Professional Standards Authority for Health and Social Care

Health Professional Regulation: a long view with Annual Report and Accounts 2017/2018



HC 1119
SG/2018/86

professional standards authority

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Foreword

The Authority is continuing to perform well; it is maintaining the high quality of its outputs and working within its business principles and budget.

Regulators have continued to generally perform well against our Standards of Good Regulation. However, they continue to be hampered by outdated legislation, particularly with regard to fitness to practise, hence our call for reform. Although the number of fitness to practise cases has risen substantially over the last decade, we have seen a slight decrease in the number of cases this year.

We continue to see 100 per cent of accredited registers reapply for renewal of their accreditation, but this year removed accreditation from one register. Following a fees consultation, we determined that we had reached the limit of affordability and that continued subvention by the Department of Health and Social Care would be necessary to sustain the programme for the foreseeable future. We were pleased to receive a positive response. The programme now covers over 85,000 practitioners. We were particularly pleased to see the inclusion of clinical physiologists and the life sciences industry, which is a step forward for public protection.

At the request of the Secretary of State for Health and Social Care, we commenced a lessons learned review of the Nursing and Midwifery Council, examining the

way in which it handled cases about midwives' fitness to practise at Furness General Hospital in Morecambe Bay. Our report is due to be published in May 2018.

This year we were also asked to provide advice to the Scottish government on the regulation of an occupation in fewer than all four UK countries. This followed the decision to regulate Nursing Associates in England only. Most other regulated occupations are regulated on a UK-wide basis.

We continued the development of our ideas on the reform of regulation with the publication of *Right-touch reform*. We welcomed and responded to the government's consultation *Promoting professionalism: reforming regulation* and look forward to seeing progress on legislative change.

We continue to be encouraged by the way in which our international regulatory colleagues welcome and adopt our ideas and publications. The exchange of ideas between us provides valuable learning.

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

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

George R Jenkins OBE
Chair

Health Professional Regulation: a long view

1. Introduction

1.1 The Council for the Regulation of Health Professionals, as the Authority was first called, was born out of the need to hold professional regulators to account and to improve the quality of regulation following the Kennedy Enquiry.[1] In the Government's response in 2002 it said it would establish:

- 'a new Council for the Regulation of Health Care Professionals to strengthen and co-ordinate the system of professional self-regulation; and
- Reform of the current arrangements for the regulation of individual health care professions so that patients will be at the heart of professional regulation.'[2]

1.2 That intention for reform has been the objective of government policy, the regulators' activities and the oversight of the Professional Standards Authority for more than a decade. It is an objective not yet fully realised.

1.3 In this 2017/18 overview of health professional regulation in the UK we think, as we wait yet again, for promised but undelivered legislation, it is timely to look back at what has been achieved both to strengthen and co-ordinate professional regulation and to put patients at its heart.

[1] Professor Ian Kennedy, Chair. (2001). *The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995: learning from Bristol*

[2] Department of Health, (2002) *Response to the report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary*

2. The direction of Government policies

2.1 The policy intention behind the arrangements for regulation in health and care is to create a system that protects patients and the public from harm and improves health outcomes. Professional regulation plays its part by setting standards for education, training, conduct and competence and by acting to remove unsuitable health and care professionals when needed to protect the public and maintain public confidence. The standards set by the professional regulators apply wherever health and care professionals work – including in the NHS, private sector and local authorities.

2.2 By 2007, government policy began to recognise some of the limits of regulation and the benefits of moving to a more risk-based approach to assurance of the workforce. *Trust, Assurance and Safety* proposed measures to ensure the independence of regulators and the need for professionals once registered, to demonstrate periodically their continuing fitness to practise.[3]

2.3 The Health and Social Care Act 2008 initiated a series of reforms to the governance of the professional regulators whose Councils reduced in size and strengthened the contribution of lay members. It also altered the composition of the Authority's governing Council (now its Board). The Act introduced a duty on the Authority to consult and inform the public and extended the Authority's remit.

2.4 By 2011, the government recognised the need for a more flexible system of regulation. The Command Paper *Enabling Excellence*[4] noted that statutory regulation required continuous government intervention to keep it up to date, was costly, complex and that there was a 'tension between enshrining professional roles in law and maximising flexibility within the workforce as a whole'. The government commissioned the Authority to carry out a cost effectiveness review[5] and anticipated that the regulators would use it to identify significant cost reductions stating that if they did not, government would revisit the possibility of reconfiguration.

2.5 The paper also proposed a uniquely novel approach to managing risks of unregulated workers, through a system of 'assured registration'. In 2012, the Health and Social Care Act tasked the Authority with establishing what has become its accredited registers programme. The Law Commissions also commenced a review of the separate legislation covering the nine professional regulators with a view to replacing it with a single Act.

2.6 The Law Commissions published their final report and draft Bill in 2014, setting out a new single legal framework for the regulation of all health and social care professionals.[6] The reforms aimed to increase consistency but also allow the regulators greater flexibility. The Authority expressed concern that whilst helpful to a degree, the proposals were by virtue of their terms of reference, too limited to achieve the more radical reform we consider is needed. We therefore welcomed the

[3] Department of Health, (2007). *Trust, assurance and safety: the regulation of health professionals in the 21st century*

[4] Department of Health, (2011). *Enabling Excellence Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers*

[5] Professional Standards Authority, (2012). *Review of the cost effectiveness and efficiency of the health professional regulators*

[6] Law Commissions, (2012). *Regulation of health care professionals*

government's 2017 consultation *Promoting professionalism, reforming regulation* and are anxious to see progress on this reform.[7]

2.7 The regulation of most existing professions is a reserved matter, meaning that the power to legislate lies with the UK Parliament in Westminster. The four governments of the UK have consistently stated their commitment to UK-wide regulation, although this year, for the first time, England decided to proceed with the regulation of a new occupation, Nursing Associates, without the support of the other nations. Social Workers are already regulated separately in each of the four countries and in England, responsibility is about to be transferred away from the Health and Care Professions Council (HCPC) to a new regulator, Social Work England.

[7] Department of Health and Social Care, (2017). *Promoting professionalism, reforming regulation – a paper for consultation*

3. Reforms to governance of regulators

3.1 Considerable progress has been made in strengthening regulators' governance arrangements. The Authority does not have standards for regulators' governance arrangements on the grounds that as independent regulators, their Councils should be responsible for ensuring their proper administration. However, we have contributed to improvement in a number of ways.

3.2 The Command paper, *Trust, Assurance and Safety*[8] instituted a series of governance reforms to ensure the independence and accountability of the health and care professional regulators. This included:

- Reforming the constitution of Councils so that there were equal numbers of professional and public members, and to become 'smaller and more Board-like', of similar size and with a consistent role across all of the regulators
- That the regulators would present annual reports to the UK Parliament, and to the Devolved Administrations where they regulated professionals whose regulation was a devolved matter
- Changes to the Council of CHRE to create a small unitary board free from any health or care professional membership
- The establishment of the General Pharmaceutical Council, separating regulation from the professional body (except Northern Ireland).[9]

3.3 In so far as it related to governance, the changes built on our recommendations made in CHRE's *Special Report to the Minister of State for Health Services on the Nursing and Midwifery Council*,[10] in particular that 'there should be no representative members on the new council and no reserved places for interest groups. All members, whether registrant or public, should be appointed against defined competencies and be subject to appraisal'.

3.4 CHRE reported at the request of the Secretary of State in September 2011 on *Board size and effectiveness: advice to the Department of Health regarding health professional regulators*.[11] The mean average size of the councils of the regulators was then 17, with a range varying from 24 (GDC and GMC) down to 12 (GOC). In that advice we concluded that smaller boards, in the range of eight to 12 members, were associated with greater effectiveness, and that a move to smaller councils across the health professional regulators would be possible without compromising effectiveness. We concluded that a smaller board would be less likely to involve itself with inappropriate matters properly the business of the executive, and would assist in a move away from representative functions.

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[8] Department of Health, (2007). *Trust, assurance and safety: the regulation of health professionals in the 21st century*

[9] The Pharmaceutical Society of Northern Ireland regulates pharmacists in Northern Ireland. It still combines the functions of professional body and regulator.

[10] CHRE, (2008). *Special report to the Minister of State for Health Services on the Nursing and Midwifery Council*

[11] CHRE, (2011). *Board size and effectiveness: advice to the Department of Health regarding health professional regulators*

3.5 At the request of the Chief Executive of the NHS we published *Standards for members of NHS boards and Clinical Commissioning Groups*[12] in November 2013, in which we stressed that all members of NHS boards and CCG governing bodies should understand and be committed to the practice of good governance and to the legal and regulatory frameworks within which they operate. As individuals, we stressed that they must understand both the extent and limitations of their personal responsibilities. The standards were expressed as a series of personal undertakings covering business principles, technical competence and personal behaviours.

3.6 In October 2012 we issued guidance on good practice on making appointments to councils, as we enacted our role to provide advice to the Privy Council about recommendations made by the regulators for appointments to their councils.

3.7 CHRE became the Professional Standards Authority for Health and Social Care from 1 December 2012, its role and duties being set out in the Health and Social Care Act 2012.

3.8 In March 2013, we published *Fit and Proper? Governance in the public interest.*[13] By this stage there had been significant progress in the reconstitution of the regulators' councils, and movement away from professional self-regulation and towards regulation being shared by professions and the public in the interests of society as a whole.

3.9 More recently, we developed a set of good standards of governance when commissioned to review the performance of the College of Registered Nurses of British Columbia, including its governance.

3.10 At the time of writing we are engaged in a review of the governance and legislation of EGBC, the regulator and professional association of engineers and geoscientists in British Columbia. We have used the standards of governance that we developed for the previous review in Canada, adapting as necessary so as to be appropriate for EGBC's legislation and context.

[12] Professional Standards Authority, (2013) *Standards for members of NHS boards and Clinical Commissioning Groups*

[13] Professional Standards Authority, (2013). *Fit and Proper? Governance in the public interest*

4. Changes to education including continuing fitness to practise

4.1 It is one of regulators' core statutory responsibilities to ensure that those qualifying from education and training courses are fit to practise and join the register for their profession. Quality-assuring the courses that prospective registrants take is one of the primary ways by which regulators achieve this. Regulators also undertake other roles in relation to education and training including quality assuring post-graduate specialty training, accreditation of independent prescriber programmes, assessment of overseas professionals and guidance for students on professionalism. Accredited Registers are required to have processes in place to set educational standards and ensure these are met in relation to unregulated occupations. The Authority assesses the performance of regulators and accredited registers in discharging these responsibilities against its *Standards of Good Regulation* and *Standards for Accredited Registers* respectively.

4.2 In 2009, we were commissioned by the Department of Health to report on *Quality assurance of undergraduate education by the healthcare professional regulators*.[14] We outlined the differences and similarities and made recommendations for good practice. It is not surprising that there is variation between regulators' responsibilities and approaches given the number of regulators, proliferation of professions and educational courses remaining largely uni-profession rather than inter-profession despite healthcare being delivered by multi-disciplinary teams.

4.3 Progress has been made within current legislation to streamline processes and pursue a more risk-based approach. However, as we set out in *Right-touch reform* there are multiple agencies within the education sector with regulatory influence over higher and further education, with some overlap and duplication. The regulatory structure of higher education in England is going through a period of substantial change alongside increasing divergence of approach across the four countries.

4.4 One area in which considerable progress has been made has been in the regulators developing mechanisms to require registrants to demonstrate their continuing fitness to practise. This has increasingly elided with their work to set and promote standards. Following the GMC's overhaul of medical revalidation following the Shipman Inquiry and the view expressed by Government in *Enabling Excellence* that any scheme introduced by the other regulators must be proportionate, the Authority published its 2012 paper, *An approach to assuring continuing fitness to practise based on right-touch regulation principles.*[15] This outlined a continuum of different frameworks for ongoing assurance, based on the level of risk to be addressed and outlined the purpose: to ensure that registrants continue to meet the standards of conduct and competence. Since then a spectrum of different approaches has emerged, with examples ranging from the GMC system of revalidation which requires doctors to participate in local systems of appraisal and receive sign-off from a local Responsible Officer who confirms their ongoing participation in revalidation activity, to the Health and Care Professions Council

[14] CHRE, (2009). *Quality assurance of undergraduate education by the healthcare professionals*
[15] CHRE, (2012). *An approach to assuring continuing fitness to practise based on right-touch regulation principles*

(HCPC), which outlines a set of CPD criteria with which registrants should comply and asks that individuals reflect on their own practice. The Nursing and Midwifery Council (NMC) process of revalidation is similar to the GMC's with the regulator responsible for making decisions about registrant renewal. Common themes across the systems put in place by the regulatory bodies include use of peer review and feedback and individual reflection on practice.

5. The power of oversight

5.1 Our ability to scrutinise the performance of regulators through the performance review process is crucial to our ability to inform Parliament whether they are performing their functions adequately. The process enables us to look at the regulator's performance both in respect of the easily measurable matters, such as the length of time taken for matters to be concluded, but also of the quality of the work. We assess whether the regulators follow appropriate processes, if decisions are consistent with those processes and are reasonable and based on evidence. We believe that this is essential to assure Parliament that the regulators are acting independently, efficiently and in patients' interests.

5.2 This function has been powerful in encouraging improvement by the regulators, maintaining standards and enabling us to assess and evaluate the effectiveness of the overall regulatory framework. It also gives us a unique overview of professional standards amongst the regulated (and more recently unregulated) workforce. It is this insight which led us to recommend the radical reforms we proposed in *Right-touch reform*[16] and our response to the government consultation *Promoting professionalism, reforming regulation.*

5.3 We assess the performance of the regulators against our *Standards of Good Regulation*. There are 24 Standards divided between four different headings: Guidance and Standards, Education and Training, Registration and Fitness to Practise.

5.4 The Standards have been in place since 2010 and have been important in enabling us to assess performance in the key areas of the regulators' activities. However, good practice in regulation moves on and we have been concerned that the Standards need revision in order to capture the full range of activities. Since the original Standards came into effect much has changed in the area of continuing fitness to practise. Similarly, the regulators are adopting new ways of dealing with fitness to practise cases by moving to Case Examiners rather than committees assessing cases and to looking at more consensual ways of disposing of cases.

5.5 We have therefore begun a review of the Standards and issued a consultation paper in June 2017. The consultation asked about different models for the Standards and the matters they should look at. It asked specifically about whether we should look at the regulator's governance arrangements and at the regulator's approach to equality and diversity. We received 29 responses to the consultation paper and held meetings with the regulators and other stakeholders to discuss the proposals. We will issue a further paper setting out the new Standards in June 2018.

5.6 We collect the performance review data quarterly, allowing us to identify trends over time and it has helped us to drill down into areas of the regulators' performance and gain better understanding of strengths and weaknesses. The feedback that we have received from the regulators has been positive. It has also enabled the Authority to identify concerns. We believe that the process is rigorous and proportionate. We have identified eight items of statistical information that, in our view, are key comparators across the Standards of Good Regulation, and said that we will

[16] Professional Standards Authority, (2017). *Right-touch reform: a new framework for the assurance of professions*

routinely report on these items. Below is a table laying this out for the period 1 April 2017-31 March 2018, the data that each of the nine health and care regulators has provided to us. This information has not been audited by us.

Data for 1 April 2017 to 31 March 2018	GCC	GDC	GMC	GOC	GOsC	GPhC	HCPC	NMC	PSNI
Number of registrants	3,255	99,347	289,029	30,759	5,288	92,973, includes 14,348 premises	361,061	690,278	2,502
Number of new initial registration applications received	194	7,729	15,216	2,982	248	25	22,026	25,459	175
Number of registration appeals concluded where no new information was presented, and that were upheld.	0	0	0	0	0	0	1	0	0
Median time (in days) taken to process initial registration applications for:									
• **UK graduates**	1	10	1	6	2	Pharmacist = 17 Pharmacy Technician = 9	5	0	3
• **International non-EU graduates**	1	14	27	14	30	Pharmacist = 6 Pharmacy Technician = 5	44	1	0
• **EU graduates**	1	55	1	8	52	Pharmacist = 17 Pharmacy Technician = 0	49	0	5
Annual retention fee	£800	£890 dentists £116 Dental care professionals	£425 *as of 1 April 2018 annual retention fee = £390	£330	£320 (year 1) £430 (year 2) £570 (year 3 onwards)	£250 (Pharmacist) £118 (Pharmacy Technician) £241 (Premises)	£90	£120	£398

	GCC	GDC	GMC	GOC	GOsC	GPhC	HCPC	NMC	PSNI
The time taken (in weeks) from receipt of initial complaint to the final investigating committee decision:									
• **Median time taken to conclude**	26	46	29.4	47	24	52	41	41	47
• **Longest case to conclude**	129	273	342.9	237	115	231	227	262	54
• **Shortest case to conclude**	5	11	1	12	4	14.1	10	8	6
The time taken (in weeks) from receipt of initial complaint to final fitness to practise hearing determination:									
• **Median time taken to conclude**	86	99	104.3	124	58	95	92	82	24
• **Longest case to conclude**	154	276	348.9	360	139	261	340	440	89
• **Shortest case to conclude**	39	35	9.7	46	19	46.7	21	18	21
The median time taken (in weeks) from initial receipt of complaint to interim order decision, and from receipt of information indicating the need for an interim order to an interim order decision:									
• **Receipt of complaint**	22	19	8.4	24	3	16.6	14	3.7	18
• **Receipt of information**	4	3	2.9	3	3	2.1	2.9	N/A[17]	2
Number of registrant/Authority appeals against final fitness to practise decisions:									
• **Registrant appeals**	1	1	97	0	1	5	10	22	0
• **Authority appeals**	0	0	1 appeal lodged by the Authority & 1 notice of interest lodged by the Authority on GMC appeals[18]	0	0	0	1	5	0
Number of data breaches reported to the Information Commissioner	0	3	0	1	0	1	1	1	0
Number of successful judicial review applications	0	2	0	0	0	0	0	1	0

5.7 Variations in the statistical performance data for the different regulators reflect the size of their registers, their legislative constraints and the different environments in which they work. For example, regulators have different statutory rules governing their processes and this may affect how long they take to deal with individual cases.

[17] The NMC does not currently collect this data.

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

We recognise that regulators with smaller caseloads may well find their overall performance skewed by a couple of unavoidably lengthy cases or even very short ones. This is a reason why we do not use the statistical data in isolation to help our understanding of performance.

Achievement against the Standards of Good Regulation

5.8 In 2017/18, the General Medical Council (GMC), the General Pharmaceutical Council (GPhC), the General Osteopathic Council (GOsC) and the Pharmaceutical Society of Northern Ireland (PSNI) met all 24 of the Standards; the General Chiropractic Council (GCC) and General Dental Council (GDC) met 23 of them; and the Health and Care Professions Council (HCPC) met 18. At the time of writing, we had yet to publish our reviews of the performance of the General Optical Council (GOC), and Nursing and Midwifery Council (NMC).[19]

5.9 The new performance review process continued to identify areas of good and poor performance by the regulators. The most notable in this year was around the HCPC's handling of the early stages of fitness to practise cases. Our judgement was that the way the HCPC is undertaking aspects of its fitness to practise processes may not be ensuring public protection. Our concerns included:

- Evidence that the HCPC was closing some complaints early that we think should have been investigated, including cases about dishonesty, alcohol abuse and inappropriate behaviour with patients
- Applying its 'Standard of Acceptance' criteria (that is, the criteria it uses to decide whether or not to investigate a complaint) inconsistently and often inappropriately.

5.10 We also identified further evidence of the concerns we had identified in our previous reviews about aspects of the HCPC's performance in fitness to practise. These concerns related to how the HCPC carried out risk assessments, as well as the time it was taking to undertake and conclude investigations.

5.11 Since we published our report, the HCPC has developed a plan and started work on a number of activities intended to address the concerns we have raised. Over the course of future reviews of the HCPC's performance, we will look at how these activities improve the way it delivers its fitness to practise function.

5.12 We also had to address problems that the regulators face through inadequate or outdated legislation. In the 2015/16 reviews we noted the difficulties that the PSNI had faced. This year, the HCPC had identified an error in the legislation that enables orthoptists to sell and supply certain medicines, and that this error meant that any orthoptist could undertake this activity, not just those who had the correct training and annotation on the HCPC register. We were satisfied that the HCPC had taken a pragmatic and proportionate approach to mitigate the effect of this error in the period before the legislation was amended.

5.13 Openness and transparency is an important feature for regulators and our work over the years has aimed to encourage this. This year, the GPhC revised its standards for pharmacy professionals, following work to consult on the draft standards and related guidance. The consultation dealt with the controversial question of the extent to which pharmacists can avoid providing drugs products

[19] We have published our special review of the Nursing and Midwifery Council, Lessons Learned Review and publication of the performance review was delayed to take account of that.

where they have personal ethical or religious concerns about doing so. The consultation attracted an unprecedentedly high level of engagement and a high volume of responses. We saw evidence that the GPhC took careful account of the responses to the consultation in reaching its final decision. We considered the approach taken by the GPhC was an example of good practice in engagement with stakeholders.

5.14 The discrepancies that can arise for black and minority ethnic (BAME) registrants at all stages of their career has been noted in previous reviews. The GMC has done important work in the past to attempt to understand the reasons why such registrants are disproportionately represented in fitness to practise hearings. The GPhC has also been carrying out work in this area and held a seminar with key stakeholders in October 2016 to explore the reasons why candidates who identify as Black-African perform least well in its pre-registration examinations. The GPhC has said it will use the information from the seminar to inform its review of initial education and training standards and the methodology it uses to accredit courses.

5.15 Fitness to practise remains a major area of concern and a challenge for regulators. Concerns have been raised that our Standards concentrate disproportionately on this area. However, it needs to be recognised that this is a key area in which regulators protect the public and that delays or inadequate decisions are a significant cause of public concern.

5.16 Over the years we have seen a number of initiatives by regulators for improving ways of dealing with complaints and identifying the most serious ones. During this review period, the GPhC consulted on proposals to change the threshold criteria it uses to decide whether a case should be referred to its Investigating Committee. The GDC has now introduced case examiners, who make decisions about whether there is a case to answer in relation to concerns raised about dental professionals. The GMC continues to expand its provisional enquiries process, where more information is obtained by the GMC prior to making a decision to close a case, send forward to investigation, or refer to an employer or Responsible Officer.

5.17 Thresholds at each stage of the fitness to practise process are important, so that the regulator can ensure that only those matters that require regulatory intervention are taken forward. However, such thresholds should be proportionate, appropriately applied, and consistent. Where this is not the case (as we identified during our review of the HCPC), this can lead to cases being closed without appropriate consideration having taken place. As regulators create or revise their thresholds, we will continue to look closely at how these are applied in practice.

Timely progressions of cases

5.18 We continue to look closely at how each of the regulators ensures that its cases are dealt with efficiently. When considering information relating to the regulators' timeliness, we consider carefully the statistical data we see, and what it tells us about the regulators' performance over time. In addition to taking a judgement on the data itself, we look at:

- Any trends that we can identify suggesting whether performance is improving or deteriorating
- How the performance compares with other regulators, bearing in mind the different environments and caseloads affecting the work of those regulators

- The individual regulator's own key performance indicators or service standards which they set for themselves.

5.19 There are difficulties in assessing timeliness because the regulators do not always begin measuring their timescales at the same point. We have introduced refinements to the data that we collect from the regulators to address this point. However, we continue to raise our concerns about the time it is taking for some regulators to progress cases to a conclusion and have explored in some detail in our reports how the regulators are managing their caseloads. We recognise, for example, that there is often a balance to be achieved between the closing of old cases and the adverse impact that these case closures can have on the median timeframes for progressing cases through the fitness to practise process. However, we would expect to see median timeframes improve as older cases are closed.

5.20 We note also that the GMC takes significantly longer as a median time to deal with cases than most other regulators. The GMC has told us that there are particular reasons connected with the complexity of some of its cases that means their timescales will be inherently long. We will be looking at these reasons in future reviews.

5.21 At the other end of the scale, regulators are often seeking to dispose of complaints by consent with the registrant – so the registrant agrees to the alleged facts and the sanction. These agreements cover a wide range of circumstances: the registrant can agree a particular sanction (for example, conditions of practice) or can ask to be removed from the register or the regulator can discontinue the proceedings (for example, because it considers that there is no evidence).

5.22 In *Right-touch reform* we set out in detail how consensual disposal is working in practice, and our thoughts on the risks and opportunities in closing cases using these mechanisms. We consider that, in principle, such arrangements are valuable and can achieve appropriate results without contested hearings. However, it is important that such processes should not be used in a way which results in serious matters not being adequately investigated.

5.23 In our review of its performance this year, we set out our concerns about how the HCPC approaches the discontinuance of cases. Our view was that the approval of discontinuance decisions by the HCPC (with no additional information or evidence being presented since the decision of the Investigation Committee to refer the case) may indicate that the Investigation Committee is failing to identify when there is no case to answer. We were also concerned that cases that should have progressed to a full hearing are being closed too soon and that, in doing so, there had been insufficient consideration of the allegations against the registrant to ensure protection of the public.

5.24 We will continue to monitor the use by the regulators of these processes.

Concerns

5.25 The Authority frequently receives concerns from registrants and members of the public about the performance of the regulators. Although the Authority does not have powers to deal with individual complaints against the regulators, we use the information from them to inform our performance reviews of each regulator.

Personal Independence Payments (PIP)

5.26 Over the course of this year, we have received some concerns about how regulators are dealing with complaints about those registrants who assess health to inform the Department for Work and Pensions' PIP assessment process. We recognise that there is considerable public concern about the PIP assessment process. We have been clear that neither the Authority nor the regulators have any involvement in the PIP process nor any influence over how it is managed.

5.27 Our sole interest in this matter is how well the professional regulators consider concerns about the fitness to practise of registrants carrying out PIP assessments. We acknowledge that dealing with these concerns may present particular challenges for the regulators. In response, we have begun a dialogue with regulators to explore their approaches to this issue. We will continue this dialogue over the coming months.

Appointments

5.28 One of the major concerns that led to the Authority's creation was the extent to which the regulators' governing bodies were dominated by registrants, which created a perceived conflict of interest. This has now changed with most regulators having Councils with a lay majority appointed on merit. The Authority scrutinises the process for making appointments to Councils and advises the Privy Council on the integrity of the process.

5.29 We set out the work undertaken this year at paragraph 1.67 in part 2. We believe that, in producing strong guidance on appropriate processes, we have enabled regulators to identify fair and transparent systems which are likely to carry public confidence. We hold regular seminars for the regulators on matters of particular interest where there is an opportunity to share best practice.

Special investigations

5.30 In March 2017, the Authority was asked by the Secretary of State to undertake a 'lessons learned' review of the NMC's handling of concerns about midwives at the Furness General Hospital, Morecambe Bay. Concerns about the practices there had been raised since 2009 and had been the subject of an Investigation by Dr Bill Kirkup CBE.[20] The NMC's fitness to practise investigations were not completed until 2017. Our review began in July 2017 once the NMC's work had been completed. We looked at over 60 case files and a Subject Access Request involving around 10,000 documents. We spoke to some of those families who had been bereaved as a result of the poor practices as well as to a number of other key stakeholders. The work continued throughout the financial year and the report was published in May 2018.[21]

[20] Dr Bill Kirkup CBE, (2015). *The Report of the Morecambe Bay Investigation*

[21] Professional Standards Authority, (2018). *Lessons Learned Review: the Nursing and Midwifery Council's handling of concerns about midwives' fitness to practise at the Furness General Hospital*

6. Fitness to practise

6.1 The number of fitness to practise cases has risen substantially over the last decade from 1,231 in 2007/08 to 4,095 in 2017/18. Overall, we have seen incremental improvement by regulators in handling cases and the development of a body of case law. However, the model of fitness to practise has become increasingly legalistic and expensive. In *Right-touch reform*, and its precursor publications *Rethinking regulation*[22] and *Regulation rethought*,[23] we explain why this is problematic and propose a series of reforms.

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

6.2 The Authority has the power under section 29 of the National Health Service Reform and Health Care Professions Act 2002 to refer cases to the High Court (or the Court of Session in Scotland) where it considers that a decision of a panel in respect of a registrant's fitness to practise is insufficient to protect the public. The GMC has a parallel power under section 40A of the Medical Act 1983 and the Authority can join the GMC in such cases if it wishes.

6.3 Under our process, we examine all decisions where the sanction is lower than a strike off. Where aspects of the decision suggest that it may be insufficient to protect the public, a member of our legal team will examine the evidence before the panel in a Detailed Case Review. Where there are further concerns, the Authority will hold a case meeting attended by an external lawyer who will provide legal advice. If, after that case meeting, the Authority still considers that the decision is insufficient, the matter is referred to the Court.

6.4 Where the GMC exercises its power under section 40 of the Medical Act, the Authority will undertake a Detailed Case Review. Under the old procedure, a Case Meeting would also be held. However, the procedure was changed in July 2017 so that the Authority will only hold such a meeting if issues are raised which suggest that the Authority should join in the case.

Caseload

6.5 In this financial year, we scrutinised 4,095 determinations provided to us by the nine regulatory bodies that we oversee. This was a decrease of 4.4 per cent on the previous year. The majority of these determinations caused us no concern. In 265 cases, however, we sought further information from the regulatory bodies and undertook a detailed case review. Last financial year, we undertook a detailed case review in 272 cases. The figure of 200 quoted in last year's annual report was inaccurate and has been corrected here.

[22] Professional Standards Authority, (2015). *Rethinking regulation*
[23] Professional Standards Authority, (2016). *Regulation rethought*

6.6 The top five categories of case that we received from all the regulators are as follows:

Category	2016/17	2017/18
Clinical failings: Record keeping/history taking errors Substandard care/treatment Poor performance/lack of competence Failures to examine/diagnose/follow up Prescription/medicine administration errors	 1,562 1,204 1,146 1,071 777	 1,482 1,027 825 1,049 672
Dishonesty/fraud/theft	1,246	1,127
Poor communication	1,099	906
Adverse Health	546	442
Conviction	467	433

6.7 In terms of safeguarding/patient safety and dignity issues, the numbers are as follows:

Category	2016/17	2017/18
Failure to maintain professional boundaries	387	294
Sexual misconduct	174	195
Rough handling of patients	128	150
Verbal abuse	149	132

Violent/aggressive behaviour	201	205
Child pornography	21	38
Treating without consent	143	159
Insufficient knowledge of English	34	78

Feeding back learning points to regulators

6.8 Where a case does not meet the very high bar for referral to the courts, but the Authority continues to have concerns about the decision or the regulator's handling of the case, the Authority will send learning points to that regulator.

6.9 Those learning points are sent in a number of ways:

- As part of the note of the Case Meeting
- By letter from the Director of Scrutiny and Quality or the Chief Executive if there are significant concerns
- In a digest of more general learning points sent to the regulators quarterly.

6.10 In addition, this financial year, we introduced an electronic learning points digest which we send to all the regulators on a twice-yearly basis. The digest adopts a thematic approach to learning from the cases that we scrutinise and includes reference to recent case law. Feedback from the regulators has been very positive and we encourage the regulators to forward the digest onto their fitness to practise panel and committee members.

6.11 The Authority also uses this process to identify and feedback where it sees particularly good practice by a panel.

Regulatory outreach and fitness to practise seminar

6.12 Members of the Scrutiny and Quality team have spoken at conferences about the Authority's work. They have regular meetings with staff at different levels within the various regulators to discuss themes arising from our scrutiny of cases. In addition, we have engaged directly with panel members and legal assessors about our approach, setting out the matters that are likely to result in us requesting further information or holding a case meeting to decide whether or not to exercise our discretion to refer a case to court. We value this direct engagement with panel members and welcome opportunities to contribute to training days and panel member events.

6.13 Last year, we held a successful conference for chairs of fitness to practise panels and committees. This year, we held a fitness to practise seminar on 14 November 2017 for Directors of Fitness to Practise, operational heads and senior staff responsible for the investigation and adjudication functions from each of the nine regulators overseen by the Authority.

6.14 The theme of the seminar was thresholds and seriousness. Representatives from the Solicitors Regulation Authority; the National College of Teaching and Leadership; the Care Quality Commission; and the Parliamentary and Health Service Ombudsman set out the approach taken by their organisations to the difficulties of defining the threshold for regulatory action and ensuring consistency in decision-making.

6.15 The conference discussed issues around managing public expectations and de-mystifying the fitness to practise process; the need to have a common approach to thresholds and to have more information about public attitudes about the seriousness of particular types of conduct; sanctions and the importance of remediation. Responding to recent criticism by the courts of the Indicative Sanctions Guidance produced by the regulators, we suggested that regulators might wish to consider introducing detailed case studies to supplement the Guidance; and might also consider the potential for working together to establish an inter-regulatory Sanctions Advisory Panel.

Referral to Court under Section 29

6.16 In this financial year, we considered three cases at a Section 29 case meeting and exercised our discretion to refer seven cases to Court. The breakdown is as follows:

Regulator	No of determinations referred to court under section 29 of the 2002 act	Outcome
NMC	Six	Two cases were settled by Consent Order. The decision of the panel was quashed in both cases. In one case, the Conditions of Practice Order imposed by the panel was substituted with another Conditions of Practice Order imposing more stringent sanctions on the registrant. In the other case, the matter was remitted to a fresh panel for rehearing to include dishonesty allegations that had been referred by the case examiners but not included in the charge before the panel.

		In two cases, the Authority's appeal was upheld by the court. In both cases, the matter was remitted back to a fresh panel for re-hearing. The Authority withdrew one Appeal. One hearing is on-going and is listed for hearing on 1 May 2018.
HCPC	One	This case is still ongoing and will be concluded during 2018/19.

6.17 In this financial year, we also concluded 13 appeals which had been lodged in 2016/17 and one Court of Appeal case that had originally been referred to the High Court in 2014/15. The breakdown is as follows:

Regulator	No of determinations referred to court under section 29 of the 2002 act	Outcome
NMC	Eight	In one case, the Authority's appeal was dismissed by the Court of Session. In two cases, the Authority's appeals were upheld by the High Court following hearings. In one case, the Order for Conditions imposed by the Panel was replaced with a Suspension Order. In the other case, the Suspension Order imposed by the panel was replaced with Striking Off.

		The remaining four cases were settled by Consent Order with the decisions of the panels being quashed. Two cases were referred back to fresh panels for re-hearings. In the third case an Order for Conditions was replaced with a Suspension Order. In the fourth case, a Caution Order was replaced with an Order for Conditions.
GDC	One	In this case, the Authority and the regulator agreed that the registrant should have been erased. The registrant did not take part in the appeal and the Court of Session quashed the Suspension Order and imposed erasure.
GMC/MPTS	Two	In both cases, the Authority's appeal was upheld by consent. In one case, the Suspension Order imposed by the tribunal was quashed and the matter remitted to a fresh tribunal for consideration of sanction. In the other case, the tribunal's finding of no impairment and the issue of a warning, was quashed and the matter was referred to a fresh tribunal for rehearing.
HCPC	Three	In one case, the Authority's appeal was

		upheld by consent. The Suspension Order imposed by the panel was quashed and replaced with a Striking-off Order. One appeal was withdrawn by the Authority. A further case originally appealed in 2014/15 was determined by the Court of Appeal and the Authority's appeal was dismissed.

Becoming party to appeals issued by the General Medical Council

6.18 The Authority may become a party to a GMC appeal under section 40B of the Medical Act 1983 (as amended).

6.19 In June 2017, the Authority and the GMC agreed a protocol for the timely exchange of information in relation to these appeals. The Authority has also modified its procedure for deciding whether or not to join a GMC appeal, and no longer automatically holds a case meeting to determine whether or not to exercise its discretion to join an appeal.

6.20 The Authority's practice is that it will normally only join the GMC's appeal where it is satisfied that it can provide additional arguments to those of the GMC, where the case may affect the Authority's own jurisdiction or for some other strong public interest reason. The fact that the Authority does not join in a GMC appeal should not be taken as indicating the Authority's view of the merits of the appeal.

6.21 Since the power was introduced on 31 December 2015 and until the end of the present financial year, the GMC has lodged 25 appeals, and the Authority has become a party to three of these appeals. This financial year, we joined one appeal, and the two GMC appeals that we joined last year, were concluded by the Court. The breakdown is as follows:

Number of GMC appeals to which the Authority become a party in 2017/18	Outcome
One	The appeal was settled by consent between all parties. The decision of the Medical Practitioner Tribunal Service (MPTS) panel not to impose any sanction was substituted with a Suspension Order.

Number of GMC appeals to which the Authority become a party in 2016/17	Outcome
Two	Both appeals were upheld by the Court. In the first case, the Court quashed the finding by the MPTS panel that the registrant's conduct was not sexually motivated. The court substituted this with a finding that the conduct was sexually motivated and remitted the matter back to the tribunal to consider the issue of impairment. In the second case, the finding of no impairment by the MPTS panel was quashed. The court substituted this with a finding that the registrant's fitness to practise was impaired, and remitted the matter back to a fresh panel to make a determination on the appropriate sanction.

6.22 The Authority continues to have a number of concerns about the GMC's right of appeal. Firstly, we consider that it duplicates our own and is likely to give rise to additional costs. Secondly, we consider that it is wrong in principle for a prosecutor to be able to appeal decisions of a panel. In any case, the GMC is not permitted to bring appeals based on the inadequacy of its own prosecution, so the Authority needs to take these forward. In one of the cases taken forward by the GMC, the registrant agreed to settle the case on the basis of inadequate prosecution, rather than the GMC's grounds. We have seen, in particular, a number of cases brought by the GMC in cases where panels have properly found that there is no risk to patient safety but the GMC has considered that the panel failed to give weight to the public interest. While this is clearly a question that needs to be considered, we wonder whether such proceedings in fact materially protect the public. The Authority may not always appeal such cases where we consider that, in practice, the sanction imposed by the panel is likely to ensure patient safety and reflects the public interest.

6.23 The Authority was not a party to the GMC's appeal in the case of Bawa Garba which was the subject of some controversy. Our reasons for this were published in a freedom of information response.[24] We had noted, particularly, that the panel had found that there was very substantial evidence of remediation and that the doctor concerned posed no threat to patients. However, the Authority has given evidence to the Review into Gross Negligence Manslaughter in Healthcare commissioned by the Department of Health and Social Care which is to be led by Professor Sir Norman Williams. We note that this case is subject to an appeal.

[24] **Bawa-Garba Recommendation and final decision** and final detailed case review.

High Court judgments delivered in 2017/18

6.24 During this financial year, the courts delivered judgment in four cases referred to the Court under our section 29 powers. These included two cases that we referred to the court in the previous financial year. The cases where the Authority was successful involved issues about possible injuries to a child in private life, abuse of patients in a psychiatric institution and also involved the court in decisions about regulators' practice in prosecuting cases. Particular points to note included:

- The importance of ensuring that a panel has access to all relevant information before it is asked to decide that there was no case to answer
- The seriousness of mistreatment of vulnerable patients
- The importance of the duty of candour.

6.25 The Authority was unsuccessful in a case that it took to the Court of Appeal – that of Doree. This is only the second time that the Authority has appealed to the Court of Appeal.

6.26 The case involved serious bullying of colleagues at work and the Authority had been concerned that the sanction of a caution imposed by the panel was insufficient to protect the public. At first instance, the court had disagreed with the Authority and had, in addition, made statements about a panel's role in amending charges and about the relevance of the regulators' Indicative Sanctions Guidance which appeared to be at odds with the existing law and which had application beyond the facts of the case.

6.27 The Authority decided to appeal to the Court of Appeal because it was concerned about the wider implications of the judgment and because it retained the view that the sanction had been insufficient. While the Court of Appeal dismissed the appeal because it did not consider that the registrant's behaviour to be so serious that a caution was insufficient to protect the public, it accepted the Authority's arguments in respect of the right of Panels to amend charges and that they should provide adequate reasons for departing from the Indicative Sanctions Guidance.

6.28 The Doree case involved inappropriate and sexualised behaviour toward professional colleagues, rather than conduct towards patients. In 2009, the Authority's appeal in the case of Khanna,[25] which also involved sexual harassment of a colleague, was dismissed. More recently, the Authority lost a similar appeal in the case of ST,[26] which was heard by the Court of Session in Scotland. Thus, the Court of Appeal in England and Wales, and the Court of Session in Scotland (which is of equivalent level) both appear to view such sexualised behaviour to colleagues less seriously than does the Authority.

6.29 In response, the Authority has commissioned research into public attitudes toward professional boundary violations that do not involve patients. Recent revelations of sexual harassment in the entertainment and other sectors have focused public attention on this type of misconduct, and it will be interesting to see whether the research indicates a shift in public attitudes to this sort of misconduct.[27]

6.30 The Authority was also unsuccessful in a case before the Court of Session in Scotland involving a nurse who had failed to give adequate pain relief to a patient at

[25] *CRHP v GMC & Khanna* [2009] EWHC 596
[26] *PSA v GDC and ST, 21 September 2015*
[27] Research now published Simon Christmas Ltd (2018). *Sexual behaviours between health and care practitioners where does the boundary lie?*

the end of her life. The Court decided that, on the facts of that case, the panel's decision that the registrant was not impaired, was sufficient to protect the public. The Court found in particular that the fact that the registrant had undergone a rigorous regulatory process which had resulted in a finding of misconduct was significant. This was despite the fact that under the NMC's regulatory scheme, a finding of no impairment amounts to a complete acquittal. This appears to be at odds with recent decisions in the High Court in London.

Section 40B decisions

6.31 The courts also delivered judgment in two GMC appeals which we joined in the previous financial year. In both cases, the Authority supported the GMC's appeal and joined because both cases had potential significance for the Authority's wider jurisdiction. In both cases, the courts confirmed the approach that it would take towards such appeals and this was consistent with the Authority's understanding of the law. The courts agreed with the GMC and the Authority that the decisions of the MPTS were insufficient to protect the public.

Issues arising from our review of panel determinations

6.32 We set out here some concerns and issues that have arisen from our examination of cases and from court decisions in the last year.

Duty of candour

6.33 We repeat the concern raised in last year's report that little reference is being made to the duty of candour in the allegations being brought by any of the regulators, or in the determinations of fitness to practise panels. This causes us concern because the duty is an essential one for health care professionals and, where it is not followed, we would expect this to be taken forward by regulators either in the allegations or in the aggravating and mitigating factors that panels consider. In our experience, it is rare to see references to this.

6.34 In our engagement with regulatory panels, it became apparent that not all fitness to practise panellists or legal assessors were fully aware of the duty, or of the joint statement signed by the regulators in October 2015. We would encourage regulators to ensure that their panellists and legal assessors are provided with refresher training on this important issue.

6.35 The Authority has initiated a research project to seek to understand why the duty of candour does not appear to have gained traction within the regulatory community.

Registrants seeking to cease practice

6.36 We see a number of cases where a registrant has been subject to a sanction from a panel which is subject to review. The registrant subsequently decides to cease practice and retire or find a new career. This frequently means that the registrant cannot display remediation of the concerns and the logic has been that review panels have decided to continue the sanction with continuing lack of engagement from the registrant. This costs the regulator money and adds to its burden of cases with no tangible benefit to the public.

6.37 The courts considered this in the case of *GOC v Clarke* and decided that it was appropriate for the registrant to be permitted to retire and that the panel was not required to impose a sanction which, in effect, kept him on the register and required further review hearings.

6.38 While noting that the matter is subject to appeal, the Authority considers that the case provides a useful principle that panels can consider so that they avoid unnecessary review hearings provided that:

- There is satisfactory evidence of the registrant's intention to cease practising
- The regulator has appropriate mechanisms to deal with cases where the registrant fails to leave the profession or seeks to return to practice
- The rule applies only to review hearings and does not lead to serious matters being unexplored.

Panel decisions

6.39 We had the following concerns about some panel decisions:

- There can be a lack of detail in decisions which makes it difficult to understand a panel's reasons or enable us to be satisfied that the panel has considered all relevant questions. This can be a particular problem where the conduct is serious and the panel has decided not to strike a practitioner off the register but did not give adequate reasons for this
- Panels do not always seem to appreciate the importance of the statutory Registered Managers scheme established by the Health and Social Care Act 2008, nor the importance of whistleblowing and the wider whistleblowing agenda within the National Health Service, particularly in respect of care homes
- Panels continue to consider the fact that no actual patient harm had occurred, to be a mitigating factor when it is simply neutral
- We remain concerned that panels are still failing to adopt the approach set out by the Court in the case of Arunkalaivanan v GMC,[28] which is that sexual motivation is a matter of inference, based on all the evidence, including the context in which words or deeds occurred, and the explanations put forward by the registrant.
- We have been concerned that in a number of NMC cases, the panel did not find misconduct in circumstances where staff had assaulted patients with challenging behaviour. We would draw the attention of regulatory panels to the factors taken into account by the Court in the recent Apeaning judgment.

Concerns about regulators' prosecution of cases

6.40 We have a number of concerns about regulators' approach to prosecutions and about some of their powers. These include:

- The extent to which some regulators, particularly the NMC and HCPC seek to amend charges at the last minute
- The fact that the NMC's legislation requires us to seek injunctions to prevent the NMC from removing individual registrants from its register before the High Court could address our referral of the relevant fitness to practise panels' decisions.

6.41 The HCPC's approach to the investigation of cases which may involve an underlying health issue causes concerns. This includes drink-driving conviction cases and a number of potentially serious cases where it did not appear to us that

[28] [2015] EWHC 3848

the HCPC had taken sufficient action to satisfy itself as to the registrant's health. As part our review of the HCPC's performance this year (and in part prompted by concerns raised through the Section 29 process), we took a closer look at its approach in relation to cases where there were possible indications of health concerns. In our report, we set out our view that the HCPC continued to fail to routinely consider the risks where there are indications of drug or alcohol misuse, or other health issues. As we described in the report, the absence of consideration by the HCPC of any underlying health issues in a number of complaints may mean that potential fitness to practise concerns may not have been explored, with resulting risks to patient safety and to the registrant themselves. We raised learning points with the NMC in similar cases.

6.42 We have had concerns about the quality of some of the expert evidence that we see referred to in Panel determinations. In some cases, individuals have been treated as experts where this is not the case and, in others, experts have appeared partisan. Sometimes regulators do not adduce expert evidence where this is necessary to give the panel a proper picture of the conduct involved. We would encourage all regulators to develop appropriate standard templates for expert reports; and to provide regular training to their experts on the role and duties of the expert witness.

6.43 In some NMC cases, we have been concerned that the investigation and drafting of allegations do not sufficiently identify or particularise individual culpability in the context of widespread failures by staff. One of the difficulties is that the focus of local investigations or investigations carried out by a system regulator such as the Care Quality Commission (CQC) is different to the focus that is necessary in relation to professional regulation. We have concerns, including in relation to care home investigations that the NMC simply relies on the CQC report, rather than obtaining direct evidence of the individual duties and actions. We identified this as an issue in the *Lessons Learned Review of the NMC's handling of concerns at the Furness General Hospital*.[29] While regulators need to take account of local reports, they need to be alert to other regulatory considerations.

[29] Professional Standards Authority, (2018). *Lessons Learned Review - The Nursing and Midwifery Council's handling of concerns about midwives' fitness to practise at the Furness General Hospital*

7. Accredited Registers

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

7.2 The introduction of this novel system of assurance, first proposed in *Enabling Excellence*, has been a significant regulatory development. A similar model, based on the Authority's accredited registers programme has now been introduced in Hong Kong. Its advantage is that it is quick to establish, flexible – so can adapt easily to change and supports a diverse workforce in the public and private sector. It covers the health scientist workforce, supporting the introducing of modernising scientific careers, the public health workforce and recently encompassed the life sciences industry too. As well as a broad range of individual professions such as clinical physiologists, psychotherapists, and acupuncturists.

7.3 Accredited registers must meet our demanding standards, which include commitment to protecting the public, governance, education and training, risk management and complaints-handling. Practitioners on accredited registers must meet approved levels of education and training and engage in continuing professional development, sign up to codes of conduct and are subject to disciplinary processes. Accredited registers provide a safety net. If someone is struck off one accredited register (or by a regulator), they may not join another accredited register.

7.4 The accredited registers programme has been operating since February 2011. Twenty-four registers have been accredited covering 31 occupations and 85,000 practitioners. Occupations covered include public health, healthcare science, genetic counselling, psychotherapy, play therapy, sports rehabilitation, acupuncture, non-surgical cosmetic practice and complementary therapies such as nutritional therapists. This year we accredited a healthcare chaplaincy register, providing further assurance of this important NHS workforce.

7.5 It costs approximately £400,000 a year to operate the programme and it is managed by 3.4 staff. It is funded through accreditation fees (currently 60 per cent of income) and a subvention from the Department of Health and Social Care.

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

7.7 Having the ability to accredit registers in over-arching legislation, such as that set out in the Health and Social Care Act 2012, allows new registers to be established quickly and cost effectively without the need for individual primary legislation. It permits new occupations to be added and for rules and standards to be changed rapidly in response to changing needs.

List of accredited registers as at 31 March 2018

- Academy for Healthcare Science
- Alliance of Private Sector Practitioners
- Association of Child Psychotherapists
- Association of Christian Counsellors
- British Acupuncture Council
- British Association for Counselling and Psychotherapy
- British Association of Play Therapists
- British Association of Sport Rehabilitators and Trainers
- British Psychoanalytic Council
- Complementary and Natural Healthcare Council
- COSCA (Counselling & Psychotherapy in Scotland)
- Federation of Holistic Therapists
- Genetic Counsellor Registration Board
- Human Givens Institute
- National Counselling Society
- National Hypnotherapy Society[30]
- Play Therapy UK
- Registration Council for Clinical Physiologists
- Register of Clinical Technologists
- Save Face
- Society of Homeopaths
- UK Board of Healthcare Chaplaincy
- UK Council for Psychotherapy
- UK Public Health Register.

Principles and standards

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

- Proportionality - our criteria and the way we apply them should be proportionate to the risk of harm to the public
- Free market - it should not create monopolies or unfairly restrict the market
- Affordability - it should avoid excluding practitioners with lower incomes
- Education - registers should determine the standards required for competent practice of an occupation

[30] Accredited with National Counselling Society

- Efficacy - we make no judgement about the efficacy of any therapy or health or care practice.

7.9 Our standards cover 11 areas:

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

Improving performance

7.10 The impact on registers who become accredited is clear. Every register we have accredited has been required to improve its practice in one or more areas to meet the Standards for Accredited Registers before gaining accreditation. Conditions, instructions and learning points may be issued by our accreditation panels at initial accreditation and annual review to improve practice against the Standards. Conditions must be met to maintain accreditation.

7.11 The table below shows the conditions, instructions and learning points issued throughout the year, including through assessed changes to the register.

Register	Last date accredited	Conditions	Instructions	Learning points
Academy for Healthcare Science	18 December 2017	1	2	0
Alliance of Private Sector Practitioners	01 August 2017	0	4	3
Association of Child Psychotherapists	20 November 2017	0	0	1
Association of Christian Counsellors	26 May 2017	0	0	1
British Acupuncture Council	14 March 2017	2	1	0
British Association for Counselling & Psychotherapy	05 March 2017	1	1	0

British Association of Play Therapists	26 November 2017	0	1	3
British Association of Sports Rehabilitators and Trainers	10 December 2017	0	0	0
British Psychoanalytical Council	20 November 2017	0	3	0
Complementary and Natural Healthcare Council	23 September 2017	1	0	0
Counselling & Psychotherapy in Scotland	19 June 2017	0	2	0
Federation of Holistic Therapists	09 January 2018	0	1	2
Genetic Counsellor Registration Board	10 May 2017	0	1	0
Human Givens Institute	13 April 2017	0	0	1
National Counselling Society/National Hypnotherapy Society	21 May 2017	0	0	1
Play Therapy UK	11 April 2017	0	0	0
Registration Council for Clinical Physiologists	13 March 2018	0	0	2
Register of Clinical Technologists	07 September 2017	2	8	8
Save Face	11 July 2017	2	6	1
Society of Homeopaths	09 September 2017	1	4	2
Treatments You Can Trust	22 July 2017	N/A	N/A	N/A
UK Board of Healthcare Chaplaincy	17 July 2017	1	8	6
UK Public Health Register	03 April 2017	0	0	7
United Kingdom Council for Psychotherapy	11 November 2017	0	0	0
		TOTAL 11	TOTAL 42	TOTAL 38

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

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

- Improving processes for handling complaints against practitioners, to ensure these are robust, fair and focus on public protection
- Improving processes for handling complaints against the organisation holding the register
- Clarifying complaints procedures for the public
- Improving the accuracy of registers to enable the public to make informed choices
- Formalising the requirement for lay involvement on committees and boards
- Clarifying complaints procedures for the public
- Clarifying education and training requirements for entry to the register
- Improving the management of conflicts of interest
- Improving processes for managing continuing professional development
- Improving risk management processes.

Strengthening public protection

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

7.15 During the year, we removed accreditation from one register, and imposed conditions on eight registers.

7.16 For the 2017/18 accreditation cycle, in addition to our usual assessment, we focused on the handling of complaints against practitioners and against the registers themselves. This amounted to a significant increase in workload for the accreditation team and has contributed to the reduction in KPIs met this year for annual renewals. We decided to undertake an in-depth review of complaints-handling as this had consistently been raised as one of the most difficult Standards for registers. As we were aware, the accredited registers have a range of similar, yet different, processes and procedures for handling complaints. We do not prescribe the procedures registers use, but these must meet our Standards. We found the processes, and the implementation of these, to be largely appropriate, with some instances of practice that required improvement and some instances of effective practice. The review resulted in a number of conditions, instructions and learning points for registers to improve their handling of complaints. The 2018/19 annual renewal cycle will test the implementation of these improvements.

7.17 While we monitor the handling of complaints against practitioners, even if these processes are handled effectively and practitioners are removed from registers, these practitioners can legally continue to practise as the titles they work to are not

protected. That is why it is so important that the profile of accredited registers is raised. By choosing practitioners from accredited registers, patients can avoid practitioners who have been determined to be unfit to practise.

7.18 We have redeveloped our annual review process, to be implemented from April 2018. Through this process we will increase the monitoring we undertake throughout the year and move towards a more risk-based approach to annual reviews, allowing us to direct our assessments and our resources more effectively.

Collaboration and cooperation

7.19 The accredited registers workforce provides an important and varied role in improving the public's health, and has the potential to have a far greater impact. We have worked with the Royal Society for Public Health on a report into how the accredited registers workforce, both working privately and commissioned by the NHS and others, could contribute further to improving the public's health. *Untapped Resources: Accredited Registers in the Wider Workforce*[31] was launched by the Minister of State for Health at an event we held in October 2017. This report demonstrated the potential of practitioners on accredited registers to be part of the wider public health workforce. These practitioners have lengthy patient contacts and develop trusted relationships, providing the potential for greater inclusion of healthy conversations where appropriate.

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

7.21 During the year, we introduced www.checkapractitioner.com, which allows those interested in checking or finding a practitioner, whether regulated or on an accredited register, to search for practitioners through the regulators' and registers' websites. This has improved the functionality of searching for practitioners through our website.

7.22 We continue to encourage employers and commissioners to use practitioners on accredited registers and to remain vigilant in checking registers, and publicly recommend that people use practitioners on either a regulator's register or on an accredited register.

Challenges and opportunities

7.23 The programme has supported the development and implementation of a life science industry credentialing register, run by the Academy for Healthcare Science. This register covers workers in the life science industry who routinely interact with patients and healthcare professionals within the NHS. The register sets national standards and allows NHS Trusts to confirm the identity, credentials and training status of individuals that visit their sites.

7.24 This year, we continued to advise the Hong Kong government on the development of its own accredited registers programme, which has been modelled on ours.

7.25 During the year, and following discussions with the Department of Health and Social Care on funding of the programme, we consulted registers on changes to our fee model. No consensus was reached on the two options consulted on. In order to

[31] Professional Standards Authority and Royal Society of Public Health, (2017). *Untapped Resources: Accredited Registers in the Wider Workforce*

continue our move towards financial self-sustainability, we have increased our fees modestly and introduced a per-registrant element to the fee model. Alongside this, we continue to work with the Department of Health and Social Care for ongoing funding of the programme. It is clear that ongoing financial commitment from the government would secure the programme's future and make sure it is available to flexibly accommodate developing workforce and service delivery needs.

7.26 We continue to raise the issue of barriers that we encounter that limit the programme's reach. We continue to seek further support from the Department of Health and Social Care on raising awareness of the programme more widely and ensuring opportunities are not missed to highlight the programme when the Department is asked to comment.

7.27 We continue to seek progress on the Rehabilitation of Offenders Act and the Safeguarding Vulnerable Groups Act, as we have done for over two years. (Currently, Accredited Registers cannot access enhanced criminal records disclosures. This affects their ability to vet entry to their registers and consider complaints. It means that accredited registers must rely on those with spent convictions pertaining to crimes involving issues of trust, honesty and violence declaring them. It also means that where an individual is on a barred list, Accredited Registers are not in a position to know that information.)

Reflections

7.28 As the programme grows, we continue our work to increase its profile among the public, commissioners, employers and other healthcare professionals. We continue to implement and support key government policy through the programme, however remain constrained by factors mentioned, which have prevented the programme from meeting its full potential for public protection. We know that the programme cannot reach its potential for public protection until awareness increases, and remain frustrated by this. We envisage that through greater collaborative working, and greater, high profile support, we could close this gap to improve the programme's public protection function.

8. The power of persuasion

8.1 The Authority relies in large measure on the power of persuasion to influence improvement in regulation. In addition to our performance reviews, which are public documents, we also publish policy advice some of which have become nationally and internationally influential. The following section charts the development of our thinking on improving regulation of the health and care workforce.

8.2 In November 2008, we published *Advice to the Department of Health and the Pharmacy Regulation and Leadership Oversight Group* on aspects of the establishment of the General Pharmaceutical Council.[32] In that advice, we added a sixth principle – agility – to the Better Regulation Executive's five key principles of better regulation:

- Proportionate: regulators should only intervene when necessary. Remedies should be appropriate to the risk posed, and costs identified and minimised
- Accountable: regulators must be able to justify decisions, and be subject to public scrutiny
- Consistent: government rules and standards must be joined up and implemented fairly
- Transparent: regulators should be open, and keep regulations simple and user-friendly
- Targeted: regulation should be focused on the problem, and minimise side effects.
- Agile: regulators must be consistently in a state of readiness to respond to changes and development in healthcare professional practice and circumstances.

8.3 We advised that the regulatory body must be able to anticipate change, including in the environment in which its registrants work, and react quickly. This should be reflected in its structure, standards, policies and processes. We advised that the General Pharmaceutical Council needed to develop its approach to risk management and proportionality so that it could focus most closely on those areas where risk to patient safety is assessed to be highest. Subsequently, the concept of agility was widely recognised, cited and discussed.

8.4 We felt however that more work was needed to establish an accessible yet rigorous framework within which risk-based decisions on regulatory policy could be taken. With this in mind, in 2010 we published our first edition of *Right-touch regulation*, (republished 2015). Right-touch regulation is based on a proper evaluation of risk, is proportionate and outcome focused; it creates a framework in which professionalism can flourish and organisations can be excellent. Right-touch regulation is about identifying the regulatory force needed to achieve a desired effect. We used the analogy of a set of scales. The right amount of regulatory force is being applied when the desired effect is achieved; too little force is ineffective, and too much force is a waste of resources. We set out a series of principles to

[32] CHRE, (2008). *Advice to the Department of Health and the Pharmacy Regulation and Leadership Oversight Group on aspects of the establishment of the General Pharmaceutical Council*

support decision-making on how that right-touch level of regulatory force could be achieved:

- One: identify the problem before the solution
- Two: quantify and qualify the risks
- Three: get as close to the problem as possible
- Four: focus on the outcome
- Five: use regulation only when necessary
- Six: keep it simple
- Seven: check for unintended consequences
- Eight: review and respond to change.

8.5 We also set out a decision tree to support specific decisions on the appropriate regulatory intervention to address a particular risk:

- 1. What is the problem?
- 2. Is the problem about risk of harm?
- 3. How great are the risks?
- 4. What causes the risks?
- 5. Are the risks currently managed?
- 6. Where and why is the problem occurring?
- 7. Can the problem be resolved locally?
- 8. Is there a regulatory solution in line with the principles of good regulation?
- 9. Are there any new risks or unintended consequences?
- 10. Do they outweigh the benefits of regulating?

8.6 In October 2013, the Chief Executive and the Research and Knowledge Manager co-authored a thought paper which was published by the Health Foundation, *Asymmetry of influence: the role of regulators in patient safety.*[33] In this paper, the authors discussed the relationship between regulators and those they regulate – be they people, places or products – and the impact this can have on patient safety. Recognising the complexity of the regulatory system, they proposed 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. They argued that 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.

8.7 In August 2015 we published *Rethinking regulation*, in which we argued that regulation needed a radical overhaul if it was to support rather than stand in the way of the serious changes being proposed for health and care services.[34] We argued

[33] Bilton, D and Cayton, H, (2013). *Asymmetry of influence: the role of regulations in patient safety*. The Health Foundation

[34] Professional Standards Authority, (2015). *Rethinking regulation*

that to the ability to change health and care services required change also to the way in which they were regulated. The application of right-touch principles was required, to understand better what regulation could and could not do to control the risk of harms, to deregulate in some areas and to focus regulation more effectively in others. We set out how health and care regulation was incoherent and expensive with little evidence for effectiveness. We argued that to create a regulatory framework for health and care fit for a more community-based health and care service of the future, run by a flexible and diversified workforce, we would need:

- A shared theory of regulation, based on right-touch thinking
- Shared objectives for system and professional regulators, and greater clarity on respective roles and duties
- Transparent benchmarking to set standards
- A rebuilding of trust between professionals, the public and regulators
- A reduced scope of regulation so it focuses on what works (evidence-based regulation)
- A proper risk assessment model for who and what should be regulated put into practice through a continuum of assurance
- To break down boundaries between statutory professions and accredited occupations
- To make it easier to create new roles and occupations within a continuum of assurance
- A drive for efficiency and reduced cost which may lead to mergers and deregulation
- To place real responsibility where it lies with the people who manage and deliver care.

8.8 In October 2015 we republished a revised version of *Right-touch regulation.*[35] A particular area of development for the second edition was to recognise the growing influence and recognition of the work of Malcolm Sparrow on regulators' role in preventing harm.

8.9 In October 2016 we built on our previous arguments when we published *Regulation rethought*,[36] in which we set out our proposals for a transformation of the regulation of health and care professionals, suggesting how we could put into practice the ideas in *Rethinking regulation.* We proposed that in future, all parts of the regulatory system should have a shared purpose:

- Protecting patients and reducing harms
- Promoting professional standards
- Securing public trust in professionals.

8.10 All regulatory functions and activities should be directed towards and only towards those purposes. We recommended a renewed focus on core functions, effectiveness and efficiency. We set out proposals for a single assurance body,

[35] Professional Standards Authority, (2015). *Right-touch regulation*
[36] Professional Standards Authority, (2016) *Regulation rethought*

common standards, a shared public register and a system of licensing. In fitness to practise we argued for a greater emphasis on local resolution, the adoption of an inquiring instead of a confrontational approach, and shared delivery of investigation, prosecution and adjudication. We set out why we believed that the methodology that we had developed and published as *Right-touch assurance: a methodology for assessing and assuring occupational risk* should be adopted as part of reformed arrangements.[37]

8.11 In October 2017, the Department of Health published *Promoting professionalism, reforming regulation: a paper for consultation* on behalf of the four UK Governments. The consultation sought views on reforms to the sector and was heavily influenced by our work.

8.12 In November 2017, during the consultation period, we published *Right-touch reform*[38] which described in great detail our vision for reform in four areas: harm prevention, fitness to practise, quality assurance of education, and registration. We expanded on our earlier proposal for a single assurance body for health and care occupations, a set of common standards, shared functions and a system of licensing, underpinned by a consistent approach to the assessment of risk. We maintained our position that a single assurance body would be the model best suited to delivering regulation that was proportionate, simple to understand, effective and efficient. We recommended that this proposal was given serious consideration by stakeholders. Separately, and drawing heavily on this publication, we submitted a detailed response to the consultation.[39] The consultation closed in January 2018.

[37] Professional Standards Authority, (2016). *Right-touch assurance: a methodology for assessing and assuring occupational risk*

[38] Professional Standards Authority, (2017). *Right-touch reform: a new framework for assurance of professions*

[39] Professional Standards Authority, (2018). *Response to the government consultation: Promoting professionalism, reforming regulation*

9. Patients at the heart of professional regulation

9.1 The government intended, when establishing the Authority, that it would help to place patients at the heart of professional regulation. This was against a backdrop of major inquiries which had identified that regulators had allowed the interests of the profession to override patients' safety.

9.2 Considerable progress has been made. Reforms to governance mean that the professions no longer dominate regulators' Councils or the Authority's Board. A substantial body of case law has developed which has firmly defined the purpose of professional regulation as being to: protect the public, uphold public confidence and declare and uphold standards. Having confidence in the profession is now understood by regulators and the courts as not being about the image or self-interest of the profession. Rather it is about the confidence that the public will feel in seeking care and treatment from members of that profession.

9.3 However, as we have explained in our papers setting out the case for regulatory reform, it has not succeeded in putting the experience of patients at its heart. As our research with the public shows, they, like professionals find the experience of complaining and attending hearings deeply upsetting.[40] Regulators have tried to provide support and to make the experience less intimidating. But there are two problems. Firstly, the concept of fitness to practise' applied by the regulators is hard to explain and to understand. This means that patients may be at a loss to understand how it is that a regulator agrees their relative may not have received the correct treatment and have died, but the health professional is not sanctioned (or punished). Secondly, patients are not complainants but witnesses and so may be left feeling totally dissatisfied if the matters they complain about are not considered to reach the regulators threshold for investigation, or result in a sanction being imposed by a panel.

9.4 The way in which these matters can impact upon the experience of patients and relatives caught up in regulatory proceedings is shown in stark relief in our recent report on the *NMC Lessons Learned Review.*[41]

9.5 We have therefore recommended wholesale reform of fitness to practise proceedings as set out in Right-touch reform and our response to the government consultation *Promoting professionalism, reforming regulation.*

[40] See *Right-touch regulation*, *Rethinking regulation*, *Regulation rethought* and *Right-touch reform* as set out at footnotes 35,36 and 37 above.

[41] Professional Standards Authority, (2018). *Lessons Learned Review - the Nursing and Midwifery Council's handling of concerns about midwives' fitness to practise at the Furness General Hospital*

10. Preventing harm

10.1 In Regulation rethought, the Authority recommended that 'protecting patients and reducing harms' should be part of the shared purpose of the regulatory system. This is a growing area of interest in research and policy development amongst the regulators and the Authority. The regulators already contribute to harm prevention through the exercise of their four core functions but there is increasing interest in using data and insights from research to proactively influence professionals' conduct and the circumstances in which patient harm arises.

10.2 There is now a considerable body of research-based evidence. We draw attention in particular to recent research conducted for the Health and Care Professions Council, *People like us? Understanding complaints about paramedics and social workers* and Professor Searle's report commissioned by the Authority, *Bad apples? Bad barrels? Or bad cellars? Antecedents and processes of professional misconduct tin UK Health and Social Care.* A team from Coventry University analysed over 6,700 final fitness to practise decisions. They used the data to identify three different types of perpetrator as well as providing insights into sexual misconduct and dishonesty by health and care professionals.

10.3 Regulators, particularly the General Medical Council are making progress in collating and using data for analytical and predictive purposes although this work is still in relatively early stages. All regulators will need to face up the challenge given to the GMC, which we believe applies to all regulators, by the *Report of the Morecambe Bay Investigation* to use its 'wealth of knowledge, experience and its capacity as a regulator to approach patient safety from a wider, more holistic perspective'. Although we caution that this should not result in a blurring of responsibilities or unrealistic expectations that they should control events from which they are distant.

Annual Report and Accounts 2017/2018

1. Performance report

Overview

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

About the Professional Standards Authority

1.2 The Professional Standards Authority for Health and Social Care (the Authority) was established on 1 December 2012. Its role and duties are set out in the Health and Social Care Act 2012.[42] In brief, the Authority protects the public by raising standards of regulation and registration of people working in health and care. The Authority is an independent UK body.

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

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

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

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

1.7 We have duties and powers in relation to:

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

1.8 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 and Social Care 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.

1.9 The Authority is an unclassified public body.[43]

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

[43] Context at www.ons.gov.uk/economy/nationalaccounts/uksectoraccounts/datasets/publicsectorclassificationguide

What we do

Regulatory and standards setting work

1.10 The Authority has powers to:

- Investigate, compare and report on the performance of each regulatory body. We are specifically required to report to Parliament on how far each regulatory body has complied with any duty imposed on it to promote the health, safety and wellbeing of patients, service users and the public
- Audit the initial stages of fitness to practise cases and report on our findings in relation to each regulator
- Review the outcome of final fitness to practise cases and refer them to court if we consider that the outcome is insufficient to protect the public[44]
- Give directions requiring a regulatory body to make rules under any power the body has to do so.

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

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

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

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

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

1.16 The regulatory bodies are the:

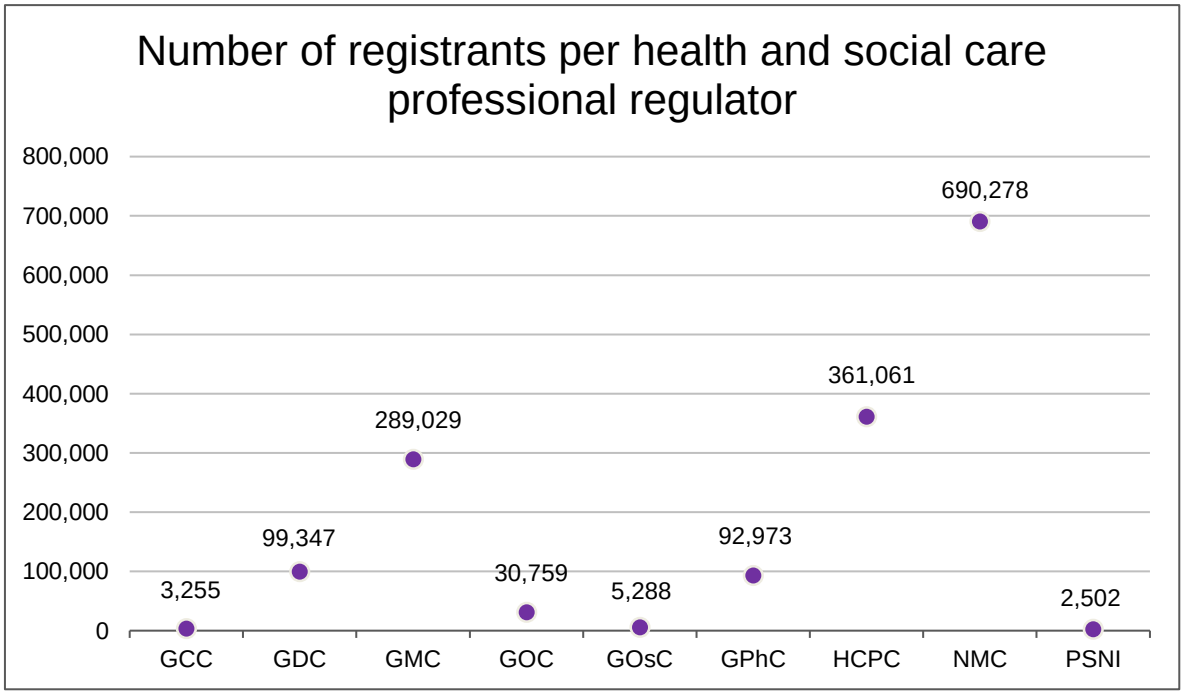
- General Chiropractic Council (GCC) which regulates chiropractors in the UK
- General Dental Council (GDC) which regulates dentists, dental nurses, dental technicians, dental hygienists, dental therapists, clinical dental technicians and orthodontic therapists in the UK
- General Medical Council (GMC)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

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

- 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.

1.17 Details of the number of registrants in each health and social care professional regulator we oversee (as at 31 March 2018) are shown below.

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



Accredited Registers

1.18 The Authority has a statutory role in strengthening quality and patient safety by setting standards and accrediting registers of people working in occupations not regulated by law. As at 31 March 2018, there were 24 accredited registers.

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

Commissions from Government(s)

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

1.21 The Secretary of State and Health Ministers in Scotland, Wales and Northern Ireland may also ask us to investigate matters of concern. As set out in the Health and Social Care Act 2012, the Department of Health and Social Care and devolved administrations pay a fee, determined by the Authority, for this work.

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

Advice to other organisations

1.23 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 these functions relate to health or social care. This work is paid for by the organisation requesting the advice.

Our values

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

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

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

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

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

1.28 We develop and promote right-touch regulation.[45] This is regulation that is proportionate to the risk of harm to the public and provides a framework in which

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

professionalism can flourish and organisational excellence can be achieved.[46] We apply the principles of right-touch regulation to our own work.

Our aim

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

Strategic objectives for 2017/18

1.30 The Authority's corporate strategic objectives for 2017/18 which were agreed by the Board at its strategic planning meeting in May 2016 are set out below.

1.31 The Authority will work to:

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

Business principles

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

- Regulatory and standards setting work: All fees from the regulatory bodies are applied solely to our statutory functions of regulatory oversight and improvement as set out in our legislation. Any surplus or deficit generated against our budget as approved by the Privy Council will be used in the calculation of the following year's fee
- Accredited Registers: All fees for accreditation or renewal from occupational registers are applied solely to provide and develop the accredited registers

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

programme. Any surplus generated will be retained for the benefit of the programme

- Commissions from Government(s): The pricing of commissions and consultancy contracts will cover all costs associated with the work. Any surplus arising will be deployed at the Board's discretion to support our organisational objectives in the public interest
- Advice to other organisations: The pricing of commissions and consultancy contracts will cover all costs associated with the work. Any surplus arising will be deployed at the Board's discretion to support our organisational objectives in the public interest.

1.33 Surpluses will be applied according to these principles after the requirements of our reserves policy have been met.

1.34 To ensure transparency we will:

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

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

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

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

Chief Executive's statement

1.37 As can be seen from the content of this report, the Authority has fulfilled its statutory duties during the year under review. We have published reviews of the performance of seven of the nine statutory regulators during the year.

1.38 The volume of work carried out by staff has remained high. The number of final determinations notified to us by the regulators this year has decreased by 4 per cent. The number of cases that we have discussed at case meetings and appealed has fallen, although the percentage of referrals remains fairly constant. The number of occupational registers we accredit has increased from 23 to 24 and we have revised the fee structure for the programme and continued to work with the Department of Health and Social Care to put it on a secure financial footing.

1.39 The Government consulted on regulatory reform towards the end of 2017 and we made a significant contribution to the background of those proposals with our publication *Right-touch reform.*

1.40 Our commitment to research and learning has continued with our annual academic conference, Welsh stakeholder conference and Accredited Registers conference being well supported by high quality speakers and participants. The Academic Conference attracted speakers and participants from all over the UK and beyond and has become a fixture in the regulatory calendar.

1.41 We have continued to develop our international relationships and have contributed to The CLEAR Education conference in Denver, the World Health Executive Forum in Montreal, and the Canadian Council of Nurse Regulatory Authorities in Toronto. Our international reputation, as demonstrated by the large number of requests for advice and meetings we receive, is significant and growing.

1.42 The quality of our work derives from the quality of our staff. In 2017/18 we carried out, with external advice, a review of our pay bands and reward structure. This has been successfully implemented and we have seen the benefits through a stable and high performing staff team.

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

Key performance indicators

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

1.45 Our performance against those KPIs that are most likely to be of public interest during 2017/18 is set out below:

Area of work	Key performance indicators	Performance
Section 29 decisions	100% of relevant decisions (received) considered within statutory deadline.	100% 4,095/ 4,095
Public concerns about Regulatory bodies	100% of concerns acknowledged within five working days.	94% 362/377
Data and Information security	All (100%) Subject Access Requests dealt with within statutory deadlines. All (100%) Freedom of Information Act requests dealt with within statutory deadlines.	100% 1/1 100% 17/17

Financial Governance and Annual Accounts	To pay undisputed invoices: 60% in five days 100% in 10 days.	 81% 559/688 100% 688/688
Human resources	Staff sickness no more than 2% Staff turnover to be less than 10%.	3% 269/9,832 7% 3/42
Complaints about the Authority	100% of complaints acknowledged in five days Response to all complaints to be completed within 28 days.	100% 10/10 100% 10/10
Information and communications technology	85% of helpdesk calls to be closed within 1 day.	84% 362/431
Accredited Registers	90% of accredited registers will apply for continued accreditation. Timescales are met: Applications are put before the Panel within 21 days of receipt of all information/documentation required Panel reviews renewal applications within five days from the renewal date provided all relevant information and documentation has been received Letters advising of need to apply for renewal are issued 12 weeks before accreditation ceases.	100% 23/23 100% 2/2 57%[47] 13/23 100% 23/23

Performance analysis

1.46 As this report shows, we have continued to focus on public protection, the improvement of professional regulation and registration and the effective delivery of

[47] We have redeveloped our annual review process, to be implemented from April 2018. Through this process we will increase the monitoring we undertake throughout the year and move towards a more risk-based approach to annual reviews, allowing us to direct our resources more effectively.

all our statutory functions. We have worked hard to ensure that we have maintained the quality of our performance.

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

1.48 The accredited registers programme is fully integrated into our work plans, governance and financial management. With 24 registers accredited covering some 85,000 practitioners, it is making a valuable contribution to quality and choice in health and care.

1.49 Our policy work and our research programme continue to grow in influence.

1.50 We are committed to best practice in governance and operations and financial management. We have refocused this function to provide even greater customer service and collaborative support to the front offices during the course of this year.

Regulatory and standards setting work

Section 29

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

1.52 This year we have seen a 4 per cent decrease in the number of fitness to practise determinations notified to us by the regulators, from 4,285 in 2016/17 to 4,095 in 2017/18.

1.53 The majority of the determinations that we reviewed (59 per cent) were NMC panel decisions.

1.54 Of the 4,095 cases we received in 2017/18, 87 per cent (3,570) were closed with no requirement for more information, (although in 66 cases a final decision is yet to be reached). However, 755 of these cases had resulted in the regulator removing the registrant's name from its register, or suspending them indefinitely, therefore raising no concerns about public protection and requiring no Authority intervention.

1.55 During 2017/18, we requested further information and undertook detailed case reviews in 265 cases. By way of comparison, we undertook 272 detailed case reviews in 2016/17.

1.56 During 2017/18, we considered 35 panel determinations at formal case meetings. 31 of these were 'section 29' case meetings and four were 'section 40B' case meetings held to consider whether or not to join GMC appeals. By way of comparison, in 2016/17, we held 55 meetings, of which 47 were 'section 29' meetings and eight of which were 'section 40B' meetings.

1.57 We referred seven cases to Court under our section 29 jurisdiction. We withdrew one case from Court which we had referred in 2016/17. Our appeal in four cases was upheld by consent or by Order of the Court after a full hearing. The two remaining cases are listed for hearing in the 2018/19 financial year and the outcome will be reported in next year's financial report. By way of comparison, we referred 13 cases to the Court in 2016/17.

1.58 In addition, we joined one appeal initiated by the GMC as a party, under section 40B of the Medical Act 1983. That appeal was settled by agreement between all the parties. In 2016/17, we joined two appeals initiated by the GMC.

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

1.60 Although we have seen a decrease in the number of cases reviewed in 2017/18, we have also seen a reduction in the percentage of cases referred to court (down to 0.2 percent in comparison to 0.3-0.4 per cent) when compared to the previous four years (see table 3).

1.61 Of the seven referrals to Court that we made in 2017/18, five related to decisions made by the NMC's Conduct and Competence Committee/Fitness to Practise Panel; and one related to a decision made by the HCPC Conduct and Competence Committee.

1.62 The relatively high proportion of NMC panel decisions that have been referred to the Court by us, reflects in part the fact that 59 per cent of all panel decisions that we receive, are from the NMC.

1.63 More information about our section 29 work can be found in paragraphs 6.1 to 6.43 in part 1 of this report.

Table 2 Number of fitness to practise cases reviewed annually

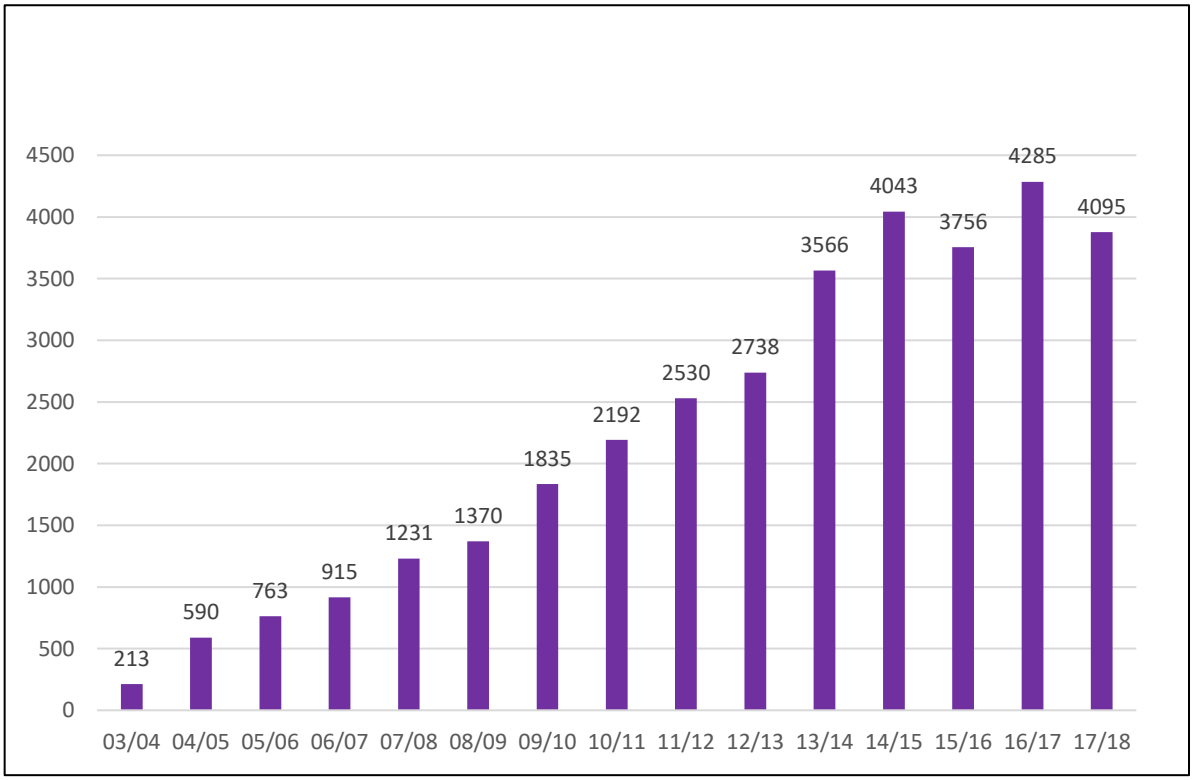
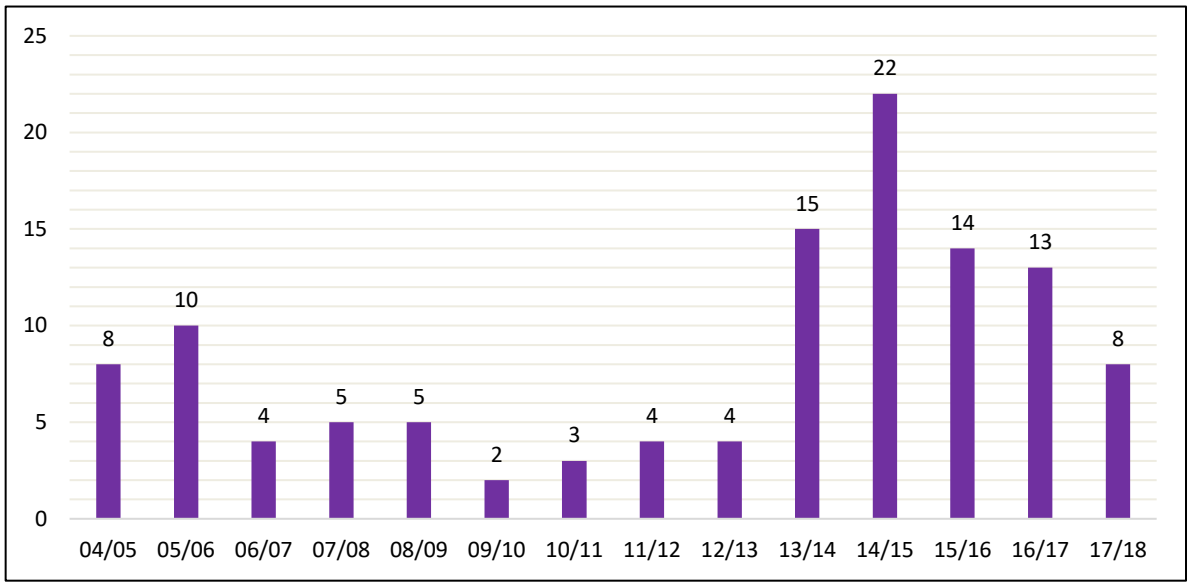


Table 3 Number of fitness to practise cases referred to court each year



* These figures represent the total number of referrals to court (including those cases where we have joined as a party to a GMC appeal in 16/17 and 17/18, but also include a small number of cases which were subsequently withdrawn, for example, 4 in 2014/15 and 2 in 2016/17.

Performance review

1.64 We have a statutory duty to report annually on the performance of each of the regulators in fulfilling their duty to protect the public. We do this by assessing their performance against a set of agreed standards (the Standards of Good Regulation). We review each regulator separately during the year, commencing in January, with our reports published when the review has been completed. We published the final report for the 2016/17 cycle in April 2017. By the end of this financial year, we had published reports for seven out of the nine regulators. We began our next cycle in January 2018.

NMC review

1.65 In March 2017, the Secretary of State for Health asked us to review the NMC's handling of concerns about midwives at the Furness General Hospital, Morecambe Bay. We began our review in July 2017 and published the report in May 2018.

Scrutiny of regulators' council appointments processes

1.66 We assist the Privy Council with appointments to the regulatory bodies' councils (except the PSNI). We provide advice to the Privy Council in relation to all open competitions for appointments and reappointments processes and, if the Privy Council requests it, in relation to any other aspect of the Privy Council's appointments function.

1.67 In 2017/18, we provided advice to the Privy Council in relation to nine processes run by five regulators. Four of these processes related to appointments via open competition, covering 12 vacancies including one chair role. Five of these processes related to reappointments, covering eight vacancies also including one chair role. We advised the Privy Council that it could have confidence in all of these processes.

1.68 In the course of our scrutiny, we have identified areas for improvement as well as instances of good practice, which we have shared with the individual regulators

throughout the year. We intend to hold a seminar with the regulatory bodies early in 2018/19 to discuss emerging issues and share good practice.

Policy and research projects

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

1.70 We have continued to work to build our relationships with academics and researchers. We have over 100 people on our list of academics and researchers with an interest in regulation, or whose work appears to us to be relevant to regulatory improvement. On 8-9 March 2018 we held our fifth academic and research conference on the theme of fitness to practise. Our academic collaborator for the event this year was Professor David, University of Manchester. Over 100 people attended including from academic institutions, regulators, research organisations, professional bodies, consultants working in this field, government officials, clinicians, and law firms. Attendees included people from all four countries of the UK, Ireland, Belgium, the Netherlands, Canada, the US and Australia. There were 36 presentations on research on different aspects of fitness to practise.

1.71 We promoted debate and discussion in the sector. In February 2018 we held a joint seminar with the Welsh government at Cardiff Stadium. It was attended by 60 people and explored some of the current developments in health and care regulatory policy in Wales and across the UK and provided an update on current issues and challenges influencing Welsh Government policy in this area. Topics discussed on the day included changes in health education and training in Wales, workforce challenges, regulation as an enabler not a barrier and the duty of candour. There was also an address from Vaughan Gething AM, Cabinet Secretary for Health and Social Services.

1.72 We built on our previous work on regulatory reform in our substantial publication *Right-touch reform* in November 2017. This comprehensive guide to our thinking on the future of health and care professional regulation gave detailed analysis and recommendations in four areas: harm prevention, fitness to practise, quality assurance of higher education and registration. It was published during the four-country government consultation *Promoting professionalism, reforming regulation,* and formed the basis of our response.

1.73 Right-touch assurance is the innovative tool that we developed for assessing the risk of harm presented by different health and care occupations, the use of which we continue to promote. In 2017/18, it was the basis of a detailed response that we provided to the consultation on the regulation of medical associate professions in the UK.

1.74 We responded to 22 public consultations in 2017/18. These included policy consultations by the regulators we oversee; the Welsh Government, the Charity commission. Our consultation responses are published on our website.

1.75 We presented at the Scottish Regulation Conference this year on the future of reform in the sector and regularly liaised with regulators and government officials in

Scotland, Northern Ireland, Wales and England. We contributed to several conferences including international regulatory conferences.

1.76 We funded ground-breaking work by Professor Rosalind Searle of Glasgow University (although Coventry University during the research) and colleagues, *Bad apples? Bad barrels? Or bad cellars? Antecedents and processes of professional misconduct in UK Health and Social Care: Insights into sexual misconduct and dishonesty.* The research was based on analysis of 6,714 cases of professional misconduct by health and care professionals and identified three different types of perpetrator; the self-serving 'bad apple'; the individual who is corrupted by the falling standards of their workplace; and the depleted perpetrator struggling to cope with the pressures of life.

1.77 We published in May 2017 the report of work commissioned from Dr Simon Christmas, *How does professional regulation affect the identity of health and care professionals: exploring the views of professionals*. This was followed in 2018 by our report *The regulator's role in professional identity: validator not creator*, a paper on regulation and professional identity that tied together our literature review and commissioned research. We found that regulation had a minimal influence on identity, and that regulators may act as validators or invalidators of identity, rather than a creator of identity.

1.78 We published work that we had funded by Professor Ann Gallagher of Surrey University and Mr Robert Jago, RHUL, *A typology of dishonesty: illustrations from the PSA Section 29 database*. This report proposed a typology of dishonesty, building on analysis of cases in which allegations of dishonesty have featured. We also published the report of our project exploring how regulators categorise their fitness to practise allegations, *Categorisation of fitness to practise data*. This was intended as a helpful contribution towards discussions in the sector supportive of greater data-sharing, consistency and comparison. It was the first time all of the regulators' categories had been published together.

Legislative reform

1.79 The Authority has been working closely with officials at the Department for Education on setting up the new social work regulator in England, Social Work England. We sit on both the Advisory Group and the Regulatory Expert Group, and have been an important source of regulatory expertise.

1.80 The four-country consultation *Promoting professionalism, reforming regulation* was published by the Department of Health and Social Care in October 2017, and ran until January 2018. The Authority submitted a detailed response based on the ideas that we set out in *Right-touch reform* in November 2017. At the time of writing an analysis of the responses has not been published, although the Authority has been reviewing those responses that we have identified and have been published on other organisations' websites. These suggest broad support for a robust method for assessing the appropriate form of assurance, support for the Authority retaining s29 powers, and general support for fitness to practise being conducted in a less confrontational way. The majority of responses we have seen agreed there should be fewer regulatory bodies, greater co-operation between regulators and greater flexibility for regulators to determine their own operating procedures.

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

Accredited Registers

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

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

1.84 The programme is financed by a combination of accreditation fees and a subvention from the Department of Health and Social Care. The programme was intended to become self-financing. We therefore consulted on a new fee model in 2017/18 to establish if it could become self-sustaining. We consulted on two options but no consensus was reached. As a result, it was apparent that the programme would require some ongoing support from the Department of Health and Social Care for the foreseeable future. However, the total costs of operating the programme are modest at approximately £400,000. While no consensus was reached through the consultation, we acknowledge our responsibility to move towards a self-sustaining model, and introduced an updated fee model for 2018/19. As of April 2018, the fees for the programme are £13,250 for initial application and an annual fee of £10,000 plus £0.10 per registrant.

1.85 We have 24 accredited registers within the programme, covering 31 occupations and 85,000 practitioners. Accreditation is reviewed annually. By the end of the financial year, we had accredited two new registers and renewed accreditation of 18. Four annual assessments have carried over into the new financial year. We removed accreditation from one register which was found not to be continuing to meet our standards.

1.86 This year we focused during annual renewal assessments on the accredited registers arrangements for handling complaints against practitioners and against the organisations themselves. We found both effective practice and examples of practice that we have required improvement on. Examples of improvements made include the implementation of a new complaints procedure, improvements in communications to complainants and registrants, updates to appeals processes, improvements to guidance, improving the clarity of outcomes and decisions made, and clarifying processes for complaining about the organisation.

1.87 We worked in partnership with the Royal Society for Public Health to explore how the accredited registers workforce can contribute further to Public Health England's initiatives to improve the nation's public health. The report was launched by the Minister of State for Health on 31 October 2017. We accredited a credentialing register for workers in the life science industry who work within NHS trusts and routinely interact directly with patients and/or NHS front-line staff. This register is the

first of its kind and sets national standards for individuals working in the life science industry, providing reassurance to the NHS.

1.88 During the year, we received and considered 17 queries about accredited registers. We included a number of these in our assessments of organisations as part of our complaints-handling review.

1.89 We have continued to work to raise awareness of the accredited registers programme and the importance of using registrants on them. We introduced a new www.checkapractitioner.com facility to our website this year to make it easier for people to search for practitioners on accredited registers. We have also conducted social media campaigns including what to check before having lip fillers and tips for safe foot care. However, given the modest resources available to the programme it is not possible for the Authority alone to raise awareness amongst a population of over 60 million people. It requires concerted effort by us, accredited registers, and other stakeholders with an interest in ensuring public protection, delivering services and promoting public health. Awareness of the programme remains insufficient for it to deliver full benefit to the public. We are grateful to NHS Employers for their continued publication of the programme and will be contacting other stakeholders in the forthcoming year to ask for their support.

1.90 We have also asked the Department of Health and Social Care to assist with securing changes to the Rehabilitation of Offenders Act and the Safeguarding Vulnerable Groups Act to strengthen the protection accredited registers can offer. At present, their exclusion from those Acts constrains their ability to respond to some complaints due to data protection issues. We are disappointed that no progress has yet been made on this. It is now the third year we have raised this.

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

Commissions from Government(s)

1.92 The Authority was commissioned to provide advice to the Scottish Government on the implications of regulating a group in fewer than all four UK countries. This advice was completed and provided..

Advice to other organisations

1.93 We provided advice to the Chinese University of Hong Kong, who have been developing an Accredited Registers programme for the Hong Kong government. This included documentary analysis of the programme's approach and processes, followed by a visit to Hong Kong to meet with stakeholders and provide further advice.

1.94 We commenced delivery of a contract with Engineers and Geoscientists BC (EGBC), the regulator and professional association for engineers and geoscientists in British Columbia. The focus of the review is EGBC's governance and legislation.

Financial summary

1.95 Our funding for 2017/18 comprised £3.9 million fees paid by the regulators. In 2016/17 our funding was £3.86 million fees raised from the regulators and £0.2 million from Department of Health and Social Care.

1.96 At 31 March 2018, we carried forward reserves of £2.06 million (2016/17: £1.87 million) after net operating income of £0.189 million (2016/17: net operating cost

£0.11 million). Net operating income for 2017/18 is calculated net of fees received from the regulators, which is recorded as an income in accordance with IAS 18.

1.97 During the year ending 31 March 2018, we generated a surplus that increased our reserve position by £0.189 million.

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

Transparency

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

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

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

1.102 During the 2017/18 financial year, 100% of invoices were paid in 10 days and 81% (by number of invoices) and 82% (by total invoice value) within five days. Details of our payment record can be found on our website.[48]

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

1.104 The balance owed to trade payables as at 31 March 2018 was £14,038 (2017/18: £17,086). As a proportion of the total amount invoiced by suppliers in the year, this is equivalent to 4.61 days (2017/18: 3.20 days).

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

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

Sustainability

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

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

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

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

1.110 Our offices have facilities to separate waste for recycling, and to encourage staff to do this, no waste is collected from bins at desks. Waste is separated into glass,

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

recyclable, non-recyclable and food waste. A contractor separates the mixed recyclables. No waste goes to landfill. Waste that cannot be recycled is incinerated. In 2017/18 98 per cent of waste, within the building, was recycled and 2 per cent was incinerated. The cost of all waste disposal is included in our building service charges.

1.111 Our gas and water consumption is calculated as 2.58 per cent of the total. Our electricity is separately monitored and the consumption for the space rented from the landlord is known. This does not, however, include the consumption by our tenants. Our consumption for 2017/18 and the previous year is set out below.

	2017/2018	2016/2017
Gas	4,589kWh	7,672kWh
Electricity	64,854kWh	65,031kWh
Water	151.02m^3	146.64m^3
Waste removed	2.66 tonnes	2.76 tonnes

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

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

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

1.115 We use ‘off-white recycled paper’ for our day-to-day needs. We used 44 cases of paper in 2017/18 (71 cases in 2016/17).

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

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

Mode of travel	2017/2018		2016/2017	
	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*	764	19	153	4
Rail	635	16	633	17

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

Human rights

1.118 We are committed to respecting human rights as embodied in the Universal Declaration of Human Rights and its two corresponding covenants, The International Covenant on Civil and Political Rights and The International Covenant on Economic, Social, and Cultural Rights.

1.119 We endeavour to ensure that we do not infringe on human rights, avoid complicity in the human rights abuses of others, and comply with the laws of the countries in which we work.

Anti-corruption and anti-bribery

1.120 We are committed to conducting our work in an honest and ethical manner. In accordance with the Bribery Act 2010 we operate governance by implementing and enforcing robust policies and procedures to guard against any illegal behaviour.

1.121 Our whistleblowing and fraud polices are reviewed annually by our Audit and Risk Committee and are messaged to our staff. We have a zero-tolerance approach to any breach of the Bribery Act 2010 and any issues raised will be treated with the utmost importance.

Risk

1.122 Details of this can be found in paragraphs 2.71-2.75.

Approved by the Board

Harry Cayton CBE
Accounting Officer
19 June 2018

2. Accountability Report

Corporate governance report

2.1 Our governance arrangements are set out in a formal Governance Framework that details the various roles and responsibilities within the Authority.

Directors' report

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

2.3 A register of senior managers' interests is available on our website.[49]

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

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

Director of Governance and Operations

2.5 The Director of Governance and Operations' principal responsibilities are:

- Finance
- Human resources
- Information and communications technology
- Information security and SAR and FOI requests
- Governance
- Risk management
- Internal and external audit
- Corporate complaints
- Accommodation and facilitates
- Health and safety
- Business continuity
- Procurement
- Office administration.

Director of Scrutiny and Quality

2.6 The Director of Scrutiny and Quality's principal responsibilities are:

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

- The Authority's functions under Section 29 of the NHS Reform and Health Care Professions Act 2002 (as amended)
- Audit of regulators
- Performance review of regulators
- Advice to the Privy Council on appointments
- Special reviews and investigations
- Complaints and concerns about the regulators.

Director of Standards and Policy

2.7 The Director of Standards and Policy's principal responsibilities are:

- Provision of section 26A advice to the Secretary of State and Ministers
- Development of regulatory policy and practice
- Research into regulatory matters
- Accredited Registers programme
- Complaints about accredited registers
- External relations and communications.

Public appointments

2.8 Appointments to the Board are made for an initial term of four years, which can be extended for a second term. The total time served should not exceed eight years.

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

2.10 No appointments were made during 2017/18.

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

2.12 Details of the directorships and significant interests held by the Board are contained within the register of interests held on our website.[50]

Board members

Board member	Appointed by
George Jenkins OBE (Chair)	Privy Council
Antony Townsend	Privy Council
Frances Done CBE	Privy Council
Renata Drinkwater	Privy Council
Thomas Frawley CBE	Department of Health Northern Ireland
Moiram Ali	Scottish Ministers

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

Marcus Longley	Welsh Ministers
Harry Cayton CBE	Authority's Board

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

The Board and Accounting Officer's Statement of responsibilities

2.14 Under the Cabinet Office's Guidance on Codes of Best Practice for Board Members of Public Bodies, we are responsible for ensuring propriety in its use of public funds and for the proper accounting of their use. Under Schedule 7, Paragraph 16 (2) of the National Health Service Reform and Health Care Professions Act 2002, as amended by the Health and Social Care Act 2008 and the Health and Social Care Act 2012, we are required to prepare a statement of accounts in respect of each financial year in the form and on the basis directed by the Secretary of State for the Department of Health and Social Care, with the consent of HM Treasury. The accounts are to be prepared on an accruals basis and must give a true and fair view of the Authority's state of affairs at the year end and of its income and expenditure, total changes in taxpayers' equity and cash flows for the financial year.

2.15 In preparing the accounts, we are required to:

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

Accounting Officer

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

2.17 The Chief Executive is an employee of the Authority. The Chief Executive's principal functions, duties and powers are:

- To ensure the Authority fulfils its statutory duties
- To prepare and issue standards of good regulation
- To arrange for the publication of policy advice and guidance
- To send to parliament an annual report on the performance of the regulators we oversee
- To keep proper accounts and proper records in relation to the accounts, to prepare a statement of accounts in respect of each financial year, and to send a

copy of the annual accounts to the Comptroller and Auditor General and for these to be prepared in accordance with international Financial Reporting Standards and government accounting

- To operate and manage the Authority in accordance with the strategy set by the Board.

2.18 The Chief Executive has responsibility for providing effective leadership on all matters relating to statutory and administrative duties. This includes the implementation of the strategy, leading on all operational matters, promoting the efficient and effective use of staff and other resources, encouraging high standards of propriety and representing the Authority in public.

Further explanation

2.19 The Health and Social Care Act 2012 changed the name of the Council for Healthcare Regulatory Excellence to the Professional Standards Authority for Health and Social Care and provided a power for the Authority to accredit voluntary registers of health and care occupations and to advise the Privy Council, if requested, on the appointment of members to the councils of the regulators. The Act also changed the basis on which the Authority was funded to a system of fees and charges on the bodies it oversees or provides services to. The fee regulations came into effect in August 2015, after which time the authority no longer receives grant in aid from either the Department of Health and Social Care in England or the devolved governments of the UK. The 2012 Act includes a provision for appointments to the Board to be made by the Privy Council not by the Secretary of State for Health and Social Care except in the case of members appointed from Scotland, Wales or Northern Ireland. The Act also includes a provision for the Accounts Direction to the Authority to be issued by the Privy Council. This provision has not yet been enacted so the Authority continues to follow the Accounts Direction issued in 2013-14 by the Department of Health and Social Care.

Data handling

2.20 Details of this can be found in paragraphs 2.76-2.82.

Governance statement

2.21 The Authority's Board comprises seven non-executive members and one executive member. No non-executive members of our Board may be or ever have been a member of a profession regulated by any of the nine regulators we oversee so that we are independent of the health and social care professions and regulators.

2.22 The Board is the Authority's highest decision-making forum, where significant strategic and operational matters are discussed and consequential decisions taken.

2.23 The Authority's Board has corporate responsibility for ensuring that it fulfils its statutory duties and for promoting the efficient and effective use of its resources.

2.24 To this end, and in pursuit of its wider corporate responsibilities, the Board:

- Sets the overall strategic direction of the Authority within statute and the policy and resources framework
- Ensures that any statutory or administrative requirements for the use of public funds are complied with; that the Authority operates within the limits of its

statutory authority, and in accordance with any other conditions relating to the use of public funds

- Ensures that the Authority receives and reviews regular financial information concerning the management of the Authority; is informed in a timely manner about any concerns about the activities of the Authority; and provides positive assurance that appropriate action has been taken on such concerns
- Demonstrates high standards of corporate governance at all times, including establishing an audit committee to help the Authority to address the key financial and other risks facing it
- Appoints the Chief Executive to the Authority and, sets performance objectives and remuneration terms linked to these objectives for the Chief Executive, which give due weight to the proper management and use of public monies.

Chair of the Board

2.25 The Chair has a leadership responsibility on the following matters:

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

Attendance at Board meetings held in public

2.26 There were six Board meetings held in public between 1 April 2017 and 31 March 2018.

2.27 Members' attendance at Board meetings during 2017/18 was as follows:

Board member	Number of meetings attended	Possible
George Jenkins OBE (Chair)	6	6
Antony Townsend	6	6
Frances Done CBE	6	6
Renata Drinkwater	5	6
Thomas Frawley CBE	6	6
Moiram Ali	6	6
Marcus Longley	6	6
Harry Cayton CBE	6	6

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

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

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

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

2.32 The Board also reviews its own performance as part of its strategic planning. The Board considers that it is functioning effectively.

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

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

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

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

Committees and working groups of the Board

Audit and Risk Committee

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

2.38 Four Audit and Risk Committee meetings were held between 1 April 2017 and 31 March 2018.

2.39 Members' attendance at committee meetings during 2017/18 was as follows:

Committee member	Number of meetings attended	Possible
Frances Done CBE	4	4
Moiram Ali	4	4
Marcus Longley	4	4

Harry Cayton CBE	4	4

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

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

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

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

Regulators internal audit hub

2.43 We have chosen to be within the Government Regulators Internal Audit Hub. The Hub's internal auditors, Grant Thornton (GT), were our internal auditors for 2017/18.

2.44 The internal audit work this year focused on:

- Procurement
- ICT (non-technical aspects)
- Business continuity
- Adherence to our business principles and reserves policy.

Procurement

2.45 The review considered the adequacy of design and operating effectiveness of the procurement policy and process.

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

'…the Authority's policy…contains the key aspects of the procurement process that we would typically expect…testing showed that the business units followed these processes…However, we found areas of significant weaknesses…in monitoring and oversight of the procurement process…'

ICT (non-technical aspects)

2.47 The review considered the adequacy of design and operating effectiveness of the new ICT processes.

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

'The Authority has increased its focus on ICT in recent past through the introduction of a more structured approach to how the services are provided …The review found that these new processes brought benefits but due to their infancy, the frameworks governing them needed to be established or further developed.'

Business continuity

2.49 The review considered the adequacy of design and operating effectiveness of the business continuity processes.

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

'…the Authority is well equipped to respond to a variety of events that may affect their ability to perform key business functions.'

Adherence to our business principles and reserves policy

2.51 This review considered whether the Authority was acting in accordance with our business principles and reserves policy which are set out above.

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

'Based on the work performed for the period April 2017 – March 2018, we found that the Authority has adhered to the set of business principles and reserves policy it has set out… We have not identified any fundamental or significant errors in relation to the application of the business principles or reserves policy, based on the work carried out.'

Risk register

2.53 The Directors Group reviews the risk register quarterly. The updated resource is considered by the Audit and Risk Committee at each meeting and by the Board every six months. Risks are added, updated or deleted outside of this process when the need arises.

2.54 During the year, the committee reviewed the risk register maintained by the executive. The main risks discussed, some of which are covered in detail in the strategic report, related to our business continuity arrangements and a programme to improve our support services.

Assurance framework

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

2.56 During 2017/18 the then new Board requested changes to the framework and a new format was agreed. The framework is now structured around those areas of good governance that will always require assurance, as opposed to the Board's annual objectives which will continually evolve.

2.57 The means of assurance listed are inputs from which the Board makes a judgement about their level of assurance. The framework does not aim to be an exhaustive list or tool for the executive to undertake operations.

Scrutiny Committee

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

2.59 Three Scrutiny Committee meetings were held between 1 April 2017 and 31 March 2018.

2.60 Members' attendance at committee meetings during 2017/18 was as follows:

Committee member	Number of meetings attended	Possible
Antony Townsend	3	3
Renata Drinkwater	3	3
Thomas Frawley CBE	3	3
Harry Cayton CBE	2	3

Appointments to regulators' councils

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

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

2.62 At each meeting, the Scrutiny Committee reviewed decisions taken about individual regulators' final fitness to practise panel decisions at different stages of the process. In February 2018 it looked at decisions in cases which involved non-clinical concerns. In each case, the Committee was satisfied that the approach taken in respect of those decisions and with the quality of the reasoning.

Annual performance review of regulators

2.63 The Scrutiny Committee has received regular reports on the progress of the Performance Review process and, in particular, any concerns that have arisen in the first year of the new process. The Committee has been content with that process. In the next financial year, it will look at the information required from the regulators to inform the review.

Standards of Good Regulation

2.64 The Scrutiny Committee has been involved in work to review the Standards of Good Regulation. These are the Standards that the Authority uses to assess regulators' performance and are now over 10 years old. The Authority is reviewing the Standards and the Committee has been involved in commenting on the process and on the key issues that have arisen. The new Standards are expected to be settled in the Autumn of 2018.

Accredited Registers

2.65 The Scrutiny Committee carried out its scrutiny of the accredited registers programme. It received progress updates on applications going through initial assessment, annual reviews of accreditation and notifications of change. It is keen to look at the process for accreditation and re-accreditation and members will be attending meetings in the course of 2018.

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

Pension scheme regulations

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

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

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

2.70 During the year we have completed the necessary technical work to achieve online access to the NHS Pensions system so that the records, especially staff records, can be updated in real time. In the coming year we will look to transition to this approach fully.

Risk and uncertainty

Approach

2.71 Every year we subject our risk management practices to a gap analysis against the industry best practice Management of Risk (MoR) methodology.

2.72 Both the approach (process and matrix scoring system) and risk register are scrutinised, and where appropriate incremental improvements are made.

2.73 Because the MoR syllabus had not changed since the last review, we did not update our practices during 2017/18.

Specific items during 2017/18

2.74 Notable risks that we considered threats during 2017/18 included the testing of our Business Continuity Plan identifying ICT inadequacies that we subsequently remediated, and the potential disruption to legal operations due to work to replace our s29 database that we mitigated though use of external resources.

2.75 Notable risks that we considered opportunities during 2017/18 included a programme to redevelop our support services that was successfully completed, and our preparation for the forthcoming General Data Protection Regulation which has since been independently audited by our internal auditors.

Data handling

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

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

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

2.79 All staff are required to complete the level appropriate to their level of responsibility for data-handling. All members of staff successfully passed the assessment in 2017/18.

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

2.81 This statement has been prepared following consideration of the Authority's Annual Assessment of Information Risk Management for 2017/18 and the assurance provided by it.

2.82 We have no personal data incidents to report.

Accounting Officer's responsibilities

Scope of responsibility

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

2.84 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 and Social Care in England, to deliver our statutory obligations and the key objectives of our business plan. This includes identifying and responding appropriately to both internal and external risks.

The purpose of the system of internal control

2.85 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 provide reasonable but not absolute assurance of effectiveness.

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

2.87 Our system of internal control has been in place for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts, and accords with HM Treasury guidance. The key elements of the system of internal control include:

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

Review of effectiveness

2.88 As Accounting Officer, I am responsible for reviewing the effectiveness of the system of internal control. My review is informed by the work of the internal auditors,

the Directors Group, which has responsibility for the maintenance of the internal controls, and comments made by the external auditors in their management letter and other reports. The Audit and Risk Committee and Board have advised me on the implications of the result of my review on the system of internal control. The Scrutiny Committee has this year considered in detail our performance against our own standards for our statutory functions and for the accredited registers programme.

2.89 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 attend the Audit and Risk Committee meetings together with the Director of Governance and Operations and the Head of Finance. Representatives of the National Audit Office and our internal auditors are also present
- Risk management arrangements identify which key risks could affect the achievement of our objectives and those risks have been managed actively, with progress being reported to the Audit and Risk Committee and, through it, to the Board of the Authority
- Our annual assessment of information risk management undertaken in accordance with the Cabinet Office's guidance. We have paid particular attention this year to preparation for the General Data Protection Regulations
- Regular reports from the internal auditors, Grant Thornton, complying with the government's Internal Audit Standards
- Comments made by external auditors, the NAO, in their management letter and other reports.

2.90 Grant Thornton, internal auditors to the Regulators Hub have been our internal auditors for the year under review. The Head of Internal Audit in his report for 2017/18 stated that:

'…none of the audits highlighted any fundamental issues…Therefore based specifically on the scope of the four reviews we carried out in 2017/18, and the testing / evaluation we performed, we have concluded that controls we tested were suitably designed and operating effectively in the areas of corporate governance, risk management and internal controls in these four areas reviewed this year.'

2.91 Grant Thornton have been replaced by Mazars as our internal auditors for the year 2018/19.

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

2.93 Our Assurance Framework is monitored along with the risk register by the Directors Group, the Audit and Risk Committee and the Board. External and internal influences are considered and any potentially significant risks are discussed with key stakeholders as soon as they become apparent. The Audit and Risk committee has reviewed our assurance framework during the year to ensure it provides an appropriate level of assurance to the Committee and the Board.

2.94 I am satisfied that the annual assessment of information risk management adequately reflects the information risks we have managed and that we have considered future risks. I consider that we have taken the actions necessary to manage information risks effectively. I am confident that staff are aware of their responsibility to store, share and destroy information securely. I am satisfied that the small number of minor information risk incidents which occurred this year were managed appropriately, that corrective action was taken and that no sensitive information was disclosed or lost.

2.95 This report has been prepared in accordance with the 2017/2018 Government Financial Reporting Manual (FReM) issued by HM Treasury.

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

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

2.98 I confirm that:

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

Harry Cayton CBE
Accounting Officer
19 June 2018

3. Remuneration and staff report

Remuneration policy

Remuneration Committee

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

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

3.3 Four Remuneration Committee meetings were held between 1 April 2017 and 31 March 2018. Members' attendance is shown below.

Board member	Number of meetings attended	Possible
George Jenkins OBE (Chair)	4	4
Frances Done CBE	4	4
Thomas Frawley CBE	4	4

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

3.5 Following financial impendence from the Department of Health and Social Care, during 2017/18 we have undertaken a job evaluation, grading and pay exercise so as to invest in the quality, recruitment and retention of our staff team. As part of this exercise we have reviewed our roles, responsibilities and the staffing levels within each team. As a consequence of this, the Remuneration Committee approved the introduction of new pay grades to bring our reward policy closer in line with the regulatory sector. We have lessened the financial impact of this exercise on our stakeholders by identifying savings in other areas of our budget. We are now confident that we have the correct staffing structure to enable the Authority to fulfil its duties in the medium term to long term.

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

Senior managers' contracts

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

Senior managers' salaries

Name	Salary 2017/2018 £'000	Expenses payments (taxable) Total £000	Performance pay and bonuses £000	Long-term performance pay & bonuses £'000	All pension-related benefits £'000	TOTAL 2017/2018 £'000
Harry Cayton	155-160	0	0	0	85-90	245-250
John McDermott	95-100	0	0	0	60-65	160-165
Mark Stobbs	95-100	0	0	0	20-25	120-125
Christine Braithwaite	95-100	0	0	0	20-25	120-125

Name	Salary 2016/2017 £'000	Expenses payments (taxable) Total £000	Performance pay and bonuses £000	Long-term performance pay & bonuses £'000	All pension-related benefits £'000	TOTAL 2016/2017 £'000
Harry Cayton	150-155	0	0	0	35-40	190-195
John McDermott	55-60***	0	0	0	10-15	65-70

Mark Stobbs	85-90***	0	0	0	20-25	105-110
Christine Braithwaite	95-100	0	0	0	20-25	115-120
Linda Allan	45-50****	0	0	0	15-20	60-65
Rosalyn Hayles	15-20****	0	0	0	10-15	30-35

***Lower figures due to mid-year start dates. Full year equivalent salary £95k-£100k.
**** Lower figures due to mid-year leaving dates. Full year equivalent salary £95k-£100k.

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

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

3.9 Total remuneration includes salary and all pension-related benefits calculated in accordance with the NHS Pensions guidance,[51] which seeks to quantify the increase in pension benefits in the year by comparing the overall pension benefits at the beginning of the year with those at the end of the year. There were no non-consolidated performance-related pay, benefits-in-kind or severance payments in 2017/18 or 2016/17.

Pensions

Name	Title	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 as at 31 March 2018 (bands of £5,000)	Lump sum at age 60 related to accrued pension as at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer Value as at 1 April 2017 (to the nearest £1,000)**	Cash Equivalent Transfer Value as at 31 March 2018 (to the nearest £1,000)**	Real increase in the Cash Equivalent Transfer Value during the reporting year (to the nearest £1,000)**
Harry Cayton	Chief Executive	5-7.5	0-2.5	35-40	20-25	N/A**	N/A**	N/A**
John McDermott	Director of Governance and Operations	2.5-5	N/A*	0-5	N/A*	7	35	14
Mark Stobbs	Director of Scrutiny and Quality	0-2.5	N/A*	0-5	N/A*	20	44	10

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

Christine Braithwaite	Director of Standards and Policy	0-2.5	2.5-5	20-25	60-65	410	470	36

* Not applicable in the 2008 scheme
**Not applicable as individual over 65

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

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

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

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

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

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

3.13 No senior manager had expenses subject to UK tax.

Authority members' remuneration

3.14 The payments made to the Board are subject to Cabinet Office guidance and have not increased since 2009/10. The Chair receives remuneration of £33,688 pa (2016/17: £33,688 pa); members receive annual remuneration of £7,881 (2016/17: £7,881) and the Audit and Risk Committee Chair receives annual remuneration of £13,135 (2016/17: £13,135). Members' remuneration during the year amounted to £90,894 (2016/17: £91,515) including social security costs.

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

3.16 In addition, expenses amounting to £11,621 (2016/17: £14,002) were reimbursed to Board members. Travel expenses related to travel to the Authority's offices are

subject to tax which is paid by the Authority on their behalf, by agreement with HMRC.

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

3.18 Payments to individual members are disclosed below.

3.19 No Board members were members of the NHS pension scheme in 2017/18. All contributions paid by two board members in 2016/17 were refunded.

Payments made to the Authority's Board members during 2017/18

	2017/2018 Salary (bands of £5,000)	2017/2018 Travel expenses (bands of £5,000)	2016/2017 Salary (bands of £5,000)	2016/2017 Travel expenses (bands of £5,000)
Chair				
George Jenkins OBE	30-35	0-5	30-35	0-5
Members				
Antony Townsend	5–10	0-5	5–10	0-5
Frances Done CBE *** (Audit and Risk Chair)	10-15	0-5	0-5	0-5
Renata Drinkwater	5–10	0-5	5–10	0-5
Thomas Frawley CBE ***	5-10	0-5	0-5	0-5
Moiram Ali ***	5-10	0-5	0-5	0-5
Marcus Longley	5-10	0-5	N/A	N/A
Ian Hamer OBE**	0-5	0-5	5–10	5-10
Andrew Hind CB*	N/A	N/A	5-10	0-5
Stuart MacDonnell*	N/A	N/A	5–10	0-5
Jayne Scott*	N/A	N/A	5–10	0-5

* Up to 31 December 2016

** Up to May 2017
*** From 1 January 2017

Staff report

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

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

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

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

3.24 Our staff turnover this year was significantly below our target. We believe that a significant factor in this has been the pay review which has ensured that our staff salaries are more in line with the sector. In addition, we increased notice periods in order to assist us with knowledge transfer.

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

Fair pay disclosures

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

3.27 The remuneration of the Chief Executive in the financial year 2017/18 was £157,500 (calculated as middle of the band)This was 3.32 times the median remuneration of the workforce, which was £47,371.

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

3.29 No employee received remuneration in excess of the Chief Executive in 2017/18 or 2016/17. Remuneration ranged from £27,000 to £160,000 (2016/17: £24,000 to £154,000).

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

3.31 In 2017/18, one member of the senior management team was female (14%) (2016/17 3 persons, 50%) while overall, 26 employees were female (62%) (2016/17 64%, 33 employees).

Sick absence

3.32 A total of 269 days (2016/17, 224 days) were lost due to sick absence in the year. This equates to 6 days (2016/17, 4.6 days) per person. More than 50% of this absence related to three members of staff who had long-term absences during the year.

Policies relating to disability

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

3.34 We work to ensure that:

- The most suitable applicant is appointed to each post, having regard to the real needs of the job
- That the process is open, fair and honest

- We make reasonable adjustments to overcome barriers during the course of interviews and employment
- Equal opportunities are provided for all applicants
- Both internal and external candidates are assessed based on the same selection criteria
- Discrimination and bias is eliminated from the process
- Legal objectives are met, and good employment practices followed
- Our application form provides a section for potential candidates to confirm whether or not they consider themselves to have a disability.

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

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

Staff numbers and related costs

Average number of persons employed

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

	Permanently employed	Other	Total 2017/18	Permanently employed	Other	Total 2016/17
Total	40.15	0.09	40.24	39.71	0.26	39.97

3.38 There were no staff engaged on capital projects in the period to 31 March 2018.

Costs of persons employed

	Permanently employed	Other	Total 2017/18	Permanently employed	Other	Total 2016/17
	£'000	£'000	£'000	£'000	£'000	£'000
Salaries	2,261	-	2,261	2,094	-	2,094
Social security costs	254	-	254	229	-	229
Superannuation costs	258	-	258	253	-	253
Agency/ temporary staff	-	4	4	-	16	16
	2,773	4	2,777	2,576	16	2,592

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

Reporting of Civil Service and other compensation schemes: exit packages

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
< £10	0	1	1
£10-£25	0	0	0
>£25	0	0	0
Total number of exit packages	0	1	1
	£'000	**£'000**	**£'000**
Total resource cost /£	0	7	7

3.40 Exit costs have been accounted for in full in the year of departure.

3.41 No redundancy costs were incurred in the financial year 2017/18.

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

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

4. Parliamentary accountability and audit report

Clarifications

Losses and special payments

4.1 Losses and special payments were individually and in total below the reporting threshold of £300k. This information has been audited by the Comptroller and Auditor General.

Regularity of expenditure

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

- Regulatory and standards setting work – paid for through fees raised from the Regulatory bodies
- Accredited Registers – self-funding with support of DH subvention, as per paragraph 9.65
- Commissions from Government(s) – paid for by the commissioning body
- Advice to other organisations – earned through fees.

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

4.4 As reported elsewhere our internal auditors undertake an annual review of the management of our finances in relation to our published business principles and reserves policy which are in paragraphs 1.32-1.36.

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

Fees and charges

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

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

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

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

4.10 2017/18 was the second full year that the Authority has been funded primarily through fees. The fee period for 2018/19 will be from April to March covering the same period as the Authority's financial year.

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

31 March 2018	Regulatory and standards setting work	Commissions from Government(s)
	£'000	£'000
Operating costs	3,876	152
Operating income	(4,201)	(159)
Net operating income	**(325)**	**(7)**

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

Long-term expenditure trends

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

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

Section 29 cases

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

4.15 This year we have seen a 4% decrease in the number of fitness to practise determinations notified to us by the regulators (4,095 in 2018/17, compared with 4,285 in 2016/17). During 2017/18, we requested further information and undertook detailed case reviews in 265 cases. By way of comparison, we undertook 272 detailed case reviews in 2016/17.

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

Changes to our legislation

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

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

Harry Cayton CBE
Accounting Officer
19 June 2018

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

Opinion on financial statements

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 2018 under the National Health Service Reform and Health Care Professions Act 2002 as amended by the Health and Social Care Act 2008 and the Health and Social Care Act 2012. The financial statements comprise: the Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity; and the related notes, including the significant accounting policies. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration and staff report, the Accountability report, and the Parliamentary accountability and audit report that is described in those reports as having been audited.

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 2018 and of the Professional Standards Authority for Health and Social Care's net operating income for the year then ended; and
- the financial statements have been properly prepared in accordance with the National Health Service Reform and Health Care Professions Act 2002 as amended by the Health and Social Care Act 2008 and the Health and Social Care Act 2012 and Secretary of State for Health and Social Care directions issued thereunder.

Opinion on regularity

In my opinion, in all material respects the income and expenditure 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.

Basis of opinions

I conducted my audit in accordance with International Standards on Auditing (ISAs) (UK) and Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'. My responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of my certificate. Those standards require me and my staff to comply with the Financial Reporting Council's Revised Ethical Standard 2016. In applying the Ethical Standards I identified a business relationship between the National Audit Office and the Professional Standards Authority for Health and Social Care. Further

details are disclosed within Note 4. The revenue received is immaterial to the National Audit Office, and I consider that appropriate safeguards have been implemented to protect my and the NAO's team's objectivity throughout the audit. I am independent of the Professional Standards Authority for Health and Social Care in accordance with the ethical requirements that are relevant to my audit and the financial statements in the UK. My staff and I have fulfilled our other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Responsibilities of the Board and Accounting Officer for the financial statements

As explained more fully in the Board and Accounting Officer's Statement of Responsibilities, the Board and the Accounting Officer are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view.

Auditor's responsibilities for the audit of the financial statements

My responsibility is to audit, certify and report on the financial statements in accordance with the National Health Service Reform and Health Care Professions Act 2002 as amended by the Health and Social Care Act 2008 and the Health and Social Care Act 2012. 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. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with ISAs (UK), I exercise professional judgment and maintain professional scepticism throughout the audit. I also:

- identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Professional Standards Authority for Health and Social Care's internal control.
- evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.

- conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Professional Standards Authority for Health and Social Care's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the entity to cease to continue as a going concern
- evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the consolidated financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

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

Other information

The Board and the Accounting Officer are responsible for the other information. The other information comprises information included in the 'Health Professional Regulation; a long view' report and Annual Report, other than the parts of the Accountability report, Remuneration and Staff Report and Parliamentary Accountability and Audit report described in those reports as having been audited, the financial statements and my auditor's report thereon. My opinion on the financial statements does not cover the other information and I do not express any form of assurance conclusion thereon. In connection with my audit of the financial statements, my responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or my knowledge obtained in the audit or otherwise appears to be materially misstated. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact. I have nothing to report in this regard.

Opinion on other matters

In my opinion:

- the parts of the Remuneration and staff report and the Parliamentary accountability and audit report to be audited have been properly prepared in accordance with Secretary of State for Health and Social Care directions made

under the National Health Service Reform and Health Care Professions Act 2002 as amended by the Health and Social Care Act 2008 and the Health and Social Care Act 2012;

- in the light of the knowledge and understanding of the Professional Standards Authority for Health and Social Care and its environment obtained in the course of the audit, I have not identified any material misstatements in the Performance Report, Accountability Report, Remuneration and Staff Report and Parliamentary Accountability and Audit Report;
- the information given in the Performance Report, Accountability Report, Remuneration and Staff Report and Parliamentary Accountability and Audit Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

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

- adequate accounting records have not been kept or returns adequate for my audit have not been received from branches not visited by my staff; or
- the financial statements and the parts of the Remuneration and staff report and the Parliamentary accountability and audit 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.

Sir Amyas C E Morse **Date 22 June 2018**

Comptroller and Auditor General

National Audit Office

157-197 Buckingham Palace Road

Victoria

London

SW1W 9SP

6. Financial statements – financial position as at 31 March 2018

		March 2018		March 2017	
	Note	£'000	£'000	£'000	£'000
Non-current assets					
Intangible assets	7	118		235	
Property, plant and equipment	8	116		115	
Total non-current assets			***234***		350
Current assets					
Trade and other receivables	9	289		253	
Short term deposits	10	750		0	
Cash and cash equivalents	11	5,082		5,425	
Total current assets			***6,121***		5,678
Total Assets			**6,355**		6,028
Current liabilities					
Trade and other payables	12	(4,281)		(4,147)	
Provisions	13	(11)		(7)	
Total current liabilities			***(4,292)***		(4,154)
Assets less liabilities			**2,063**		**1,874**
Reserves					
General reserves			**2,063**		**1,874**

The notes on pages 93 to 106 form part of these accounts.

Harry Cayton CBE
Accounting Officer
19 June 2018

7. Financial statements – comprehensive net expenditure for the year ended 31 March 2018

			March 2018 £'000		March 2017 £'000
Expenditure					
Staff costs	3		2,777		2,592
Other administrative costs	4		1,645		1,928
Income					
Fees Income	5		(3,909)		(3,855)
Operating income	6		(702)		(555)
Net operating cost / (income)			**(189)**		**110**

The notes on pages 93 to 106 form part of these accounts.

Other comprehensive net expenditure

7.1 There was no other comprehensive net expenditure in the year ended 31 March 2018 (none in the year ended 31 March 2017)

8. Financial statements – cash flows for the period ended 31 March 2018

	Note	March 2018	March 2017
		£'000	**£'000**
Cash flows from operating activities			
Net operating (costs)/income for the year		189	(110)
Adjustment for non-cash transactions	4	184	95
(Increase) in trade and other receivables	9	(36)	769
Increase in trade and other payables	12	134	5
Increase in provisions	13	4	-
Net cash inflow/(outflow) from operating activities		***475***	759
Cash flow from investment activities			
Purchase of property, plant and equipment	8	(68)	(84)
Net acquisition of investments	10	(750)	
Net cash outflow from investment activities		***(818)***	(84)
Cash flow from financing activities			
Funding from the Department of Health and Social Care:			
Revenue		-	171
Capital		-	-
Net cash flow from financing activities		**-**	171
Net financing			
Net increase in cash and cash equivalents	11	(343)	846
Cash and cash equivalents at the beginning of the financial year	11	5,425	4,579
Cash and cash equivalents at the end of the financial period	11	**5,082**	5,425

The notes on pages 93 to 106 form part of these accounts.

9. Financial statements – changes in taxpayer's equity for the year ended 31 March 2018

	Note	General reserve
		£'000
Balance as at 31 March 2016		**1,813**
Changes in reserves in the year ended 31 March 2017		
Net operating (costs)/income		(110)
Funding the Department of Health and Social Care:		
Revenue		171
Capital		-
Balance as at 31 March 2017		**1,874**
Changes in reserves in the year to 31 March 2018		
Net operating (costs)/income		189
Funding from the Department of Health and Social Care:		
Revenue		-
Capital		-
Balance as at 31 March 2018	14	**2,063**

The notes on pages 93 to 106 form part of these accounts.

10. Notes to the accounts

1. Accounting policies

Basis of preparation

10.1 These financial statements have been prepared in accordance with the 2017/18 Government Financial Reporting Manual (FReM) issued by HM Treasury.

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

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

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

Critical accounting judgements and key sources of estimation uncertainty

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

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

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

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

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

Intangible assets

Internally generated intangible assets

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

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

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

10.12 The amortisation period and amortisation method of an intangible asset is reviewed at each financial year end. If the expected useful life of the asset is different from previous estimates, amortisation period and method will be changed to reflect the charged pattern.

10.13 Until 01 April 2017 database amortisation had been charged from the date the asset was brought into use and was amortised on a straight-line basis over 10 years.

10.14 Following 2017/18 review of Authority's internally generated intangible asset useful life has been changed from 10 years to six years reflecting assumption that the asset will no longer be in use after 2018/19 as current software will no longer be supported from July 2019. Further detail provided in note 7, page 100.

10.15 This has been accounted as change in an accounting estimate.

Non-current assets

Property, plant and equipment

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

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

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

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

10.19 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.

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

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

Investments

10.22 These are short term deposits held with banks with maturity date of over 3 month and no longer than 9 months

Cash at bank and in hand

10.23 Cash is cash in hand and deposits with any financial institution.

Grant in aid and general reserve

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

10.25 Revenue grant in aid received from the Department of Health and Social Care, was used to finance activities and expenditure which supported the statutory and other objectives of the Authority, was treated as contributions from a controlling party giving rise to a financial interest in the residual interest in the Authority, and

therefore accounted for as financing by crediting them directly to the general reserve on a cash received basis.

10.26 In the year to 31 March 2018 the Authority has not received any funding from the Department of Health and Social Care.

Reserves policy

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

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

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

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

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

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

10.33 The policy is set out below.

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

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

Fees income

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

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

Operating income

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

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

Section 29 costs and recoveries

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

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

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

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

Value added tax

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

Retirement benefit costs

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

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

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

Operating leases

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

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

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

- IFRS 15 – Revenue from contracts with customers
- IFRS 9 – Financial instruments
- IFRS 16 – Leases

10.49 IFRS 15 and 9 are effective from 2018/19 and will be implemented by Authority in the financial year 2018/19. IFRS 16 is effective from 2019/20 and will be implemented by Authority in the financial year 2019/20.

10.50 Following a detailed assessment, the Authority has determined that no material transaction or balances will be affected by these changes. Therefore, we can state that the implementation and application of both IFRS 15 and IFRS 9 are not expected to have a material impact on Authority's Financial Statements. It should be noted that during the assessment for IFRS 9 a cautious default rate of 10% was used in absence of any actual default data.

Accounting standards issued that have been adopted early

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

2. Analysis of net operating costs/(income) by segment

Segmental analysis

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

31 March 2018	Regulatory and Standards setting work	Accredited registers	Commissions from Government(s)	Advice to other organisations	Total
	£'000	£'000	£'000	£'000	£'000
Operating costs	3,876	376	152	18	4,422
Operating income	(4,201)	(225)	(159)	(26)	(4,611)
Net operating costs/(income)	(325)	151	(7)	(8)	(189)
31 March 2017	**Regulatory and Standards setting work**	**Accredited registers**	**Commissions from Government(s)**	**Advice to other organisations**	**Total**
	£'000	£'000	£'000	£'000	£'000
Operating costs	4,137	355	17	11	4,520
Operating income	(4,176)	(215)	(17)	(2)	(4,410)
Net operating costs/(income)	(39)	140	-	9	110

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

3. Staff numbers and related costs

Costs of persons employed

	Permanently employed	Other	Total 2017/18	Permanently employed	Other	Total 2016/17
	£'000	£'000	£'000	£'000	£'000	£'000
Salaries	2,261	-	2,261	2,094	-	2,094
Social security costs	254	-	254	229	-	229
Superannuation costs	258	-	258	253	-	253

Agency/ temporary costs	-	4	4	-	16	16
	2,773	**4**	**2,777**	**2,576**	**16**	**2,592**

10.54 Full details regarding these matters are on pages 80 to 81 in the Staff Report.

4. Other administrative costs

	Notes	31 March 2018	31 March 2017
		£'000	**£'000**
Members' remuneration		91	92
Legal and professional fees		468	800
Premises and fixed plant		561	549
Training and recruitment		43	140
PR, communications and conferences		109	71
Establishment expenses		86	85
External audit fee		20	19
Other costs		83	77
Total		**1,461**	**1,833**
Non cash expenditure:			
Amortisation	7	117	39
Depreciation	8	67	56
Total non cash expenditure		**184**	**95**
Total administrative costs		**1,645**	**1,928**

* The Authority made payments of £301,015.27 (£308,683 in 2016/17) to the National Audit Office for non-audit work in respect of accommodation costs of the Authority for use of office space at 157-197 Buckingham Palace Road, London.

5. Fee Income

	31 March 2018	31 March 2017
	£'000	**£'000**
Fee Income from Regulators	3,909	3,855
Total	**3,909**	**3,855**

10.55 Fee income received from General Medical Council (£710k), Nursing and Midwifery Council (1,750k) and Health and Care Professions Council (£879k) amounted to more than 10 per cent of the total PSA's revenue individually. The fees are paid accordance with the Health and Social Care Act 2012 and The Professional Standards Authority for Health and Social Care (Fees) Regulations 2015.

6. Operating Income

	31 March 2018	31 March 2017
	£'000	**£'000**
Section 29 cost recoveries	112	152
Accredited registers' income	225	215

Fees from external customers	26	2
Subtenancy income	132	132
Other operating income	48	37
Income from UK Governments	159	17
Total operating Income	**702**	**555**

7. Intangible assets

31 March 2018	**Section 29 database**
	£'000
Valuation	
At 1 April 2017	393
Amortisation	
At 1 April 2017	158
Charge for the period	117
At 31 March 2018	275
Net book value	
At 31 March 2018	118
At 31 March 2017	235
31 March 2017	**Section 29 database**
	£'000
Valuation	
At 1 April 2016	393
Amortisation	
At 1 April 2016	119
Charge for the period	39
At 31 March 2017	158
Net book value	
At 31 March 2017	235
At 31 March 2016	274

10.56 Further detail provided in note 10.10 page 93-94.

8. Non-current assets

Property, plant and equipment

31 March 2018	Furniture, fixtures and fittings	IT equipment	Total
	£'000	£'000	£'000
Valuation			
At 1 April 2017	149	432	581
Additions	1	67	68
Disposals			
At 31 March 2018	150	499	649
			Depreciation
At 1 April 2017	132	334	466
Charge in period	8	59	67
Disposals			
At 31 March 2018	140	393	533
			Net book value
At 31 March 2018	**10**	**106**	**116**
At 31 March 2017	17	98	115

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

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

At 31 March 2017	**17**	**98**	**115**
At 31 March 2016	**24**	**63**	**87**

9. Trade receivables and other current assets

10.58 Amounts falling due within one year:

	31 March 2018	31 March 2017
	£'000	**£'000**
Trade and other receivables	78	54
Prepayments	211	199
Total trade and other receivables	**289**	**253**

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

10. Short term deposits

	31 March 2018	31 March 2017
	£'000	**£'000**
Balance at 1 April 2017	0	0
Net change in deposits	750	0
Balance at 31 March 2018	750	0

10.60 Short term deposits are entered with banks and have a term of up to 9 month. The deposits comply with the Authority's reserves policy. As at 31 March 2018, no short term deposits were maturing after more than one year.

11. Cash and cash equivalents

	31 March 2018	31 March 2017
	£'000	**£'000**
Balance at 1 April 2017	5,425	4,579
Net changes in cash and cash equivalent balances	(343)	846
Balance at 31 March 2018	**5,082**	**5,425**
The following balances were held at:		
Government Banking Service	83	239
Commercial banks and cash in hand	4,999	5,186
Balance at 31 March 2018	**5,082**	**5,425**

12. Trade payables and other current liabilities

10.61 Amounts falling due within one year:

	31 March 2018	31 March 2017
	£'000	£'000
Trade and other payables	14	17
Taxation and social security	73	64
Accruals and deferred income	4,194	4,066
Total trade and other payables	***4,281***	**4,147**

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

13. Provisions for liabilities and charges

	HMRC provision
	£'000
Balance at 31 March 2017	7
Arising during the period	57
Provision used	(53)
Balance at 31 March 2018	**11**

10.63 The HMRC provision as at 31 March 2018 represents the Authority's estimated liability for income tax and National Insurance Contributions in relation to Board members' travel and subsistence expenses and tax liability on interest received from bank investments

14. Additional general reserves note

	Unrestricted Element All work (Regulatory and standards setting / Accredited Registers / Commissions from Government(s) / Advice to other organisations)	Restricted Element (Regulatory and standards setting work)	Total
	£'000	£'000	£'000
Balance as at 31 March 2017	919	955*	1,874
Changes in reserves in the year ended 31 March 2017			
Regulatory and Standards setting work		325	325
Accredited registers	(151)		(151)
Commissions from Government(s)	7		7
Advice to other organisations	8		8

Other accounting adjustments			
Balance as at 31 March 2018	**783**	**1,280**	**2,063**

*This includes both cash and non-cash elements.

15. Contingent assets and liabilities

Assets

10.64 There were no contingent assets as at 31 March 2018 (none as at 31 March 2017).

Liabilities

10.65 Four High Court cases under the Authority's Section 29 powers were undecided as at 31 March 2018. There was therefore uncertainty, as at that date, as to the related financial consequences, pending a final judgment.

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

10.67 In the post reporting period three out of four of the cases have been determined in Authority's favour.

10.68 Based on current agreement with the Department of Health and Social Care £161k of the old Grant in Aid Funding is retained by the Authority to be spent as agreed with the Department on an ongoing basis, as a result in the future circumstances could arise in which a proportion or all of this amount could potentially be payable to the Department of Health and Social Care.

16. Capital commitments

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

17. Commitments under leases

Operating leases

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

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

Buildings	31 March 2018	31 March 2017
	£'000	**£'000**
Not later than one year	297	297
Later than one year and not later than five years	0	297
Total commitments under operating leases	**297**	**594**

10.72 An amount of £297k has been recognised as lease payment in Statement of Comprehensive Net Expenditure.

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

10.74 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 2018	31 March 2017
	£'000	**£'000**
Not later than one year	83	83
Later than one year and not later than five years	0	36
Total minimum sub-lease receipts	**83**	**119**

Finance leases

10.75 The Authority did not have any finance leases in the period to 31 March 2018 and 31 March 2017.

18. Related parties

10.76 The Authority is accountable to the UK Parliament.

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

10.78 During the period to 31 March 2018, there was no grant in aid or other funding provided by Department of Health and Social Care (2016/17: £0.17m). During the period to 31 March 2018 the Authority has received £144K from the Department of Health and Social Care in respect of commissioned work (2016/17: £17K).

10.79 During the period to 31 March 2018 the Authority has received £15k from Scottish Government in respect of commissioned work.

10.80 The Health and Care Professions Council belongs to the Department of Health and Social Care group and regarded as a related party. During the period to 31 March 2018 the Authority has received £0.88m in respect of 2018/19 fee income (2016/17 £0.88 million in respect of 2017/18 fee income) from HCPC. In addition to this Authority has received £6k from HCPC (2016/17 £41k) in respect of four High Court cases under the Authority's Section 29 power.

10.81 The Nursing and Midwifery Council belongs to the Department of Health and Social Care group and is regarded as a related party. During the period to 31 March 2018 the Authority has received £1.75m in respect of 2018/19 fee income from NMC. In addition to this Authority has received £84k from NMC in respect of six High Court cases under the Authority's Section 29 power.

10.82 The Authority maintains a register of interests for the Chair and Board members, which is available on the website. The register is updated on a periodic basis by the Executive Secretary to reflect any change in Board members' interests. During the period ending 31 March 2018, no Board member undertook any related party

transactions with the Authority (other than the standard remuneration detailed above in the Remuneration and Staff Report).

10.83 The senior management team is also asked to disclose any related party transactions. During 2017/18, there were no related party transactions to disclose (other than the standard remuneration detailed above in the Remuneration and Staff Report).

19. Losses and special payments

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

20. Post statement of financial position events

10.85 These accounts were authorised for issue on the date they were certified by the C&AG.

21. Financial Instruments

Financial risk management

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

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

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

Currency risk

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

Interest rate risk

10.90 The Authority had no borrowing and the fees from the regulatory bodies were received in 2017/18 so the Authority's exposure to this risk was very low. As at 31 March 2018, the Authority had a non-interest-bearing cash balance of £4,423,948.69 and £1,408,141.85 in a bank deposit generating small interest.

Credit risk

10.91 Because the majority of the Authority's income comes from statutory fees payable by regulatory bodies the credit risk that the Authority is exposed to is low**.**

Liquidity risk

10.92 The Authority relies primarily on fee income with statutory fees payable at the commencement of financial year therefore, the Authority has low exposure to liquidity risk. However, the timing of the receipt of statutory fees could potentially result in short-term cash flow issues. The Authority is mitigating this risk by maintaining a reasonable level of reserves.

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