Finance and Resources Committee 18 September 2008

Council for Healthcare Regulatory Excellence report on Nursing and Midwifery Council

Executive summary and recommendations

Introduction

At its meeting on 3 July 2008, the Council agreed that the CHRE report on the performance of the Nursing and Midwifery Council should be considered at the next meeting of all HPC's committees and that each committee should consider what actions it would request the Executive to take forward as a result of this report. It was also agreed that a list of those actions would be brought back to the Council to agree how they should be prioritised.

Decision

The Committee is asked to discuss the report and consider whether the report has any implications for HPC and, if so, agree a list of those actions to be considered by Council for prioritisation.

Background information

None.

Resource implications

If there are any recommendations for the Executive in the current financial year 2008-9 which fall outside of the current work plan, resource implications will need to be considered.

Financial implications

If there are any recommendations for the Executive in the current financial year 2008-9 which fall outside of the current work plan, financial implications will need to be considered.

Appendices

1. Council paper of 3 July - Analysis of issues identified by the CHRE following review of the Nursing and Midwifery Council
2. CHRE Performance review of Health Regulators

Date of paper

9 September 2008

Council 3 July 2008

Analysis of issues identified by the Council for Healthcare Regulatory Excellence following review of the Nursing and Midwifery Council

Executive summary and recommendations

Introduction

On Monday 16 June the Council for Healthcare Regulatory Excellence (CHRE) published a special report on the Nursing and Midwifery Council (NMC). This report was the outcome of a Ministerial request that CHRE undertake an independent review of the NMC to address the central question of whether the NMC was fulfilling its statutory functions. The report also comments on allegations of racism and bullying at the NMC made in an Adjournment Debate. CHRE used its performance standards as a basis for assessing the NMC in all areas of its work.

The CHRE press release states:

"The report identifies serious weaknesses in the NMC's governance and culture, in the conduct of its Council, its ability to protect the interest of the public through the operation of fitness to practise processes and its ability to retain the confidence of key stakeholders."

A copy of the report and the press release are attached as background information.

The CHRE report makes numerous observations on specific issues and makes recommendations. In the light of this and in the interests of learning lessons about its own work, the HPC Executive reviewed each of the recommendations and have produced a draft analysis of HPC's position in relation to each of the issues raised in the CHRE report. The report follows.

Decision

The Council is requested to

i Approve the draft HPC report

ii Decide whether any further action that should be taken by the HPC in relation to its own processes and governance

Background information
- CHRE special report to the Minister of State for Health Services on the Nursing and Midwifery Council
- CHRE press release
- HPC risk register
- List of PKF internal audit reports (PKF act as HPC's internal auditors)
- List of ISO audit reports

Resource implications
To be addressed in future papers

Financial implications
To be addressed in future papers

Appendices
HPC analysis

Date of paper
3 July 2008

Table of contents

Introduction

This report has been prepared by the Executive of the Health Professions Council.

It:

- dentifies the issues raised in the Council for Healthcare Regulatory Excellence (CHRE) report of the Nursing and Midwifery Council (NMC) published on 16 June 2008.

- Identifies HPC's position in relation to each issue.

- Some issues may be left blank where HPC has no comments to make or to avoid duplication of information.

CHRE issue 3.1 (p6) Standards and Guidance

CHRE issue 3.1.1 (p6)

Publishing standards and guidance is a strong area of the NMC's work. The NMC's general standards prioritise patient safety and interests. Additionally, there are separate standards where needed and relevant for particular groups of nurses or midwives. Guidance is comprehensive and new guidance is developed when new practices require it. We particularly welcome the NMC's recognition that it needs to strengthen the advice given to nurses in the care of older people, and that this has come about from the analysis of fitness to practise cases. Guidance also takes account of developments in nursing and midwifery in the four countries of the United Kingdom.

Key CHRE issue/s

- Publication of standards and guidance

HPC position

- The Council reviews its standards on a periodic and ongoing basis in order to ensure that they continue to be robust and fit for purpose.

- Formal guidance and information is published in a number of areas. For example, guidance is published on the standards of education and training; guidance is published for disabled people considering training to become a health professional.

- Guidance on confidentiality is expected to be published in July 2008.

- Guidance is currently being developed for applicants, registrants and education and training providers about criminal convictions. This arises out of the review of the health and character process administered by the fitness to practise department.

Details of internal audit conducted in this area

- No internal audit conducted

Risk register
14.1, 14.2

Health Professions Order 2001
Articles 3(14), 5(2)(a), 15(1), 19(1), 19(4)(a), 21(1)(a)

CHRE issue 3.1.2 (p6)

The NMC has reviewed its Code of Professional Conduct and published a new document: The Code: standards of conduct, performance and ethics for nurses and midwives. The code has now been publicly launched.

Key CHRE issue/s

- Standards of conduct, performance and ethics

HPC position

- HPC first published the Standards of conduct, performance and ethics in April 2003.

- The Standards of conduct, performance and ethics have been reviewed and revised. New standards will become effective from 1 July 2008.

Health Professions Order 2001
Article 21(1)(a)

Details of internal audit conducted in this area

- No internal audit conducted

CHRE issue 3.1.3(p6)

3.1.3 The Website provides the information that registrants and members of the public need and has a useful A-Z of Advice.

Key CHRE issue/s

- Website content

HPC position

- Our main website provides information for use by all of our stakeholders including registrants, employers, students and the public www.hpc-uk.org

  Website accessibility

- The main website has also been awarded an 'Internet crystal mark', approved by the Plain English Campaign.

- The website has recently been refreshed and updated in line with the Communications work-plan to improve usability and accessibility.

- The HPC has a specific micro-site which provides information to members of the public about registration of health professionals. This includes access to the online register which enables the public to check the registration of health professionals www.hpcheck.org

Details of internal audit conducted in this area

Communications Committee

- 'Website statistics' – 21 May 2008 (Tony Glazier, Web Manager, paper CC18/08)

- 'Update on website development and statistics' – 24 May 2007 (Tony Glazier, Web Manager, paper CC07/07)

- Internal audit of external communications – September 2007

Risk register

3.1, 10.2

CHRE issue 3.1.4 (p7)

3*.1.4 The NMC sets satisfactory standards for Continuing Professional Development. We note, however, that the Council decided on the basis of cost not to proceed with auditing CPD undertaken by nurses and midwives in order to work towards revalidation.*

Key CHRE issue/s

- Standards for Continuing Professional Development (CPD)

HPC position

- Standards for continuing professional development became effective on 1 July 2006.

- CPD audits have begun with chiropodists and podiatrists the first profession to be audited.

Details of internal audit conducted in this area

- CPD process implementation review audit conducted by PKF May 2008.

Risk register
8.1

Health Professions Order 2001
Article 19(1), Article 19(4)(a)

CHRE issue 3.2 (p7) Registration

CHRE issue 3.2.1 (p7)

3.2.1 The NMC receives over 30,000 applications for registration annually and in 2007 its call centre processed over 600,000 enquiries. The NMC also receives very large numbers of international applicants. This volume creates significant challenges, nevertheless applications are processed efficiently and there are procedures for bringing in additional staff during busy periods of the year.

Key CHRE issue/s

- A high volume of applications and customer enquiries received annually with peaks in demand for this service.

HPC position

- The HPC registration department received 11,271 international and UK applications and 138,395 telephone calls in the year ending 31 March 2008. Employees are cross trained in the services offered to maintain consistent service delivery during the peaks in the workload.

- The registration department has service standards which have been agreed by the Council.

- The registration department reports on the service performance achieved at each Council and Finance and Resources Committee meeting.

Details of internal audit conducted in this area

- Registration audit conducted by PKF January 2008.

Risk register

2.2, 5.2, 6.1, 8.4, 8.8, 8.9, 10.1, 10.2, 10.3, 10.4, 10.5, 10.6

CHRE issue 3.2.2 (p7)

3.2.2 The NMC has effective checks on applicants' identities, qualifications and good character. The NMC has a process set up with the British Council to check the International English Language Testing System certificates of nurses without European
Economic Area rights.

Key CHRE issue/s

- Applicant checks

HPC position

- In addition to effective checks on applicants' identities, qualifications and good character the HPC also has effective checks on applicants' health.

- The Council has approved a number of language tests for international applicants without European Economic Area rights as follows - Cambridge ESOL, Cambridge International Examinations, International English Language Testing System (IELTS), Hong Kong Examinations and Assessment Authority (HKEAA), Test of English as a Foreign Language (TOEFL), Test of English for International Communication (TOEIC).

- If English is not their first language then they are required to sit an English proficiency test. Using the International English Language Testing System (IELTS) they must score 7.0 with no element below 6.5.

- The exception is speech and language therapists. If English is not their first language, then they are required to score 8.0 with no element below 7.5, irrespective of whether they are an EEA national or not. The requirement is higher for speech and language therapists than for all other professions, as communication in English is a core professional skill (see 2b.4 of the standards of proficiency).

Details of internal audit conducted in this area

- Registration audit conducted by PKF January 2008.

Health Professions Order 2001
Article 5(2)(b), Article 12(1)(c)(iii)

CHRE issue 3.2.3 (p7)

3.2.3 The Register is clear and accessible and shows whether a nurse has been struck off or is subject to sanctions. The Register records when conditions have been imposed on a registrant but does not inform members of the public what these conditions are. This is not satisfactory as it is important that the Register is complete and accurate. The NMC tells us that remedying this is part of its ICT strategy. When checking the Register we found two cases where sanctions had been imposed on a registrant but no record of this appeared on the Register. We were told this was a technical error, and that it has been rectified since CHRE brought it to the NMC's attention. In order to protect the public the Register should be complete and accurate, and we will check on progress in next year's performance review.

Key CHRE issue/s

- Usability of the on-line register
- Accuracy of the on-line register

HPC position

- The FTP Net Regulate statuses rationalisation project is due to be initiated in July 2008 and it is anticipated that this will be completed by the end of the 2008/9 financial year. The project will make operational and technology change to optimise use of the Net Regulate system within FTP. Part of the considerations for this project will include what, if any, changes need to be made regarding the fitness to practise statuses that appear on the online register.
- A review of statuses takes place on bi-monthly basis to ensure that the correct statuses appear on the register.
- The full details of all decisions and orders are available on HPC's website as part of the final hearing decision.

Details of internal audit conducted in this area

- No internal audit conducted

Risk register

10.4, 10.6

CHRE issue 3.2.4 (p7)

3.2.4 The NMC does not collect diversity or ethnicity data on its registrants and is the only regulator that does not attempt to do this. The NMC is intending to collect this data under its Equality and Diversity Strategy. We welcome this and will note progress next year.

Key CHRE issue/s

- Collection of diversity and ethnicity data.

HPC position

- The Council has published an Equality and Diversity Scheme which became effective from 1 July 2008.

- The Council already collects data on gender, age and nationality from applicants for admission and readmission to the Register and holds this information on existing registrants.

- The fitness to practise department collects equality and diversity data from complainants and registrants involved in the fitness to practise process. Anonymous data is collected on disability, age, gender, sexual orientation, race and religion.

- The Equality and Diversity scheme action points include considering whether the Council should collect data from applicants for admission to the Register and from existing registrants. A paper will be brought to the Council on 3 July 2008.

Details of internal audit conducted in this area

- No internal audit conducted

Risk register
8.5, 8.6

CHRE issue 3.3 (p7) Fitness to Practise

CHRE issue 3.3.1 (p7)

3*.3.1 The NMC has made progress in carrying out some aspects of its fitness to practise*
function but we have serious concerns about whether all of its current processes are fit for
purpose. Without doubt some of the weaknesses are the result of historical problems. The
NMC had a large financial deficit at the time of the transfer of responsibilities to it from the
United Kingdom Central Council for Nursing, Midwifery and Health Visiting.

Key CHRE issue/s

- Effectiveness of the fitness to practise process

HPC position

- HPC continually reviews its processes to ensure that they are fit for purpose; this includes the production of variety of practice notes which are designed to provide guidance to fitness to practise panels and those appearing before them, the production of internal operating guidance for those working within the fitness to practise area, the development of new systems to ensure that processes are fit for purpose (filing system, reorganisation of the fitness to practise department to create an adjudication and case management function).

- Internally, the fitness to practise department produces 'operational guidance' documents to clarify procedures for team members.

- In 2008/2009 the fitness to practise department will undertake a wholesale review of all of their processes to ensure that they continue to be fit for purpose, this will range from reviewing the IT to log cases to the arrangements for organising shorthand writers. This is part of the work plan for 2008/2009 approved by the fitness to practise committees in February 2008. The process audits began in June 2008.

- The five year plan provides for an integrated case management system to be implemented in the financial year 2009/10.

- We encourage and respond to feedback from those involved in the fitness to practise process, including registrants, representatives and complainants and incorporate this feedback into the continual review and improvement of processes.

- HPC has ISO 9001 registration.

Details of internal audit conducted in this area

- PKF Review of filing and of fitness to practise database – February 2007 and September 2007

Risk register
4.7, 11.4, 13.1, 13.2, 13.3, 13.4, 13.7, 15.1, 15.9

CHRE issue 3.3.2 (p7)

3*.3.2 Fitness to practise is generally the most high profile of the regulators' functions. Ensuring that fair, proportionate and timely action is taken when a registrant's fitness to*
practise has been called in to question is crucial for the following reasons:
• to ensure that the patients are protected from direct harm
• to maintain public confidence in the profession
• to maintain public confidence in the system of regulation
• to ensure that registrants are treated fairly
• to ensure that registrants have confidence in their own regulatory body.

Key CHRE issue/s

- The fitness to practise function of regulators is high profile and it is important to ensure that cases are dealt with expeditiously and in a fair manner.

HPC position

- The Executive are currently developing service level standards for the fitness to practise area. This will include expected response time to queries and complaints and the service that we will provide to those who come into contact with the fitness to practise department. They will also include internal service level standards to aid in the management of the department. (To go to September 2008 FTP Committees.)

- Each case undergoes a risk assessment when it is received by the department. This risk assessment includes whether any consideration need to be given to an interim order. The risk assessment forms an ongoing part of the investigations process and is reviewed should further information be received that increases the level of risk to the public or to the registrant concerned.

- The fitness to practise department (as well as the HPC) makes every attempt to operate procedures in a clear and transparent manner.

Details of internal audit conducted in this area

- No internal audit conducted

Risk register
4.7, 13.2, 13.3

CHRE issue 3.3.3 (p8)

3.3.3 Since the latter part of 2006 there have been a number of important achievements
and improvements in relation to fitness to practise and we appreciate that these have been
achieved in circumstances which are far from ideal. The following are all notable developments and achievements in the view of CHRE:
• progress made in reducing the backlog of cases that have been referred to the Conduct and Competence Committee
• an increased volume of cases heard by the Conduct and Competence Committee
• improved feedback to fitness to practise panel members ('panellists'), including CHRE learning points, especially through the 'Best Practice' publication
• the establishment of an Appointments Board to oversee the recruitment, training and assessment of fitness to practise panellists.

CHRE issue 3.3.4 (p8)

3*.3.4 In spite of these achievements the current fitness to practise processes of the NMC*
are not always sufficiently robust to protect the interests of the public and hold the confidence of the profession.

CHRE issue 3.3.5 (p8)

3.3.5 The NMC does not always provide a good level of service to complainants. Delays in dealing with cases and, on occasions, insensitive, misleading or unhelpful communications from the NMC do not assist in the timely and appropriate assessment of fitness to practise cases. Our biggest concern is that some complainants or potential complainants might be put off from pursuing legitimate concerns about registrants. This cannot be in the public interest.

Key CHRE issue/s

- Service provided to complainants or potential complainants.

HPC position

- HPC Standard of Acceptance for allegations and allegations practice notes set out the requirements for allegations.

- HPC undertake a risk assessment on receipt of allegations.

- HPC have produced two publications '***How to make a complaint about a health professional***' and '***Fitness to Practise: information for employers***' which provides information on the complaints process. The document '***How to make a complaint***' has been translated into 10 languages to ensure accessibility to the complaints process and has been reviewed by a group of service users for comment on its accessibility.

- Information about the fitness to practise process is on the website and is regularly reviewed.

- HPC have processes in place by which a statement of complaint can be taken over the telephone or in person ensuring those with accessibility or literacy difficulties can make a complaint. Case Managers within the fitness to practise team have been trained in taking complaints using interpreters should this be necessary.

- A complaints form is available on the website.

- HPC have run a series of employer events in 2007/8 to provide information on the FTP process.

- There is a dedicated number for the fitness to practise team.

- There is a telephone rota to ensure that the telephone is always covered.

- Each complaint is allocated to a dedicated case manager who will remain the same and their contact details are provided to all parties.

- HPC Lead Case Managers hold monthly meetings with case managers to ensure cases are proceeding expeditiously and we have now implemented a process to audit case management files on a monthly basis.

- After each hearing witnesses are asked to complete a questionnaire providing their feedback on the process. We are also looking into undertaking a complainant satisfaction survey.

Details of internal audit conducted in this area

- PKF audit on FTP department files – February 2007

Risk register
4.7, 9.1, 13.4

CHRE issue 3.3.6 (p8)

3.3.6 Our main areas of concern about the NMC's fitness to practise work relate to the
following areas:
• the absence of an IT-based case management system
• delays in dealing with cases
• timeliness and poor quality of correspondence which is sometimes insensitive, misleading and/or discourages people from making complaints about a registrant's fitness to practise
• the quality, comprehensiveness and variability of information and statistics provided by the executive to Council members on fitness to practise cases
• concerns about delays in setting up systems for the assessment of fitness to practise panellists and decisions to extend the terms of office of existing panellists
• delays in providing agreed training for panellists on child protection issues.
The absence of an IT-based case management system

Key CHRE issue/s

- Lack of case management system
- Quality of statistics
- Assessment of panel members
- Quality of correspondence
- Delay

HPC position

- The 2009/10 five year project plan includes the provision for updating the existing case management system. This will be the third version of the system. All previous case management systems have been built by internal employees.
- HPC also have access to Kingsley Napley's (the lawyers who present and prepare HPC fitness to practise cases) case management system and can run reports from this system.
- The Executive provide various HPC committees (Fitness to Practise Committees, Finance and Resources Committee) and Council with regular management reports.
- The Health Professions Order 2001 requires that once in every calendar year a statistical report, with the Council's comments is published indicating the efficiency and effectiveness of the processes that it has put in place to protect the public. The report is on the Council agenda for 3 July.

- Every 6 months a review day for legal assessors and panel chairs is held covering a range of topics including decision making, regulatory case law and CHRE learning points.

- In October and December refresher training is being held for panel members. Those who do not receive refresher training in this financial year will be provided it in 2009/2010. A rolling programme of refresher training will take place thereafter.

- Approximately every 3 months, an email update is sent to partners. This updates them with relevant fitness to practise issues.

- The fitness to practise committees have considered a report into a review of complaints literature and will shortly be asked to consider a proposal to undertake a complainant satisfaction survey which will also ask questions about the expectations of complainants.

Details of internal audit conducted in this area

- No internal audit conducted

Health Professions Order 2001
Article 44(1)

CHRE issue 3.3.7 (p9)

3.3.7 In CHRE's view the absence of an IT-based formal case management system is a fundamental weakness. Many other problems stem from the absence of a formal system which would allow for the recording and tracking of all cases. In particular, it is very difficult for managers to track the progress of cases and to identify those cases which have become delayed or on which action is outstanding.

Key CHRE issue/s

- Lack of IT based case management system.

HPC position

- The current fitness to practise database records all cases and has the functionality to run reports allowing managers to identify cases where there is a delay.

- There is intuitive work flow process built within the system which means certain fields cannot be completed until the previous stage is complete.

- The system logs who has made any key changes to the database.

- There is hierarchical structure within the database which means that certain fields have to be authorised by managers.

- A report is run from the Kingsley Napley system allowing HPC to track cases and review where there is a delay. The Executive also review the monthly billing on cases to ensure that action is taken on a case and not delayed in any way.

- The management reports include length of time information, allowing management to identify cases where there is a delay.

- Monthly case meetings take place with case managers to review case loads.

- The service level standards which are due to be implemented imminently will mean that reports are run which identify a delay or where action is outstanding. Standards will be implemented following FTP Committee approval.

- Lead Case Managers audit the case files of the case team that they do not lead.

Details of internal audit conducted in this area

- PKF audit on FTP department files – February 2007

CHRE issue 3.3.8 (p9)

3.3.8 We are concerned that evidence from complaints which we have received suggested
that the NMC had failed to follow up issues in a timely manner, in particular where a complainant had failed to provide enough information in their original letter. Although the
NMC assured us that it is their policy to write to complainants at least twice in such circumstances, we believe that it is essential for managers to be able to check that this
happens in all such cases. An IT-based case management system is necessary to be able
to do this systematically.

Key CHRE issue/s

- Quality of service provided to complainants

HPC position

- We have a Standard of Acceptance for allegations.
- HPC have FTP operational guidance on investigating an allegation.
- It is also HPC policy to write to complainants at least twice.
- Case Managers review their cases on a monthly basis.
- Cases can only be closed on the IT system by either a Lead Case Manager, the Head of Case Management or the Director of Fitness to Practise. Until a case is closed in this way it remains on the Case Manager's list of cases.
- We constantly review our processes, taking account of feedback from those involved in the fitness to practise process.

Details of internal audit conducted in this area

- PKF audit of FTP department files – February 2007

Risk register
9.1, 11.4, 13.1, 13.4

CHRE issue 3.3.9 (p9)

3.3.9 The absence of a case management system also makes it difficult for staff to provide
reliable and meaningful statistics to Council members and others.

CHRE issue 3.3.10 (p9)

3.3.10 We welcome the fact that the NMC now recognises the importance of having an integrated case management system and that this is a prioritised part of the NMC's ICT strategy. The introduction of a case management system should be taken forward in the context of potential changes to the NMC's fitness to practise procedures. It is important that the NMC ensures that any database can be modified to adapt to future changes in the NMC's fitness to practise rules.

Key CHRE issue/s

- Lack of integrated case management system

HPC position

- HPC's FTP database provides for additional professions and requirements.

Details of internal audit conducted in this area

- PKF audit of FTP database – September 2007

CHRE issue 3.3.11 (p9)

3.3.11 We note that the development of a case management system is now identified as a top risk in the corporate risk register. However, this should have been identified sooner and is essential that the NMC takes this work forward without any further delay. The NMC might find it helpful to find out how other regulators and CHRE developed their databases.

CHRE issue 3.3.12 (p9)

3.3.12 It is not in the interests of complainants, registrants or the public for there to be delays in resolving fitness to practise issues. We appreciate that there will be some cases which, for a variety of reasons, will unavoidably be delayed. This can include cases in which there is an ongoing criminal investigation or where there have been difficulties in getting witnesses to give evidence.

Key CHRE issue/s

- Delay in considering cases

HPC position

- Please see response at 3.3.13

Details of internal audit conducted in this area

- No internal audit conducted

Risk register

13.5

CHRE issue 3.3.13 (p9)

3.3.13 The NMC has made progress in the last year in dealing with the backlog of cases which have been referred to the Conduct and Competence Committee and the Professional Conduct Committee, which continues to hear some cases under the NMC's old fitness to practise rules. However, we are concerned that there are still many delays in the system. In particular, there are delays in dealing with initial complaints or enquiries and referrals to the Investigating Committee. In addition, it would appear that the Investigating Committee adjourn many cases several times which builds in additional delays. According to the NMC, during the last year the average period between receipt of an allegation and closure of the case at a final hearing has been 29 months. This represents an improvement, as in the previous year the timescale was 35 months. However, it is still too long and the NMC recognises this. Over the same period the average time from a case entering the system to it being closed was 16 months. This figure is for all cases handled by the NMC and includes cases closed at the pre-enquiry, Investigating Committee and final hearing stages.

Key CHRE issue/s

- Length of time taken to consider cases

HPC position

- All HPC cases have been dealt with using the new legislation since July 2004. All cases under the old CPSM arrangements were concluded in July 2004.

- Out of 299 cases considered by panels of the Investigating Committee (ICP) in 2007/2008 five requests for further information were made.

- The Investigating Committee have authorised the Executive to allow a once only 28 day extension of time, any future request has to be granted by the chair of the investigating panel.

- In 2007-2008 it took an average of 75 weeks (17 months) from receipt of allegation for the final hearing to be held.

- In 2007-2008 it took an average of 50 weeks (11½ months) from referral by the ICP for the final hearing to be held. 156 cases were concluded at final hearing in 2007-2008.

- In 2006-2007 the average was 67 weeks (15½ months) and 48 weeks (11 months) respectively.

- In 2007-2008 the average length of time for a case to reach an investigating panel was 32 weeks (7½ months), in 2006-2007 the average was 26 weeks (6 months). We will aim for 30 weeks (7 months) in 2008-2009. 299 cases were considered by Investigating Panels in 2007-2008 compared to 224 in 2006-2007.

- Of the current cases waiting to be considered by an investigating committee, the average length of time that a case has been under investigation is 26 weeks.

- The statistics that HPC report in the annual report and management statistics do not include cases that were closed prior to an investigating panel, or fitness to practise enquiries that never become full allegations. Therefore the average length of time is greater than if these cases were included. The NMC have included these cases in the overall figure.

Details of internal audit conducted in this area

- No internal audit conducted

Risk register
4.5, 4.7, 6.1, 6.2, 9.1, 11.4, 13.1, 13.2, 13.3, 13.4, 13.7

CHRE issue 3.3.14 (p10)

3.3.14 CHRE have received a number of complaints from people raising legitimate concerns about delays by the NMC in dealing with fitness to practise cases. We are concerned about public safety implications of failure to resolve these issues quicker. Additionally it is unfair on registrants to have cases against them unresolved for long periods of time. The NMC executive assured us that these delayed cases are now exceptions and most related to cases started under the old procedures. We will want to
assess whether there have been fewer complaints of this sort in the next 12 months. Timeliness and poor quality of correspondence which is sometimes insensitive, misleading
and/or discourages people from making complaints about a registrant's fitness to practise

Key CHRE issue/s

- Delays in dealing with fitness to practise cases and quality of correspondence

HPC position

- As far as we are aware, no complaints of this nature have been made to CHRE about the HPC.

- HPC also have a complaints process in which those who are dissatisfied with the service provided by HPC and its individual departments can complain.

Details of internal audit conducted in this area

- No internal audit conducted

Risk register
9.1, 11.4, 13.2, 13.3, 13.7

CHRE issue 3.3.15 (p10)

3.3.15 In addition to the complaints about delays in resolving cases, we have received complaints from people about delays in receiving replies to their correspondence. This includes queries about the progress of cases. When they do receive a response this is not always helpful, accurate or sensitive. Some members of the public are not receiving the service to which they are entitled.

Key CHRE issue/s

- Quality of correspondence

HPC position

- The team receive regular training in dealing with complaints.

Details of internal audit conducted in this area

- No internal audit conducted

Risk register

9.1, 11.4, 13.2, 13.3, 13.7

CHRE issue 3.3.16 (p10)

3.3.16 By way of example, one complainant who wrote to us had written to the NMC with a complaint about a registrant. In their letter to the NMC they explained that they had already raised the issue locally with the registrant's employers. The NMC's response was unhelpful and appeared to us to discourage a complaint. The complainant was told that the NMC could not, for statutory reasons, take action on the complaint unless it had been raised and investigated locally. Not only did this ignore the fact that the complainant had already raised the issues locally but it was also untrue that the NMC cannot act unless a complaint has already been investigated locally. Although the NMC assured us that this letter was not a standard letter we are aware that the same misleading comment, that the NMC could not take a case forward for statutory reasons unless it had already been investigated locally, appeared on the NMC's website at the time. The comment was removed from the NMC's website after CHRE made the NMC aware of it. In another case the NMC responded in an inappropriate manner to a complainant who had lost a baby with a letter that failed to acknowledge this and express any sympathy.

Key CHRE issue/s

- Quality of correspondence

HPC position

- HPC can consider complaints that have not been investigated locally.
- Standard letters are reviewed on a regular basis to ensure that they adhere to current practice.
- HPC provide appropriate responses to correspondence, seeking to ensure that the complainant understands the role of the regulator.
- The Investigations guidance for Case Managers highlights the need to ensure that complainants are provided with appropriate advice, guidance and reassurance and to provide a positive but realistic assessment of the case.
- The website is reviewed regularly to ensure all information is correct and accurate.

Details of internal audit conducted in this area

- No internal audit conducted

Risk register
9.1, 11.4, 13.2, 13.3, 13.7

CHRE issue 3.3.17 (p10)

3.3.17 The NMC has assured us that it intends to review its standard letters shortly, and
that this had been delayed because it has been concentrating on tackling the backlog of
cases. This review of the letters must be done quickly.
The quality, comprehensiveness and variability of information and statistics provided by
the executive to Council members on fitness to practise cases

Key CHRE issue/s

- Accuracy of standard letters

HPC position

- The 2008/2009 work plan provides that a further review of correspondence is undertaken.

- The Investigation fitness to practise operational guidance provides case managers with the principles they should apply when investigating cases and includes guidance on appropriately communicating with all parties involved in FTP proceedings.

- Management reports are provided to every meeting of the Council and Committees. They follow the same format and provide historic information to allow comparison of the statistics. The information provided is regularly reviewed and feedback from council members is incorporated into the review of the information provided.

Details of internal audit conducted in this area

- No internal audit conducted

CHRE issue 3.3.18 (p10)

3.3.18 One of the important roles of Council members is to scrutinise the work of the executive. Bearing in mind the public protection issues involved, we feel that it is particularly important that members scrutinise the work of the fitness to practise function.

Key CHRE issue/s

- Role of the Council in scrutinising the work of the Executive

HPC position

- The fitness to practise committees are provided with regular updates on the work of the department, including management information statistics.

Details of internal audit conducted in this area

- Internal audit of governance and risk management in January 2008 and December 2006

Risk register

4.1, 4.3, 9.1

CHRE issue 3.3.19 (p10)

3.3.19 A number of members and former members raised with us concerns about the quality of information which they received about fitness to practise cases. They felt that the information, particularly statistical information, was not always clear or comprehensive. They also felt that the way in which the information was presented was not consistent which made it difficult for them to judge whether progress was being made, especially with regard to timescales. We were also told that committee members themselves asked for data to be presented in different ways thus making comparisons difficult.

Key CHRE issue/s

- Quality of information provided to committees

HPC position

- All committee agendas are agreed at the start of the meeting and there is always an opportunity for members to request that items are placed on a future agenda.

- The management information pack has been continually reviewed and developed since the inception of the HPC.

Details of internal audit conducted in this area

- Internal audit of governance and risk management in January 2008 and December 2006

Risk register

4.1, 4.3, 11.4

CHRE issue 3.3.20 (p11)

3.3.20 It may be that the reason why it has been difficult for the executive to provide comprehensive statistics is the absence of the case management system. It also appears from our reading of the papers that the statistics have focussed on the backlog of cases which have been referred to the Conduct and Competence Committee and that there has not always been full information on those cases earlier in the process. This includes the initial queries and cases referred to the Investigating Committee which are stages at which we are aware there have been considerable delays in some cases.

Key CHRE issue/s

- Provision of comprehensive statistics

HPC position

- The Council and Committees are provided with comprehensive data regarding the fitness to practise process.

- The HPC Fitness to Practise Department produces an annual report.

Details of internal audit conducted in this area

- Internal audit of governance and risk management in January 2008 and December 2006

CHRE issue 3.3.21 (p11)

3.3.21 In conclusion, we do not feel that the executive has always provided sufficiently
clear and comprehensive information to members. However, we believe that Council members should have thought about this issue more thoroughly and been clearer and
more consistent about what information they needed, and in what format, in order to scrutinise appropriately.

Key CHRE issue/s

- Provision of information by the Executive to Council

HPC position

- HPC considers the availability of accurate, timely, comprehensible and appropriate information to be vital to enable the organisation to deliver its main objective of protecting the public.

- A range of documents are available including: annual budget, strategic intent, management information pack, department strategies, department annual work plans, annual report and accounts, approvals and monitoring annual report, and monthly management accounts.

- All HPC's committees undertook a self assessment in 2007 and as part of this scrutiny process they were asked to assess if they were receiving the appropriate information. They confirmed that they were.

Details of internal audit conducted in this area

- Internal audit of governance and risk management in January 2008 and December 2006

Risk register
1.1, 2.3, 4.1, 4.3, 9.1

Health Professions Order 2001
Article 3(4)

CHRE issue 3.3.22 (p11)

3.3.22 The NMC, like most of the regulatory bodies, has been developing proposals for the assessment of panellists for a number of years. Some members and former members raised concerns with us about delays in setting up this system. Particular concerns were raised with us that some existing panellists' terms of office have been extended in the past without systematic assessment of their performance.

Key CHRE issue/s

- Assessment of panellists

HPC position

- The reappointments process was approved by Council in 2006. Any terms of office which have been extended have been through a shortlisting process for the first extension of any partner agreements with involvement of a representative from the Office of the Commission of Public Appointments (OCPA). The process for any second extensions to partner contracts has been approved by the Finance and Resources committee in 2007 and 2008.

- We have consistently used a representative from OCPA for the partners reappointments process, to provide services of general shortlisting.

- For any new professions which may come onto the HPC register, a representative is on the panels for partner roles.

- Following Council approval, the performance review system for partners was set up in 2006 as trial for those who act for HPC as Visitors. This was implemented on a permanent basis in 2007 for visitors and registration assessors. We are currently in the process of rolling out the appraisal system for partners for the Fitness to Practise Department.

- HPC has a complaints process in place for partner complaints and appeals. This was recently updated and approved by the Finance and Resources Committee in 2007. This has informal and formal complaints processes and covers either complaints by partners or about partners.

Details of internal audit conducted in this area

- No internal audit conducted

Risk register

6.1, 9.1

CHRE issue 3.3.23 (p11)

3.*3.23 It is important that there are robust assessment arrangements. Some other regulators have now set up a process for assessment of panellists. However, we are aware that this is an issue with which a number of regulators are still grappling and it is*
important that the system developed is effective. We suggest that the NMC should consult
with the other regulators with the aim of developing an assessment system as soon as
possible.

Key CHRE issue/s

- Assessment of panellists

HPC position

- Please see 3.3.22

Details of internal audit conducted in this area

- No internal audit conducted

Risk register
6.1, 9.1

CHRE issue 3.3.24 (p11)

3.3.24 It is essential that panellists receive appropriate and relevant training to ensure that
they have the necessary knowledge and skills to adjudicate on fitness to practise cases.
We were concerned to see long delays in arranging training for panellists on child protection issues, including assessment of cases involving child pornography. This issue
was originally raised by a Council member in March 2003 and acknowledged to be necessary by the then President. It was not formally agreed by the Conduct and Competence Committee until April 2005. In July 2006 the Conduct and Competence Committee was told that training would take place in September/October that year. The
training did not happen, however, until October 2007.

Key CHRE issue/s

- Training of panellists

HPC position

- Please see response to 3.3.6 in relation to training of panellists.

- Fitness to Practise department employees have received training in a wide range of issues. This has included a BTEC in Investigative Practice for all department employees, equality and diversity issues, dealing with people with mental health difficulties, advocacy training, data protection act and freedom of information act training. There are operating guidance documents on a wide range of the department's work and regular updates provided in team meetings on a wide range of training. We are also proposing to provide further training to the team on issues around child exploitation and online protection from an organisation called CEOP.

Details of internal audit conducted in this area

- No internal audit conducted

Risk register
6.2, 9.1, 11.4

CHRE issue 3.3.25 (p11)

3.3.25 The former Professional Conduct Committee and the Conduct and Competence
Committee dealt with a number of cases involving child pornography between early 2003
and late 2007, including some in which CHRE expressed concern about the outcome. We
understand that the training was very effective. Whilst this is good to report, we feel that
the delay in providing this training was very unfortunate.

CHRE issue 3.4 (p12) Education

CHRE issue 3.4.1 (p12)

3.4.1 The NMC currently approves 90 programme providers across the UK covering preregistration nursing and midwifery. The NMC has created a UK wide Quality Assurance
Framework to support greater consistency in the quality of nursing and midwifery education. In 2006-7 80 per cent of approval events were subject to conditions which had
to be met before the course was approved for commencement. A base-line review of all
providers and programmes has taken place to support quality assurance activity in coming
years.

Key CHRE issue/s

- Approval process for pre-registration education programmes identified and in operation

HPC position

- The HPC currently approves 452 programmes (387 pre-registration programmes and 65 post-registration entitlement programmes).

- The HPC's standards of education and training are the standards that an education programme must meet in order to be approved by us. These generic standards ensure that anybody who completes an approved programme meets the standards of proficiency and is therefore eligible for registration.

- In the 2006-2007 academic year, 95% of approval events were subject to conditions which had to be met before the programme could be approved. In the 2006-2007 academic year, 1% of annual monitoring submissions and 6% of major change submissions resulted in an approval event.

Details of internal audit conducted in this area

- PKF audit of Approval and Monitoring – May 2008

Risk register
7.1, 7.2, 7.3

Health Professions Order 2001
Part IV, Articles 14-18

CHRE issue 3.4.2 (p12)

3.4.2 We note that there have been tensions at times between the NMC and some parts of
higher education, for instance relating to the introduction of the new UK-wide Quality Assurance Framework. We consider that improvements to communication and stakeholder
management would help in this area.

Key CHRE issue/s

- Communication with and support of key education stakeholders

HPC position

- The Education department communicates with key education stakeholders through a series of annual presentations, our website and our publications. The presentations are held annually and feedback from attendees is obtained and taken into account in the next presentations. The publications include three guides on our operational processes, guidance on the standards of education and training, guidance on disabled students as well as annual reports.

- In 2007-2008, a questionnaire was circulated to all approved education providers. In general, the feedback was very positive; however recommendations were made on how we communicate with education providers. Consequently, the Education department is working on a project in 2008-2009 to amend our database to allow more flexibility in how we communicate with stakeholders.

- The Policy and Standards department also communicates with key education stakeholders through relevant consultations and professional liaison groups (PLG). In 2007-2008, all approved education providers were sent a questionnaire prior to the start of the PLG's review of the standards of education and training, so that their feedback could be considered. They were also sent consultation documents on the changes to standard of education and training 6.7.5, changes to the standards of proficiency for ODPs, changes to the optional standards of proficiency for Chiropodists/Podiatrists.

- The Policy and Standards department also held discussion events on student fitness to practice, health, disability and registration and post registration qualifications, which education stakeholders were invited to.

- Members of the Executive attend regular meetings of the AHPF Education Leads and Academic Registrars Council.

Details of internal audit conducted in this area

- PKF audit of Approval and Monitoring – May 2008

Risk register
7.2, 7.4

Health Professions Order 2001
Part IV, Articles 14-18

CHRE issue 3.4.3 (p12)

3.4.3 The NMC assures us that they always seek the views of students on their experiences of their course when inspecting programmes and providers. We feel it is important that the NMC also seeks the views of patients on the care that they receive from
student nurses as part of its inspections

Key CHRE issue/s

- Input of students and patients into the approval and monitoring processes.

HPC position

- The HPC always meets with students as part of an approval visit. The view of students will be sought, if appropriate to an issue, raised through the annual monitoring or major change process.

- The HPC do not have any explicit requirements for patients' perspectives as part of their approval and monitoring processes.

- In 2007-2008, students attended a meeting of the PLG who were reviewing the standards of education and training, so that their feedback could be considered. In 2008-2009, students will be invited to contribution to the production a new ethical guidance publication for students.

Details of internal audit conducted in this area

- PKF audit of Approval and Monitoring – May 2008

Risk register
7.1

Health Professions Order 2001
Part IV, Articles 14-18

CHRE issue 3.4.4 (p12)

3.4.4 The NMC is currently reviewing pre-registration nursing education as part of the project undertaken by the health departments in the four countries following the Modernising Nursing Careers report. This aims to deliver a nursing workforce equipped with the competencies required for contemporary healthcare practice. The first stage of this review, which began in November 2007, focuses on the future framework of preregistration nursing education. The second stage, taking place this year, will look at the proficiencies, outcomes and other requirements needed for this future framework, following which the NMC anticipates the issuance of new standards of proficiency for preregistration nursing education.

Key CHRE issue/s

- Review of the standards and processes used in approving pre-registration education programmes.

HPC position

- The HPC has a rolling programme to review its standards. This means the standards of education and training and standards of proficiency are reviewed every five years. However, we can bring forward a review if necessary and can change individual standards if they feel that a certain standard is inappropriate. An example of this was the change made the HPC's requirement for external examiners in 2007-2008.

- The HPC is currently reviewing the standards of education and training. A Professional Liaison Group (PLG) has drafted revised standards which will go out for consultation between August – November 2008. It is intended that the revised standards will be finalised in March 2009 and become effective in the 2009-2010 academic year.

- The standards of proficiency were reviewed in 2006-2007 and the revised standards become effective in November 2007.

- In addition to the standards, the HPC have produced guidance for students with disabilities, on obtaining health reference and on confidentiality. In 2008-2009, guidance is being produced for students on ethical issues, on criminal conviction checks and on age discrimination.

Details of internal audit conducted in this area

- PKF audit of Approval and Monitoring – May 2008

Risk register

7.1, 7.4

CHRE issue 3.5 (p12) Governance and External Relations

CHRE issue 3.5.1 (p12)

3.5.1 The NMC recognises the limitations and the weaknesses of its governance and set up a Governance Working Group to examine the issues. This resulted in the formation of a Governance Committee and we acknowledge that the NMC is seeking to improve its practice. The creation of an independent Appointments Board to appoint fitness to practise panellists is welcome.

Key CHRE issue/s

- Governance
- Partner appointments

HPC position

- The HPC Council has overall responsibility for governance. The Council reviews its strategy on an annual basis, both in formal meetings and through seminar and workshop discussions. Last year it gave particular focus on identifying the components of 'better governance' as: more time for strategic debate, improved efficiency at meetings, clarity about HPC's culture, role and values, and clarity about the competencies required of Council members (Ref Council minutes, February 2007).
- The HPC does not have a Governance Working Group or a Governance Committee.

Partners

- HPC uses partners on its fitness to practise panels.
- See 3.3.22.

Details of internal audit conducted in this area

- Internal audit of governance and risk management in January 2008 and December 2006

Risk register

4.1 to 4.11

CHRE issue 3.5.2 (p12)

3.5.2 We have four main areas of concern about governance and external relations in the
NMC. These are:
• the inadequate operation of the governance framework, including policies, committees and decision-making, and organisational behaviour
• the inconsistent availability and provision of information to Council to ensure effective planning and decision-making
• the inappropriate conduct of Council members and lack of strategic leadership
• a lack of confidence from key stakeholders.

CHRE issue 3.5.3 (p13)

3.*5.3 The NMC has some of the right processes and policies in place but these do not*
seem to have general acceptance and are sometimes disputed or disregarded. An overhaul and simplification of the governance framework of the NMC is needed.

Key CHRE issue/s

- Overly complicated governance framework

HPC position

- The Council and the Education and Training Committee have agreed a scheme of delegation to committees and specified members of the Executive.

- The Council has agreed a process for appointment to committees with specific skills and experience required for membership of certain committees.

Details of internal audit conducted in this area

- Internal audit of governance and risk management in January 2008 and December 2006

Risk register
4.1, 4.2, 4.3, 4.5, 4.6, 4.10

CHRE issue 3.5.4 (p13)

3.5.4 We do not think that the decision-making processes are clear and transparent. A great deal of time is spent on the interpretation and application of standing orders. There are 13 committees dealing with different aspects of the NMC's work. It does have a large programme but the numerous committees obscure the lines of accountability for decisions and inhibit the strategic oversight of the Council. For example, long-standing members of fitness to practise panels were reappointed by the Appointments Board outside the processes for reappointment that had been anticipated. The Conduct and Competence Committee was told that the reappointment of panellists is the Appointments Board's responsibility and was outside its remit. We understand, however, that the Appointments Board was under the impression that the Conduct and Competence Committee's priority of tackling the backlog and the scheduling of case-hearings required urgent reappointments if the NMC was to be able to run panels, leaving no time for the proper processes to take place. It appears that neither committee was provided with the timely information or support that would have enabled this problem to be addressed.

Key CHRE issue/s

- Need for clear and accountable decision making and clear lines of accountability

HPC position

- HPC has four statutory committees:
  Conduct and Competence Committee
  Education and Training Committee
  Health Committee
  Investigating Committee

- HPC has four non-statutory committees:
  Audit Committee
  Communications Committee
  Finance and Resources Committee
  Remuneration Committee

- Two non-statutory committees were established and then disbanded, Registrations and Approvals, as they fulfilled their use.

- The committees have clear terms of reference and standing orders, lines of accountability and reporting mechanisms. The Committee self scrutiny process allows for ongoing evaluation of the effectiveness of Committee work.

Details of internal audit conducted in this area

- Internal audit of governance and risk management in January 2008 and December 2006

Risk register
4.1, 4.2, 4.3, 4.5, 4.6, 4.10

CHRE issue 3.5.5 (p13)

3.5.5 The NMC has an Audit and Risk Committee, and recently some of its responsibilities were passed to the Governance Committee. The assessment of internal risk, particularly risks arising from disagreements within the Council and between the Council and executive, has led to regular and continuing recourse to lawyers. The expense is regrettable but given the breakdown in relationships this appears largely unavoidable since the trustees have responsibility to seek appropriate professional advice when making decisions. Stronger leadership and a more conciliatory attitude on all sides should have enabled these issues to be resolved without recourse to law.

Key CHRE issue/s

- Need for clear committee terms of reference and clear risk management process

HPC position

- The functions of the HPC's four statutory committees are set out in the Health Professions Order 2001 and the committee rules. HPC's three non-statutory committees have terms of reference and standing orders.

- The Audit Committee oversees the risk register which is considered twice a year according to an agreed timetable by the Audit Committee and by Council.

- Advice is sought from the internal auditors as necessary.

- The HPC does not have trustees as it undertakes no charitable functions and is therefore not a registered charity.

Details of internal audit conducted in this area

- Internal audit of governance and risk management in January 2008 and December 2006

Risk register

4.10, 11.4

CHRE issue 3.5.6 (p13)

3.5.6 The NMC has published an Equality Scheme and created an Equality and Diversity
Unit to lead its work in this area. We did not observe any racism or receive any accusations of racism although we note this allegation is to be tested in a tribunal and is
also subject of an internal investigation. We therefore draw no conclusions on this matter.

Key CHRE issue/s

- Equality and diversity

HPC position

- The Council has agreed an equality and diversity scheme, with clear objectives and an implementation plan. The scheme impacts on all aspects of the work of the HPC, and is considered key to the organisation's development.

Details of internal audit conducted in this area

- No internal audit conducted

Risk register
8.5, 8.6

CHRE issue 3.5.7 (p13)

3.5.7 Our review of minutes and background papers and our discussions with Council members suggests that considerable information is provided to Council and its committees. However, Council members told us that they do not always have confidence that they have received full information or that the information they were given is always accurate or presented in a manner to support them to make decisions. Statistics on fitness to practise cases are an example. We make further comments on this in paragraphs 3.3.18-21 above. We have also seen and heard examples of Council members asking for information outside of meetings and not receiving it.

Key CHRE issue/s

- Inadequate provision of information

HPC position

- An information pack which contains a report from the Chief Executive and a written and a statistical report from each department (where appropriate) is considered and discussed at every Council meeting (except the meeting held in October).

- Directors and heads of departments report to each meeting of committee which covers their area of work.

- The risk register is updated twice yearly and is considered by the Audit Committee and the Council.

- The Audit Committee has a regular timetable for the undertaking of internal audits by the internal auditors and the consideration of the reports by the Audit Committee. Any divergence from the agreed timetable has to be justified to the Committee. As well as reports on specific HPC functions the internal auditors produce an annual report which covers all internal audits carried out during the year for consideration by the Committee.

- The Audit Committee also considers the external ISO audit reports.

- The Audit Committee considers the external audit plan and the subsequent report from the external auditors and the annual report and accounts.

- The Finance and Resources Committee considers the annual report and accounts.

- The Council agrees the annual report and accounts.

- In March 2007 Council agreed a self-evaluation process for all committees which took the form of a questionnaire to be completed and discussed by each committee. A question was asked 'whether the committee received the appropriate information to undertake its role'. The response to this question was in general positive.

- Annual work plans for each department are approved by committees and Council.

- HPC has a strategic intent document.

- HPC has a vision statement.

- Requests are rarely received for information outside committees but are always considered.

- Members are aware that they can contact directors or departmental heads for information and can arrange to visit HPC departments. Feedback to the President via the annual performance review process was that the quality and flow of information at HPC was good and in many instances reported as excellent (Council minutes July 2007, July 2008).

Details of internal audit conducted in this area

- Internal audit of governance and risk management in January 2008 and December 2006

Risk register
4.1, 4.3, 4.5, 15.9

CHRE issue 3.5.8 (p14)

3.5.8 Decisions of Council are not always based on information of sufficient quality. An example of this is that the NMC had to overturn its decision to allow direct entry to a third part of its Register for Specialist Community Public Health Nurses. Specialist Community Public Health Nurses had previously been required to maintain their original registration on the nursing or midwifery part of the Register. The decision taken by the Council in December 2005 to remove this requirement came into effect in December 2006. However, the decision had to be revoked in December 2007 when it became apparent that the NMC had misinterpreted its own legislation, with consequent difficulties for the individuals involved and damage to the NMC's reputation. The decision has been the subject of a threat of judicial review, which has not yet materialised, and resulted in a vote of no confidence in the NMC by Unite/CPHVA. This is also another example where sectional interests within the professions, rather than public safety and good regulation, seem to have influenced the NMC's decision-making.

Key CHRE issue/s

- Quality of legal advice
- Negative influence of sectional interests on decision making

HPC position

- Advice from legal and financial advisors is sought as necessary and is reported to the Committee.
- External advisors attend Council and committee meetings as required and with the permission of the Committee Chairman.

Details of internal audit conducted in this area

- Internal audit of governance and risk management in January 2008 and December 2006

Risk register

4.3, 4.5, 12.1, 15.9

CHRE issue 3.5.9 (p14)

3.5.9 There has been a breakdown of confidence and trust between some office holders
and some members of the Council of the NMC and between some members and the executive. These problems are long-standing and show no sign of immediate resolution.
There is little evidence the Council has the leadership to extract itself from these difficulties.

Key CHRE issue/s

- Breakdown of relationships
- Lack of strategic leadership

HPC position

- .
- Since it was established, the HPC has spent considerable time articulating its underlying principles and values and has a clear vision statement underpinning its strategy. It considers these underlying values to be core to its external functions and to its internal growth and stability. The need to constantly refer to these and ensure that values are being adhered to is considered key to the health of any organisation, and HPC is no exception. The Council places particular emphasis on the importance of self scrutiny and upon the need for open and transparent communication, and the need to work with conflict.
- In terms of process, a Code of Conduct was agreed by the Council in December 2004 and has been updated on a regular basis.
- The Code of Conduct supplements the provisions in the Council's Standing Orders which deal with expectations for members' behaviour in meetings and the process to be followed if these expectations are not met. The Code of Conduct includes an informal process for dealing with minor breaches of the Code.
- All members attend a two day induction programme during which time the HPC's expectations of members are discussed.
- Members have received equality and diversity training and further updates on this key area are planned.

Details of internal audit conducted in this area

- Internal audit of governance and risk management in January 2008 and December 2006

Risk register
4.5, 4.6, 4.7, 11.4, 11.8, 15.9

CHRE issue 3.5.10 (p14)

3.5.10 We have seen and heard evidence of inappropriate and aggressive language by
and between Council members and between Council members and the executive. We
have also heard accounts of emotional and aggressive behaviour in meetings. This behaviour is undoubtedly experienced as threatening and bullying by many Council members and staff involved.

Key CHRE issue/s

- Aggressive language and inappropriate behaviour at meetings and on other occasions

HPC position

- The Health Professions Order 2001 Schedule 1, Part 1, Article 9(f)(g) specifically refers to the conduct or performance at meetings.

- A Code of Conduct supplements the provisions in the Council's Standing Orders which deal with expectations for members' behaviour in meetings and the process to be followed if these expectations are not met. The Code of Conduct includes an informal process for dealing with minor breaches of the Code.

- The Code was revised and approved by the Council on 29 May 2008 (paper HPC15/08). The document is available on the HPC website. As with all areas relating to conduct and working relationships, the processes reflect the values and culture of the organisation.

- Our expectations of HPC employees' behaviour is set out in the Employee Handbook
  Code of conduct and behaviour – section 5(d)
  Anti-bullying and harassment policy – section 5(g)

- HPC operates an Employee Assistance Programme, which includes a 24/7 helpline.

Details of internal audit conducted in this area

- PKF audit of governance and risk management including policies and procedures relating to conduct of members – January 2008

Health Professions Order 2001
Schedule 1, Part 1, Article 9(f)(g)

Risk register
4.5, 4.6, 4.7, 4.10, 11.1, 11.8

CHRE issue 3.5.11 (p14)

3.5.11 There is a code of conduct for Council members but this has clearly not been adequate. An appraisal system for Council members is being developed and this is urgently required.

Key CHRE issue/s

- Inadequate code of conduct
- Lack of a members' appraisal system

HPC position

- A Code of Conduct was agreed by the Council in December 2004 and has been updated on a regular basis. A copy is available on the HPC website and is discussed with members as part of their induction.
- All members are required to participate in the performance review with the President on an annual basis. The process was approved by the Council at its meeting on 14 December 2006.(Paper HPC165/08). The document is available on the HPC website.
- The review includes a competency based member self appraisal, competency based appraisal of the President, and a process for commenting on any aspect the work of the organisation. The organisational review provided by members in the course of the performance review is collated and considered by the Council at its July meeting and agreed points are actioned.

Details of internal audit conducted in this area

- Internal audit of governance and risk management in January 2008

Risk register

4.5, 4.6, 4.11

CHRE issue 3.5.12 (p14)

3.5.12 Council members are drawn from a wide range of stakeholders, including appointed public members. Appointed members must meet a defined set of competencies, elected members need not. The fact that registrant members are elected from different groups within nursing and midwifery does not mean that they do or should represent the interests of those groups however it appears to us that decisions have sometimes been influenced by the interests of professionals rather than the public interest. An example is the ongoing position of the Council not to require midwives to demonstrate that they are covered by indemnity insurance as a condition of registration.

Key CHRE issue/s

- Failure to act in the public interest

HPC position

Representation

- HPC Council members are not "representatives" of any particular group. Each Council member brings a set of skills and expertise, some of which is profession specific, but there is rarely if ever a strategic debate at Council which requires members to take a 'representative' stance. In general terms members have adopted this view of their contribution throughout the decision making processes.

- The Council set out its position on how all members would work together in a paper which was agreed at the 18 July 2002 Council meeting (Paper HPC66/02). This paper is discussed with new members at their induction and is included in the members' information pack and extranet. It remains a complex area, which benefits from regular review and discussion in different contexts. The HPC Council is committed to this ongoing dialogue, both internally and externally.

Competencies

- All HPC Council members will be appointed from spring 2009.

- A common set of competencies has been drafted and will be presented to the Council for approval on 3 July 2008.

Indemnity insurance

- The HPC Council considered this issue on 21 January 2003 (see Council minute 12.4 below)

  '12.4: Following the recommendation of the Conduct and Competence Implementation Working Party the Council agreed that an item on professional indemnity should not be included in the Statement of Good Character, Conduct and Health. The Council also agreed that registrants be strongly advised in accompanying explanatory leaflets, to obtain such insurance, and that the public, in the appropriate explanatory leaflets and brochures, be advised to satisfy themselves, when they were considering consulting or seeking treatment from practitioners in private practice registered with the Council, that these registrants be so covered'.

Details of internal audit conducted in this area

- Internal audit of governance and risk management in January 2008 and December 2006

Risk register
4.1, 4.2, 4.3, 4.10

CHRE issue 3.5.13 (p14)

3.5.13 Council should scrutinise and hold the executive to account but it should do so primarily on matters of strategic or organisational importance. In other words, scrutiny should be proportionate to the other tasks of ensuring strategic planning and demonstrating leadership. Some of the requests for information we have seen seem disproportionate but in other cases members of Council have not been provided with the information they need to fulfil their role.

Key CHRE issue/s

- Council scrutiny of the Executive

HPC position

Information requests

- All Council meetings and committee meetings specifically commence with formal approval of the agenda. This allows members to ensure that the appropriate information is provided and also request additional agenda items.

Scheme of delegation

- The relationship between the Council and the Executive is defined by the use of a Scheme of Delegation.

- The role of the Council is to scrutinise the work of the Executive and there are inevitably issues upon which disagreement arises. However, differences of opinion have not led to any ongoing difficulties and feedback from Council members has been, in general, that papers are of a high quality and at no time has there been a sense of information being withheld.

Details of internal audit conducted in this area

- Internal audit of governance and risk management in January 2008 and December 2006

Risk register

4.1, 4.3, 4.5, 4.6, 4.7, 11.4

CHRE issue 3.5.14 (p15)

3.5.14 The strife within the Council has inevitably had an impact on the NMC's effectiveness as a regulator, notwithstanding the efforts of members and staff to maintain
and continue its day-to-day work.

CHRE issue 3.5.15 (p15)

3.5.15 The NMC does not have the confidence of all its stakeholders and has not always
managed to get its communication strategy right. In particular, stakeholder groups, while
they should not unduly influence the NMC's decisions, do need to be consulted on their
viability. In some cases this is a requirement of the legislation. For example, the NMC
issued a circular in 2005 changing the arrangements for progression of students in preregistration nursing programmes. After two months the circular had to be deferred and was subsequently withdrawn because the proposals were impractical. A new circular was
reissued following consultation. More recently there have been tensions with education
providers over the introduction of the NMC's new Quality Assurance Framework.

Key CHRE issue/s

- Lack of stakeholder consultation and communication on specific guidance or policies affecting registrants and the public.

HPC position

Communications strategy

HPC has a communications strategy which is updated annually. As a regulator of 13 professions and with many aspirant groups, it has a wide and complex array of professional stakeholders, as well as the challenge of making regulation more accessible and more visible to patients and the public. There has been considerable focus at the HPC on increasing understanding and awareness of regulation amongst the healthcare users through focus groups, opinion polling, literature distribution and advertising campaigns. All of HPC's public facing literature has been refreshed to make it more accessible and new leaflets made available through a range of outlets. However, the HPC is aware of that much more needs to be done in relation to raising awareness and increasing accessibility, and it continues to work through the Joint Regulators PPI Group as well as through other initiatives (eg exploring understanding of regulation amongst older people, working with employers, commissioning MORI polls) to achieve more in this area.

We are committed to engaging with our stakeholders, and take account of their views and input in the way that we carry out our work. One of the ways in which we do this is by consulting when we are planning a new area of work, or planning to change the way that we do something.

We publicise our **official consultations** through:

- Press releases to professional body journals and local, regional and national media

- Direct mail to approx 400 stakeholders on consultation list with hard copy enclosed
- HPC In Focus newsletter
- News items on HPC website and information on consultation page
- External conferences, Listening Events and Employer Events

The Communications Department undertakes regular **stakeholder research** including:

- Bi-annual opinion polling including public, registrant and stakeholder views
- Focus groups evaluating public awareness concepts and campaigns. This includes views from practitioners, referrers and the public.
- HPC website evaluation. This looks at HPC's main website www.hpc-uk.org and the public facing microsite www.hpcheck.org. The key audiences include the public, registrants, students and stakeholders.

Professional liaison groups (or 'PLG') provide advice to the Council or committees on strategic issues. PLGs are project-based and either the Council, or a committee can decide to set one up. For example, the Professional Liaison Group (PLG) reviewing the standards of education and training benefited from the input of education and training providers, students and visitors.
Membership may include professional body members or umbrella organisations, employer representatives, patient/client/user representatives, lay members, or other representatives or experts. The convenor of a PLG will normally be a Council member.

Details of internal audit conducted in this area

- Internal audit of external communications in September 2007.

Risk register
3.1, 3.2, 14.2, 14.4

CHRE issue 3.5.16 (p15)

3.5.16 It is important that the NMC upholds the highest standards of public communication.
In a Press Statement issued on 14 March 2008 the NMC stated: 'At no stage has any
Council member raised any formal concerns regarding the use of the NMC's finances on
legal fees'. This appears to us to be misleading. We have seen evidence of repeated attempts by a Council member to elicit the details of legal costs, and have also been told
by others of an unwillingness to disclose these costs in meetings.

Key CHRE issue/s

- Misleading information issued to the media and public.
- Lack of transparency.

HPC position

Legal fees

- HPC spends significant resources on legal fees.
- The Council approved HPC strategy in the provision of legal services on 11 May 2006 (HPC 46/06).

Public communications

- The Health Professions Order 2001 sets out our statutory responsibility to inform the public of the work we do.
- Where appropriate, key communication documents are approved by Council or committees, for example HPC annual reports on Fitness to Practise and Approvals and Monitoring.
- We issue media alerts and news releases based on fitness to practise hearings to promote our public protection role through the regional and national media.
- We also issue press releases on Council elections, consultations and changes affecting the HPC.
- All our Council and Committee papers and decisions are available to the public through our website.
- Legal advice is sought when appropriate.

Details of internal audit conducted in this area

- Internal audit of external communications in September 2007.
- Internal audit of governance and risk management in January 2008 and December 2006.

Risk register
4.7

Health Professions Order 2001
Article 3(13)

CHRE issue 4.0 (p15) Conclusion

CHRE issue 4.1.1 (p15)

4.1.1 This CHRE performance review concludes that the NMC is carrying out its statutory functions but fails to fulfil these to the standard of performance that the public has the right to expect of a regulator. The NMC maintains a register, takes action when a registrant's fitness to practise is called into doubt, assures the quality of professional education, and sets and issues standards and guidance for the nursing and midwifery professions. These are the basic functions of a regulator. However, there are serious weaknesses in the NMC's governance and culture, in the conduct of its Council, in its ability to protect the interests of the public through the operation of fitness to practise processes and in its ability to retain the confidence of key stakeholders.

CHRE issue 4.1.2 (p15)

4.1.2 The NMC's relative strengths are in its standards and guidance and registration processes.

CHRE issue 4.1.3 (p15)

4.1.3 The NMC has had difficulties with the administration of fitness to practise for many
years. There were real problems, including a large financial deficit, at the time of the transfer of responsibilities to the NMC from the United Kingdom Central Council for Nursing, Midwifery and Health Visiting in 2002.These were daunting challenges but, although the NMC made a difficult but necessary decision to increase registrants' fees
significantly, it has not made the necessary long-term strategic investments in the infrastructure required to create a long-term solution. We are told that it is about to do so,
and it must with a greater sense of urgency than it has shown so far on this matter.

Key CHRE issue/s

- Fitness to practise

HPC position

- Please see previous comments – dealing with all cases under "new system" since July 2004.
- Implementation of new organisation structure in FTP department.
- New filing system in place since 2004.
- Regular reviews of all processes.
- 2009/2010 development of new case management system.

Details of internal audit conducted in this area

- Internal audit of governance and risk management in January 2008 and December 2006.
- Internal audit of finance systems in December 2007.

Risk register

4.7, 5.2, 8.2, 15.1, 15.2, 15.4

CHRE issue 4.1.4 (p15)

4.1.4 The NMC has made a number of commitments to improving its work and these are mentioned in this report. As this report and our recommendations make clear more are needed. We will keep the NMC's progress in addressing the issues identified in this report under review over the next year.

CHRE issue 5.0 (p17) Recommendations

CHRE issue 5.1 (p17) Recommendations to the NMC

CHRE issue 5.1.1 (p17) Recommendations to the NMC

5.1.1 The NMC should commit itself to work towards more effective governance. This should include reviewing its committee and accountability structure, and agreeing on the level of detail of reporting to meetings. It should also include introducing and enforcing an effective statement of organisational values and code of conduct for Council members and staff, and appraisals for all Council members. Collectively and individually office holders and other Council members should accept responsibility for the current difficulties and for their future resolution.

Key CHRE issue/s

- Effective governance

HPC position

The HPC agrees that all regulatory bodies should be committed to working towards more effective governance and, as part of that aim, should undertake regular scrutiny of their governance role. This scrutiny should ensure that the strategic direction of the organisation remains aligned with the guiding vision, values and principles, recognising that these must reflect the changes in the wider landscape of regulation and healthcare. Scrutiny of process must run alongside scrutiny of the way in which Council and the Executive interact and work together to achieve shared objectives. This includes annual appraisal of Council members, President, Committee work as well as the annual appraisal of the Executive through clear management structures.

Details of internal audit conducted in this area

- Internal audit of governance and risk management in January 2008 and December 2006.

Risk register
4.1 – 4.11

CHRE issue 5.1.2 (p17) Recommendations to the NMC

5.1.2 The NMC must introduce an IT-based case management system in fitness to practise as a matter of urgency and should direct the necessary resources towards this.
The NMC must improve its service to both the public and registrants in fitness to practise
processes.

Key CHRE issue/s

- Lack of case management system

HPC position

- The HPC agrees with this general principle.

Details of internal audit conducted in this area

- No internal audit conducted

Risk register
2.3, 5.2, 8.2, 13.4

CHRE issue 5.1.3 (p17) Recommendations to the NMC

5.1.3 The NMC should examine its stakeholder relations and communications strategy so
that it is clear the NMC exists to protect patients and the public, and that it has effective
and mutually respectful relationships with interested parties to achieve this. This improvement in communication also needs to include communication with patients, the
public and registrants.

Communication strategy should focus on working collaboratively with stakeholders to protect the public

Key CHRE issue/s

- Stakeholder relations and communications strategy

HPC position

The HPC has a detailed five year Communications strategy, which is available to the public via the website. The overarching objective of the communications strategy is set out in Article 3 (13) of the Health Professions Order (2001) which states

- The Council shall inform and educate registrants, and shall inform the public, about its work

The main purpose of the communications strategy is to directly implement this objective and we will aim to do this with the following five objectives:

1. To raise awareness and understanding of the HPC's role in regulation across all our audiences

2. To extend our reach to the public enabling them to access easily information about the HPC

3. To influence the regulatory agenda through ongoing dialogue and engagement with key stakeholders

4. To engage with our registrants to ensure they understand the benefits of regulation, the work of the Council and what is required of them

5. To further strengthen and ensure effective internal communications within the organisation

Details of internal audit conducted in this area

- External communications audit in September 2007.

Risk register
3.1, 3.2, 3.3

CHRE issue 5.2 (p17) Recommendations to the Department of Health

CHRE issue 5.2.1 (p17) Recommendations to the Department of Health

5.2.1 We recommend that plans to create a new governance structure for the NMC should
proceed as rapidly as possible and sooner than currently planned. 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. The President should be appointed not elected.

Key CHRE issue/s

- New governance structure

HPC position

- HPC agrees with the general principles.
- HPC Council does not have representative members, although it recognises that some registrants continue to perceive Council members as their 'representatives'.
- All Council members will be appointed from spring 2009.
- All Council members are appraised annually.
- HPC will have a chair not a president from spring 2009.
- The Chair will be appointed.
- HPC registrant Council members and Chair will be appointed using competencies from spring 2009.

Details of internal audit conducted in this area

- Internal audit of governance and risk management in January 2008 and December 2006.

Risk register
4.5, 4.10

CHRE issue 5.2.2 (p17) Recommendations to the Department of Health

5.2.2 We recommend that consideration be given to the relevant responsibilities of the NMC's Conduct and Competence Committee being transferred to the new Office of the Health Adjudicator at an early stage, thus allowing the NMC to concentrate its resources on investigations and the efficient management of cases.

Key CHRE issue/s

- Office of the Health Adjudicator

HPC position

- The legislation for the establishment of the Office of the Health Adjudicator (OHA) has not been published and the business model that it will use has also not yet been determined.

- Once published the Council will review its position, bearing in mind that HPC registrants will have to fund the cost of OHA.

CHRE issue 5.3 (p17) The Charity Commission

CHRE issue 5.3.1 (p17) The Charity Commission

5.3.1 We hope that the Charity Commission, as an independent body, will take note of this performance review and will work with the Council and executive of the NMC to improve governance and to support all parties to act appropriately at all times.

Key CHRE issue/s

- Charity Commission

HPC position

- The HPC undertakes no charitable functions and is therefore not a registered charity.

Special report to the Minister of State for Health Services on the Nursing and Midwifery Council

11 June 2008

Contents

Summary

On 14 March 2008 the Minister of State for Health Services, Ben Bradshaw MP, wrote to the Chief Executive of the Council for Healthcare Regulatory Excellence asking CHRE to expedite its annual performance review and if it would address 'the central question of whether the NMC is fulfilling its statutory functions.'

This report is CHRE's response to the Minister's request.

CHRE reviews the performance of the health professional regulators against five key standards and a set of minimum requirements of each standard. The performance reviews focus on the outcomes for regulation and the protection of patients and the public. This report does not deal with individual complaints by or about individuals involved with the Nursing and Midwifery Council[1].

This CHRE performance review concludes that the NMC is carrying out its statutory functions but fails to fulfil these to the standard of performance that the public has the right to expect of a regulator. The NMC maintains a register, takes action when a registrant's fitness to practise is called into doubt, assures the quality of professional education, and sets and issues standards and guidance for the nursing and midwifery professions. These are the basic functions of a regulator. However, there are serious weaknesses in the NMC's governance and culture, in the conduct of its Council, in its ability to protect the interests of the public through the operation of fitness to practise processes and in its ability to retain the confidence of key stakeholders.

The NMC's relative strengths are in its standards and guidance and registration processes.

The NMC has had difficulties with the administration of fitness to practise for many years. There were real problems, including a large financial deficit, at the time of the transfer of responsibilities to the NMC from its predecessor body, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting, in 2002. These were daunting challenges but, although the NMC made a difficult but necessary decision to increase registrants' fees significantly, it has not made the necessary long-term strategic investments in the infrastructure required to create a long-term solution. We are told that it is about to do so, and it must with a greater sense of urgency than it has shown so far on this matter.

We identify in this report six areas of significant weakness in the management of fitness to practise by the NMC. These are:

- the absence of an IT-based case management system
- delays in dealing with cases

[1] For clarity we use the following in this report
The Nursing and Midwifery Council or NMC – the whole organisation
The Council – the elected and appointed body of trustees responsible for strategy and oversight
The Office Holders – The President, Vice-President and chairs of committees
The Executive – the senior staff team led by the Chief Executive, responsible for operations, for the delivery of the business plan and for ensuring the Council can fulfill its role.

- timeliness and poor quality of correspondence which is sometimes insensitive, misleading and/or discourages people from making complaints about a registrant's fitness to practise

- the quality, comprehensiveness and variability of information and statistics provided by the executive to Council members on fitness to practise cases

- concerns about delays in setting up systems for the assessment of fitness to practise panel members ('panellists') and decisions to extend the terms of office of existing panellists

- delays in providing agreed training for panellists on child protection issues.

They are dealt with in more detail in 3.3 below.

No one improvement would help rebuild the reputation of the NMC more than resolving the administration problems and backlog of cases in fitness to practise, and yet too often sectional interests and the internal difficulties of the NMC have distracted the executive and some members of Council from their task of protecting patients and the public.

Our other area of major concern about the NMC is its governance and external relations. We report in 3.5 below on four areas of concern:

- the inadequate operation of the governance framework, including policies, committees and decision-making, and organisational behaviour

- the inappropriate conduct of Council members and lack of strategic leadership

- the inconsistent availability and provision of information to Council to ensure effective planning and decision-making

- a lack of confidence from key stakeholders.

In meeting with members and reviewing the conduct of the Council and the executive we have borne in mind the allegations made in an Adjournment Debate in Westminster Hall on 11 March 2008 of a 'culture of bullying and racism'. No one made allegations of racism to us and we neither heard nor saw evidence of racism. We note that allegations of racism are the subject of an internal investigation and are also to be tested in a tribunal, and therefore draw no conclusions on this matter.

We have seen and heard evidence of inappropriate and aggressive language by Council members, between each other and towards staff, and have heard accounts of emotional or aggressive behaviour in meetings. This behaviour is undoubtedly experienced as bullying by many people involved. The immediate involvement of lawyers in all and any complaint is also perceived as intimidating by those involved. These behaviours are a symptom of the NMC's problems and also exacerbate them.

Allegations have also been made that the NMC wasted money on legal fees. The constant recourse to lawyers in all and every complaint has not been helpful. Nevertheless trustees have a duty to seek professional advice especially when dealing with disputed decisions.

In this context we conclude that the legal costs were not excessive. The unwillingness of office holders and the executive to disclose these costs clearly and fully to Council members was unjustified.

The NMC has made a number of commitments to improving its work and these are mentioned in this report. As this report and our recommendations make clear more are needed. We will keep the NMC's progress in addressing the issues identified in this report under review over the next year.

1. Introduction

1.1 Complaints were made in a private letter from some members of the Council of the NMC to the Minister of Health of June 2007. These and other complaints became public in an Adjournment Debate in Westminster Hall on 11 March 2008. A number of allegations were made by Mr Jim Devine MP, in particular that the NMC appeared to be a 'fundamentally dysfunctioning organisation' and that there was 'an ingrained culture of bullying and racism.' It was also alleged that 'legal fees are paid not to address the organisation's proper purposes', that the Council was not given the necessary information by the executive to hold it to account and that the Council's decisions were ignored by the executive.

1.2 On 14 March 2008 the Minister of State for Health Services, Ben Bradshaw MP, wrote to the Chief Executive of the Council for Healthcare Regulatory Excellence asking CHRE to expedite its annual performance review and if it would address 'the central question of whether the NMC is fulfilling its statutory functions.'

1.3 This report is the response to the Minister's request. In carrying out its performance review of the NMC, the Council for Healthcare Regulatory Excellence is acting under Section 26(2)(a) of The National Health Services Reform and Health Care Professions Act 2002, which says 'The Council may…investigate, and report on, the performance of each regulatory body of its functions'. Section 27(1) of the same Act states that 'Each regulatory body must in the exercise of its functions co-operate with the Council'.

2. The scope of our performance review and our enquiries

2.1 CHRE reviews the performance of the health professional regulators against five key standards and a set of minimum requirements of each standard. The standards were developed during 2007 in collaboration with the regulators themselves, and focus on the outcomes for regulation and the protection of patients and the public. An initial self-assessment by the regulator is tested by CHRE though written and face-to-face exchanges. The five functions on which we assess performance are below. The full document appears at Annex 2.

- First Function: Standards and Guidance
- Second Function: Registration
- Third Function: Fitness to Practise
- Fourth Function: Education
- Fifth Function: Governance and External Relations

2. 2 Our performance review of the NMC is against these standards as it is for all the other regulators. The overall performance review of health professional regulation will be published in summer 2008. We are publishing this separate report on the NMC to meet the request of the Minister and to enable us to examine in more detail its governance and the allegations made about its performance.

2.3 It is important to note, however, that it was not within the remit of the CHRE investigation to deal with specific complaints by or about individuals connected to the NMC and we have not done so. A number of formal complaints covered by six investigations are being taken forward by the NMC.

2.4 As the NMC is registered as a charity, we have discussed our investigation with the Charity Commission and kept it informed of progress throughout. The Charity Commission is an independent body and it is entirely a matter for it how it proceeds.

2.5 We have reviewed some hundreds of pages of Council and committee papers and minutes, other records, emails, reports and statistics.

2.6 We received numerous items of correspondence from interested parties, including copies of letters and emails written over the last four years, all of which we have noted although some were outside our remit. We have not taken account of anonymous letters as we have no means of validating them.

2.7 We have held face-to-face (or in a few instances telephone) interviews with 10 office holders, committee chairs, members and former members of the Council. We have also had interviews with the Chief Executive at both the beginning and end of our investigation. These interviews were confidential to enable full and frank discussion to take place.

2.8 We have received complete co-operation throughout from everyone concerned. The NMC has been open and helpful, and has provided us with all the information we asked for without hesitation including arranging for us to view legally privileged documents under a confidentiality agreement. Everyone we asked to speak to agreed. The NMC and some individuals have gone to considerable trouble to provide us with background documentation.

3 Performance review of the Nursing and Midwifery Council

3.1 Standards and Guidance

3.1.1 Publishing standards and guidance is a strong area of the NMC's work. The NMC's general standards prioritise patient safety and interests. Additionally, there are separate standards where needed and relevant for particular groups of nurses or midwives. Guidance is comprehensive and new guidance is developed when new practices require it. We particularly welcome the NMC's recognition that it needs to strengthen the advice given to nurses in the care of older people, and that this has come about from the analysis of fitness to practise cases. Guidance also takes account of developments in nursing and midwifery in the four countries of the United Kingdom.

3.1.2 The NMC has reviewed its Code of Professional Conduct and published a new document: *The Code: standards of conduct, performance and ethics for nurses and midwives*. The code has now been publicly launched.

3.1.3 The Website provides the information that registrants and members of the public need and has a useful *A-Z of Advice*.

3.1.4 The NMC sets satisfactory standards for Continuing Professional Development. We note, however, that the Council decided on the basis of cost not to proceed with auditing CPD undertaken by nurses and midwives in order to work towards revalidation.

3.2 Registration

3.2.1 The NMC receives over 30,000 applications for registration annually and in 2007 its call centre processed over 600,000 enquiries. The NMC also receives very large numbers of international applicants. This volume creates significant challenges, nevertheless applications are processed efficiently and there are procedures for bringing in additional staff during busy periods of the year.

3.2.2 The NMC has effective checks on applicants' identities, qualifications and good character. The NMC has a process set up with the British Council to check the International English Language Testing System certificates of nurses without European Economic Area rights.

3.2.3 The Register is clear and accessible and shows whether a nurse has been struck off or is subject to sanctions. The Register records when conditions have been imposed on a registrant but does not inform members of the public what these conditions are. This is not satisfactory as it is important that the Register is complete and accurate. The NMC tells us that remedying this is part of its ICT strategy. When checking the Register we found two cases where sanctions had been imposed on a registrant but no record of this appeared on the Register. We were told this was a technical error, and that it has been rectified since CHRE brought it to the NMC's attention. In order to protect the public the Register should be complete and accurate, and we will check on progress in next year's performance review.

3.2.4 The NMC does not collect diversity or ethnicity data on its registrants and is the only regulator that does not attempt to do this. The NMC is intending to collect this data under its Equality and Diversity Strategy. We welcome this and will note progress next year.

3.3 Fitness to Practise

3.3.1 The NMC has made progress in carrying out some aspects of its fitness to practise function but we have serious concerns about whether all of its current processes are fit for purpose. Without doubt some of the weaknesses are the result of historical problems. The NMC had a large financial deficit at the time of the transfer of responsibilities to it from the United Kingdom Central Council for Nursing, Midwifery and Health Visiting.

3.3.2 Fitness to practise is generally the most high profile of the regulators' functions. Ensuring that fair, proportionate and timely action is taken when a registrant's fitness to practise has been called in to question is crucial for the following reasons:

- to ensure that the patients are protected from direct harm
- to maintain public confidence in the profession

- to maintain public confidence in the system of regulation
- to ensure that registrants are treated fairly
- to ensure that registrants have confidence in their own regulatory body.

3.3.3 Since the latter part of 2006 there have been a number of important achievements and improvements in relation to fitness to practise and we appreciate that these have been achieved in circumstances which are far from ideal. The following are all notable developments and achievements in the view of CHRE:

- progress made in reducing the backlog of cases that have been referred to the Conduct and Competence Committee
- an increased volume of cases heard by the Conduct and Competence Committee
- improved feedback to fitness to practise panel members ('panellists'), including CHRE learning points, especially through the 'Best Practice' publication
- the establishment of an Appointments Board to oversee the recruitment, training and assessment of fitness to practise panellists.

3.3.4 In spite of these achievements the current fitness to practise processes of the NMC are not always sufficiently robust to protect the interests of the public and hold the confidence of the profession.

3.3.5 The NMC does not always provide a good level of service to complainants. Delays in dealing with cases and, on occasions, insensitive, misleading or unhelpful communications from the NMC do not assist in the timely and appropriate assessment of fitness to practise cases. Our biggest concern is that some complainants or potential complainants might be put off from pursuing legitimate concerns about registrants. This cannot be in the public interest.

3.3.6 Our main areas of concern about the NMC's fitness to practise work relate to the following areas:

- the absence of an IT-based case management system
- delays in dealing with cases
- timeliness and poor quality of correspondence which is sometimes insensitive, misleading and/or discourages people from making complaints about a registrant's fitness to practise
- the quality, comprehensiveness and variability of information and statistics provided by the executive to Council members on fitness to practise cases
- concerns about delays in setting up systems for the assessment of fitness to practise panellists and decisions to extend the terms of office of existing panellists

- delays in providing agreed training for panellists on child protection issues.

The absence of an IT-based case management system

3.3.7 In CHRE's view the absence of an IT-based formal case management system is a fundamental weakness. Many other problems stem from the absence of a formal system which would allow for the recording and tracking of all cases. In particular, it is very difficult for managers to track the progress of cases and to identify those cases which have become delayed or on which action is outstanding.

3.3.8 We are concerned that evidence from complaints which we have received suggested that the NMC had failed to follow up issues in a timely manner, in particular where a complainant had failed to provide enough information in their original letter. Although the NMC assured us that it is their policy to write to complainants at least twice in such circumstances, we believe that it is essential for managers to be able to check that this happens in all such cases. An IT-based case management system is necessary to be able to do this systematically.

3.3.9 The absence of a case management system also makes it difficult for staff to provide reliable and meaningful statistics to Council members and others.

3.3.10 We welcome the fact that the NMC now recognises the importance of having an integrated case management system and that this is a prioritised part of the NMC's ICT strategy. The introduction of a case management system should be taken forward in the context of potential changes to the NMC's fitness to practise procedures. It is important that the NMC ensures that any database can be modified to adapt to future changes in the NMC's fitness to practise rules.

3.3.11 We note that the development of a case management system is now identified as a top risk in the corporate risk register. However, this should have been identified sooner and is essential that the NMC takes this work forward without any further delay. The NMC might find it helpful to find out how other regulators and CHRE developed their databases.

Delays in dealing with cases

3.3.12 It is not in the interests of complainants, registrants or the public for there to be delays in resolving fitness to practise issues. We appreciate that there will be some cases which, for a variety of reasons, will unavoidably be delayed. This can include cases in which there is an ongoing criminal investigation or where there have been difficulties in getting witnesses to give evidence.

3.3.13 The NMC has made progress in the last year in dealing with the backlog of cases which have been referred to the Conduct and Competence Committee and the Professional Conduct Committee, which continues to hear some cases under the NMC's old fitness to practise rules. However, we are concerned that there are still many delays in the system. In particular, there are delays in dealing with initial complaints or enquiries and referrals to the Investigating Committee. In addition, it would appear that the Investigating Committee adjourn many cases several times which builds in additional delays. According to the NMC, during the last year the average period between receipt of an allegation and closure of the case at a final hearing has been 29 months. This represents an improvement, as in the previous year the timescale was 35 months. However, it is still too

long and the NMC recognises this. Over the same period the average time from a case entering the system to it being closed was 16 months. This figure is for all cases handled by the NMC and includes cases closed at the pre-enquiry, Investigating Committee and final hearing stages.

3.3.14 CHRE have received a number of complaints from people raising legitimate concerns about delays by the NMC in dealing with fitness to practise cases. We are concerned about public safety implications of failure to resolve these issues quicker. Additionally it is unfair on registrants to have cases against them unresolved for long periods of time. The NMC executive assured us that these delayed cases are now exceptions and most related to cases started under the old procedures. We will want to assess whether there have been fewer complaints of this sort in the next 12 months.

Timeliness and poor quality of correspondence which is sometimes insensitive, misleading and/or discourages people from making complaints about a registrant's fitness to practise

3.3.15 In addition to the complaints about delays in resolving cases, we have received complaints from people about delays in receiving replies to their correspondence. This includes queries about the progress of cases. When they do receive a response this is not always helpful, accurate or sensitive. Some members of the public are not receiving the service to which they are entitled.

3.3.16 By way of example, one complainant who wrote to us had written to the NMC with a complaint about a registrant. In their letter to the NMC they explained that they had already raised the issue locally with the registrant's employers. The NMC's response was unhelpful and appeared to us to discourage a complaint. The complainant was told that the NMC could not, for statutory reasons, take action on the complaint unless it had been raised and investigated locally. Not only did this ignore the fact that the complainant had already raised the issues locally but it was also untrue that the NMC cannot act unless a complaint has already been investigated locally. Although the NMC assured us that this letter was not a standard letter we are aware that the same misleading comment, that the NMC could not take a case forward for statutory reasons unless it had already been investigated locally, appeared on the NMC's website at the time. The comment was removed from the NMC's website after CHRE made the NMC aware of it. In another case the NMC responded in an inappropriate manner to a complainant who had lost a baby with a letter that failed to acknowledge this and express any sympathy.

3.3.17 The NMC has assured us that it intends to review its standard letters shortly, and that this had been delayed because it has been concentrating on tackling the backlog of cases. This review of the letters must be done quickly.

The quality, comprehensiveness and variability of information and statistics provided by the executive to Council members on fitness to practise cases

3.3.18 One of the important roles of Council members is to scrutinise the work of the executive. Bearing in mind the public protection issues involved, we feel that it is particularly important that members scrutinise the work of the fitness to practise function.

3.3.19 A number of members and former members raised with us concerns about the quality of information which they received about fitness to practise cases. They felt that the information, particularly statistical information, was not always clear or comprehensive.

They also felt that the way in which the information was presented was not consistent which made it difficult for them to judge whether progress was being made, especially with regard to timescales. We were also told that committee members themselves asked for data to be presented in different ways thus making comparisons difficult.

3.3.20 It may be that the reason why it has been difficult for the executive to provide comprehensive statistics is the absence of the case management system. It also appears from our reading of the papers that the statistics have focussed on the backlog of cases which have been referred to the Conduct and Competence Committee and that there has not always been full information on those cases earlier in the process. This includes the initial queries and cases referred to the Investigating Committee which are stages at which we are aware there have been considerable delays in some cases.

3.3.21 In conclusion, we do not feel that the executive has always provided sufficiently clear and comprehensive information to members. However, we believe that Council members should have thought about this issue more thoroughly and been clearer and more consistent about what information they needed, and in what format, in order to scrutinise appropriately.

Concerns about delays in setting up systems for the assessment of fitness to practise panellists and decisions to extend the contracts of existing panellists

3.3.22 The NMC, like most of the regulatory bodies, has been developing proposals for the assessment of panellists for a number of years. Some members and former members raised concerns with us about delays in setting up this system. Particular concerns were raised with us that some existing panellists' terms of office have been extended in the past without systematic assessment of their performance.

3.3.23 It is important that there are robust assessment arrangements. Some other regulators have now set up a process for assessment of panellists. However, we are aware that this is an issue with which a number of regulators are still grappling and it is important that the system developed is effective. We suggest that the NMC should consult with the other regulators with the aim of developing an assessment system as soon as possible.

Delays in providing agreed training for panellists on child protection issues

3.3.24 It is essential that panellists receive appropriate and relevant training to ensure that they have the necessary knowledge and skills to adjudicate on fitness to practise cases. We were concerned to see long delays in arranging training for panellists on child protection issues, including assessment of cases involving child pornography. This issue was originally raised by a Council member in March 2003 and acknowledged to be necessary by the then President. It was not formally agreed by the Conduct and Competence Committee until April 2005. In July 2006 the Conduct and Competence Committee was told that training would take place in September/October that year. The training did not happen, however, until October 2007.

3.3.25 The former Professional Conduct Committee and the Conduct and Competence Committee dealt with a number of cases involving child pornography between early 2003 and late 2007, including some in which CHRE expressed concern about the outcome. We

understand that the training was very effective. Whilst this is good to report, we feel that the delay in providing this training was very unfortunate.

3.4 Education

3.4.1 The NMC currently approves 90 programme providers across the UK covering pre-registration nursing and midwifery. The NMC has created a UK wide Quality Assurance Framework to support greater consistency in the quality of nursing and midwifery education. In 2006-7 80 per cent of approval events were subject to conditions which had to be met before the course was approved for commencement. A base-line review of all providers and programmes has taken place to support quality assurance activity in coming years.

3.4.2 We note that there have been tensions at times between the NMC and some parts of higher education, for instance relating to the introduction of the new UK-wide Quality Assurance Framework. We consider that improvements to communication and stakeholder management would help in this area.

3.4.3 The NMC assures us that they always seek the views of students on their experiences of their course when inspecting programmes and providers. We feel it is important that the NMC also seeks the views of patients on the care that they receive from student nurses as part of its inspections.

3.4.4 The NMC is currently reviewing pre-registration nursing education as part of the project undertaken by the health departments in the four countries following the Modernising Nursing Careers report. This aims to deliver a nursing workforce equipped with the competencies required for contemporary healthcare practice. The first stage of this review, which began in November 2007, focuses on the future framework of pre-registration nursing education. The second stage, taking place this year, will look at the proficiencies, outcomes and other requirements needed for this future framework, following which the NMC anticipates the issuance of new standards of proficiency for pre-registration nursing education.

3.5 Governance and External Relations

3.5.1 The NMC recognises the limitations and the weaknesses of its governance and set up a Governance Working Group to examine the issues. This resulted in the formation of a Governance Committee and we acknowledge that the NMC is seeking to improve its practice. The creation of an independent Appointments Board to appoint fitness to practise panellists is welcome.

3.5.2 We have four main areas of concern about governance and external relations in the NMC. These are:

- the inadequate operation of the governance framework, including policies, committees and decision-making, and organisational behaviour

- the inconsistent availability and provision of information to Council to ensure effective planning and decision-making

- the inappropriate conduct of Council members and lack of strategic leadership
- a lack of confidence from key stakeholders.

The inadequate operation of the governance framework, including policies, committees and decision-making, and organisational behaviour

3.5.3 The NMC has some of the right processes and policies in place but these do not seem to have general acceptance and are sometimes disputed or disregarded. An overhaul and simplification of the governance framework of the NMC is needed.

3.5.4 We do not think that the decision-making processes are clear and transparent. A great deal of time is spent on the interpretation and application of standing orders. There are 13 committees dealing with different aspects of the NMC's work. It does have a large programme but the numerous committees obscure the lines of accountability for decisions and inhibit the strategic oversight of the Council. For example, long-standing members of fitness to practise panels were reappointed by the Appointments Board outside the processes for reappointment that had been anticipated. The Conduct and Competence Committee was told that the reappointment of panellists is the Appointments Board's responsibility and was outside its remit. We understand, however, that the Appointments Board was under the impression that the Conduct and Competence Committee's priority of tackling the backlog and the scheduling of case-hearings required urgent reappointments if the NMC was to be able to run panels, leaving no time for the proper processes to take place. It appears that neither committee was provided with the timely information or support that would have enabled this problem to be addressed.

3.5.5 The NMC has an Audit and Risk Committee, and recently some of its responsibilities were passed to the Governance Committee. The assessment of internal risk, particularly risks arising from disagreements within the Council and between the Council and executive, has led to regular and continuing recourse to lawyers. The expense is regrettable but given the breakdown in relationships this appears largely unavoidable since the trustees have responsibility to seek appropriate professional advice when making decisions. Stronger leadership and a more conciliatory attitude on all sides should have enabled these issues to be resolved without recourse to law.

3.5.6 The NMC has published an Equality Scheme and created an Equality and Diversity Unit to lead its work in this area. We did not observe any racism or receive any accusations of racism although we note this allegation is to be tested in a tribunal and is also subject of an internal investigation. We therefore draw no conclusions on this matter.

The inconsistent availability and provision of information to Council to ensure effective planning and decision-making

3.5.7 Our review of minutes and background papers and our discussions with Council members suggests that considerable information is provided to Council and its committees. However, Council members told us that they do not always have confidence that they have received full information or that the information they were given is always accurate or presented in a manner to support them to make decisions. Statistics on fitness to practise cases are an example. We make further comments on this in paragraphs

3.3.18-21 above. We have also seen and heard examples of Council members asking for information outside of meetings and not receiving it.

3.5.8 Decisions of Council are not always based on information of sufficient quality. An example of this is that the NMC had to overturn its decision to allow direct entry to a third part of its Register for Specialist Community Public Health Nurses. Specialist Community Public Health Nurses had previously been required to maintain their original registration on the nursing or midwifery part of the Register. The decision taken by the Council in December 2005 to remove this requirement came into effect in December 2006. However, the decision had to be revoked in December 2007 when it became apparent that the NMC had misinterpreted its own legislation, with consequent difficulties for the individuals involved and damage to the NMC's reputation. The decision has been the subject of a threat of judicial review, which has not yet materialised, and resulted in a vote of no confidence in the NMC by Unite/CPHVA. This is also another example where sectional interests within the professions, rather than public safety and good regulation, seem to have influenced the NMC's decision-making.

The inappropriate conduct of Council members and lack of strategic leadership

3.5.9 There has been a breakdown of confidence and trust between some office holders and some members of the Council of the NMC and between some members and the executive. These problems are long-standing and show no sign of immediate resolution. There is little evidence the Council has the leadership to extract itself from these difficulties.

3.5.10 We have seen and heard evidence of inappropriate and aggressive language by and between Council members and between Council members and the executive. We have also heard accounts of emotional and aggressive behaviour in meetings. This behaviour is undoubtedly experienced as threatening and bullying by many Council members and staff involved.

3.5.11 There is a code of conduct for Council members but this has clearly not been adequate. An appraisal system for Council members is being developed and this is urgently required.

3.5.12 Council members are drawn from a wide range of stakeholders, including appointed public members. Appointed members must meet a defined set of competencies, elected members need not. The fact that registrant members are elected from different groups within nursing and midwifery does not mean that they do or should represent the interests of those groups however it appears to us that decisions have sometimes been influenced by the interests of professionals rather than the public interest. An example is the ongoing position of the Council not to require midwives to demonstrate that they are covered by indemnity insurance as a condition of registration.

3.5.13 Council should scrutinise and hold the executive to account but it should do so primarily on matters of strategic or organisational importance. In other words, scrutiny should be proportionate to the other tasks of ensuring strategic planning and demonstrating leadership. Some of the requests for information we have seen seem disproportionate but in other cases members of Council have not been provided with the information they need to fulfil their role.

3.5.14 The strife within the Council has inevitably had an impact on the NMC's effectiveness as a regulator, notwithstanding the efforts of members and staff to maintain and continue its day-to-day work.

A lack of confidence from key stakeholders

3.5.15 The NMC does not have the confidence of all its stakeholders and has not always managed to get its communication strategy right. In particular, stakeholder groups, while they should not unduly influence the NMC's decisions, do need to be consulted on their viability. In some cases this is a requirement of the legislation. For example, the NMC issued a circular in 2005 changing the arrangements for progression of students in pre-registration nursing programmes. After two months the circular had to be deferred and was subsequently withdrawn because the proposals were impractical. A new circular was reissued following consultation. More recently there have been tensions with education providers over the introduction of the NMC's new Quality Assurance Framework.

3.5.16 It is important that the NMC upholds the highest standards of public communication. In a Press Statement issued on 14 March 2008 the NMC stated: 'At no stage has any Council member raised any formal concerns regarding the use of the NMC's finances on legal fees'. This appears to us to be misleading. We have seen evidence of repeated attempts by a Council member to elicit the details of legal costs, and have also been told by others of an unwillingness to disclose these costs in meetings.

4 Conclusion

4.1.1 This CHRE performance review concludes that the NMC is carrying out its statutory functions but fails to fulfil these to the standard of performance that the public has the right to expect of a regulator. The NMC maintains a register, takes action when a registrant's fitness to practise is called into doubt, assures the quality of professional education, and sets and issues standards and guidance for the nursing and midwifery professions. These are the basic functions of a regulator. However, there are serious weaknesses in the NMC's governance and culture, in the conduct of its Council, in its ability to protect the interests of the public through the operation of fitness to practise processes and in its ability to retain the confidence of key stakeholders.

4.1.2 The NMC's relative strengths are in its standards and guidance and registration processes.

4.1.3 The NMC has had difficulties with the administration of fitness to practise for many years. There were real problems, including a large financial deficit, at the time of the transfer of responsibilities to the NMC from the United Kingdom Central Council for Nursing, Midwifery and Health Visiting in 2002.These were daunting challenges but, although the NMC made a difficult but necessary decision to increase registrants' fees significantly, it has not made the necessary long-term strategic investments in the infrastructure required to create a long-term solution. We are told that it is about to do so, and it must with a greater sense of urgency than it has shown so far on this matter.

4.1.4 The NMC has made a number of commitments to improving its work and these are mentioned in this report. As this report and our recommendations make clear more are

needed. We will keep the NMC’s progress in addressing the issues identified in this report under review over the next year.

5 Recommendations

5.1 Recommendations to the NMC

5.1.1 The NMC should commit itself to work towards more effective governance. This should include reviewing its committee and accountability structure, and agreeing on the level of detail of reporting to meetings. It should also include introducing and enforcing an effective statement of organisational values and code of conduct for Council members and staff, and appraisals for all Council members. Collectively and individually office holders and other Council members should accept responsibility for the current difficulties and for their future resolution.

5.1.2 The NMC must introduce an IT-based case management system in fitness to practise as a matter of urgency and should direct the necessary resources towards this. The NMC must improve its service to both the public and registrants in fitness to practise processes.

5.1.3 The NMC should examine its stakeholder relations and communications strategy so that it is clear the NMC exists to protect patients and the public, and that it has effective and mutually respectful relationships with interested parties to achieve this. This improvement in communication also needs to include communication with patients, the public and registrants.

5.2 Recommendations to the Department of Health

5.2.1 We recommend that plans to create a new governance structure for the NMC should proceed as rapidly as possible and sooner than currently planned. 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. The President should be appointed not elected.

5.2.2 We recommend that consideration be given to the relevant responsibilities of the NMC's Conduct and Competence Committee being transferred to the new Office of the Health Adjudicator at an early stage, thus allowing the NMC to concentrate its resources on investigations and the efficient management of cases.

5.3 The Charity Commission

5.3.1 We hope that the Charity Commission, as an independent body, will take note of this performance review and will work with the Council and executive of the NMC to improve governance and to support all parties to act appropriately at all times.

ANNEX 1

CHRE are grateful to the following people who have met with us and given their time to contribute to this enquiry.

Nancy Kirkland	President
Moi Ali	Vice-President
Andrew Middleton	Chair, Audit and Risk Committee
Rosemary Carter	Chair, Governance Committee
Brenda Poulton	Member of Council, former chair of the Governance Committee
Sandra Arthur	Former President
Anthea Rose	Former member of Council
Stephen Powell	Former member of Council
Sarah Thewlis	Chief Executive and Registrar

And one member and one former member of Council who have asked to remain anonymous.

ANNEX 2

Standards of good regulation

Introduction

CHRE has decided that the performance review process should be built on a set of standards. The standards aim to remain at a high level and focus on outcomes. The development of the draft standards has been informed by previous work carried out in 2003 by CHRE Council members and by the work of the Better Regulation Task Force (BRTF, now called the Better Regulation Commission). The BRTF defined five principles of good regulation:

- Proportionality
- Accountability
- Consistency
- Transparency
- Targeting

The BRTF principles apply across all regulatory functions and have been central to the definition of the draft standards. The draft standards were revised following comments from regulatory bodies.

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

Definitions

Standards are the foundation of the performance review process and will evolve over time. They describe what the public should expect from regulators and enunciate principles of good practice. Regulators are asked to demonstrate how they ensure that they meet the standards. For each standard, a number of minimum requirements and supporting evidence are described.

All **minimum requirements** must be met to meet the standards, but are not standards in themselves. They are not exhaustive, in that regulators can demonstrate that they meet the standards in additional ways. Minimum requirements vary: they sometimes describe current duties, give examples of current practice, or indicate best practice.

Supporting evidence is the evidence that we suggest regulators can draw upon in demonstrating how they meet the standards. Supporting evidence is only an indication of the evidence that can support the declaration of whether the standards are met, and how. It only illustrates the kind of information that can be used, and is not exhaustive. We do not ask for supporting evidence to be provided with the performance review responses. We may ask for some evidence at a later stage.

We would not expect that regulators should change their own information gathering or reporting cycles to fit in with the performance review cycle. For the purposes of the performance review regulators should just use the most up-to-date information they have.

Supporting evidence will normally be considered to be in the public domain, except where the regulator specifically indicates that this information is provided in confidence only.

1 First function: standards and guidance

Aim: all registrants comply with a suitable set of standards, and the public are aware of the standards that they can expect.

1.1 The regulator publishes standards of competence and conduct[2] which are appropriate, comprehensive, prioritise patient[3] interests and reflect up-to-date professional practice.

Minimum requirements

i) Standards prioritise patient safety and patient interests.
ii) Core standards are formulated as general principles which apply widely to all situations and areas of practice.
iii) The core standards are easy to understand for registrants and clearly outline registrants' personal responsibility for their practice.
iv) The core standards include, as a minimum, the principles expressed in the Statement of Common Values[4].
v) Where appropriate, supplementary guidance is produced to help registrants apply the core standards about specialist or specific issues.
vi) Standards form the basis for all regulatory functions.
vii) The regulator regularly reviews its standards to ensure that they are up-to-date, and revises its standards and produces supplementary guidance as required.

Supporting evidence

- *Standards and guidance*
- *Documentation showing the development process of the standards, e.g. consultation documents*

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

Minimum requirements

i) Standards are published in formats that are easily accessible to potential registrants and registrants.
ii) The regulator has a clear communications strategy, which is targeted to meet the needs of registrants, to promote the standards.

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

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

[4] *Common Values Statement by the Chief Executives Group of the Health Care Regulators on professional values,* 2004, available on CHRE website.

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

Minimum requirements

i) Information on the standards that professionals should meet is available in accessible formats.
ii) The regulator has a clear and targeted communications strategy to inform the public, employers and other stakeholders.

Supporting evidence (1.2 and 1.3)

- *Information on how the standards are published*
- *Communication strategy*

1.4 The regulator requires registrants to maintain standards through a process of continuing professional development (CPD) or equivalent systems, and is working towards a system of revalidation.

Minimum requirements

i) The regulator requires / encourages registrants to complete an appropriate amount of CPD, the amount and type varying between registrants proportionally to risks identified by the regulator (e.g. clinical or regulatory).
ii) CPD is targeted to the specific learning needs of individual registrants and focused on public protection.
iii) The regulator produces clear guidance for registrants on how they should meet their CPD requirements.
iv) The regulator works with others towards a system of revalidation carried out at appropriate intervals and with appropriate intensity proportionate to risk for each registrant, and with targeted remedial action.

Supporting evidence

- *Information on the CPD system or equivalent*
- *Revalidation proposals*

2 Second function: registration

Aim: applicants to the register who meet the standards of competence and conduct are registered, while applicants not meeting the standards are prevented from entering the register. The Register is accurate and accessible to employers and the public.

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

Minimum requirements

i) The process is well-defined and details are accessible.

ii) All applicants are treated fairly and assessed against a well-defined set of criteria (e.g. using the concept of good character) that are linked to the standards of competence and conduct.
iii) Applications are processed efficiently.
iv) The regulator takes steps to ensure against fraudulent or erroneous entry to the register.
v) There is a process to appeal registration decisions.

Supporting evidence

- *Information on applications dealt with within statutory deadlines or performance target*
- *Information on the process for registration, e.g. on the website*
- *Information on whether there is someone available with whom a potential registrant can discuss their application.*
- *The appeals process*
- *The process for considering applications for registration.*
- *Customer satisfaction surveys*

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

Minimum requirements

i) The regulator makes its registers accessible to the public.
ii) The public and where applicable employers are easily able to find a specific registrant and identify if they are eligible to practise.
iii) Relevant fitness to practise history and sanctions are included within registration information.

Supporting evidence

- *The register*
- *Information on the content of register and how it can be accessed*
- *Customer satisfaction surveys*

2.3 The regulator takes appropriate action to prevent non-registrants practising under a protected title.

Minimum requirements

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

Supporting evidence

- *Information on the measures in place to publicise the importance of checking registration and to deal with those using a protected title fraudulently.*
- *Information on the usage of the register and the number of detected cases using a protected title fraudulently*

3 Third function: fitness to practise

Aim: all concerns about the fitness to practise of registrants are dealt with appropriately, and necessary action is taken to protect the public.

3.1 The regulator has a process through which patients, the public and others can raise concerns about registrants and understand how their concerns will be dealt with.

Minimum requirements

i) The regulator has a process to raise concerns[5] against registrants that is publicly available and easy to understand.
ii) The regulator ensures that there is someone available with whom a potential complainant can discuss a concern about a registrant.

Supporting evidence

- *Complaints leaflet.*
- *Website content.*
- *Feedback and outcomes from surveys involving people who have made complaints.*

3.2 The regulator keeps all relevant parties informed of progress on cases at all appropriate stages.

Minimum requirements

i) The registrant, complainant and, where appropriate employers, are informed of progress at the following stages at least:
    a) initial consideration;
    b) referral to a Fitness to Practise panel;
    c) final outcome.
ii) The regulator has a disclosure policy and complies with it and/or any legislative requirements on disclosure.
iii) The regulator publishes the outcomes of final FtP hearings, apart from health cases.

Supporting evidence

- *Disclosure policy.*
- *Feedback and outcomes from surveys involving the members of the public, employers and others.*

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

Minimum requirements

[5] Some regulators use the word 'allegations' to refer to complaints against registrants.

i) Cases are listed and heard quickly by Fitness to Practise panels after referral.
ii) Serious cases are identified and prioritised and, where appropriate and possible, referred to a panel to consider whether it is necessary to impose an interim order.
iii) There are systems and guidance to identify serious cases and cases which have become delayed.
iv) The regulator has service standards or equivalent and monitors its performance against them.
v) The regulator has a case management system.

Supporting evidence

- *Audits and management reports.*
- *Feedback and outcomes from surveys involving people who have made complaints.*

3.4 There are quality processes for the appointment, assessment and training of Fitness to Practise Panel members. Panel members also have clear guidance on how to assess cases.

Minimum requirements

i) The regulator has comprehensive Indicative Sanctions Guidance, which facilitates consistent and appropriate decision making.
ii) Where appropriate the regulator has guidance on criteria for referral from initial stage committee to final committee.
iii) The regulator uses clear and appropriate competences when recruiting panel members.
iv) There is an assessment and appraisal process for FtP panel members.
v) Members receive feedback in relation to cases they have considered.
vi) There is a training programme for panel members.

Supporting evidence

- *Committee handbooks.*
- *Appraisal scheme.*
- *Appointments process.*
- *Training schedules.*
- *Recruitment criteria.*

3.5 Decisions made at the initial stages of the fitness to practise process (pre-Fitness to Practise Panel stage) are quality assured.

Minimum requirements

i) Staff and panels involved in taking decisions at the initial stages receive appropriate training and guidance.
ii) There are internal audits of decisions.

Supporting evidence

- *Number of judicial review or appeal cases upheld against the regulator.*

- *Internal audit reports.*

3.6 Fitness to Practise panels make appropriate, well reasoned decisions on cases.

Minimum requirements

iii) The regulator ensures that its panel members take account of learning from Court outcomes and feedback from CHRE.

Supporting evidence

- *Number of Section 29 and registrant appeals upheld.*
- *Feedback to panel members on learning points arising from Court outcomes and CHRE feedback.*

4 Fourth function: Education

Aim: students[6] are given appropriate training that equips them to meet the standards of competence and conduct set by the regulator, and registrants maintain appropriate standards within their scope of practice.

4.1 The regulator ensures that its standards for the education and training to be met by students are appropriate, comprehensive, prioritise patient safety and interests and reflect up-to-date professional practice.

Minimum Requirements

(i) Standards for education and training prioritise patient safety and patient interests and link in with the standards of competence and conduct for registrants.

(ii) The regulator has taken steps to ensure that standards are widely applicable and appropriate to the different stages of training and education. Standards outline students' future personal responsibility for their own practice as well as for inter-professional working.

(iii) Standards of education and training are focused on the abilities required for that profession.

(iv) The regulator regularly reviews its standards to ensure that they are up-to-date and reflect modern practice, revising standards or producing supplementary guidance as required.

(v) All standards development is carried out in consultation with stakeholders.

Supporting Evidence:

- *Standards for the education and training of students (this can be in the same document as standards for the delivery of education)*
- *Documentation showing the development process of the standards*

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

Minimum Requirements

(i) Standards for the delivery of education and training prioritise patient safety and patient interests and link in with the standards of competence and conduct for registrants.

(ii) The regulator has taken steps to ensure that standards are applicable to all situations, including placements.

(iii) Standards balance the requirements for safety of patients and consistency of educational outcomes with the encouragement of innovation.

(iv) The regulator constantly reviews its standards to ensure that they are up-to-date, revising standards or producing supplementary guidance as required.

[6] The term students include all those in accredited education and training which aim to provide entry to a regulated profession.

(v) All standards development is carried out in consultation with stakeholders.

Supporting Evidence:

- *Standards for the delivery of education (this can be in the same document as standards for the education and training of students) and additional guidance*
- *Documentation showing the development process of the standards, e.g. how relevant developments in higher education are taken into account*

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

Minimum Requirements

(i) The regulator assesses education and training providers, including arrangements for placements, at appropriate intervals which may vary between establishments proportionally to risk.

(ii) Educational providers that meet the required standards are approved, and appropriate and targeted steps are taken where a provider falls short of the standards.

(iii) Students' and patients' perspectives are taken into account as part of the evaluation.

(iv) Information on the assessment process and final results of assessments are accessible to all stakeholders.

Supporting Evidence

- *Training of educational assessors*
- *Quality Assurance process*
- *Assessment reports*

5 Fifth function: governance and external relations

Aim: the regulator is a transparent and accountable organisation with effective processes, focused on protecting the public working in partnership with all its key interest groups and continuously improving all areas of its work.

5.1 The regulator is a transparent and accountable organisation and significant policy decisions are demonstrably based on the public interest.

Minimum requirements

(i) The regulators' decision making is based on the best available information and directed to protecting the public.
(ii) The regulator has a clearly defined aim and a strategy.
(iii) It has a Code of Conduct for Council members.
(iv) The Council includes expertise from a range of stakeholders and no one group dominates.
(v) Individuals are appointed against defined competencies[7].
(vi) Council and the executive have clear lines of accountability.
(vii) The decisions and the decision making processes of the Council are open, transparent and accessible.

Supporting evidence

- *Mission statement*
- *Code of Conduct*
- *Council policies and decisions.*
- *Information on number of public Council meetings and publication of papers and decisions; attendance at public Council meetings*
- *List of competences against which members are appointed*
- *Appraisal policy for Council members*
- *Schemes of delegation, standing orders and financial instructions*

5.2 The regulator establishes and works within efficient and effective organisational processes.

Minimum requirements

(i) The regulator has an effective planning process which ensures that functions are resourced appropriately.
(ii) The regulator ensures that its planning documents take account of risk.
(iii) The regulator sets appropriate key performance indicators or equivalent and publishes information on its performance against them.
(iv) There are effective appraisal systems and processes.

[7] Until all Council members are appointed, this is likely to apply to lay members only.

(v) The regulator meets its statutory responsibilities in sharing information and in seeking and retaining confidential information.
(vi) The regulator is committed to promoting equality and diversity and ensures that all activities are free from any discrimination.

Supporting evidence

- *The published business plan*
- *Reports from internal and external auditors*
- *Published accounts*
- *HR policies, including appraisal policy*
- *Strategic plan*
- *Annual plan*
- *Risk register*
- *Rules or procedures for raising fees*
- *Equality and Diversity Policy and reports from the Equality and Diversity Committee*
- *Information on how responsibilities under the Freedom of Information and Data Protection Acts are met*

5.3 The regulator fosters a culture of continuous improvement within the organisation.

Minimum requirements

(i) The regulator has a culture of continuous improvement.
(ii) The regulator gathers evidence from its activities and external information and disseminates it throughout the organisation. This evidence informs policy development.
(iii) Evidence-based decision making and innovation are promoted. Audit is carried out at appropriate intervals and focuses on areas of high risk.

Supporting evidence

- *Processes for complaints against the organisation and information on how complaints are taken into account.*
- *Systems for measuring quality and effectiveness and information about how these bring about improvement.*
- *Annual plan/assessment process*
- *Audit reports*

5.4 The regulator co-operates with stakeholders and other organisations.

Minimum requirements

(i) The regulator engages with stakeholders, in particular patients and the public, in all of its work.
(ii) The regulator cooperates with other organisations with a common interest, developing strategic alliances and coordinating goals and project planning.

(iii) The regulator engages in cross-regulatory work and projects, and takes account of recommendations from CHRE and others about cross-regulatory projects, best practice and its performance.

(iv) The regulator takes into account the differences between England, Scotland, Wales and Northern Ireland when devising its policies and processes and in engaging with stakeholders.

Supporting evidence

- *Strategy for involving stakeholders*
- *Council policies and decisions*
- *Consultation documents*

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council for healthcare regulatory excellence

PRESS RELEASE

13 June 2008

PERFORMANCE REVIEW MAKES STRONG RECOMMENDATIONS FOR IMPROVEMENTS TO THE NURSING AND MIDWIFERY COUNCIL

Embargo conditions apply until 01.00 am Monday 16 June 2008

The Nursing and Midwifery Council is carrying out its statutory functions but fails to fulfil these to the standard of performance that the public has the right to expect of a regulator the Council for Healthcare Regulatory Excellence said today as it published results of its performance review of the NMC.

The report identifies serious weaknesses in the NMC's governance and culture, in the conduct of its Council, its ability to protect the interest of the public through the operation of fitness to practise processes and its ability to retain the confidence of key stakeholders.

The report also says the NMC has strengths in its standards and guidance and its registration processes and acknowledges the progress which the NMC has made in improving its performance over time.

CHRE reports annually on the performance of the health professions regulators in protecting the public. CHRE examines five standards of performance, including registration, fitness to practise and governance

The special report on the NMC is a response to a request from the Minister of State for Health Services, Ben Bradshaw MP on 14 March 2008 to address the central question of whether the NMC was fulfilling its statutory functions.

CHRE Chief Executive, Harry Cayton said: "We have serious concerns about the inadequate operation of the NMC's fitness to practise processes, governance framework and lack of strategic leadership, the inconsistent availability and provision of information to Council to ensure effective planning and decision making and its ability as an organisation to retain the confidence of key stakeholders".

The CHRE report also comments on the allegations of racism and bullying at the NMC which were made by Jim Devine MP in an Adjournment Debate in Westminster Hall on 11 March 2008. CHRE says it heard and saw no evidence of racism but draws no conclusions on the matter. It states '.We have seen and heard evidence of behaviour that is undoubtedly experienced as bullying by many people involved.'

The Report makes recommendations to the NMC and the Department of Health to address the problems it identifies.

ENDS

Full details of CHRE's Performance Review on the NMC can be found at www.chre.org.uk .

Public Affairs contacts:
1. During 14 and 15 June please contact
Harry Cayton, Chief Executive, CHRE on 07912 300410.
2. For weekday calls please contact
Rachael De Souza, Public Affairs Manager, CHRE, Tel: 020 7389 8031, Email: Rachael.desouza@chre.org.uk

Notes to editors

1. Statutory duties for any healthcare regulator include

- Maintaining a register
- Taking action when a registrant's fitness to practise is called in doubt
- Assuring the quality of professional education
- Setting and issuing standards and guidance for registered professionals.

2. The report makes the following recommendations

Recommendations to the NMC

- The NMC should commit itself to work towards more effective governance. This should include reviewing its committee and accountability structure and agreeing on the level of detail of reporting to meetings. It should also include introducing and enforcing an effective statement of organisational values and code of conduct for Council members and staff, and appraisals for all Council members. Collectively and individually office holders and other Council members accepting responsibility for the current difficulties and for future resolution.

- The NMC must introduce an IT-based case management system in fitness to practise as a matter of urgency and should direct the necessary resources towards this. The NMC must improve its service to both the public and registrants in fitness to practise processes.

- The NMC should examine its stakeholder relations and communications strategy so that it is clear the NMC exists to protect patients and the public and that it has effective and mutually respectful relationships with interested parties to achieve this. This improvement in communication needs to include communication with patients, the public and registrants.

Recommendations to the Department of Health

- We recommend that plans to create a new governance structure for the NMC should proceed as rapidly as possible and sooner than currently planned. 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. The President should be appointed not elected.

- We recommend that consideration be given to the relevant responsibilities of the NMC's Conduct and Competence Committee being transferred to the new Office of the Health Adjudicator at an early stage, thus allowing the NMC to concentrate its resources on investigations and the efficient management of cases.

3. CHRE was established on 1 April 2003 to

- Promote the interests of the public and patients in the regulation of the healthcare professions.
- Promote best practice in the regulation of the healthcare professions.
- Develop principles for good professionally-led regulation.
- Promote co-operation between regulatory bodies and other organisations.

CHRE reviews the performance of the health professional regulators against five key standards and a set of minimum requirements in relation to each standard. The standards were developed during 2007 in collaboration with the regulators and an initial self-assessment by the regulator is tested by CHRE through written and face to face exchanges.

4. The five functions on which CHRE assesses performance are

- First function: Standards and Guidance
- Second function: Registration
- Third function: Fitness to Practise
- Fourth function: Education
- Fifth function: Governance and External Relations

5. The Council for Healthcare Regulatory Excellence (CHRE) is the overarching, independent body overseeing the regulatory work of nine regulatory bodies

- The General Chiropractic Council
- The General Dental Council
- The General Medical Council
- The General Optical Council
- The General Osteopathic Council
- The Health Professions Council
- The Nursing and Midwifery Council
- The Pharmaceutical Society of Northern Ireland
- The Royal Pharmaceutical Society of Great Britain.

6. CHRE is acting under Section 26 (2) (a) of The National Health Services Reform and Health Care Professions Act 2002, which says 'The Council may…investigate and report on the performance of each regulatory body of its functions'. Section 27 (1) of the same Act states that 'Each regulatory body must in the exercise of its functions co-operate with the Council' in carrying out its investigations.

APPENDIX ONE - Top HPC Risks **RISK ASSESSMENT Feb 2008**

	Description	Risk owner (primary person responsible for assessing and managing the ongoing risk)	Mitigation I	Mitigation II	Mitigation III	SIGNIFICANCE Feb 2008	PROBABILITY Feb 2008
13.3	Tribunal exceptional costs, FTP, Registrations and CPD Appeals	FTP Director	Quality of legal advice	Quality of operational processes	Legal Insurance cover for lawyer costs (rather than tribunals) costing between £125k and £250k	**High**	**High**
12.1	Judicial review of Rules, Standards & Guidance	Chief Executive	Consultation. Stds determined by PLG's. Agreement by Council.	Appropriate legal advice sought	-	High	Medium
4.10	Member recruitment problem (with the requisite skills)	President	Skills audit. Preparation of a detailed role description for restructured Council and communications strategy for potential applicants	Use of the Office of Public Appointments Commission to advertise and recruit new members	Use of the Office of Public Appointments for advice (on recruitment of the requisite skills)	Medium	Medium
7.3	Inability to manage Education Provider (EP) visits	Director of Operations Education Manager	Adequate resourcing, training and visit scheduling	Approvals & Monitoring processes	Temporary staff hire to backfill or clear wk backlogs	Medium	Medium
13.1	Legal cost over-runs	FTP Director	Processes and strict arrangements with law firm suppliers	Professional Indemnity Insurance	Good process management for arranging hearings	Medium	Medium
14.3	Changing/evolving legal advice rendering previous work inappropriate	Policy & Stds Director	Use of well-qualified legal professionals. Regular reviews.	Legal advice obtained in writing.	Appropriately experienced and trained members of Policy team and others eg HR.	Medium	Medium
17.2	Paper record Data Security	Head of Business Improvement and Facilities Manager	Use of locked document destruction bins in each dept. Use of shredder machines for confidential record destruction in some depts eg Finance.	Data Protection agreements signed by the relevant suppliers. Dept files stored onsite in locked cabinets.	Regarding Reg Appln forms processing, employment contract includes Data Protection Agreement	Medium	Medium (Reg Assessor registered mail still to arrange)
17.3	Data held by Third Parties	Director of Ops and Director of IT	Data Protection/Controller agreements signed by the relevant suppliers. Use of electronic firewalls by suppliers.	Use of locked Tape Archive boxes and sign out procedures.	DSL access LISA via secure VPN and password security. Only sample set of data held by DSL. Print UK password encryption. Peladon access using remote access tool. Electral Reform Society data is password protected and encrypted.	Medium	Medium (Servicepoint tamper proof boxes still to arrange)

APPENDIX ONE - THE HEALTH PROFESSIONS COUNCIL

RISK ASSESSMENT Feb 2008

Guide - look for Risks rated as Medium or High PROBABILITY (of occurrence in next 12 mths). Then for those ones, look for SIGNIFICANCE (Impact) ratings of Medium or High. SIGNIFICANCE is Net i.e.Gross Risk less mitigations in place.
"Premises" in this document covers 184 Kennington Park Rd, 20 Stannary St and 22-26 Stannary St.

Ref	Category		Description	Risk owner (primary person responsible for assessing and managing the ongoing risk)	Mitigation I	Mitigation II	Mitigation III	SIGNIFICANCE Feb 2008	PROBABILITY Feb 2008	SIGNIFICANCE Sept 2007	PROBABILITY Sept 2007
1	**Strategic**	1.1	HPC fails to deliver Order in Council (OIC) Links to 7.1-7.5, 8.1-8.3, 10.4, 10.5, 11.4, 15.9	Council	Delivery of HPC Strategy	Publication of Privy Council Annual Report	-	High	Low	High	Low
		1.2	Unexpected change in UK legislation Links to 2.2, 15.14	Chief Executive	Relationship with Government depts	Lobbying	-	Medium	Low	Medium	Low
		1.3	Incompatible OIC and EU legislation	Chief Executive	Monitoring of EU directives e.g. Professional Qualifications Directive	Membership of Alliance of UK Health Regulators on Europe (lobby group)	-	Low	Medium	Low	Medium
		1.4	CHRE conflict	Chief Executive	HPC President sits on the CHRE Council	Communications	-	Low	Low	Low	Low
2	**Operations**	2.1	Inability to occupy premises or use interior equipment	Facilities Mger & Director of IT	Invoke Disaster Recovery/Business Continuity plan	Commercial Combined insurance cover (fire, contents, terrorism etc)	-	Low	Low	Low	Low
		2.2	Rapid increase in registrant numbers Links to 1.2	Chief Executive and Director of Operations	Scaleable IT systems/registration	22-26 Stannary St fit out.	Influence the rate at which New Professions are regulated	Low	Low	Low	Low
		2.3	Unacceptable service standards Links to 9.1, 10.4	Director of Operations	ISO 9001 Registration, Process maps, well documented procedures & BSI audits	Hire temporary staff to clear service backlogs	Market Research surveys to prioritise service offerings	Low	Low	Low	Low
		2.4	Postal or telephone disruption	Director of Comms & Facilities Mger	Website, newsletter & messages	Invoke Disaster recovery plan	Collection of >80% income fees by DD	Low	Low	Low	Low
		2.5	Public transport disruption	Facilities Mger & Head of Business Process Improvement	Invoke Disaster Recovery plan	-	-	Low	Low	Low	Low
		2.6	Inability to accommodate HPC employees Links to 5.2	Facilities Mger	Temporary premises rented	22-26 Stannary St fit out.	Ongoing Space planning	Low	Low	Medium	Low
3	**Communications**	3.1	Failure to inform public Article 3 (13)	Director of Comms	Delivery of communications strategy	AGM, Biennial awareness survey	-	Low	Low	Low	Low
		3.2	Loss of support from the professional bodies	Director of Comms	Delivery of HPC Strategy	Delivery of communications strategy	Regular Listening Events held	Low	Low	Low	Low
		3.3	Inability to inform stakeholders following crisis	Director of Comms	Invoke Disaster recovery plan	Mailing address details kept as current as possible in LISA	-	Low	Low	Low	Low
4	**Corporate Governance**	4.1	Council inability to make decisions Links to 4.4	Secretary to Council	Regular meetings, agendas and decision processes in place	Well researched and drafted decision papers at meetings	Attendance by external professionals as required	Low	Low	Low	Low
		4.2	Council members conflict of interest	President	Disclosure of members' interests to the Secretariat	Disclosure of conflict of interest in the Annual Report & on the HPC website	-	Low	Low	Low	Low
		4.3	Poor decision-making eg conflicting advice or conflicting advice and decisions	President	Well-researched & drafted decision papers, Council member Inductions, training & Away Days	President's involvement in the appointments process for lay members	Attendance by external professionals, as required.	Low	Low	Low	Low
		4.4	Failure to meet Council/Committee quorums Links to 4.1	Secretary to Council	Clear communication of expectations of Councillors duties upfront	Adequate processes notifying Council & Committee members of forthcoming meetings	Committee secretary's and chairmen advised that inquorate meetings must not proceed	Low	Low	Low	Low
		4.5	Members' poor performance	President	President's annual appraisal of Council members	Training & support at Away Days and Inductions	Removal under Sch 1, Para 9(1)(f) of the HPO 2001	Low	Low	Low	Low
		4.6	Poor performance by the President	Council	Standing Orders	Power to remove the President under Sch 1, Article 12(1) C of the HPO 2001	-	Low	Low	Low	Low
		4.7	Poor performance by Chief Executive	President	Performance reviews and regular "one to ones" with the President	Contract of Employment	-	Low	Low	Low	Low

APPENDIX ONE - THE HEALTH PROFESSIONS COUNCIL

RISK ASSESSMENT Feb 2008

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		4.8	Improper financial incentives offered to Council members/employees	President and Chief Executive	Gifts policy	Council member code of conduct		Low	Low	Low	Low
		4.9	Health & Safety of Council members Links to 6.3, 11.5	Secretary to Council	Personal Injury and Travel insurance	Restricted access to the building site (22/26 Stannary St)	Road safety policy (for vehicle drivers) with training to follow	Low	Low	Low	Low
		4.10	Member recruitment problem (with the requisite skills) Links to 6.1, 11.13	President	Skills audit. Preparation of a detailed role description for restructured Council and communications strategy for potential applicants	Use of the Office of Public Appointments Commission to advertise and recruit new members	Use of the Office of Public Appointments for advice (on recruitment of the requisite skills)	Medium	Medium	Medium	Medium
		4.11	Expense claim abuse by members	Secretary to Council	Members Code of Conduct (public office)	Clear and comprehensive policies posted on the Council member Extranet and made clear during induction	Budget holder review and authorisation procedures	Medium	Low	High	Low
5	IT	5.1	Software Virus damage Links to 2.3, 10.2	Director of IT	Firewalls and anti-virus SW checks run	Adherence to IT policy, procedures and training	Regular externally run security tests and probes	Low	Low	Low	Low
		5.2	Technology obsolescence, (HW or SW) Links to 2.6, 10.2	Director of IT	Accurate asset records and technology refresh strategy	Employ mainstream technology with recognised support and maintenance agreements	Anually review IT technology strategy	Low	Low	Medium	Low
		5.3	IT fraud or error Links to 10.2 and 17.1	Director of IT	Adequate access control procedures maintained. System audit trails.	Regular, automatic password changes. External reviews. Daily backups.	Regular externally run security teats and probes	Medium	Low	Medium	Low
6	Partners	6.1	Inability to recruit and/or retain suitable Partners Links to 4.10, 11.3	Partner Manager	Sound recruitment strategy. Training	HR Strategy: Appropriate compensation package in place.	-	Low	Low	Low	Low
		6.2	Incorrect interpretation of law and/or SI's resulting in CHRE review	Director of FTP & Director of Operations (Visitors)	Training	Legal Assessors advice availability	-	Low	Low	Low	Low
		6.3	Health & Safety of Partners Links to 4.9, 11.5	Partner Manager	Personal Injury and Travel insurance. Liability Insurance	Road Safety policy (for vehicle drivers) with training to follow	Restricted access to the building site (22/26 Stannary St	Low	Low	Low	Low
7	Approvals & Monitoring & CPD	7.1	Non-detection of low education providers standards Links to 1.1	Director of Operations Head of Education	Annual Approvals & Monitoring processes	-	-	Medium	Low	Medium	Low
		7.2	Education providers refusing visits or not submiting data Links to 1.1	Director of Operations Head of Education	Legal powers (HPO 2001)	-	-	Medium	Low	Medium	Low
		7.3	Inability to manage Education Provider (EP) visits Links to 1.1	Director of Operations Head of Education	Adequate resourcing, training and visit scheduling	Approvals & Monitoring processes	Temporary staff hire to backfill or clear wk backlogs	Medium	Medium	Medium	Medium
		7.4	Loss of support from EP Links to 1.1	Chief Executive	Delivery of Education strategy	Partnerships with Visitors and professional groups.	-	Low	Low	Low	Low
		7.5	CPD processes not operational by July 2008 Links to 1.1	Director of Operations	Annual Business Plan	-	-	Low	Low	Low	Low
8	Project Management	8.1	CPD processes not operational by July 2008 Links to 1.1, 15.3	Director of Operations Project Manager Registration Manager	Annual Business Plan	Project progress monitored by EMT	Apply HPC's project management methodology	Medium	Low	Medium	Low

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RISK ASSESSMENT Feb 2008

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		8.2	Fee change processes not operational by June 2009 Links to 1.1, 15.3	Director of Operations and Director of Finance	Project progress monitored by EMT	Apply HPC's project management methodology	Maintain regular informal contact with Privy Council staff throughout all stages of the project	High	Low	High	Low
		8.3	Professional Qualification Directives processes not operational by October 2007 Links to 1.1, 15.3	Director of Operations Project Manager Registration Manager	Project progress monitored by EMT	Apply HPC's project management methodology	Liaison with Dept of Health lawyers	Medium	Low	Medium	Low
		8.4	Failure to regulate a new profession or a post-registration qualification as stipulated by legislation Links to 1.1, 15.3	Director of Operations Project Manager Registration Manager Director of Policy & Standards	Project progress monitored by EMT	Apply HPC's project management methodology	Maintain regular informal contact with Privy Council staff throughout all stages of the project	Medium	Low	Medium	Low
		8.5	Legal challenge to equality and diversity scheme	Equality and diversity project lead	Appropriate legal and professional advice sought in scheme development	Consultation with external organisations	Oversight by project team and EMT	Low	Low	Low	Low
		8.6	HPC added to organisations which are legally required to publish a scheme but no scheme is published	Equality and diversity project lead	Equaltiy and diversity project plan	Scheme publication by December 2007		Low	Low	Low	Low
		8.7	Stannary St project - Phase Two	Chief Executive Facilities Manager	Detailed planning, design and quanty surveying of costs	Project progress monitored by EMT	Apply HPC's project management methodology	Medium	Low	-	-
		8.8	Online Applications and Renewals Projects	Registration Manager		Project progress monitored by EMT	Apply HPC's project management methodology	Medium	Low	-	-
		8.9	Applied Psychologists Onboarding	Director of Operations		Project progress monitored by EMT	Apply HPC's project management methodology	High	Low	-	-
		8.10	Bichard Project	Director of Fitness to Practice		Project progress monitored by EMT	Apply HPC's project management methodology	Low	Low	-	-
9	**Quality Management**	9.1	Loss of ISO 9000 Certification Links to 2.3, 10.3	Director of Operations Quality Manager	Regular & internal audits	QMS standards applied across HPC	Management buy - in	Low	Low	Low	Low
10	**Registration**	10.1	Customer service failures Links to 11.1, 11.2	Director of Operations	Accurate Manning level forecasts	Adequate manpower resourcing & training	Supporting automation infrastructure eg call centre systems, LISA system enhancements, registration re-structure	Low	Low	Low	Low

APPENDIX ONE - THE HEALTH PROFESSIONS COUNCIL

RISK ASSESSMENT Feb 2008

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Ref	Category		Description	Risk owner (primary person responsible for assessing and managing the ongoing risk)	Mitigation I	Mitigation II	Mitigation III	SIGNIFICANCE Feb 2008	PROBABILITY Feb 2008	SIGNIFICANCE Sept 2007	PROBABILITY Sept 2007
		10.2	LISA Registration system failure Links to 5.1-5.3 and 17.1	Director of Operations and Director of IT	Effective backup and Recovery proceedures	Third party maintenance and support contract	Disaster recovery tests	Low	Low	Low	Low
		10.3	Inability to detect fraudulent applications Links to 9.1, 17.1 and 17.2	Director of Operations	Financial audits, System audit trails	Policy and procedures supported by interal quality audits & speciualised external Risk Management guidance	Regular, automatic password changes	Medium	Low	Medium	Low
		10.4	Backlogs of registration and GP applns Links to 1.1, 2.3	Director of Operations	Adequate staffing levels maintained to clear backlogs, based on accurate demand-forecasting	Process streamlining	-	Low	Low	Low	Low
		10.5	Failure to meet the Registration Dept merger project timetable Links to 1.1	Director of Operations	Detailed Project Plan/Training Plan and regular progress reviews (EMT)	Close teamwork with IT and Space planning teams (allied projects)	HR advice around re-organisation	High	Low	High	Low
11	HR	11.1	Loss of key HPC employees (person cover risk)	President, Chief Executive and EMT	Committee chairmen cover for President loss, President and EMT cover for CE loss until interim appointment made	Cross training (partial or full) and process documentation	CE Succession plan held by HR Director. Succession planning generally.	Medium	Low	Medium	Low
		11.2	High turnover of employees Links to 11.3	HR Director	Remuneration and HR strategy	Regular performance reviews	Exit interview analysis	Low	Low	Low	Low
		11.3	Inability to recruit suitable employees Links to 4.10, 6.1, 11.2, 11.8	HR Director	HR Strategy and adequate resourcing of the HR dept	Careful specification of recruitment adverts and interview panel selection	Hire skilled temporary staff in the interim	Low	Medium	Low	Medium
		11.4	Lack of technical and managerial skills to delivery the strategy Links to 1.1	Chief Executive	HR strategy and goals and objectives (buy in the skills v staff upskilling on the job v training)	Training needs analysis & training delivery.	Some projects or work initiatives delayed or outsourced	Low	Medium	Low	Medium
		11.5	Health & Safety of employees Links to 4.9, 6.3	HR Director & Facilities Mger	Health & Safety Training, policies and procedures	H&S Assessments (Lawrence, Webster Forrest). Restricted access to the building site (22/26 Stannary St).	Personal Injury & Travel insurance	Low	Low	Low	Low
		11.6	High sick leave levels	EMT	Adequate staff (volume and type) including hiring temporary staff	Return to work interviews and sick leave monitoring	Regular progess reviews	Low	Medium	Low	Medium
		11.7	Employee and ex-employee litigation	HR Director	Regular one on one sessions between manager and employee and regular performance rviews.	HR legislation and HR disciplinary policies	Compromise agreements	Low	High	Low	High
		11.8	Employer/employee inappropriate behaviour Links to 11.3	HR Director	Whistle blowing policy	Other HR policy and procedures	Employee Assistance programme	Low	Low	Low	Low
		11.9	Non Compliance with Employment legislation	HR Director	HR Strategy	Obtain legislation updates and legal advice	HR policies and Manager training	Low	Low	Low	Low
12	Legal	12.1	Judicial review of Rules, Standards & Guidance Links to 1.2	Chief Executive	Consultation. Stds determined by PLG's. Agreement by Council.	Appropriate legal advice sought	-	High	Medium	High	Medium
13	Fitness to Practise	13.1	Legal cost over-runs Links to 13.4, 15.2	FTP Director	Processes and strict arrangements with law firm suppliers	Professional Indemnity Insurance	Good process management for arranging hearings	Medium	Medium	Medium	Medium
		13.2	Legal challenge to HPC operations	Chief Executive	Legal advice and ISO	Communications	-	Low	Low	Low	Low
		13.3	Tribunal exceptional costs, FTP, Registrations and CPD Appeals	FTP Director	Quality of legal advice	Quality of operational processes	Legal Insurance cover for lawyer costs (rather than tribunals) costing between £125k and £250k	**High**	**High**	**High**	**High**
		13.4	Rapid increase in the number of tribunerals and resultant legal costs Links to 13.1	FTP Director	Accurate and realistic budgeting	Resource planning	-	Low	Medium	Low	Medium

APPENDIX ONE - THE HEALTH PROFESSIONS COUNCIL

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		13.5	Witness non-attendance	FTP Director	Witness summons	Witness support programme	-	Low	Medium	Low	Medium
		13.6	Employee/Partner physical assault by Hearing attendees	FTP Director	Advice sought from the Police	Adequate facilities security	Periodic use of security contractors and other steps	Medium	Low	Medium	Medium
		13.7	Registration Appeals	FTP Director & Director of Operations	Training and selection of Registration Assessors, so reasoned decisions are generated	Effective processes and criteria for arranging hearings and cases	-	Low	Low	Low	High
14	**Policy & Standards**	14.1	Incorrect process followed to establish stds/guidance/policy eg no relevant Council decision	Policy & Stds Director	Legal advice sought on processes	Appropriately experienced and trained members of Policy team.	Quality mgt system & processes	Low	Low	Low	Low
		14.2	Inappropriate stds/guidance published eg stds are set at inappropriate level, are too confusing or are conflicting	Council/Committees	Use of professional liaison groups, and Council and committees including members with appropriate expertise	Appropriately experienced and trained members of Policy team.	Consultation with stakeholders & legal advice sought	Low	Low	Low	Low
		14.3	Changing/evolving legal advice rendering previous work inappropriate	Policy & Stds Director	Use of well-qualified legal professionals. Regular reviews.	Legal advice obtained in writing.	Appropriately experienced and trained members of Policy team and others eg HR.	Medium	Medium	Medium	Medium
		14.4	Inadequate preparation for a change in legislation (Health Professions Order, or other legislation affecting HPC)	Policy & Stds Director & Director of Ops	Policy team and others remaining up to date re: forthcoming developments, via contacts, consultations, etc.	Project planning process and teams	Legal advice sought	Medium	Low	Medium	Low
15	**Finance**	15.1	Insufficient Cash to meet commitments	Finance Director	Maintain an appropriate level of cash reserves using weekly Cashflow planning	Annual and Five Year Plan forecasting of income (volumes & fees) and costs to ensure adherence to Reserves Policy. Fee rises as required.	Monthly forecasts/reviews	Low	Low	Low	Low
			Links to 15.5, 15.6, 15.17, 16.1, 16.2, 16.3								
		15.2	Unexpected rise in operating expenses	EMT	Finance & Resources Committee review of the Monthly variances to date	Budgetary control clarity around permanent and timing differences.	Regular Budget-holder reviews	Medium	Low	Medium	Low
			Link to 13.1								
		15.3	Large Capital Project Cost Over-runs	EMT	Finance & Resources Committee review of the monthly variances to date	Effective project specification, management and project progress reporting (financial and non financial)	Detailed cost estimations eg Quantity Surveyor estimates for the 22/26 SS project	Medium	Low	Medium	Low
			Links to 8.1-8.4								
		15.4	Loss in value of investment portfolio	Finance Director	Adherence to Investments and Reserves policies. Long run view.	Monthly monitoring and periodic fund performance benchmarking.	Professional fund management incorporating diversification and relatively low risk holdings	Low	Low	Low	Low
		15.5	Inability to pay creditors	Finance Director	Adequate payment procedures	Adequate cash-flow forecasting	Monthly Aged Creditors review	Low	Low	Low	Low
			Links to 15.1								
		15.6	Inability to collect from debtors	Finance Director	Collection via Direct Debit for >80% of fees income	Registrant Debtors policy compliance.	Request new DD details from Registrants when informed by the bank that the Registrant's DD was rejected. Periodic rviews of Misc Debtors.	Low	Low	Low	Low
			Links to 15.1								
		15.7	Registrant Credit Card record fraud/theft	Finance Director and Head of Business Process Improvement	Daily credit card payment reconciliations in Finance dept - Streamline to LISA and Bank records.	Project in progress to retrieve sensitive paper records in archive, rationalise records kept and retain sensitive current year records with security tagging and in compliance with cr card record storage stds in more secure storage.	Replacement of Streamline system with Worldpay (online cr card auth and payments received)	Medium	Low	Medium	Low
			Links to 5.3								
		15.8	Total receipt of correct fee income	Finance Director	LISA controls in place (charging & receipts)	Revenue reconciliations LISA to SAGE	-	Low	Low	Low	Low

APPENDIX ONE - THE HEALTH PROFESSIONS COUNCIL

RISK ASSESSMENT Feb 2008

Guide - look for Risks rated as Medium or High PROBABILITY (of occurrence in next 12 mths). Then for those ones, look for SIGNIFICANCE (Impact) ratings of Medium or High. SIGNIFICANCE is Net i.e.Gross Risk less mitigations in place.
"Premises" in this document covers 184 Kennington Park Rd, 20 Stannary St and 22-26 Stannary St.

Ref	Category		Description	Risk owner (primary person responsible for assessing and managing the ongoing risk)	Mitigation I	Mitigation II	Mitigation III	SIGNIFICANCE Feb 2008	PROBABILITY Feb 2008	SIGNIFICANCE Sept 2007	PROBABILITY Sept 2007
		15.9	Mismatch between Council goals & approved financial budgets Links to 1.1	Chief Executive	Adequate quantification of the budgetary implications of proposed new initiatives	Close and regular communication between the Executive, Council and its Committees.	Spending prioritisation criteria	Low	Low	Low	Low
		15.10	Unauthorised payments to organisations Links to 5.3	Finance Director	Purchase Order compliance	Signatory list maintenance	Approved and one-off supplier processes	Low	Low	Low	Low
		15.11	Unauthorised payments to personnel Links to 5.3	Finance Director	Expense claim processes	Signatory list reviews	Professional Indemnity & fraud insurance	Low	Low	Low	Low
		15.12	Unauthorised removal of assets (custody issue)	Director of IT & Facilities Mger	IT asset labelling & asset logging (issuance to employees)	Fixed Asset register itemising assets. Job exit procedures (to recover HPC laptops etc)	Computer insurance	Low	Low	Low	Low
		15.13	Mis-signing of cheques (forgery) Links to 5.3	Finance Director	Regular reviews of cheque signatories against invoices paid by cheque.	Monthly bank reconciliations	Minimial use of manual chqs. Two signatories on cheques.	Low	Low	Low	Low
		15.14	Non compliance with Privy Council/FReM Links to 1.2	Finance Director	Periodic reviews of website updates. Technical updates from CA firms. HM Treasury rulings sought.	Employee training (CPD hours)	Reference materials held in Finance Dept including FReM.	Low	Low	Low	Low
		15.15	Qualified opinion received by the Auditors on the Annual Financial Statements	Finance Director	Internal control compliance	FReM compliance	-	Low	Low	Low	Low
		15.16	Late submission of the Financial Statements/08/09 Annual Report, beyond sector standards	Finance Director and Comms Director	Upfront agreement on the Year End and Annual Report reporting process dates	Process management	Obtain further clarification from governing body on status (Privy Council guidance)	Low	Low	Low	High
		15.17	Fund Manager or Money Market provider insolvency Links to 15.1	Finance Director	Periodic reviews of supplier financial strength	-	-	Low	Low	Low	Low
		15.18	VAT compliance	Finance Director	Professional tax advice sought including regarding deregistration process	Tax provisions made		Low	Low	Low	Low
		15.19	PAYE/NI compliance	Finance Director	Professional tax advice sought including status of CCM's and partners	Tax provisions made. PAYE Settlement Agreement sought (via Baker Tilly)	HMRC website periodic reviews. Employee training (CPD hours)	Medium (amts involved)	Low	Low	Low
		15.20	Corporate Tax compliance	Finance Director	Professional tax advice sought eg Corporate Tax Return preparation and filing.	Tax provisions made		Low	Low	Low	Low
16	**Pensions**	16.1	Under-funded pension liabilities (CPSM Retirement Benefits Scheme*) Links to 15.1, 15.5	Finance Director	Benefits secured by insurance policies issued by the Scottish Life Assurrance (SLA)	Periodic review of the actuarial valuation of assets of the fund to cover pension liabilities.	Specialist pensions legal advice sought	Low	Low	Low	Low
		16.2	Section 75 (Pensions Act 1995) liability resulting if the number of active members of the Capita Flexiplan scheme drops to zero Links to 15.1, 15.5	Finance Director	Notional membership by six scheme members to avoid triggering S75 laibility	Employee exit procedure modified so when any of the six named inviduals resign, a replacement member is enrolled in the Flexiplan scheme	-	Low	Low	Medium	Low
		16.3	Capita Flexiplan funding liability resulting from new Scheme Specific Funding Standard (SSFS) and insufficient Pensions Capital to meet fund obligations	Finance Director	Monitoring of Actuarial valuation reports on the Pension scheme	Professional Trustee (Entrust) actions to rebalance the pension investments towards less market-volatile securities	Employer's Group actions to wind up the scheme and distribution any net surplus	Low	Low	Medium	Medium
17	**Data Security**	17.1	Electronic record Data Security Links to 5.3	Director of IT and Director of HR	Employment contract includes Data Protection Agreement	Adequate access control procedures maintained. System audit trails.	Laptop security encryption and VPN access.	Medium	Low	-	-

APPENDIX ONE - THE HEALTH PROFESSIONS COUNCIL

RISK ASSESSMENT Feb 2008

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"Premises" in this document covers 184 Kennington Park Rd, 20 Stannary St and 22-26 Stannary St.

Ref	Category	Description	Risk owner (primary person responsible for assessing and managing the ongoing risk)	Mitigation I	Mitigation II	Mitigation III	SIGNIFICANCE Feb 2008	PROBABILITY Feb 2008	SIGNIFICANCE Sept 2007	PROBABILITY Sept 2007
		17.2 Paper record Data Security Links to 15.7	Head of Business Improvement and Facilities Manager	Use of locked document destruction bins in each dept. Use of shredder machines for confidential record destruction in some depts eg Finance.	Data Protection agreements signed by the relevant suppliers. Dept files stored onsite in locked cabinets.	Regarding Reg Appln forms processing, employment contract includes Data Protection Agreement	Medium	Medium (Reg Assessor registered mail still to arrange)	-	-
		17.3 Data held by Third Parties	Director of Ops and Director of IT	Data Protection/Controller agreements signed by the relevant suppliers. Use of electronic firewalls by suppliers.	Use of locked Tape Archive boxes and sign out procedures.	DSL access LISA via secure VPN and password security. Only sample set of data held by DSL. Print UK password encryption. Peladon access using remote access tool. Electral Reform Society data is password protected and encrypted.	Medium	Medium (Servicepoint tamper proof boxes still to arrange)	-	-
		17.4 Data received from Third Parties	Director of Ops, Director of IT and FTP Director	Read only, password protected access by a restricted no of FTP employees to electronic KN data.	Registrant payments taken in compliance with Payment Card Industry (PCI) Security standards ie with quarterly PCI testing.	Ensure third party data providers eg professional bodies provide the data password protected/encrypted/door to door courier/registered mail/sign in sign out as appropriate.	Medium	Low	-	-

* The Fund wind up is being managed by Capital Trust Ltd (formely FPS). Since 1995, eligible employees have belonged to a new scheme - Flexiplan 1.

PKF Internal Audits

Internal audit completed reports

September 2006	Human Resources (follow up on recommendations made by BDO Stoy Hayward when they were internal auditors)
December 2006	Corporate governance and risk management
February 2007	Financial systems
February 2007	Fitness to practise
March 2007	IT service level agreement
May 2007	IT strategy and management
June 2007	Business continuity planning
August 2007	External communications
August 2007	Fitness to practise
October 2007	New building project (see February 2008 for follow up)
October 2007	Laptop controls
November 2007	Financial systems
January 2008	Registrations
January 2008	Corporate governance
January 2008	Data security
February 2008	New building project follow-up
May 2008	Continuing Professional Development implementation
June 2008	Approvals and Monitoring process

Internal audit scheduled reports

Third quarter of 2008-9	Financial systems
Third quarter of 2008-9	Follow up on recommendations from previous report
Fourth quarter of 2008-9	Corporate governance and risk management

Audit date	Dept or area audited by BSI	BSI Comments
08/07/2004	Top management commitment Quality policy and objectives Customer focus and management review Documentation review, Document and record control Core process of service delivery, Registration and grandparenting including purchasing, communications, complaint management, customer satisfaction, Improvement, Risk Management and Analysis Council committees role, meetings and members Staff recruitment, training needs and effectiveness Core process of allegations and fitness to practise	1 non conformance around records of Communications project planning, recommended for registration
08/11/2004	Quality Management System Management Review Process Internal Audits Communications Dept - to verify actions around non conformance UK Registrations International Registrations and Grandparenting	
04/04/2005	Management System and Business overview Communication department - Customer services Corrective and Preventative action Education dept - Approvals process Secretarit Purchasing	1 issue around access to documents
12/10/2005	HR Partners Fitness to Practise UK Registrations Education dept - Approvals process, document control checked	
24/04/2006	Management System Management Review Customer Service International Registration Internal Audits Human Resources	1 issue around how objectives against KPI's are evaluated, and how Suppliers are evaluated and re-evaluated
16/10/2006	Internal audits Work environment / infrastructure Finance / Purchasing Communications Policy & Standards Quality Management System Management Review - Objectives, KPI's Suppliers assessment assessed	Comment around positioning of storage unit - out of scope
01/05/2007	Management Systems organisations and review Senior Management Review Review of assessment findings Review of progress in relation to organisations objectives Management system strategy and objectives Communications - (storage unit confirmed as out of scope)	Re-certification visit (every third year)
23/10/2007	UK Registrations Policy HR - Staff development and training	1 issue around evidence of in-process checking
08/04/2008	International Registrations Grandparenting Registrations Quality Management System organisation and review UK Registrations - Record keeping of in-process checking Overview of Risk Based audit process	

Performance review of health professions regulators 2007/08

Helping regulation to improve

August 2008

council for healthcare regulatory excellence

Contents

Performance review of health professions regulators 2007/08

Summary

The public is being protected by the regulators of health professions in the UK. Standards prioritise patient safety and care; the registers are maintained and made public. With the exception of the Nursing and Midwifery Council (NMC), fitness to practise processes are well managed, although delays and lengthy timeframes are a concern in some cases. In education, the regulators have different powers and ways of ensuring the quality of entrants to professions. All the regulators, again with the exception of the NMC, have effective leadership and governance.

This report finds considerable variation in practice between the regulators in how they carry out their functions. This is sometimes due to differences in legislation, sometimes to the specific needs of the professions they regulate and sometimes to differences in approach. We also find many examples of good practice and highlight some areas for improvement.

In the introduction to this report we set out the process of our performance review. Part 2 considers professional regulation overall. In Part 3 we provide reports on the performance of each of the nine regulators. In Part 4 we identify areas for future consideration and make recommendations for improvements.

1. Introduction

1.1.1 The regulation of health professions has an important contribution to make to patient safety, to public confidence in the skills and behaviour of the people who care for them, and to the reputation and standing of the health professions. The Council for Healthcare Regulatory Excellence (CHRE) oversees the nine regulators of health professions in the UK. Each year, with the assistance of the regulators, we carry out a performance review and report our findings to Parliament, to health ministers in England, Wales, Scotland and Northern Ireland, and to the public. This is the report for 2007/08.

Council for Healthcare Regulatory Excellence

CHRE is an independent body accountable to Parliament. Its primary purpose is to promote the health, safety and well-being of patients and other members of the public. It scrutinises and oversees the health professions regulators, works with them to identify and promote good practice in regulation, carries out research, develops policy and gives advice.

1.1.2 During 2007 we worked with the regulators to create a set of standards against which they could assess themselves and which we could use as a basis for our judgements. The aim is to enable the regulatory bodies to identify their own strengths and weaknesses and to compare their performance with each other. This was a major shift in approach from previous performance reviews, which means that direct comparisons between these reviews and those of previous years cannot be made.

1.1.3 As this is the first year that we have carried out our performance review in this way, we are reviewing the process with the regulators, with the intention of refining and clarifying the standards and improving the process for next year. This performance review should therefore be seen as work in progress but will form an important benchmark for the performance review in 2008/09. In our comments on each of the regulators in Part 4 we highlight issues that we will wish to consider in future.

Who are the health professions regulators?

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

1.1.4 It is important that regulation is proportionate. It is therefore important that our oversight of the regulators is also proportionate. We are conscious that the pilot process this year involved significant additional work and reporting for the staff of many regulators.

We hope that we can reduce this burden in the future and are discussing with the regulators how the process can be improved whilst ensuring that it remains robust.

1.2 Standards for professions regulation

1.2.1 All professions' regulators must be able perform certain functions to fulfil their statutory responsibilities. These functions are: setting and promoting standards for admission to the register and for remaining on the register; maintaining a register of those who meet the standards; taking appropriate action where a registrant's fitness to practise has been called into question; and ensuring high standards of education for the health professionals that they regulate.[1]

1.2.2 All these things must be done efficiently, proportionately, objectively and fairly, and with the protection of patients and the public as the overriding priority. There are five standards which CHRE and the regulators use to assess their performance. Full details appear in Annex 1 to this report. The five standards are:

- Standards and guidance

This standard looks at how the regulator sets standards for the professions it regulates, how those standards promote patients' safety and well-being, how it keeps those standards up-to-date and how it ensures that all registrants are aware of them. It also looks at the regulators' activities in enabling the public to be aware of the standards they can expect from people working in those professions.

- Registration

This standard covers how the regulators register health professionals, how they carry out appropriate checks on their identity and qualifications, enter their details and keep the register up-to-date. It looks at what procedures are in place for the registration of applicants from both inside and outside the European Union. This standard also looks at the important issue of how easy it is for the public or employers to check the registration of an individual and to find out whether there are any limitations on their fitness to practise.

- Fitness to practise

This standard looks at how the regulators deal with concerns raised with them about the fitness to practise of registrants, how they ensure that concerns are dealt with and decisions made in a timely, fair and consistent manner and how all the relevant parties are kept updated during the process. It also covers how the regulators appoint, assess and train fitness to practise panel members.

- Education

This standard covers how the regulators ensure that students are given appropriate training that equips them to meet the standards of competence and conduct for their profession. It also looks at the regulators' processes for the quality assurance of education providers to ensure that the delivery of education and training is appropriate and prioritises patient safety and interests.

[1] Secretary of State for Health (2007) *Trust, Assurance and Safety – the regulation of healthcare professionals in the 21st century,* London: The Stationery Office, chapter 1, para 1.2.

- Governance and external relations

This standard looks at how the regulators ensure that they are effective, efficient, transparent and accountable organisations that are focused on protecting the public. It also looks at how they foster a culture of continuous improvement within their organisations and, in doing this, how they take account of the views of their stakeholders.

1.3 The performance review

1.3.1 The performance review took place between December 2007 and July 2008. It had four stages:[2]

- written submissions by the regulators setting out their self-assessment of their performance against the standards and minimum requirements
- a written response from CHRE with initial assessments and requests for additional information or clarification
- a face-to-face meeting between CHRE and the regulator to discuss the assessment and to test the validity of the judgements being made
- a final written report from CHRE summarising its assessment of the regulator's performance.

1.3.2 Overall, the regulators have told us that the new process has been helpful to them, more rigorous than in previous years and constructive. Everyone involved with the process also agrees that there is scope for improvement, particularly in reducing the burden of work on the regulators, clarifying the language of the standards and in deepening CHRE's understanding of the differences between the regulators.

1.3.3 As this was a pilot process it is important that CHRE and the regulators learn from it and improve it for future years. We are committed to doing this and a review of the process is currently underway. The outcome of that review will be implemented in 2008/09.

1.3.4 It is also important to note that the review took place against a background of major change in healthcare regulation. The Health and Social Care Bill was before Parliament during the period the reviews were taking place, all the regulators were actively involved in preparing for the differing changes to their constitutions, councils and roles, and both the pharmacy regulators (the RPSGB and the PSNI) were preparing for major reforms. The performance review therefore added to the burden of work on the regulators during this period. We wish to acknowledge this and to thank the regulators for their active co-operation in the process of the review.

[2] In the case of the NMC, where this year we were asked by the Minister of State for Health Services to expedite our performance review, we have published a separate report. This can be found on our website at www.chre.org.uk.

2. How is health professions regulation doing?

2.1. Introduction

2.1.1 In many areas of their work, the nine regulators carry out their functions in substantially different ways. This may derive from the requirements of their legislation or the very real differences in the nature of the professions they regulate. However, it is also true that the quality of regulation and the level of protection provided to the public differ between the regulators.

2.1.2 All of the regulators are carrying out the full range of their statutory functions. They all set standards for their professions, maintain a register or registers of regulated professionals, take action where a registrant's fitness to practise is called into question and set standards for and quality assure educational provision.

2.1.3 Most of the regulators' work is carried out effectively, with a clear focus on protecting the public. Indeed, we have identified many areas where regulators are exhibiting particularly good practice. One of CHRE's important tasks is to encourage the dissemination of good practice. In adopting good practice, the regulators will need to consider whether it will need to be adapted for their organisation or professions.

2.1.4 Our performance review has, however, identified areas in which some regulators have shown weaknesses. This is a concern. We hope that the recommendations that we make in this report will address these areas for improvement.

2.1.5 We are committed to working with all of the regulators to promote good practice and to help them to improve in those areas where there are currently weaknesses. For all of the regulators we have identified particular issues on which we wish to focus next year and we will report on these in next year's performance review.

2.1.6 Turning to the five areas which we assessed, we set out below the main issues that have arisen from the reviews and, most important, examples of good practice that we identified.

2.2 Standards and guidance

2.2.1 All of the regulators set standards for their professions, but the content of their standards and guidance varies considerably. In all cases, the standards prioritise public safety and all regulators review their standards periodically. The extent to which the regulators communicate their standards to registrants, potential registrants and the public varies but some of the regulators do this particularly effectively.

2.2.2 An issue which needs to be given consideration is the future and value of schemes for continuing professional development (CPD), or their equivalent, in light of the developing proposals for revalidation of health professionals. All regulators have set standards for CPD, although the extent to which they audit or quality assure registrants' compliance with these standards varies. Some regulators have expended considerable resources on this, while others feel that this is not necessary or appropriate. The GMC in particular has decided to concentrate instead on developing proposals for revalidation.

Examples of good practice

Standards and guidance documents

The **GMC's** core document, *Good Medical Practice*, sets out the standards and behaviours which doctors must follow. It is a model of clarity and concision and is widely recognised as an example of good practice. An interactive version of *Good Medical Practice* has recently been created on the GMC's website in order to make the standards more accessible for members of the public and patients. The GMC's core standards are supported by other more detailed guidance on areas such as consent, confidentiality and maintaining sexual boundaries. The GMC standards and guidance are accessible, clear and the materials are available in a wide range of formats.

Communication about the standards and guidance

The **GOsC** demonstrates good practice in its work communicating GOsC standards. It promotes 'The Critical Cs' – communication, consent, case history taking and confidentiality – to osteopaths through workshops and training events and has produced two training DVDs for registrants highlighting the code of practice in relation to specific areas of practice.

The **GCC** is active in informing the public of the standards that professionals should meet and the action that they can take if these standards are not met. An example of this commitment is *What Can I Expect When I See a Chiropractor?*, a leaflet produced by the GCC in consultation with professional and public stakeholders. The GCC encourages practitioners to display this leaflet, which is also available in nine additional languages and Braille on request.

The **GDC** *Gazette* is one mechanism used by the GDC to communicate its standards to all registrants. The *Gazette* contains a review of conduct cases considered by its Fitness to Practise Committees from which lessons of good and poor practice and conduct are highlighted for registrants as key learning points from the GDC's standards.

The **GMC** has made real efforts to engage with patients in seldom-heard groups, including people with dementia, people with learning difficulties, homeless people and children and young people, when developing guidance. For example, in developing its guidance for children, it held meetings with children and young people in all four countries and ran an online consultation devised for young people. When consulting on its guidance on consent, the GMC worked with the Royal National Theatre, the Alzheimer's Society and other patient groups to run 'forum theatre' events for people in the early stages of dementia, their carers and doctors.

2.3 Registration

2.3.1 Generally, the regulators' processes for registration are effective and efficient, although again practices vary, particularly in relation to how they try to ensure against fraudulent entry to the register and take action where someone is fraudulently using a protected title.

2.3.2 An issue for consideration by CHRE and the regulators in the coming year is the content of the registers, particularly in relation to current and past fitness to practise outcomes. Regulators vary in what fitness to practise information they put on their registers and disclose to enquirers. As the range of sanctions available to the regulators is likely to become more harmonised, it follows that there should be greater commonality in how these sanctions are reflected on their registers. In order to assist the public, we consider that all fitness to practise outcomes should be on the registers. We note the reasons that some regulators give for not including fitness to practise outcomes, such as warnings and undertakings. We also note that in some cases there would need to be changes to legislation to enable regulators to include some outcomes on their registers. This is, therefore, a matter which we intend to consider further.

Examples of good practice

Application to the register

The **GMC** holds a comprehensive and well-managed register of medical practitioners. It also operates an effective system of identity checks. Most doctors who apply for registration, and those applying for restoration to the register following a period out of medical practice, are required to attend an identity check as part of the assessment of their application. Photographs of the doctors taken at the identity check are retained by the GMC and these can be shared with employers wishing to check that the doctor applying to them for employment is the same person who is registered with the GMC.

Information available on the register

The **GMC** register includes information about doctors' qualifications and limits to their fitness to practise that an employer or member of the public might need to know. In particular, the GMC includes all relevant fitness to practise restrictions, including warnings and undertakings given by doctors to fitness to practise panels. The GMC has been successful in securing the necessary changes to its legislation to give it the power to publish this information on the register.

Communication about the register

The **HPC** is commendably active in ensuring that the public and employers are aware of the importance of checking a professional's registration. It has advertised on Google, on public transport and in the Yellow Pages. This is particularly important work for a regulator who is regulating professions for which there is less public knowledge about regulation.

2.4 Fitness to practise

2.4.1 The regulators all have a process by which people can make complaints about a registrant's fitness to practise, and in most cases these complaints processes are clear. The best systems provide either a named caseworker or a central contact centre for processing initial complaints or concerns about a registrant.

2.4.2 There is considerable variation in how effectively the regulators use their fitness to practise processes. In particular, we have concerns about the timescales for resolving some complaints. It is important, both in terms of protecting the public from direct harm from registrants who are not fit to practise and in maintaining confidence in health professionals and regulation generally, that the regulators deal with fitness to practise cases in a timely manner. Regulators need to set clear and challenging targets and make sure that cases are monitored closely. It is essential that regulators have effective IT-based case management systems to enable them to do this.

2.4.3 While it is very important that cases are dealt with as quickly as possible this must not compromise quality, and we recognise that there is sometimes a compromise to be made between speed and quality of process. Under the powers given to us by the Health and Social Care Act 2008, we will in future audit a sample of decisions made by the regulators in the early stages of their fitness to practise cases. We will, therefore, have more evidence on the quality of decisions for future performance reviews.

2.4.4 Some of the regulators have set up systems for auditing their own fitness to practise decisions. We welcome this, and will have to consider how CHRE's audits will fit in with these internal audits. One issue, which some regulators are considering, is whether it is possible or appropriate for their staff to comment on or assess decisions made by fitness to practise panels. Some, like the GMC, have robust procedures for auditing their panels' decisions, while others take a different approach. Our concern, however, is that the regulators should have robust processes for assessing the quality of panel members. Some of the regulators have set up such systems and we hope that the others will consider their experience when setting up their systems.

2.4.5 One of our main concerns at the moment is that a number of regulators are hampered in their fitness to practise work by the limitations of their legislation. This is particularly the case in relation to the range of sanctions and, in some cases, the lack of interim sanctions available to some regulators. We hope that this will be addressed in forthcoming legislative changes. We also hope that these legislative changes will allow the regulators to be able to disclose all relevant fitness to practise outcomes on their registers.

2.4.6 During the passage of the Health and Social Care Bill through Parliament, there was considerable discussion about the value of legally qualified chairs for fitness to practise panels. Two of the regulators (the RPSGB and the PSNI) are currently required to have legally qualified chairs for their fitness to practise panels. From our consideration of over 4,000 decisions by fitness to practise panels, we conclude that panels with legally qualified chairs do not produce higher quality decisions or better written adjudications than panels with chairs who are not legally qualified.

Examples of good practice

Process

We consider it essential that mechanisms are in place to ensure that cases requiring urgent action are identified in a timely manner. A senior manager at the **GDC** reviews all complaints within one working day of receipt to determine whether urgent action, such as an interim suspension order or a referral to the police, is required.

Customer service

The **GDC** has introduced customer service training for its fitness to practise team and has a system of peer review and telephone mystery shopping. These were introduced to support GDC's quality of service: to ensure that its service standards and targets operate harmoniously rather than at the expense of each other. The GDC also allocates complainants to a caseworker and ensures that they are regularly updated throughout the process.

Audit

The **GMC** has robust quality assurance processes to ensure that decisions are made in line with the appropriate guidance and policy, and that operational activity complies with established guidance and protocols and is of optimal quality. Its Investigations Quality Assurance Group oversees this work.

Assessment and appraisal of panel members

The **GOC** has implemented systems for the assessment and appraisal of fitness to practise panel members, and these appear to be working effectively. The assessment and appraisal process identifies further development and training for panel members and forms the basis of their regular training.

Working with other agencies

In the oversight of pharmacy practice, the **RPSGB** collaborates effectively with the Medicines and Healthcare Products Regulatory Agency, the Healthcare Commission and the police to ensure that any fitness to practise complaints are identified and dealt with appropriately.

2.5 Education

2.5.1 Education is a very important area of the regulators' work, not least because evidence suggests that poor performance or misconduct as a student is often an indicator of later fitness to practise problems as a registered health professional.

2.5.2 There is considerable variation in the regulators' work in education. Some regulators set specific standards for students and educational providers, while others include this within their general standards and guidance.

2.5.3 All of the regulators have procedures for quality assuring educational providers, although in some cases this is done by or with other organisations. Generally we are concerned that insufficient account tends to be taken of patients' perspectives in this area.

2.5.4 As a result of the recently published report, *A High Quality Workforce: NHS next stage review*, CHRE is to be commissioned to conduct research to identify and promote best practice in the quality assurance of education.[3]

Examples of good practice

Communication of the standards

The **PSNI** employs both a pre-and post-registration facilitator. These are qualified pharmacists who have technical knowledge as well as experience of reviewing performance. The facilitators aim to ensure that standards of education and training are up-to-date and reflect modern practice, advising the Head of Professional Services on the need or otherwise for revising standards or producing supplementary guidance as required.

The **GOsC's** code of practice is applicable to osteopathy students as well as registered osteopaths and the GOsC runs a programme of presentations to students aimed at embedding these standards in its future registrants at the earliest opportunity.

[3] Department of Health (2008) *A High Quality Workforce: NHS next stage review,* London: DH, p 41, para 138.

2.6 Governance and external relations

2.6.1 A well-led council, with an appropriate mix of skills, expertise and experience, is essential if a regulator is to perform effectively in protecting the public. The members need to provide leadership and strategic direction for the executive. They also need to hold the executive to account and scrutinise their work in a proportionate way.

2.6.2 Currently many of the regulators are prevented from having a truly balanced council membership, but the forthcoming legislative changes, leading to smaller appointed boards with a balance of public and professional membership recruited against defined competencies, should help to resolve this. All regulators will also need to adopt good practice involving strong codes of practice and systems for appraisal of council members as well as staff. They will also need to ensure that they have a robust procedure for dealing with complaints about council members.

2.6.3 Our performance review identified serious concerns about the governance of the NMC. We hope that the actions that the NMC are currently taking and forthcoming legislative changes will result in effective leadership.

2.6.4 Many regulators put a great deal of time and effort into working with their stakeholders. However, in some cases, there could be more involvement of the public and patients.

Examples of good practice

Council membership

The membership of the **HPC's** Council is well balanced and all members work within a code of conduct. All Council members are appraised, which includes a feedback process and review of performance annually. The HPC has undertaken a skills audit for members to identify areas of particular expertise and any gaps that could be filled by training or future appointees. The regulator has also used this to help inform its competencies for Council members. These currently apply only to lay appointees but will apply to all members when the Council is reconstituted from summer 2009.

Use of performance indicators

The **GMC's** Evaluation Framework Review Group is developing a hierarchy of performance indicators to ensure that public protection is always the focus of the GMC's performance. This is intended to ensure that when there are conflicting demands for resources measures of performance are always focused on public protection.

Stakeholder management

The **GDC** has introduced a scheme for managing relationships with interested parties, through which a senior member of staff is identified as the relationship manager for each organisation. The relationship manager is responsible for sending the organisation information, for keeping them up-to-date with any developments and for answering any questions they may have. The GDC considers that this has had a significant effect, particularly with those organisations with which it has complex interactions, and that the

scheme provides the interested party with a better service and the GDC with improved oversight of its relationship with them.

3. How are the health professions regulators doing?

3.1 Introduction

3.1.1 This section of the report includes the performance review reports for all of the individual regulators. It provides our overall assessment of their performance against the five functions: standards and guidance; registration; fitness to practise; education and governance; and external relations. The individual reports also highlight, where appropriate, areas of good practice, areas of weakness and those areas on which we wish to focus next year.

3.2 General Chiropractic Council

Overall assessment

3.2.1 The General Chiropractic Council meets all the performance standards against which it has been assessed. There are some areas of its operations in which it demonstrates particular strength and effectiveness, and some in which CHRE believe there is room for improvement.

3.2.2 The GCC is particularly strong in its communications with registrants and the public and demonstrates a deep commitment to informing the public about chiropractics and the regulatory role of the GCC and its services. Recent work undertaken by the GCC on its governance systems is worthy of note, in particular its Code of Conduct for Council members and effective procedures for their assessment and appraisal.

3.2.3 However, we believe that the GCC should give further thought to the following issues, on which we will wish to consider progress, in particular during next year's performance review:

- consideration of whether there is scope for repeating on a regular basis the audit by an external organisation of fitness to practise decisions, including decisions by the Investigating Committee, Professional Conduct Committee and Health Committee; and
- setting more ambitious service standards in fitness to practise.

Standards and guidance

3.2.4 The GCC's *Code of Practice and Standards of Proficiency* provides robust and comprehensive guidance for registrants. We note that the GCC has circulated the recent guidance produced by CHRE for practitioners on maintaining clear sexual boundaries to registrants and exhorted the importance of maintaining these boundaries to them.

3.2.5 The GCC is active in informing the public of the standards that professionals should meet and the action that they can take if these standards are not met. An example of this commitment is the leaflet *What can I expect when I see a chiropractor?* that the GCC produced in consultation with professional and public stakeholders. The GCC encourages practitioners to display this and the leaflet is available from the GCC in nine additional languages and Braille on request. During the production of its complaints leaflet, *How to*

complain about a chiropractor?, the GCC also consulted with complainants and had advice from Connect, the communications disability charity.

3.2.6 The GCC has informed us that it will be considering whether applicants for registration and restoration should be asked to sign a statement confirming they have understood the *Code of Practice and Standard of Proficiency* issued by the GCC and intend to practise in line with them. We would warmly welcome such a development as in our experience there are occasions where registrants in fitness to practise proceedings claim not to have fully understood these documents and their implications. We also feel that other regulators should consider this issue.

3.2.7 The GCC requires practitioners to undertake, and maintain a record of, 30 hours of continuing professional development each year, and to submit an annual summary identifying how their learning relates to improving patient care and/or the development of the profession. Over a five-year period, it reviews the detailed CPD records of each registrant to verify the information provided in the annual summary.

Registration

3.2.8 The GCC has a highly efficient process for dealing with applications to the register and takes satisfactory steps to ensure against fraudulent or erroneous entry to the register. The GCC also requires foreign applicants to undergo a competence test, at the University of Glamorgan, at which the applicants must present their passport.

3.2.9 An anonymous ethnic monitoring study conducted on behalf of the GCC received a response rate of approximately 68 per cent, but when registrants were asked to provide attributable information about ethnic origin and disability the response rate was only 55 per cent. All new registrants are asked to provide this information and a reply-paid envelope is included with the form – the response rate runs at less than 5 per cent.

3.2.10 It is the GCC's policy to publish all current restrictions on registrants' practice on the website version of the register, but not admonishments, which are published only on the section of the website that provides the outcomes of all Professional Conduct and Health Committees. This is an issue which CHRE wishes to consider further.

3.2.11 The GCC is conscious of the low public awareness of the registration requirements to be a chiropractor and publicises that the public should check the registration of chiropractors with a banner advert on relevant pages of yell.com. It is the GCC's established policy to pass on any information it has regarding unregistered individuals claiming to be chiropractors to the police and to leave cases in the hands of the police and Crown Prosecution Service. We note this policy, but consider it is important that the GCC keep open the option to pursue a private prosecution if it considers there to be an issue of public protection at stake and no public prosecution is brought.

Fitness to practise

3.2.12 The GCC provides the public with good information that clearly outlines the role of the GCC, how to make complaints, and the operation of its fitness to practise processes. In addition, we consider these fitness to practise processes to have good accessibility to

members of the public. However, we consider its service targets for the investigation and determination of complaints to be insufficiently challenging and that the targets could be more ambitious and forward-looking. At the moment they are based on previous performance. We note, however, that the current timescales for dealing with cases are generally acceptable.

3.2.13 The GCC has comprehensive Indicative Sanctions Guidance for panels and codified guidance for staff on dealing with serious cases and referrals for interim suspension orders. The GCC is statutorily limited in that its interim suspension orders last only two months, meaning it must arrange a Professional Conduct Committee or Health Committee meeting before the expiry period, to determine whether to impose a further interim suspension order to last until the full hearing. We support the GCC's request that this time limit on interim suspension orders be altered by the Department of Health as part of its series of statutory instruments for the health professional regulators.

3.2.14 We also believe that changes are needed to the GCC's legislation to ensure proper separation of its Council functions from those of its Investigating, Professional Conduct, and Health Committees. The GCC has taken positive steps, within its statutory limitations, to appoint co-opted members against competencies to provide a partial redress to this problem.

3.2.15 The GCC's staff participate in all training sessions for members of the Investigating, Professional Conduct and Health Committees, which we consider to be a good measure.

3.2.16 The GCC has undertaken an independent analysis of the reasons for Professional Conduct Committee decisions, including comparison with its Indicative Sanctions Guidance, and used this to provide more detailed feedback to the Committee. We also note that members of staff review the decisions of the Investigating Committee, but believe the Council should consider setting up a formal mechanism for auditing these decisions.

Education

3.2.17 The standards set by the GCC for education and training to be met by students on completion of their course are appropriate, comprehensive and prioritise patient safety, with the learning outcomes of pre-registration education and training directly linked to the requirements of its *Code of Practice and Standard of Proficiency*. After each review of the *Code*, the GCC also reviews its standards for education and training courses.

3.2.18 The GCC does not register chiropractic students and all clinical work students undertake during their training takes place within the accredited institution, which means they do not practise in private practice until after qualification and registration.

3.2.19 Reviews of chiropractic training institutions carried out by the GCC are satisfactory, with the visit reports available to the public on its website. However, the only input from the perspective of patients is derived from considering any complaints received by the institution. We feel this is an area in which the GCC could be more active and visiting teams could talk directly to patients about their experiences with the students on the courses.

Governance and external relations

3.2.20 The Council's decision-making process is open and transparent. Its meetings are held in public with papers provided to members of the public on request and a bulletin summary of the decisions made by the Council normally published on the GCC's website within 48 hours of the meeting.

3.2.21 The GCC has a strong Code of Conduct for its Council members, including the competencies to be displayed and developed by members and effective assessment and appraisal procedures. Assessment against these, introduced in 2007, is robust and is comprised of a number of strands: self-assessment; peer assessment; feedback from staff; and one-to-one meetings with the Chairman. The job description of the GCC Chair includes responsibility for the annual appraisal of each Council member.

3.2.22 There is a detailed and effective planning process at the GCC ensuring that its functions are appropriately resourced. We note that the GCC has an Audit Committee with comprehensive responsibilities in relation to processes for risk, control and governance. It also has a Resource Management Committee that has oversight on behalf of the Council of the management of the human, financial and physical resources. The RMC monitors the delivery of the business plan and on a quarterly basis it considers the detailed management accounts. Both Committees provide reports and advice at every meeting of Council. The GCC has set out the competences to be met by the chairmen of the Committees.

3.3 General Dental Council

Overall assessment

3.3.1 The General Dental Council is a highly effective and well-managed regulator. It exhibits a consistent focus on public protection and a noteworthy commitment to continuous improvement across all areas of its operations. The standards and guidance it produces and its communications strategies are areas of real strength.

3.3.2 Notwithstanding this, CHRE have some concerns in relation to the following areas on which we will wish to focus in next year's performance review:

- the information published by the GDC on its register, in particular that the specific detail of conditions do not appear. However, we note that the GDC has expressed a commitment to address this matter over the next year; and
- timescales for resolution of fitness to practise cases. We note that in fitness to practise the GDC has directed increased resources to improve the 20 month average time between receipt of a complaint and final hearing. It has set strong targets in this area and we are heartened by its belief they will be met during the next year.

Standards and guidance

3.3.3 This is a strong area of performance for the GDC. Its *Standards for Dental Professionals* prioritises patients' interests, and its suite of standards and guidance documents is well-focused and clearly written. We note that these have achieved Plain English approval.

3.3.4 The GDC is active in communicating these standards to registrants and potential registrants. This includes providing its whole suite of documents to applicants and hard copies of any new documents or existing ones that have been updated. Additionally in the GDC *Gazette*, sent to all registrants, there is a review of conduct cases considered by Fitness to Practise committees from which lessons of good and poor practice and conduct are highlighted for registrants as key learning points of the GDC's standards. CHRE consider this to be a good mechanism for communicating standards and their practical implications with registrants.

3.3.5 The GDC sets standards for continuing professional development with an explicit focus on public protection. The GDC audits a random sample of registrants' CPD records and additionally reviews those of all registrants who have been late in submitting fee payment, for example, to ensure those who are poor at keeping on top of such things are not slack at keeping up with other requirements the GDC places upon them.

Registration

3.3.6 The GDC regulates dental professionals in the UK. Currently all dentists, dental hygienists, dental therapists, clinical dental technicians and orthodontic therapists must be registered with the GDC. This is currently being extended to include all dental nurses and dental technicians who must be registered with the GDC from 31 July 2008.

3.3.7 The GDC has a robust process for ensuring against fraudulent or erroneous entry to the register. However, it has longer processing times for applicants than most other regulators, 15 to 20 working days for dentists and six to eight weeks for the dental nurses and dental technicians for whom statutory regulation is not yet mandatory but which will come into effect from 31 July 2008. However, we understand that the GDC has recently reduced the average processing time for dental care professional registration considerably. The length of this process is due to the one-off challenge of registering these new groups and next year we expect to see that the GDC has faster processing times for applications. CHRE also acknowledges the GDC has contingency plans in place to address the delay ahead of the deadline for registration. We welcome the GDC's actions in regularly reviewing its processes to learn from the challenges it faces and increase its effectiveness in this area of operation.

3.3.8 CHRE has concerns that conditions do not appear on the public part of the register and nor do admonishments, although the GDC does make clear its policy to disclose these to members of the public should they wish to enquire. The GDC informs us that it is going to put admonishments on the register and is also working towards adding conditions. We feel this is important for public protection and should be a priority for the GDC.

3.3.9 Many of the GDC's registrants are self-employed and the GDC has set up a service with Primary Care Trusts in England to verify the registration of a professional before they are added to the PCT's list of practitioners. Similarly, the GDC is active in informing a PCT if the eligibility to practise of someone in their area changes.

Fitness to practise

3.3.10 The average time taken from receipt of a complaint to it reaching a final hearing is approximately 20 months. However, the GDC has targets to cut this down to 12 months, with six month target times for receipt to Investigating Committee and from the Investigating Committee to a final hearing. The GDC has deployed increased resources to meet these targets, and informs CHRE that it expects to reach the first of these by the end of this year. We will look forward to reviewing the progress it has made in next year's performance review.

3.3.11 All complaints are reviewed within one working day of receipt to determine if urgent action is required. This is good practice and we consider it essential that all regulators have mechanisms in place which ensure cases requiring urgent action are picked up in a timely manner.

3.3.12 The GDC demonstrates a strong commitment to providing a good service to those with complaints. The GDC mailed its leaflet *How to report a dental professional to us* to Citizens Advice Bureaux. Complainants are allocated a named caseworker and their contact details for the entire fitness to practise process, and are kept well-informed throughout. The GDC has introduced customer service training for its fitness to practise team and has a system of peer review and mystery shopping to support its quality of service, to ensure that service standards and targets operate harmoniously.

3.3.13 We are pleased to see that the GDC has undertaken a process of auditing its activities, beginning in fitness to practise.

Education

3.3.14 The GDC sets appropriate requirements for the outcomes of dental education, which prioritise patient safety and are comprehensive and reflecting of up-to-date professional practise. The GDC specify key attitudes, in addition to the necessary skills, as required learning outcomes, these cover: respect for patients and colleagues; an awareness of moral and ethical responsibilities; and an understanding of patients' rights. The GDC believes that having a strong focus on the outcomes required of students in education without prescribing curriculum is a proportionate approach to assuring the quality of graduates entering the register and one that encourages innovation in the delivery of dental education.

3.3.15 Education programmes for the dental professions are approved by the GDC. This involves carrying out at least one full inspection per cohort of students. As part of its inspections the GDC incorporates the views of students and evaluates patient feedback where this is available. In addition the GDC has a system of annual paper-based monitoring of educational institutions and carries out ad hoc inspections should the need arise. The GDC visits new graduate schools every year and identifies experts to help them

develop. Likewise if areas of weakness are discovered during the inspection of an institution, experts are identified to help it overcome these.

3.3.16 The GDC does not, however, currently have the power to remove a degree from the approved course list. For this to happen it must apply to the Privy Council. CHRE notes that the Department of Health is planning to give the GMC this power with regard to the list of approved medical courses in a forthcoming statutory instrument. This will allow the GMC to remove courses without application to the Privy Council. We recommend that the Department consider introducing a similar measure for the GDC.

Governance and external relations

3.3.17 The GDC displays a consistent and thorough approach to ensuring decision-making is supported by the best available evidence and focused on the public interest. The decision-making processes are transparent. Council meetings are held in public and begin with a question and answer session for members of the public. Council and committee meeting agendas, papers and decisions are posted on the GDC's website and key decisions are publicised through press releases, a monthly newsletter and the GDC *Gazette*. We also note that the GDC has an alert system to which people can sign up to be informed when a new item is posted on its website.

3.3.18 The GDC does not currently publish details about its performance with respect to its key performance indicators. We note, however, that it intends to do so, beginning with fitness to practise and extending this to its other activities in due course.

3.3.19 The Council currently has 29 members of whom 19 are elected professionals and 10 are appointees from the public. Only the public members are appointed against defined competencies. However, we note that in the next year the GDC will move to an all-appointed Council comprising 12 professional and 12 public members, and that all these individuals will go through an appointments process including objective requirements for prospective members. The GDC includes members from outside Council on its working groups to draw on additional expertise and the chairs of these groups are subject to an appointments process.

3.3.20 The GDC has introduced a scheme for managing relationships with interested parties, under which a senior member of staff is identified as the relationship manager for each organisation and has the responsibility to send them information and keep them up-to-date on any developments, and answer any questions they may have. The GDC considers that this has had a significant effect, particularly with organisations it has complex interactions with, and generally provides the interested party a better service and the GDC a better oversight on its relationship with them. The GDC has recently taken the decision to open offices in Northern Ireland, Scotland and Wales, which it considered a necessary measure due to different developments in the dental professionals taking place in the four countries of the United Kingdom.

3.3.21 The GDC takes equality and diversity issues seriously and has produced a number of guidance documents aiming to ensure all its activities are free from discrimination. It also demonstrates a desire to continually improve in these areas, reviewing the impact of its policies and seeking to develop more effective impact assessment methodology.

3.4 General Medical Council

Overall assessment

3.4.1 The General Medical Council is a well-run regulator with strong leadership and a commitment to continuous improvement. The GMC demonstrates good practice across many areas of its work. These include:

- the standards and guidance that it provides to the profession;
- the accessibility and comprehensive nature of the information on its register;
- its Indicative Sanctions Guidance for fitness to practise panels;
- its internal quality assurance processes; and
- its patient and public involvement strategies.

3.4.2 The GMC has a well-developed system for appraisal of Council members. It has also developed member role descriptions and competencies, which are being used for the recruitment process which is underway for appointments to the reconstituted Council. Together with other professional healthcare regulators, the constitution of the GMC Council will be changed so that it is smaller in size, with parity of medical and lay membership, and for all Council members to be appointed by the Appointments Commission.

3.4.3 The GMC has taken a lead in international aspects of regulation and is successfully managing a period of significant internal reform.

3.4.4 Like the other regulators the GMC will face considerable challenges in the year ahead and next year we be will particularly interested to assess developments in the following areas:

- progress in developing an effective system of revalidation; and
- further development of assuring the quality of medical education in light of the forthcoming merger of the Postgraduate Medical Education and Training Board with the GMC.

Standards and guidance

3.4.5 Standards clearly and explicitly form the basis of all regulatory functions of the GMC and are focused on public protection.

3.4.6 The core document *Good Medical Practice* sets out the standards and behaviours which doctors must follow and is a model of clarity and concision and is widely recognised as an exemplar of good practice. The GMC's core standards are supported by other more detailed specific guidance on areas such as consent, confidentiality and maintaining sexual boundaries.

3.4.7 The GMC has demonstrated a strong commitment to communicating with those who need to use its register and services and makes materials available in a wide range of formats. Guidance is accessible and clear and an interactive version of *Good Medical Practice* has recently been created on the GMC's website. In our performance review we

were particularly impressed by the GMC's practice around patient and public involvement. Real efforts have been made to engage with patients in seldom-heard groups including people with dementia, people with learning difficulties, homeless people and children and young people. We commend this work to other regulators as good practice.

3.4.8 The GMC issues guidance for doctors on continuing professional development but does not monitor or audit whether doctors follow this guidance. Demonstration of CPD is not a requirement for continuing registration as it is with some of the other professional regulators. The GMC has deliberately chosen to concentrate on developing an approach to revalidation that will be based on evidence derived from actual practice rather than simply the accumulation of CPD hours or points.

Registration

3.4.9 The GMC holds a comprehensive and well-managed register of medical practitioners. It also provides an efficient and effective process for applicants for registration. It operates an effective system of identity checks. We were particularly impressed to learn that most doctors who apply for registration, and those applying for restoration to the register following a period out of medical practice, are required to attend an identity check as part of the assessment of their application. Photographs of the doctors taken at the identity check are retained by the GMC and these can be shared with employers wishing to check that the doctor applying to them for employment is the same person that is registered with the GMC.

3.4.10 The GMC register is accessible by phone, online or in person and includes the information about doctors' qualifications and limits to their fitness to practise that an employer or member of the public might need to know. In particular the GMC includes all relevant fitness to practise restrictions, including warnings and undertakings given by doctors to fitness to practise panels. The GMC has been successful in securing the necessary changes to its legislation to give it the power to publish this information on the register. The content of the GMC's register demonstrates good practice. We believe the Department of Health should take note of the value of this when drafting new legislation for other regulators.

3.4.11 The GMC also undertakes comprehensive collection of ethnicity and diversity data.

Fitness to practise

3.4.12 The GMC has a good accessible process for fitness to practise complaints and its publications and guidance include information about the areas in which the GMC handles complaints and when these are more appropriately dealt with at a local level and by other organisations. We were particularly impressed by the GMC's central contact centre for dealing with initial complaints. We were also pleased to note that the GMC is active in ensuring that complainants are informed about progress of cases.

3.4.13 The GMC's Indicative Sanctions Guidance is a very authoritative document, and contains more detail than most of the other regulators' guidance. We feel that it is a clear example of good practice and the other regulators should consider whether they could usefully incorporate parts of the GMC's guidance in their own indicative sanctions

guidance documents. There is also good guidance for staff on referral of cases to fitness to practise panels.

3.4.14 The GMC has robust quality assurance processes to ensure that decisions are made correctly in line with the appropriate guidance and policy, and that operational activity complies with established guidance and protocols and is of optimal quality. This work is overseen by the Investigations Quality Assurance Group. Again we feel that the GMC has exhibited good practice here and the other regulators should consider similar mechanisms for assuring the quality of their work.

Education

3.4.15 The GMC has a comprehensive system of quality assurance for medical education and has a separate set of standards for medical students; *Tomorrow's Doctors.* We are satisfied that the GMC meets all the minimum requirements in this area of its work. We note that the Postgraduate Medical Education and Training Board will be merged with the GMC over the next eighteen months and will watch the effect of that process.

Governance and external relations

3.4.16 The GMC has high quality leadership and good governance. As an organisation it is committed to continuous improvement. It is, like other regulators, preparing for further reforms to its structure and to its Council.

3.4.17 The GMC has a well developed system of appraisal of Council members. It has also developed member role descriptions and competencies, which are being used for the recruitment process which is underway for appointments to the reconstituted Council.

3.4.18 We were particularly impressed by the GMC's Evaluation Framework Review Group which is developing a hierarchy of performance indicators to ensure public protection is always the focus of the GMC's performance. This is intended to ensure that measures of performance are always focused to this end, rather than potentially making conflicting demands for resources. Again we feel that this demonstrates good practice, and we believe the other regulators should consider similar approaches.

3.4.19 The GMC has strong and effective external relations and communications, and it is active in working with other regulators, in Europe and internationally. It also has a clear commitment to patient and public engagement.

3.5 General Optical Council

Overall assessment

3.5.1 The General Optical Council is an efficient and effective regulator which is meeting all of the performance standards. Its work is clearly focused on enhancing public protection. The GOC is strong in areas of its internal governance. Noteworthy developments include its internal Code of Conduct, which applies widely across all members and contractors, and its comprehensive appraisal system. The GOC is

particularly commended for implementing effective systems for the assessment and appraisal of fitness to practise panel members.

3.5.2 Some of the GOC's functions, such as the setting of additional standards and guidance to the professions and the administration of continuing education and training of registrants, are delegated to other organisations. However, the GOC maintains an appropriate level of oversight of these functions and ensures that they continue to focus on public protection.

3.5.3 Whilst recognising these important achievements we do believe that there are a few areas of relative weakness and we will want to review progress in these areas in 2009. These include:

- the current content of the register;
- the processes for the management of fitness to practise cases, in particular the absence of a formal IT-based case management system; and
- ensuring the views of patients and the public take sufficient priority in the GOC's policy development.

Standards and guidance

3.5.4 The GOC has produced codes of conduct for both individual registrants and business registrants. Both of these give sufficient regard to patient safety issues and are issued to all new registrants on registration. Supplementary guidance is produced by the professional and representative bodies in discussion with the GOC or at the GOC's instigation. The GOC also reserves the right to produce its own additional guidance if it becomes necessary, although it has not done so to date. The GOC has asked the professional bodies to consider whether to issue separate guidance on sexual boundaries, based on the CHRE guidance and will produce their own guidance if necessary.

3.5.5 The GOC recognises the need for good communication of its standards to registrants and the public. Its website is accessible to the visually impaired and is W3C AAA compliant.

3.5.6 The GOC oversees a mandatory scheme for continuing education and training for all fully qualified optometrists and dispensing opticians. The scheme is run by an outside organisation on contract to the GOC, and they maintain a website through which registrants are able to manage their portfolios online.

3.5.7 The GOC is working towards revalidation. They have been represented on the Non-Medical Revalidation National Working Group. The GOC also held a seminar on the topic of revalidation key stakeholders in October 2007.

Registration

3.5.8 The GOC operates an accessible register in an efficient way. The processes for registration work effectively, through good planning and management of the workload. Identity checks for new registrants are made by the examining bodies on application and

enrolment. Non UK applicants are required to present their passports to the GOC or to an approved body in their home state.

3.5.9 The register is accessible to the public, who are able to check individual's registration by telephone or online. The online version of the register contains a good search function. However, we were concerned that conditions imposed by fitness to practise panels do not appear where relevant alongside individual registrants' records. Although the register indicates where a registrant has conditions on their registration it does not actually show what those conditions are. The GOC have accepted, in principle, that conditions should appear on the register but they have said that they need to make some technical changes to the register before this can happen. We feel this should be given priority and this is a matter on which we will assess progress in next year's performance review.

Fitness to practise

3.5.10 The GOC's processes for managing fitness to practise cases appear to work effectively. The process for considering allegations about a registrant's fitness to practise is accessible to potential complainants.

3.5.11 Timescales for the dealing with cases are generally acceptable, but given the relatively small number of allegations which it receives, the GOC should give consideration to setting more challenging service standards in relation to this area of its work. The GOC should also consider adopting a formal IT-based case management system which would assist in the management of cases. Due to the relatively small number of allegations received by the GOC it is able to manage these currently without an IT-based case management system but we do feel that the GOC should give serious consideration to setting up such a system in the future.

3.5.12 We welcome the GOC's commitment in implementing systems for the assessment and appraisal of fitness to practise panel members, and these appear to be working effectively. We are also pleased to see that where weaknesses are identified training is planned to remedy these. We know that other regulators are giving consideration to developing similar systems of assessment and appraisal for panel members and we would recommend to them that they should share the GOC's experience in this area.

3.5.13 We note that there are no internal audits of fitness to practise decisions, so the GOC does not meet the standard in relation to that minimum requirement. Also, although we have no evidence to suggest that there are any concerns about the decisions, we do feel that the GOC should consider setting up written guidelines on referral of cases by the Investigation Committee for a final stage hearing.

Education

3.5.14 Unlike other professions all students undergoing training in the work of optometrists or dispensing opticians are required to be registered with the GOC on the student registers. The GOC provides specific guidance on training and its handbooks contain standards documents and resources required for the training, and focus on the abilities required for the particular profession. These emphasise patient safety and are linked to its general standards.

3.5.15 Education courses are assessed by GOC visitors at least every five years. Following a visit a report is prepared giving the visitors' recommendations for approval and/or conditions for remedial action. The reports are considered by the Education Committee, which recommends to Council whether the establishment is approved and, if appropriate, what conditions should be imposed.

3.5.16 Whilst students' and employers' perspectives are taken into account in assessing courses the GOC recognises that it needs to do more work on gaining patients' perspectives. We believe this is important and it is an area on which we will wish to consider progress in next year's performance review. The GOC might wish to reconsider, for example, as part of its review of its visit process the proposal that patient groups be invited to join the GOC Panel of Visitors.

Governance and external relations

3.5.17 Governance is an area of relative strength for the GOC. The Council has a lay Chair. Committee membership balances stakeholder interests across the GOC's committees and working groups. However, there are a relatively small proportion of lay members on the Council. We recommend that the proposals put forward in the report *Enhancing confidence in healthcare professional regulators*[4] should be considered when decisions are made about the structure of the new Council.

3.5.18 The Council has used person specifications for the appointment of lay members since 2000.

3.5.19 The GOC has a strong Code of Conduct for Council members and this also applies to advisers, visitors and panel members.

3.5.20 With regard to performance measurement and management, the GOC uses its business plan to review milestones and achievements, but does not currently use key performance indicators. The GOC indicated that they would consider whether these could provide a useful additional planning tool.

3.6 General Osteopathic Council

Overall assessment

3.6.1 The General Osteopathic Council meets all the performance review standards, and while it has weaknesses in a few areas, it has assured us that it has immediate plans to address these.

3.6.2 The GOsC has a particularly strong commitment to communication with registrants and also, to a lesser extent, with patients and the public. Its communication with

[4] **(**Niall Dickson from the King's Fund and DH - Regulation, Workforce 2008) Implementing the White Paper Trust, Assurance and Safety: enhancing confidence in healthcare professional regulators - final report

pre-registrant students is very strong and CHRE considers it to represent good practice in this field. The GOsC has also taken a particularly active role in promoting co-operation across Europe in regulation.

3.6.3 Our main concerns with the GOsC relate to its register. Specifically:

- where an osteopath has conditions, the restrictions on their practise did not appear on the register. However, information on registrants' conditions of practise are now clearly indicated on the web; and
- the GOsC's presentation of its online register does not make clear to members of the public that it is the register of all the individuals entitled to practise as osteopaths in the United Kingdom.

3.6.4 The GOsC has recognised these issues and plans to address them over the coming year and we will follow up its progress as part of next year's performance review.

Standards and guidance

3.6.5 The GOsC's *Code of Practice* and *Standard of Proficiency* clearly set out the standards osteopaths must follow and prioritises the safety and interests of patients. The standards are well publicised both to registrants and to students.

3.6.6 We believe that the GOsC's work in communication and support for registrants is good practice. We particularly note the promotion of 'The Critical Cs' – communication, consent, case history taking and confidentiality – to osteopaths through workshops and training events. The GOsC has an effective communication strategy with a strong regional component, carries out numerous workshops explaining its standards and has produced two training DVDs for registrants highlighting the *Code* in relation to specific areas of practice.

3.6.7 The GOsC has compulsory continuing professional development which is monitored to ensure compliance through an effective and proportionate sampling process. The Council is working towards the revalidation of osteopaths.

Registration

3.6.8 The GOsC has effective and highly efficient registration processes. It actively communicates the registration process to final year undergraduates and provides the relevant documentation to them in a timely manner, enabling students to register speedily upon graduation. In addition, the GOsC uses unique identification numbers on its forms to enable it to track applications and improve the efficiency of its registration service.

3.6.9 The GOsC is currently developing an equality and diversity programme. In a previous data collection exercise it received a response from more than half its registrants to ethnic monitoring questions and hopes to receive a higher response rate in a future survey to provide an evidence base to help inform its work in this area.

3.6.10 The GOsC is active in protecting the osteopath title. If non-registered individuals do not cease from describing themselves as 'osteopaths' upon the GOsC's request, it will

gather evidence and seek to prosecute them. A number of individuals have been convicted before the courts. In other cases where the GOsC has conducted investigations but lacked sufficient evidence to pursue a prosecution, it continues to monitor the individuals concerned.

3.6.11 We have two concerns with the GOsC's public online register. The first of these is that the GOsC's Register is presented on its website the under the heading 'Find an Osteopath'. This does not make at all clear to members of the public that they are in fact searching the Register. The GOsC has informed us that it is planning to make changes to its website to make it clear to the public that they are searching the United Kingdom's official Register of Osteopaths. However, it has also informed us that it plans to keep the heading 'Find an Osteopath' for the register. We hope these changes will make the purpose and content of its register more clear and accessible, and will review these as part of next year's performance review.

3.6.12 Our second area of concern is that admonishments and conditions do not currently appear on the GOsC's register. However, the GOsC informed us that it would change its website to indicate clearly those registrants who are subject to restrictions on their practice and that this information would be clearly indicated on the register from 31 July 2008. We are also heartened by its plans to add a link from register entries to determinations and that it anticipates the way decisions are drafted will be influenced as a result to ensure clarity for members of the public.

Fitness to practise

3.6.13 The GOsC's processes for managing fitness to practise cases appear to work effectively, and its complaints process is accessible to potential complainants. In addition, during 2008 the GOsC plans to produce a public information leaflet for display in all osteopathic practices on what patients can expect when consulting an osteopath. The leaflet is intended to ensure patients can recognise when a practice falls below the standard expected of an osteopath and inform them of how to raise their concerns. We consider this a good initiative, particularly for a profession with lower levels of public awareness and concomitant less clear understanding of what can be expected.

3.6.14 The GOsC has adequate procedures for identifying serious cases. These have not yet been formally codified, although given the volume of complaints it deals with, this has not jeopardised the effectiveness with which the public has been protected. The GOsC plans, however, to develop written guidance, and we support the GOsC in doing this. Although the GOsC does not yet have formal service targets, it does actively review its performance each year to identify potential improvements for the forthcoming year. Currently it deals with cases within a reasonable timescale. The investigation stage is completed within six months in 83 per cent of cases and 75 per cent of cases are heard by the Professional Conduct Committee within 12 months of referral from the Investigating Committee.

3.6.15 The GOsC has a statutory requirement to use Council members on its panels and so lacks some control on who is appointed to them. However, we note that it has taken steps to redress this partially by trying to identify Council members with the most relevant experience and adding co-opted members to panels. Fitness to practise panels are comprised of three Council members, statutorily required for quoracy, and two co-optees.

The Investigating Committee sits with up to 16 members, including at least eight Council members (of which two must be Privy Council appointees), with four Council members statutorily required for it to be quorate. A forthcoming statutory instrument is expected to remove the requirement to use Council members. We consider it to be important that members of panels are appointed against appropriate defined competencies for the role and are subject to robust appraisal. The GOsC has an ongoing project regarding competency-based appointments to panels and is developing a new appraisal scheme that will be applied to all fitness to practise panel members annually.

Education

3.6.16 The GOsC's *Standard of Proficiency* sets out the competence requirements of an osteopath at the point of registration and course providers also have a duty to ensure that students meet these standards. Additionally, the *Code of Practice* is applicable to osteopathy students like it is to osteopaths in practice and the GOsC runs a programme of presentations to students aimed at embedding these standards in its future registrants at the earliest opportunity. In 2007 the Benchmark Statement in Osteopathy was launched, which provides specific standards for the delivery of osteopathy education.

3.6.17 The GOsC has developed a system of quality assurance review in conjunction with the Quality Assurance Agency, which manages the reviews to the GOsC's required standards on its behalf. All courses are reviewed at intervals of between six months and five years relative to perceived risk. Some institutions are reviewed less frequently if they are more established and have had good past review, whereas others are reviewed more often if they are newer or have had conditions imposed on them at a previous review. From this year the GOsC has begun publishing all reports, following consultation with course providers, and believes that this will lead to improvements for both students and patients.

Governance and external relations

3.6.18 The Council has open decision-making processes and the GOsC aims to facilitate the participation of observers at the meetings of its Council. The GOsC is currently looking to undertake a major project with osteopathy patients focused on obtaining a more comprehensive view of what members of the public expect of osteopaths and osteopathy to provide a more robust evidence base for its decision making. The GOsC also gathers evidence from fitness to practise and other operations and actively uses this to inform amendments to its standards. In 2007 it produced supplementary guidance on how to respond to patient complaints as a result of recurring themes in fitness to practise cases. This year the GOsC plans to conduct a programme of research appraising complainants' and registrants' experiences of its complaints system.

3.6.19 Compared with other regulators, the GOsC has a good balance of interests and expertise on its Council. Half the members are appointed against defined competencies although the other half are elected by the profession without reference to these. In the recent recruitment of two new public members to its Council the GOsC sought to attract candidates with expertise in areas in which it believed its current Council was lacking. We welcome this and believe all regulators should actively seek to ensure there is a wide range of expertise on their Councils.

3.6.20 The work that the GOsC has undertaken at the European level is particularly noteworthy. Standards of osteopathic practice vary widely across Europe, which with the increased mobility of patients and professionals within the European Economic Area has created a need for greater co-operation to ensure patients are effectively protected. The GOsC has been instrumental in the development of the Forum for Osteopathic Regulation in Europe. This group brings together the national registers of osteopathy to promote the exchange of information and best practice, to develop cross-border regulatory mechanisms and to promote robust professional regulation across Europe.

3.7 Health Professions Council

Overall assessment

3.7.1 The Health Professions Council is an effective, publicly accountable regulator which has good communications with registrants and the public. It regulates a larger number and a wider range of health professions than the other regulators. This brings particular challenges, especially in finding the right balance between generic and profession-specific regulation. In this context the HPC has well-founded and thought through policies and practice.

3.7.2 The HPC is a well-organised regulator and is clearly committed to constantly improving the efficiency of its performance.

3.7.3 We feel that the HPC displays good practice with respect to:

- its communication with the public around the register and about the work of the HPC;
- the development of a skills audit and appraisal of Council members; and
- the quality of its management information and data collection.

3.7.4 During next year's performance review will be particularly interested to see developments on the following areas:

- systems for the assessment, appraisal and reappointment of fitness to practise panel members;
- updating the register so that conditions of practice are attached to individual registrants' entries; and
- processes for ensuring that patients' views are taken account of in assessments of educational providers.

Standards and guidance

3.7.5 The HPC has standards which are well publicised, very clearly set out and written in plain English. The standards can be met in various ways to enable the different professions to apply them. Most importantly the HPC's standards prioritise patient safety and patient interests.

3.7.6 Continuing professional development is not specified in terms of hours or points as is done by some other regulators. This seems reasonable in the circumstances as it allows for the difference between the professions being regulated. Sample CPD profiles are published to assist professionals. The HPC does have an effective sampling system to monitor and check CPD in practice. We consider this is a proportionate approach both in what is prescribed and in the level of auditing.

Registration

3.7.7 Registration processes are efficient and applications are dealt with promptly. Identity checks on those applying for registration are appropriately carried out.

3.7.8 The HPC is commendably active in ensuring that the public and employers are aware of the importance of checking a professional's registration, and has advertised on Google, on public transport and in the Yellow Pages. This is an example of good practice which the other regulators should consider replicating, particularly those regulating professions for which there is less public knowledge about regulation.

3.7.9 When we checked the register, we noted that whilst it recorded whether conditions had been applied to a registrant it did not record what those conditions were. A specific condition might have real public safety considerations (for instance in one case we noted the HPC has imposed a condition that the registrant could not treat women patients without a chaperone present) and so should be easily available to the public. We welcome the HPCs decision to create a direct link from the registration record to the fitness to practise report on their website and note that it is possible now to access the conditions although it is necessary to re-enter the registrant's name. This is something which we will continue to review, in particular in next year's performance review. However, we hope that the change will happen well before then.

3.7.10 The HPC is active in collecting and analysing diversity data about registrants. The HPC demonstrates a strong commitment in this area, the work it has done for persons with disabilities on becoming a health professional is particularly commendable. This is an area many other regulators could gain from exploring.

Fitness to practise

3.7.11 The HPC's fitness to practise procedures are well-organised and effective. There is a dedicated telephone line for people with concerns and the process is clearly explained. Written information about fitness to practise is in plain English. Each case is allocated a case manager from the start and there is an effective tracking system to monitor cases through the process.

3.7.12 The procedure for identifying serious cases is based on clear criteria and on an appropriate risk assessment model. If concerns are serious the HPC can arrange an interim order in seven days which is important in terms of protecting the public.

3.7.13 We are pleased to note that the HPC is introducing a process for assessment against competences and reappointment of its fitness to practise panel members. We

understand this will include peer assessment. We will be interested to see how this progresses during the year.

3.7.14 We also note the plans for refresher training for panel members and the ongoing generic feedback and regular updates to panel members, including from CHRE and the courts, through review days and email updates.

Education

3.7.15 The HPC sets three types of standards. The standards of proficiency apply to all prospective registrants including students. The standards of education and training apply to education and training programmes. The standards of conduct, performance and ethics of which part four applies to prospective registrants, including students. These standards are reviewed at least every three years.

3.7.16 Courses are inspected and the assessors make recommendations in their report to the HPC's Education and Training Committee. They also publish an annual report explaining the processes and breaking down outcomes.

3.7.17 When inspecting courses the HPC's assessors take account of student views. We did not see evidence of the views of patients and service users being taken into account. We think the HPC should consider this as part of their gathering of information in the future and this is something we will wish to consider next year. The HPC have informed us that they will be consulting on revised standards of education and training and guidance from August 2008. As part of this the HPC will be seeking the views of stakeholders on service user involvement and input into programme design and delivery.

Governance and external relations

3.7.18 The approach to governance is based on good information and the HPC's policy is open, transparent and supported by effective publications policies.

3.7.19 The membership of the Council is well-balanced and all members work within a Code of Conduct. All Council members are appraised, including a feedback process and review of performance annually. The HPC has undertaken a skills audit for members to identify areas of particular expertise and any gaps that could be filled by training or future appointees. In addition the HPC has used this to help inform its competencies for Council members. Currently these only apply to lay appointees but will apply to all members when the Council is reconstituted from summer 2009.

3.7.20 The HPC do not use formal key performance indicators but do have effective systems for measuring their own efficiency and meet the standard of ISO9001-2000.

3.8 Nursing and Midwifery Council

Overall assessment

3.8.1 This CHRE performance review[5] concludes that the Nursing and Midwifery Council is carrying out its statutory functions but fails to fulfil these to the standard of performance that the public has the right to expect of a regulator. The NMC fulfils the basic functions of a regulator. It has relative strengths in its standards and guidance and registration processes. However, there are serious weaknesses in the NMC's governance and culture, in the conduct of its Council, in its ability to protect the interests of the public through the operation of fitness to practise processes and in its ability to retain the confidence of key stakeholders.

3.8.2 The NMC should commit itself to work towards more effective governance. This should include reviewing its committee and accountability structure, and agreeing on the level of detail of reporting to meetings. It should also include introducing and enforcing an effective statement of organisational values and code of conduct for Council members and staff, and appraisals for all Council members. Collectively and individually the President, Vice-President, chairs of committees and other Council members should accept responsibility for the current difficulties and for their future resolution.

3.8.3 The NMC must introduce an IT-based case management system in fitness to practise as a matter of urgency and should direct the necessary resources towards this. The NMC must improve its service to both the public and registrants in fitness to practise processes.

3.8.4 The NMC should examine its stakeholder relations and communications strategy so that it is clear the NMC exists to protect patients and the public, and that it has effective and mutually respectful relationships with interested parties to achieve this. This improvement in communication also needs to include communication with patients, the public and registrants.

3.8.5 The NMC has made a number of commitments to improving its work and these are mentioned in this report. As this report and our recommendations make clear more are needed. We will keep the NMC's progress in addressing the issues identified in this report under review over the next year.

Standards and guidance

3.8.6 Publishing standards and guidance is a strong area of the NMC's work. The NMC's general standards prioritise patient safety and interests. Additionally, there are separate standards where needed and relevant for particular groups of nurses or midwives. Guidance is comprehensive and new guidance is developed when new practices require it. We particularly welcome the NMC's recognition that it needs to strengthen the advice given to nurses in the care of older people, and that this has come about from the analysis

[5] This performance review is an edited version of the *Special Report to the Minister of State for Health Services on the Nursing and Midwifery Council*, CHRE, June 2008. The full report is available at www.chre.org.uk.

of fitness to practise cases. Guidance also takes account of developments in nursing and midwifery in the four countries of the United Kingdom.

3.8.7 The NMC has reviewed its Code of Professional Conduct and published a new document: *The Code: standards of conduct, performance and ethics for nurses and midwives*. The Code was publicly launched in April 2008.

3.8.8 The website provides the information that registrants and members of the public need and has a useful 'A-Z of Advice'.

3.8.9 The NMC sets satisfactory standards for continuing professional development. We note, however, that the Council decided on the basis of cost not to proceed with auditing CPD undertaken by nurses and midwives in order to work towards revalidation.

Registration

3.8.10 The NMC receives over 30,000 applications for registration annually and in 2007 its call centre processed over 600,000 enquiries. The NMC also receives very large numbers of international applicants. This volume creates significant challenges, nevertheless applications are processed efficiently and there are procedures for bringing in additional staff during busy periods of the year.

3.8.11 The NMC has effective checks on applicants' identities, qualifications and good character. The NMC has a process set up with the British Council to check the International English Language Testing System certificates of nurses without European Economic Area rights.

3.8.12 The register is clear and accessible and shows whether a nurse has been struck off or is subject to sanctions. The register records when conditions have been imposed on a registrant but does not inform members of the public what these conditions are. This is not satisfactory as it is important that the register is complete and accurate. The NMC tells us that remedying this is part of its ICT strategy. When checking the register we found two cases where sanctions had been imposed on a registrant but no record of this appeared on the register. We were told this was a technical error, and that it has been rectified since CHRE brought it to the NMC's attention. In order to protect the public the register should be complete and accurate, and we will check on progress in next year's performance review.

3.8.13 The NMC does not collect diversity or ethnicity data on its registrants and is the only regulator that does not attempt to do this. The NMC is intending to collect this data under its Equality and Diversity Strategy. We welcome this and will note progress next year.

Fitness to practise

3.8.14 The NMC has made progress in carrying out some aspects of its fitness to practise function but we have serious concerns about whether all of its current processes are fit for purpose. Without doubt some of the weaknesses are the result of historical problems. The

NMC had a large financial deficit at the time of the transfer of responsibilities to it from the United Kingdom Central Council for Nursing, Midwifery and Health Visiting.

3.8.15 Since the latter part of 2006 there have been a number of important achievements and improvements in relation to fitness to practise and we appreciate that these have been achieved in circumstances which are far from ideal. The following are all notable developments and achievements in the view of CHRE:

- progress made in reducing the backlog of cases that have been referred to the Conduct and Competence Committee
- an increased volume of cases heard by the Conduct and Competence Committee
- improved feedback to fitness to practise panel members ('panellists'), including CHRE learning points, especially through the *Best Practice* publication
- the establishment of an Appointments Board to oversee the recruitment, training and assessment of fitness to practise panellists.

3.8.16 However, we still have serious concerns regarding the NMC's handling of fitness to practise cases. The absence of an IT-based formal case management system is a fundamental weakness. Many other problems stem from the absence of a formal system which would allow for the recording and tracking of all cases. In particular, it is very difficult for managers to track the progress of cases and to identify those cases which have become delayed or on which action is outstanding.

3.8.17 We are concerned that evidence from complaints which we have received suggested that the NMC had failed to follow up issues in a timely manner, in particular where a complainant had failed to provide enough information in their original letter. Although the NMC assured us that it is their policy to write to complainants at least twice in such circumstances, we believe that it is essential for managers to be able to check that this happens in all such cases. An IT-based case management system is necessary to be able to do this systematically. We welcome the fact that the NMC now recognises the importance of having an integrated case management system and that this is a prioritised part of the NMC's ICT strategy.

3.8.18 Although improvement has been made over the last year, delays in dealing with cases are an area of concern. According to the NMC, during the last year the average period between receipt of an allegation and closure of the case at a final hearing has been 29 months. This represents an improvement, as in the previous year the timescale was 35 months. However, it is still too long and the NMC recognises this.

3.8.19 We have received complaints from people about delays in receiving replies to their correspondence. This includes queries about the progress of cases. When they do receive a response this is not always helpful, accurate or sensitive. Some members of the public are not receiving the service to which they are entitled. The NMC has assured us that it intends to review its standard letters shortly, and that this had been delayed because it has been concentrating on tackling the backlog of cases. This review of the letters must be done quickly.

3.8.20 The NMC, like most of the regulatory bodies, has been developing proposals for the assessment of panellists for a number of years. Some members and former members raised concerns with us about delays in setting up this system. Particular concerns were

raised with us that some existing panellists' terms of office have been extended in the past without systematic assessment of their performance. It is important that there are robust assessment arrangements. Some other regulators have now set up a process for assessment of panellists. However, we are aware that this is an issue with which a number of regulators are still grappling and it is important that the system developed is effective. We suggest that the NMC should consult with the other regulators with the aim of developing an assessment system as soon as possible.

3.8.21 It is essential that panellists receive appropriate and relevant training to ensure that they have the necessary knowledge and skills to adjudicate on fitness to practise cases. Training for panellists on child protection issues, including assessment of cases involving child pornography, took place last year, but there were long delays in arranging this training.

Education

3.8.22 The NMC currently approves 90 programme providers across the UK covering pre-registration nursing and midwifery. The NMC has created a UK wide Quality Assurance Framework to support greater consistency in the quality of nursing and midwifery education. In 2006/07 80 per cent of approval events were subject to conditions which had to be met before the course was approved for commencement. A base-line review of all providers and programmes has taken place to support quality assurance activity in coming years.

3.8.23 We note that there have been tensions at times between the NMC and some parts of higher education, for instance relating to the introduction of the new UK-wide Quality Assurance Framework. We consider that improvements to communication and stakeholder management would help in this area.

3.8.24 The NMC assures us that they always seek the views of students on their experiences of their course when inspecting programmes and providers. We feel it is important that the NMC also seeks the views of patients on the care that they receive from student nurses as part of its inspections.

3.8.25 The NMC is currently reviewing pre-registration nursing education as part of the project undertaken by the health departments in the four countries following the *Modernising Nursing Careers* report. This aims to deliver a nursing workforce equipped with the competencies required for contemporary healthcare practice. The first stage of this review, which began in November 2007, focuses on the future framework of pre-registration nursing education. The second stage, taking place this year, will look at the proficiencies, outcomes and other requirements needed for this future framework, following which the NMC anticipates the issuance of new standards of proficiency for pre-registration nursing education.

Governance and external relations

3.8.26 There are inadequacies in the operation of the NMC's governance framework, including policies, committees and decisionmaking, and organisational behaviour. There are 13 committees dealing with different aspects of the NMC's work. It does have a large

programme but the numerous committees obscure the lines of accountability for decisions and inhibit the strategic oversight of the Council.

3.8.27 The NMC recognises the limitations and the weaknesses of its governance and set up a Governance Working Group to examine the issues. This resulted in the formation of a Governance Committee and we acknowledge that the NMC is seeking to improve its practice. The creation of an independent Appointments Board to appoint fitness to practise panellists is welcome.

3.8.28 The information provided to Council members is important for ensuring effective planning and decision making. Council members told us that they do not always have confidence that they have received full information or that the information they were given is always accurate or presented in a manner to support them to make decisions. Statistics on fitness to practise cases are an example. We have also seen and heard examples of Council members asking for information outside of meetings and not receiving it.

3.8.29 There has been a breakdown of confidence and trust between some members of the Council of the NMC and between some members and the executive. These problems are long-standing and show no sign of immediate resolution. There is little evidence the Council has the leadership to extract itself from these difficulties. There is a code of conduct for Council members but this has clearly not been adequate. An appraisal system for Council members is being developed and this is urgently required. Council members are drawn from a wide range of stakeholders, including appointed public members. Appointed members must meet a defined set of competencies, elected members need not. The fact that registrant members are elected from different groups within nursing and midwifery does not mean that they do or should represent the interests of those groups however it appears to us that decisions have sometimes been influenced by the interests of professionals rather than the public interest.

3.8.30 The NMC does not have the confidence of all its stakeholders and has not always managed to get its communication strategy right.

3.9 Pharmaceutical Society of Northern Ireland

Overall assessment

3.9.1 The Pharmaceutical Society of Northern Ireland fulfils most of its functions satisfactorily within the constraints of its existing legislation, although there are areas where improvements could be made. It is a small regulator and operates only in Northern Ireland. The PSNI and the Royal Pharmaceutical Society of Great Britain are the only regulators of healthcare professionals overseen by CHRE that do not cover the whole of the UK. Like the RPSGB, the PSNI also operates as a professional body for pharmacists.

3.9.2 PSNI is limited in its ability to perform its functions better and to innovate by its outmoded legislation. The powers provided for it in legislation also affect its performance in the recruitment on members to the Council of the Society, in the chairmanship of the Statutory Committee, in determining fitness to practise, in its lack of power to impose interim orders and in its requirements for registrants to undertake continuing professional development.

3.9.3 Although the performance of the PSNI is satisfactory in protecting the public in Northern Ireland it is not able consistently to demonstrate best practice in any area of its work nor, because of its limited resources, governance structure and legal powers has it the potential to develop best practice. This is despite the obvious desire and commitment of its leadership to do so.

3.9.4 The Council for Healthcare Regulatory Excellence strongly recommends that a new legal framework for the regulation of pharmacy in Northern Ireland is put in place a soon as possible.

3.9.5 CHRE noted the following areas of PSNI's work where specific improvements are already underway or recommended and will want to review progress in these areas in 2009:

- the development of key performance indicators and monitoring against them;
- improvement in the information recorded in the register and the accessibility and availability of the register;
- improvement in the public protection focus of continuing professional development;
- a disclosure policy and improvements in communication with the public;
- the development of case management procedures and a Memorandum of Understanding with the Pharmacy Inspectorate in Northern Ireland and with Boards and Trusts;
- a response to CHRE's concern that the Chair of the Statutory Committee also gives guidance to the Society on matters of fitness to practise; and
- the recruitment of independent members of the Statutory Committee, including lay members, and evidence of training and appraisals for Statutory Committee members.

Standards and guidance

3.9.6 Overall the PSNI meets the requirements in relation to setting and promoting standards and ensuring appropriate and timely guidance to registrants. The content of PSNI's standards is good and clearly written and gives proper priority to the protection of the public. Efforts are made to communicate the standards to registrants and to consult them on changes but we note that unless participation is compulsory – as with the 'Ethics and Practice Day' held for new registrants – the response rate from registrants is not high. CHRE is pleased to note that the PSNI reviews its standards regularly.

3.9.7 Communication with the public about the standards is less well developed. Indeed from our perspective calling the standards a *Code of Ethics* (as indeed the Royal Pharmaceutical Society of Great Britain also does) might appear confusing to members of the public. However, we were encouraged to learn that the PSNI are producing a shorter more public-facing version of the Code.

3.9.8 There are some limitations in the powers of PSNI in relation to the implementation and monitoring of continuing professional development. We recognise that new legislation is needed to enable it to enforce CPD standards. However, CHRE is concerned, and PSNI acknowledges, that its current recommendations for CPD should be more focused on public protection.

Registration

3.9.10 PSNI is dealing with applications for registration efficiently. We welcome its intention to improve timescales and to establish key performance indicators for registration.

3.9.11 CHRE attaches great importance to the content, accessibility and promotion of registers to employers, patients and the public. PSNI's legislation limits the sanctions available to it to removal from the register. This is inflexible and inadequate. PSNI has introduced voluntary undertakings from registrants found to have some impairment of practice not warranting removal from the Register. Voluntary Undertakings are not recorded on the register and so not available to the public. This is unsatisfactory. However, we recognise that most registrants would be unlikely to agree to give such undertakings if they were to be published on the register and accept that, at the moment, in the absence of any statutory sanctions other than removal from the register, the PSNI has little scope to put such undertakings on a more formal basis.

3.9.12 While the PSNI complies with the relevant legislation in Northern Ireland we think that a wider diversity data set should be collected and that efforts should be made to improve response rates. The PSNI assure us that they are making positive plans to take this work forward.

Fitness to practise

3.9.13 PSNI has few fitness to practise cases and because of both the separate legal powers of the Pharmacy Inspectorate and the limitation of its own sanctions, removal from the register is rare. The membership of the Statutory Committee does not reflect best practice in having a balance between professional and public members. PSNI assures us that they are going to recruit independent panel members, including lay members, shortly. In addition, we support their view that their legislation should be changed so that they are also able to recruit the Chair of the Statutory Committee, who is currently appointed by the Department for Health Social Services and Public Safety Northern Ireland.

3.9.14 PSNI does not yet have training or appraisal for Statutory Committee members. This is unsatisfactory. We are pleased to note that competencies are in place but training and appraisal are also needed and the PSNI tells us that these will be put in place shortly.

3.9.15 We are concerned that the Chair of the Statutory Committee also provides legal guidance to the Society, including on which cases should be referred to the Statutory Committee. We are concerned at the potential conflict of interests here and of perceived compromise to the independence of both the registrar and the Chair of the Statutory Committee. We consider the two roles should be separate and have asked PSNI to look again at this.

3.9.16 PSNI also has no power to impose interim suspension orders on registrants when they may be a risk to the public. This puts patients and the public potentially at risk and should be addressed though legislation as soon as possible.

3.9.17 We note that PSNI does not have a disclosure policy although it complies with Data Protection and Freedom of Information legislation. We understand this is in preparation.

3.9.18 CHRE supports the process by which cases of fitness to practise are investigated by the Pharmacy Inspectorate. However the separation of the Inspectorate from the regulator in Northern Ireland risks introducing delay and poor communication. As there are such a small number of cases PSNI does not have a formal case management system and this is appropriate. Nevertheless in order to avoid unnecessary delays and to identify cases where delays are occurring a case tracking system would be useful backed by a Memorandum of Understanding with the Pharmacy Inspectorate and with the Boards and Trusts.

Education

3.9.19 Pharmacy education is provided by universities in the UK and Ireland only one of which is in Northern Ireland. Students may study in one jurisdiction and work in another. PSNI does not oversee education to the same degree as other regulators so the RPSGB takes the lead in the oversight of pharmacy education with PSNI contributing in Northern Ireland.

3.9.20 We welcome the appointment of pre- and post- registration facilitators by PSNI. These professionals have a useful role to play in improving communication and promoting standards with students, registrants and employers. Other regulators might consider whether to develop such posts.

Governance and external relations

3.9.21 The Council of the PSNI does not meet the requirements of a modern regulator as it does not include a wide enough range of stakeholders and, in particular, has no public members. As its legislation does not allow for this we support the PSNI in the objective to seek modernising legislation. All members of the Council are elected or nominated and are, therefore, not appointed against defined competencies.

3.9.22 As noted above, PSNI does not have a disclosure policy and, at present, minutes and papers from Council are not published. We welcome PSNI’s intention to do so. We also support its intention to advertise its Council meetings and to welcome the public as observers. We also welcome its intention to publish performance indicators in the coming year, and an audit of its performance against these in its annual report.

3.10 Royal Pharmaceutical Society of Great Britain

Overall assessment

3.10.1 The Royal Pharmaceutical Society of Great Britain has successfully carried out its regulatory functions during a difficult period of change and organisational challenge. This is a good performance review and should be seen in that context.

3.10.2 The RPSGB and the PSNI are the only regulators of healthcare professionals overseen by CHRE that do not cover the whole of the UK. Like the PSNI, the RPSGB also operates as a professional body for pharmacists.

3.10.3 The RPSGB is limited in its ability to perform some of its functions because of its legislation. This particularly affects its ability to require registrants to undertake continuing professional development. We feel that the Department of Health should take account of this in preparing the legislation for the General Pharmaceutical Council.

3.10.4 There will be further considerable challenges for the RPSGB in the coming year, particularly relating to the transition to the GPhC. However, in particular, we will wish to consider progress next year on the following issues arising from this performance review:

- raising the profile of the register, particularly with the public; and
- the introduction of an updated IT-based case management system in fitness to practise.

Standards and guidance

3.10.5 We are satisfied that standards form the basis of the RPSGB's statutory functions and that they are comprehensive and prioritise patient safety. The *Code of Ethics* is well laid-out, clear and concise.

3.10.6 The RPSGB has an effective communications strategy to ensure that registrants, employers and members of the public are aware of their standards. The RPSGB makes particular effort to communicate with students and recently it has developed a strong programme of patient and public involvement.

3.10.7 The RPSGB does not have the statutory power to make continuing professional development mandatory for pharmacists but it is doing everything it can under its current legislation. This includes making participation in and recording of CPD a professional obligation for registrants. Registrants are expected to sign a formal declaration annually that they will comply with the requirements of the CPD scheme. However, ensuring that the new GPhC has the right statutory powers in this area should be a matter of priority for the Department of Health in preparing the legislation.

Registration

3.10.8 The registration process is well-managed and applications are dealt with in a timely manner.

3.10.9 The register is accessible and reasonably easy to understand and to search. However, we note that admonishments and reprimands are not on the register. We understand that the RPSGB does not feel the inclusion of this information is appropriate and fair to registrants or would help to protect the public. This is an issue which CHRE wishes to consider further.

3.10.10 The RPSGB recognises that more work needs be done in informing the public about the registration requirements to be a pharmacist and making the register more

accessible to the public. We discussed with the RPSGB a proposal to raise the profile of the register through making it a requirement for clear information about registration to be displayed in all pharmacy premises.

3.10.11 We note that the RPSGB has an effective process to deal with cases of unregistered individuals claiming to be working as pharmacists.

Fitness to practise

3.10.12 The RPSGB has had an IT-based case management system for some time but it has recognised that its system has limitations, especially in relation to providing statistical information. A new database is going to be introduced shortly and we will be interested to see how this improves the management of cases when we undertake next year's performance review.

3.10.13 Cases appear to be dealt with relatively quickly. The RPSGB says that it is now meeting its performance target of referring new cases to the Investigating Committee within six months of receipt. We hope that the new case management system will assist the RPSGB to move beyond this. We also feel that the RPSGB should consider setting further service standards relating to the rest of the fitness to practise process.

3.10.14 The Pharmacy Inspectorate plays a crucial role both in detecting Fitness to Practise concerns and investigating them. We feel that it has real value as a means of monitoring pharmacists and for members of the public to raise concerns that they may have.

3.10.15 In the oversight of pharmacy practice the RPSGB collaborates effectively with the Medicines and Healthcare Products Regulatory Agency, the Healthcare Commission and the police.

Education

3.10.16 RPSGB reviews its standards for education every five years, unless a reason emerges to review it before this.

3.10.17 The RPSGB has a team visiting existing schools of pharmacy every five years as part of its reaccreditation, and can go in following complaints or to check up on them more frequently if a reason to do so arises.

3.10.18 In the oversight and quality assurance of pharmacy education the RPSGB takes on UK wide responsibilities and collaborates effectively with the PSNI in Northern Ireland.

Governance and external relations

3.10.19 The membership of the Council of the RPSGB does not reflect a sufficiently broad range of interests in view of the wide range of stakeholders in pharmacy regulation but we appreciate that this is not possible within the existing legislative constraints. We recommend that this be addressed when pharmacy regulation in Great Britain is taken on

by the new General Pharmaceutical Council, and that the new Council is constituted in line with the proposals put forward in the report *Enhancing confidence in healthcare professional regulators*[6].

3.10.20 The RPSGB does not have a system for the appraisal of Council members and is not meeting the minimum requirements in this respect. Although the RPSGB accept, in principle, that Council members should be appraised they feel that there is little value in setting up a mechanism at this stage due to the limited life of the current Council and considering that the GPhC will wish to have its own system for appraisal.

3.10.21 With regard to performance management the RPSGB has some key performance indicators beyond fitness to practise, although some of them appear to be less explicit particularly in registration. It also has turnaround times in finance and publishing targets and operates a 'traffic-light' system to enable the Executive and Council to know that teams are delivering to established standards and to enable them to scrutinise this activity.

[6] **(**Niall Dickson from the King's Fund and DH - Regulation, Workforce 2008) Implementing the White Paper Trust, Assurance and Safety: enhancing confidence in healthcare professional regulators - final report

4. Recommendations and conclusions

4.1 During the performance reviews and in discussion with the regulators, we have identified a number of issues that require further consideration. We have also noted matters on which we consider the Department of Health, or in the case of PSNI the Department of Health, Social Services and Public Safety, Northern Ireland, should take action. There are other improvements which the regulators themselves have agreed to implement. These are detailed below.

4.2 **Areas CHRE will be taking forward**

4.2.1 We will be considering three issues in particular next year:

- What information should be publicly available on the regulators' registers regarding registrants' fitness to practise?
- What is good practice in terms of carrying out quality assurance of education and training?
- Advice on the establishment of the GPhC.

4.2.2 What information should be publicly available on the regulators' registers regarding registrants' fitness to practise? Generally, CHRE believes that all fitness to practise outcomes should be on the register. However, currently what fitness to practise information is put on the registers and disclosed to enquirers varies between regulators. We will be working with the regulators to see whether a harmonised approach to this issue can be reached.

4.2.3 What is good practice in terms of carrying out quality assurance of education and training? The regulatory bodies are amongst a number of organisations with responsibility for and interest in the quality assurance of education and training. They must ensure that future health professionals are trained to a sufficient level of competence to ensure high levels of patient safety in their everyday practice. To help the regulators achieve this, we are being commissioned by the Department of Health, following a recommendation in *A High Quality Workforce: NHS next stage review*,[7] to carry out research into identifying and promoting good practice around the quality assurance of education and training. In particular, we will be looking at whether there is excessive burden on the education and training providers, how that burden manifests itself, who creates it and whether reducing that burden would adversely affect public protection.

4.2.4 Advice on the establishment of the GPhC. The GPhC is being established, which will take over the regulatory role of the RPSGB. We have been commissioned to advise on how this should take place. Our report, *Advice on Aspects of the Establishment of the General Pharmaceutical Council* (CHRE, 2008), is available on our website.

4.3 **Recommendations to the Department of Health**

4.3.1 We have made a number of recommendations and suggestions to the Department of Health regarding its role in assisting individual regulators to improve performance.

[7] Department of Health (2008) *A High Quality Workforce: NHS next stage review,* London: DH, para 54, p 20.

General Chiropractic Council

4.3.2 The GCC is statutorily limited in that its interim suspension orders last only two months. This means that it must arrange a Professional Conduct Committee or Health Committee meeting before the expiry period to determine whether to impose a further interim suspension order to last until the full hearing. We support the GCC's request that this time limit on interim suspension orders be altered by the Department of Health as part of its series of statutory instruments for the health professions regulators.

4.3.3 We recommend that changes are needed to the GCC's legislation to ensure proper separation of its Council functions from those of its Investigating, Professional Conduct, and Health Committees.

General Dental Council

4.3.4 We recommend that the Department of Health consider providing the GDC with the power to remove a degree from the approved course list. This would allow the GDC to remove courses without application to the Privy Council. It would also give it the same power as that proposed by the Department for the GMC.

Nursing and Midwifery Council

4.3.5 We recommend that plans to create a new governance structure for the NMC should proceed as rapidly as possible and sooner than currently planned. 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. The president should be appointed, not elected.

4.3.6 We recommend that consideration be given to the relevant responsibilities of the NMC's Conduct and Competence Committee being transferred to the new Office of the Health Professions Adjudicator at an early stage, thus allowing the NMC to concentrate its resources on investigations and the efficient management of cases.

Pharmaceutical Society of Northern Ireland

4.3.7 We recommend that the Department for Health, Social Services and Public Safety, Northern Ireland acts to modernise the PSNI's legislation. In doing this, it should consider providing the PSNI with:

- the powers to implement and monitor systems of continuing professional development
- a wider range of sanctions for fitness to practise cases
- the power to impose interim suspension orders on registrants when they may be a risk to the public
- the power to recruit the chair of the Statutory Committee, who is currently appointed by the Department for Health, Social Services and Public Safety, Northern Ireland

- a Council which meets the recommendations of the report of the working group, *Implementing the White Paper Trust Assurance and Safety: enhancing confidence in healthcare professional regulators*.[8]

Royal Pharmaceutical Society of Great Britain

4.3.8 The RPSGB does not have the statutory power to make CPD mandatory for pharmacists. However, ensuring that the new GPhC has the right statutory powers in this area should be a matter of priority for the Department of Health in preparing the legislation.

4.4 Recommendations to the regulators

4.4.1 We have highlighted a number of areas of weakness, which we hope the regulators will address in the coming year. We have also identified a number of examples of good practice, which we hope the regulators will review and consider adapting for their own organisations. These are set out in Parts 2 and 3 of this report. In relation to the NMC, we have also made specific recommendations as set out below.

Nursing and Midwifery Council

4.4.2 The NMC should commit itself to working towards more effective governance. This should include reviewing its committee and accountability structure, and agreeing on the level of detail of reporting to meetings. It should also include introducing and enforcing an effective statement of organisational values and code of conduct for Council members and staff, and appraisals for all Council members. Collectively and individually, the president, chairs of committees and other Council members should accept responsibility for the current difficulties and for their future resolution.

4.4.3 The NMC must introduce an IT-based case management system in fitness to practise as a matter of urgency and should direct the necessary resources towards this. The NMC must improve its service to both the public and registrants in fitness to practise processes.

4.4.4 The NMC should examine its stakeholder relations and communications strategy so that it is clear that the NMC exists to protect patients and the public, and that it has effective and mutually respectful relationships with interested parties to achieve this. This improvement in communication also needs to include communication with patients, the public and registrants.

4.5 Conclusion

4.5.1 This performance review of the health professional regulators demonstrates that they take their roles and responsibilities seriously and that they are committed to improvement. We also are committed to working with them to protect the public and to be publicly accountable for doing so.

[8] Department of Health (2008) *Implementing the White Paper Trust Assurance and Safety: enhancing confidence in healthcare professional regulators.*

4.5.2 In the Health and Social Care Act 2008, CHRE acquired new responsibilities. Our objective is clear – ‘to promote the health, safety and well-being of patients and other members of the public’ – and our performance reviews will in future be part of our statutory report to Parliament. In 2009 we will start to audit the early stages of fitness to practice cases as well as continuing to scrutinise their final outcome.

4.5.3 We will report in next year’s performance review on the progress made against our recommendations above and will work with the regulators to ensure that our performance reviews continue to be proportionate, fair and robust.

Annex 1: Standards of good regulation

Standards of good regulation

1. Introduction

1.1 CHRE has decided that the performance review process should be built on a set of standards. The standards aim to remain at a high level and focus on outcomes. The development of the draft standards has been informed by previous work carried out in 2003 by CHRE Council members and by the work of the Better Regulation Task Force (BRTF, now called the Better Regulation Commission). The BRTF defined five principles of good regulation:

- proportionality;
- accountability;
- consistency;
- transparency; and
- targeting.

1.1.1 The BRTF principles apply across all regulatory functions and have been central to the definition of the draft standards. The draft standards were revised following comments from regulatory bodies.

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

2. Definitions

2.1 **Standards** are the foundation of the performance review process and will evolve over time. They describe what the public should expect from regulators and enunciate principles of good practice. Regulators are asked to demonstrate how they ensure that they meet the standards. For each standard, a number of minimum requirements and supporting evidence are described.

2.1.2 All **minimum requirements** must be met to meet the standards, but are not standards in themselves. They are not exhaustive, in that regulators can demonstrate that they meet the standards in additional ways. Minimum requirements vary: they sometimes describe current duties, give examples of current practice, or indicate best practice.

2.1.3 **Supporting evidence** is the evidence that we suggest regulators can draw upon in demonstrating how they meet the standards. Supporting evidence is only an indication of the evidence that can support the declaration of whether the standards are met, and how. It only illustrates the kind of information that can be used, and is not exhaustive. We do not ask for supporting evidence to be provided with the performance review responses. We may ask for some evidence at a later stage.

2.1.4 We would not expect that regulators should change their own information gathering or reporting cycles to fit in with the performance review cycle. For the purposes of the performance review regulators should just use the most up-to-date information they have.

2.1.5 Supporting evidence will normally be considered to be in the public domain, except where the regulator specifically indicates that this information is provided in confidence only.

1 First function: standards and guidance

Aim: all registrants comply with a suitable set of standards, and the public are aware of the standards that they can expect.

1.1 The regulator publishes standards of competence and conduct[9] which are appropriate, comprehensive, prioritise patient[10] interests and reflect up-to-date professional practice.

Minimum requirements

i) Standards prioritise patient safety and patient interests.
ii) Core standards are formulated as general principles which apply widely to all situations and areas of practice.
iii) The core standards are easy to understand for registrants and clearly outline registrants' personal responsibility for their practice.
iv) The core standards include, as a minimum, the principles expressed in the Statement of Common Values[11].
v) Where appropriate, supplementary guidance is produced to help registrants apply the core standards about specialist or specific issues.
vi) Standards form the basis for all regulatory functions.
vii) The regulator regularly reviews its standards to ensure that they are up-to-date, and revises its standards and produces supplementary guidance as required.

Supporting evidence

- *Standards and guidance*
- *Documentation showing the development process of the standards, e.g. consultation documents*

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

Minimum requirements

i) Standards are published in formats that are easily accessible to potential registrants and registrants.

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

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

[11] *Common Values Statement by the Chief Executives Group of the Health Care Regulators on professional values,* 2004, available on CHRE website.

ii) The regulator has a clear communications strategy, which is targeted to meet the needs of registrants, to promote the standards.

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

Minimum requirements

i) Information on the standards that professionals should meet is available in accessible formats.
ii) The regulator has a clear and targeted communications strategy to inform the public, employers and other stakeholders.

Supporting evidence (1.2 and 1.3)

- *Information on how the standards are published*
- *Communication strategy*

1.4 The regulator requires registrants to maintain standards through a process of continuing professional development (CPD) or equivalent systems, and is working towards a system of revalidation.

Minimum requirements

i) The regulator requires / encourages registrants to complete an appropriate amount of CPD, the amount and type varying between registrants proportionally to risks identified by the regulator (e.g. clinical or regulatory).
ii) CPD is targeted to the specific learning needs of individual registrants and focused on public protection.
iii) The regulator produces clear guidance for registrants on how they should meet their CPD requirements.
iv) The regulator works with others towards a system of revalidation carried out at appropriate intervals and with appropriate intensity proportionate to risk for each registrant, and with targeted remedial action.

Supporting evidence

- *Information on the CPD system or equivalent*
- *Revalidation proposals*

2 Second function: registration

Aim: applicants to the register who meet the standards of competence and conduct are registered, while applicants not meeting the standards are prevented from entering the register. The register is accurate and accessible to employers and the public.

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

Minimum requirements

i) The process is well-defined and details are accessible.
ii) All applicants are treated fairly and assessed against a well-defined set of criteria (e.g. using the concept of good character) that are linked to the standards of competence and conduct.
iii) Applications are processed efficiently.
iv) The regulator takes steps to ensure against fraudulent or erroneous entry to the register.
v) There is a process to appeal registration decisions.

Supporting evidence

- *Information on applications dealt with within statutory deadlines or performance target*
- *Information on the process for registration, e.g. on the website*
- *Information on whether there is someone available with whom a potential registrant can discuss their application.*
- *The appeals process*
- *The process for considering applications for registration.*
- *Customer satisfaction surveys*

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

Minimum requirements

i) The regulator makes its registers accessible to the public.
ii) The public and where applicable employers are easily able to find a specific registrant and identify if they are eligible to practise.
iii) Relevant fitness to practise history and sanctions are included within registration information.

Supporting evidence

- *The register*
- *Information on the content of register and how it can be accessed*

- *Customer satisfaction surveys*

2.3 The regulator takes appropriate action to prevent non-registrants practising under a protected title.

Minimum requirements

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

Supporting evidence

- *Information on the measures in place to publicise the importance of checking registration and to deal with those using a protected title fraudulently.*
- *Information on the usage of the register and the number of detected cases using a protected title fraudulently*

3 Third function: fitness to practise

Aim: all concerns about the fitness to practise of registrants are dealt with appropriately, and necessary action is taken to protect the public.

3.1 The regulator has a process through which patients, the public and others can raise concerns about registrants and understand how their concerns will be dealt with.

Minimum requirements

i) The regulator has a process to raise concerns[12] against registrants that is publicly available and easy to understand.
ii) The regulator ensures that there is someone available with whom a potential complainant can discuss a concern about a registrant.

Supporting evidence

- *Complaints leaflet.*
- *Website content.*
- *Feedback and outcomes from surveys involving people who have made complaints.*

3.2 The regulator keeps all relevant parties informed of progress on cases at all appropriate stages.

Minimum requirements

i) The registrant, complainant and, where appropriate employers, are informed of progress at the following stages at least:
    a) initial consideration;
    b) referral to a fitness to practise panel;
    c) final outcome.
ii) The regulator has a disclosure policy and complies with it and/or any legislative requirements on disclosure.
iii) The regulator publishes the outcomes of final fitness to practise hearings, apart from health cases.

Supporting evidence

- *Disclosure policy.*
- *Feedback and outcomes from surveys involving the members of the public, employers and others.*

[12] Some regulators use the word 'allegations' to refer to complaints against registrants.

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

Minimum requirements

i) Cases are listed and heard quickly by fitness to practise panels after referral.
ii) Serious cases are identified and prioritised and, where appropriate and possible, referred to a panel to consider whether it is necessary to impose an interim order.
iii) There are systems and guidance to identify serious cases and cases which have become delayed.
iv) The regulator has service standards or equivalent and monitors its performance against them.
v) The regulator has a case management system.

Supporting evidence

- *Audits and management reports.*
- *Feedback and outcomes from surveys involving people who have made complaints.*

3.4 There are quality processes for the appointment, assessment and training of fitness to practise panel members. Panel members also have clear guidance on how to assess cases.

Minimum requirements

i) The regulator has comprehensive Indicative Sanctions Guidance, which facilitates consistent and appropriate decisionmaking.
ii) Where appropriate the regulator has guidance on criteria for referral from initial stage committee to final committee.
iii) The regulator uses clear and appropriate competences when recruiting panel members.
iv) There is an assessment and appraisal process for fitness to practise panel members.
v) Members receive feedback in relation to cases they have considered.
vi) There is a training programme for panel members.

Supporting evidence

- *Committee handbooks.*
- *Appraisal scheme.*
- *Appointments process.*
- *Training schedules.*
- *Recruitment criteria.*

3.5 Decisions made at the initial stages of the fitness to practise process (pre-fitness to practise panel stage) are quality assured.

Minimum requirements

i) Staff and panels involved in taking decisions at the initial stages receive appropriate training and guidance.
ii) There are internal audits of decisions.

Supporting evidence

- *Number of judicial review or appeal cases upheld against the regulator.*
- *Internal audit reports.*

3.6 Fitness to practise panels make appropriate, well reasoned decisions on cases.

Minimum requirements

i) The regulator ensures that its panel members take account of learning from Court outcomes and feedback from CHRE.

Supporting evidence

- *Number of Section 29 and registrant appeals upheld.*
- *Feedback to panel members on learning points arising from Court outcomes and CHRE feedback.*

4 Fourth function: Education

Aim: students[13] are given appropriate training that equips them to meet the standards of competence and conduct set by the regulator, and registrants maintain appropriate standards within their scope of practice.

4.1 The regulator ensures that its standards for the education and training to be met by students are appropriate, comprehensive, prioritise patient safety and interests and reflect up-to-date professional practice.

Minimum Requirements

(i) Standards for education and training prioritise patient safety and patient interests and link in with the standards of competence and conduct for registrants.

(ii) The regulator has taken steps to ensure that standards are widely applicable and appropriate to the different stages of training and education. Standards outline students' future personal responsibility for their own practice as well as for inter-professional working.

(iii) Standards of education and training are focused on the abilities required for that profession.

(iv) The regulator regularly reviews its standards to ensure that they are up-to-date and reflect modern practice, revising standards or producing supplementary guidance as required.

(v) All standards development is carried out in consultation with stakeholders.

Supporting Evidence

- *Standards for the education and training of students (this can be in the same document as standards for the delivery of education)*
- *Documentation showing the development process of the standards*

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

Minimum Requirements

(i) Standards for the delivery of education and training prioritise patient safety and patient interests and link in with the standards of competence and conduct for registrants.

(ii) The regulator has taken steps to ensure that standards are applicable to all situations, including placements.

[13] The term 'students' includes all those in accredited education and training which aim to provide entry to a regulated profession.

(iii) Standards balance the requirements for safety of patients and consistency of educational outcomes with the encouragement of innovation.

(iv) The regulator constantly reviews its standards to ensure that they are up-to-date, revising standards or producing supplementary guidance as required.

(v) All standards development is carried out in consultation with stakeholders.

Supporting Evidence

- *Standards for the delivery of education (this can be in the same document as standards for the education and training of students) and additional guidance*
- *Documentation showing the development process of the standards, e.g. how relevant developments in higher education are taken into account*

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

Minimum Requirements

(i) The regulator assesses education and training providers, including arrangements for placements, at appropriate intervals which may vary between establishments proportionally to risk.

(ii) Educational providers that meet the required standards are approved, and appropriate and targeted steps are taken where a provider falls short of the standards.

(iii) Students' and patients' perspectives are taken into account as part of the evaluation.

(iv) Information on the assessment process and final results of assessments are accessible to all stakeholders.

Supporting Evidence

- *Training of educational assessors*
- *Quality Assurance process*
- *Assessment reports*

5 Fifth function: governance and external relations

Aim: the regulator is a transparent and accountable organisation with effective processes, focused on protecting the public working in partnership with all its key interest groups and continuously improving all areas of its work.

5.1 The regulator is a transparent and accountable organisation and significant policy decisions are demonstrably based on the public interest.

Minimum requirements

(i) The regulators' decisionmaking is based on the best available information and directed to protecting the public.
(ii) The regulator has a clearly defined aim and a strategy.
(iii) It has a Code of Conduct for Council members.
(iv) The Council includes expertise from a range of stakeholders and no one group dominates.
(v) Individuals are appointed against defined competencies[14].
(vi) Council and the executive have clear lines of accountability.
(vii) The decisions and the decisionmaking processes of the Council are open, transparent and accessible.

Supporting evidence

- *Mission statement*
- *Code of Conduct*
- *Council policies and decisions.*
- *Information on number of public Council meetings and publication of papers and decisions; attendance at public Council meetings*
- *List of competences against which members are appointed*
- *Appraisal policy for Council members*
- *Schemes of delegation, standing orders and financial instructions*

5.2 The regulator establishes and works within efficient and effective organisational processes.

Minimum requirements

(i) The regulator has an effective planning process which ensures that functions are resourced appropriately.
(ii) The regulator ensures that its planning documents take account of risk.
(iii) The regulator sets appropriate key performance indicators or equivalent and publishes information on its performance against them.

[14] Until all Council members are appointed, this is likely to apply to lay members only.

(iv) There are effective appraisal systems and processes.
(v) The regulator meets its statutory responsibilities in sharing information and in seeking and retaining confidential information.
(vi) The regulator is committed to promoting equality and diversity and ensures that all activities are free from any discrimination.

Supporting evidence

- *The published business plan*
- *Reports from internal and external auditors*
- *Published accounts*
- *HR policies, including appraisal policy*
- *Strategic plan*
- *Annual plan*
- *Risk register*
- *Rules or procedures for raising fees*
- *Equality and Diversity Policy and reports from the Equality and Diversity Committee*
- *Information on how responsibilities under the Freedom of Information and Data Protection Acts are met*

5.3 The regulator fosters a culture of continuous improvement within the organisation.

Minimum requirements

(i) The regulator has a culture of continuous improvement.
(ii) The regulator gathers evidence from its activities and external information and disseminates it throughout the organisation. This evidence informs policy development.
(iii) Evidence-based decisionmaking and innovation are promoted. Audit is carried out at appropriate intervals and focuses on areas of high risk.

Supporting evidence

- *Processes for complaints against the organisation and information on how complaints are taken into account.*
- *Systems for measuring quality and effectiveness and information about how these bring about improvement.*
- *Annual plan/assessment process*
- *Audit reports*

5.4 The regulator co-operates with stakeholders and other organisations.

Minimum requirements

(i) The regulator engages with stakeholders, in particular patients and the public, in all of its work.

(ii) The regulator cooperates with other organisations with a common interest, developing strategic alliances and coordinating goals and project planning.

(iii) The regulator engages in cross-regulatory work and projects, and takes account of recommendations from CHRE and others about cross-regulatory projects, best practice and its performance.

(iv) The regulator takes into account the differences between England, Scotland, Wales and Northern Ireland when devising its policies and processes and in engaging with stakeholders.

Supporting evidence

- *Strategy for involving stakeholders*
- *Council policies and decisions*
- *Consultation documents*

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