cash balance of £256,000.

Credit risk

Because the majority of the Authority's funding income comes from the Department of Health, with contributions from the devolved administrations, the Authority has low exposure to credit risk.

Liquidity risk

The Authority relies primarily on grant in aid from the Department of Health, financed from resources voted annually by Parliament, and contributions from the devolved administrations; therefore, the Authority has low exposure to liquidity risk.

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