Fitness to Practise Committee– 26 May 2011

CHRE Fitness to practise audit report: Audit of health professional regulatory bodies' initial decisions

Executive summary and recommendations

Introduction

In March 2011, the Council for Healthcare Regulatory Excellence published its report on its second audit of the initial stages of the nine regulatory bodies fitness to practise processes. As with the previous report, the Executive has undertaken a review of that report and its recommendations to identify both whether there is any learning for the HPC from the CHRE's recommendations on the work of the other regulator and whether any action is required as a result of CHRE's recommendations about the HPC.

Attached as an appendix to this cover paper is report into that review

Decision

The Committee is requested to discuss the attached report; and recommend that the Council instruct the Executive to proceed with the recommendations outlined on page 15 of HPC's response

Background information

The first report and HPC's response can be found at:

http://www.hpc-uk.org/assets/documents/10002CEE20100325Council-enc07-FtPCHREreport.pdf

Resource implications

To be discussed in future papers

Financial implications

To be discussed in future papers

Appendices/Links

Appendix One: CHRE report: Fitness to practise audit report; Audit of the health professional regulatory bodies' initial decisions

Appendix Two: HPC response

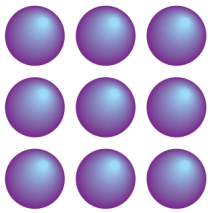
Date of paper

16 May 2011

Fitness to practise audit report

Audit of health professional regulatory bodies' initial decisions

March 2011



council for healthcare regulatory excellence

About CHRE

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

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

Our aims

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

Our values and principles

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

Our values are:

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

Our principles are:

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

Right-touch regulation

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

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

Contents

[2] Updated on 26/4/11 for factual clarification at paragraph 5.13

1. Executive summary

1.1 This is CHRE's second annual audit of the 'initial stages' of the fitness to practise process of the nine health professional regulatory bodies that we oversee. We conducted these audits between May 2010 and February 2011. We audited fitness to practise cases that the regulators had closed without referral to a final stage fitness to practise hearing.

1.2 The overall purpose of the audit is to ensure that the regulators' decisions protect the public and maintain public confidence in the professions and system of regulation. We looked for evidence of risks to public protection or public confidence as a result of each regulator's case-handling procedures and standards.

1.3 In our first audit[3] (carried out in 2009/10) we reviewed 100 cases that each regulator had closed in the financial year 2008/09.[4] These were similarly cases that had been closed without referral for a formal hearing by a fitness to practise panel.

1.4 We decided to make some changes to the process used for this year's audit to ensure that we targeted the areas of highest current risk. We decided that we would continue to review up to 100 cases per regulator, but that we would focus the audit on cases that had been closed by each regulator in the previous six months (rather than looking at cases that had been closed during the previous financial year). We also decided to target the audit at cases that we considered were more likely to involve higher-risk elements. The aim of these changes was to increase the likelihood that our audit would identify any issues of significant concern in the regulators' current practices.

Main findings

1.5 Other than the NMC and GDC, we found evidence at all the regulators of a continuation of good practice or of improvement of previous practice compared to last year's audit.

1.6 We were concerned about several weaknesses we found in the NMC's and GDC's processes of case management, investigation, decision making and communication. In the case of the NMC, our recent progress review identifies the actions that the NMC is already taking to address these weaknesses.[5] The GDC has also assured us that it is taking steps to resolve the problems that we identified during our audit.

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[3] CHRE, 2010. *Fitness to Practice Audit Report: audit of health professional regulatory bodies' initial decisions*. London: CHRE. Available at http://www.chre.org.uk/publications/#folder6

[4] Where an individual regulator had not closed as many as 100 such cases during the 12 month period, we reviewed all the cases they had closed during that period.

[5] CHRE, 2011. *NMC Progress Review - A review of the NMC's fitness to practise directorate's progress since 2008*. London: CHRE. Available at www.chre.org.uk/_img/pics/library/110124_NMC_Progress_Review_Report.pdf

1.7 We found that the other seven regulators have sound casework systems and that they generally achieve good standards in record keeping, decision making, explaining decisions and communicating with the public.

1.8 At the RPSGB, we reviewed cases closed in the initial stages during the last three months in which it was the pharmacy regulator. This function was passed to the new GPhC on 27 September 2010. We reviewed the cases that the GPhC closed without a final hearing during its first three months of operation. We looked in particular at cases the GPhC closed by applying its 'legacy criteria'. These were the criteria the GPhC used to close certain cases inherited from the RPSGB, outside its normal procedures.

1.9 We found several strengths in the way the RPSGB handled cases. However there was evidence of significant delay in some cases, and we recommend that the GPhC takes account of this finding when assessing future risks. We found that the GPhC's application of the legacy criteria in the cases that we audited had been reasonable, had adequately protected the public and would maintain confidence in the profession and system of regulation.

1.10 As a result of our audit we recommend that each regulator:

- Reviews its processes and practices in the light of the risks we have identified in its own and other regulators' processes
- Considers whether its key performance indicators that relate to the timescales between receipt of a complaint and closure of the case are sufficiently demanding
- Where this does not already exist, actively considers introducing a computerised casework management system that links into the regulator's computerised registration system. We consider that this is especially important for the larger regulators
- Ensures that investigation committees, and equivalent decision makers, have relevant previous fitness to practise history available to them, to help in risk assessment. Such information may assist the committee in any finely balanced decision about whether or not to require further investigation. Information about previous history may also be relevant when the investigation committee considers whether or not it should authorise an application for an interim order.

SECTION ONE
Overall assessment

2. Introduction

2.1 In the initial stages of their fitness to practise procedures, the nine health professional regulatory bodies decide whether cases should be closed or referred to a final fitness to practise panel hearing.

2.2 In February 2010 we published the report of our first annual audit of cases closed by the regulators at the initial stages without referral to a fitness to practise hearing. In that audit we looked at cases that had been closed in the financial year 2008/09.

2.3 We have now completed our second annual audit. We undertook the individual audits of each regulator between May 2010 and February 2011. This year, instead of auditing cases that had been closed during the whole of the previous financial year, we looked only at cases that had been closed in the six months before we started each audit.[6] This means that it is more likely that our audit findings reflect current practice at each regulator.

2.4 We are very grateful for the constructive and helpful approach taken by the regulators' staff during our audits.

2.5 All health professional regulatory bodies must perform four main 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
- Ensuring high standards of education for the health professionals that they regulate.

The importance of the regulators' work in fitness to practise

2.6 The effective operation of fitness to practise procedures is crucial in protecting the public, and the public is entitled to know whether the regulators are providing this protection. It is essential that fair, proportionate and timely action is taken when a registered professional's fitness to practise may be impaired. This is essential for the following reasons:

- To ensure that the public are protected from professionals who present a risk of harm to them
- To uphold professional standards and to maintain confidence in the regulated professions
- To maintain confidence in the systems of regulation

[6] In relation to the RPSGB and its successor body, the GPhC, we looked at cases closed over a three-month period. We reviewed initial closures made by the RPSGB in its last three months of operation, and by the GPhC in its first three months of operation.

- To ensure that professionals are treated fairly
- To ensure that professionals have confidence in their regulatory body.

2.7 We carried out this audit of decisions made by the regulators in the initial stages of their fitness to practise processes in order to establish whether or not the regulators' processes do protect the public, and to identify any areas in which individual regulators need to improve. Publishing this report of our findings is key to assuring the public that health professional regulation is operating effectively.

Why and how we carried out the audit

Statutory powers

2.8 Most fitness to practise complaints or enquiries do not reach a final stage fitness to practise panel hearing. This is because, during the investigation stage of the fitness to practise process, the regulators decide that the complaints do not meet the threshold for referral to a final stage fitness to practise panel hearing.

2.9 The Health and Social Care Act 2008 gave us new powers to audit the regulators' decisions not to refer individual cases for a hearing in front of a fitness to practise panel or committee. These powers came into operation in 2009.

Identifying risks and strengths in protecting the public

2.10 This audit focused on identifying risks and strengths in the way each regulator handles cases during the initial stages of the fitness to practise process, up until the point at which a case is closed. We sought to identify areas of risk which could lead to a regulator's processes and decisions failing to protect the public or that might undermine public confidence in the regulated profession and the system of regulation.

2.11 In February 2010 we hosted a forum for representatives of the fitness to practise functions of the regulators. At the forum we sought consensus on the key elements that should be found in any good casework system that is focused on protecting the public. A copy of the resulting 'Casework Framework' can be found at annex 1 of this report. We incorporated this framework into our auditing tools and used it to focus on performance at the following key stages of a case's lifetime:

- Receipt of information stage
- Risk assessment stage
- Gathering information and evidence stage
- Evaluation and decision stage.

2.12 We also assessed each regulator's performance in the following areas:

- Record keeping
- Customer care
- Ongoing risk assessment

- Guidance and assistance to caseworkers and decision makers
- Timeliness and monitoring of progress.

2.13 In last year's audit we identified some weaknesses in many of the regulators' processes and practices. As part of our 2010 performance review of the regulators we asked them to report on action they had taken in response to our audits. This year's audit has given us an opportunity to test whether the changes they made have been effective.

Selecting the sample

2.14 We reviewed cases that had been closed at the initial stages of each regulator's fitness to practise process during the six month period immediately before each audit started.

2.15 Where regulators had closed fewer than 100 cases at the initial stages during those six months, we audited all the cases that had been closed during that period. This meant that we reviewed every case closed during a six month period by each of the GCC, the GOC, the GOsC and the PSNI.

2.16 Where a regulator had closed more than 100 cases during that six month period we looked at a sample of 100 of its closed cases. Fifty cases from that sample of 100 were selected at random, so that they reflected the proportion of case closures at different stages of the initial fitness to practise process. Where possible, the remaining 50 cases were selected at random from those cases that we considered were more likely to involve elements of higher risk. We identified these higher-risk elements based on the findings from our first year's audit, as well as from other information available to us (including complaints we had received about individual regulators' fitness to practise processes).

2.17 The GDC's management information does not allow it to categorise cases by reference to all of the higher-risk elements we considered to be relevant. Therefore our audit sample at the GDC consisted of 75 cases that were selected at random across the various different closure points. The remaining 25 cases were selected on the basis of risk, using such information as the GDC was able to supply.

2.18 The GPhC took over from the RPSGB as the pharmacy regulator on 27 September 2010. We therefore carried out smaller-scale audits of the cases closed by each of the RPSGB and the GPhC. We audited 50 cases closed by each body during a three month period prior to our audit. This meant that we looked overall at a total of 100 cases dealt with by the pharmacy regulator.

Timetable of audits and numbers audited

2.19 The audits of the nine regulators took place between May 2010 and February 2010 according to the following timetable:

- General Medical Council (GMC) – May/June 2010 (100 cases audited, 2,733 cases eligible for audit)
- General Chiropractic Council (GCC) – June 2010 (47 cases audited, 47 cases eligible for audit)

- Nursing and Midwifery Council (NMC) – July 2010 (100 cases audited, 779 cases eligible for audit)
- General Optical Council (GOC) – August 2010 (75 cases audited, 75 cases eligible for audit)
- General Osteopathic Council (GOsC) – September 2010 (13 cases audited, 13 cases eligible for audit)
- General Dental Council (GDC) – September/October 2010 (100 cases audited, 709 cases eligible for audit)
- Pharmaceutical Society of Northern Ireland (PSNI) – November 2010 (17 cases audited, 17 cases eligible for audit)
- Royal Pharmaceutical Society of Great Britain (RPSGB) – November 2010 (50 cases audited, 215 cases eligible for audit)
- Health Professions Council (HPC) – December 2010 (100 cases audited, 433 cases eligible for audit)
- General Pharmaceutical Council (GPhC) – January/February 2011 (50 cases audited, 165 cases eligible for audit)

3. Our findings

Overview

3.1 We found that all but two of the regulators have sound casework systems, with evidence of competent record keeping, reasonable decision making and achievement of good standards in explaining decisions and communicating with the public. The details of all our findings are set out in the individual regulators' reports. In only a few individual case files did we find examples of slightly lower standards of record keeping, quality control, investigation or decision making. We did not consider that any of these cases had been closed inappropriately. However our findings in these cases did give rise to a concern that the regulators should take action to improve consistency of the standards they generally achieve in casework, in order to minimise any potential risk to public protection or to public confidence.

3.2 However, we were concerned about several weaknesses in case management, investigation, decision making and communication at the GDC and the NMC. We set out more details about our concerns below.

3.3 At the GOC we identified some historic weaknesses in the management of individual cases that in our view raised a risk to public confidence and protection. However, having reviewed more recent cases, we did not consider that these historic weaknesses reflect recent practice, or lead to any current risks.

3.4 We made a recommendation to the GOC that should be considered by all the regulators. This concerned the setting of more challenging key performance indicators for the initial stages of the fitness to practise process. We also recommended to the GOC that more information should be given to investigating committees about a registrant's previous fitness to practise history.

3.5 We reviewed initial closures made by the RPSGB in its last three months as the regulator for pharmacy (until 27 September 2010). We also reviewed the cases closed by the GPhC in the first three months of its operation. We looked in particular at cases closed by the GPhC using its 'legacy criteria' (see annex 2). These legacy criteria allow the GPhC to close certain cases it 'inherited' from the RPSGB when its regulatory functions were transferred. We found several strengths in the way the RPSGB had handled cases. However there was evidence of significant delay in some cases, and we recommend that the GPhC takes this finding into account when assessing future risks. We considered that the GPhC's application of the legacy criteria in the cases we reviewed had been reasonable, had adequately protected the public and would maintain confidence in the profession and system of regulation.

Strengths in case handling

3.6 In our first audit report we especially commended various regulators in the following areas of practice:

- Treating drink driving convictions as evidence that the registrant might have an underlying health problem which could impair their fitness to practise

- Quality assurance and procedures to drive forwards continuous improvement, such as the use of regular internal audits of casework to identify problem areas and check that processes are being followed consistently
- Adopting the practice of sharing registrants' responses with complainants, which provides an opportunity for correction of any errors, and can help complainants to understand the eventual decision about their case
- Using effective computerised casework management systems to monitor progress of casework
- Liaising with employers to improve the flow of information to assist in protecting the public.

3.7 The Casework Framework that we developed with the regulators in February 2010 is included at annex 1 to this report. The Casework Framework explains the key elements of an effective fitness to practise casework system. In the individual regulator reports (see section 2) we highlight examples of strengths in case handling that we found in the particular cases we audited. The following are examples of these strengths which we consider contribute to fulfilment of the Casework Framework's requirements:

- Good liaison with complainants, including chasing up consent forms and making clear what information a regulator needs from a complainant in order to progress an investigation
- Explaining to complainants other possible avenues of complaint when the regulator closes a case
- Access to clinical and professional advice for staff when considering complaints or conducting investigations
- Clear internal reports, with a useful case summary and investigator's structured findings and recommendations for case closure
- The use of closure forms that include a checklist to ensure that all the necessary actions have been carried out and that proper reasons are recorded and signed off by the appropriate person before the case is closed
- Sending questionnaires to registrants and complainants after closure of a case to ask about their experience of the process.

Particular concerns

3.8 In section 2 of this report we provide individual reports which give detailed assessments of each of the regulators. However in the section below we discuss our particular concerns about the NMC and GDC.

NMC

3.9 In our first audit report we set out the findings from our review of 100 cases that the NMC had closed between April 2008 and March 2009. We expressed concern about several weaknesses in the NMC's handling of fitness to practise casework. In summary, our concerns were as follows:

- Closure of some cases without sufficient information to assure the NMC that the registrant is not a risk to patients
- A lack of clear or comprehensive written guidance and procedures for staff and investigating committee members on how to deal with cases
- A lack of formal systems for gaining internal or external advice on appropriate nursing and midwifery practice
- Poorly defined delegations to staff of the power to close cases and inconsistent compliance with this delegated authority
- Lack of reasoning on cases and poor explanations given to complainants and others involved
- Lack of proper audit trails of who made decisions, and when and why they were made.

3.10 In this year's audit we reviewed 100 cases that the NMC had closed at the initial stages in the six months from January to June 2010. We were disappointed to find that the considerable weaknesses that we had identified during our first audit were still present in the NMC's handling of its casework. We found examples of the following:

- Inadequate information gathering, including sometimes relying on the registrant's uncorroborated account of events
- Poor or no analysis to explain some final decisions
- Poor record keeping and electronic case management, with some key documents missing from files, and inadequate controls on case closure
- Poor links between the computerised fitness to practise case management system and the NMC's registration system, creating a risk that registrants might be able to evade fitness to practise action
- Poor customer service, including inadequate communication with members of the public, and poor information sharing with employers
- Significant delays and poor case management.

3.11 We recognise that our audit of the NMC was carried out in July and August 2010 and that the NMC is currently undertaking a considerable programme of change in order to improve in all the areas of deficiency in its fitness to practise function that we have identified both in this year's audit and previously. Further information about the work that the NMC is undertaking is set out in our progress review, published in January 2011, which is available from our website.[7] We said in our progress review that we will continue to work with the NMC to help it to monitor the impact of the improvements it is making and plans to make.

[7] CHRE, 2011. *NMC progress review - A review of the NMC's fitness to practise directorate's progress since 2008*. London: CHRE. Available at www.chre.org.uk/_img/pics/library/110124_NMC_Progress_Review_Report.pdf

GDC

3.12 We found evidence that the GDC takes a helpful approach to complainants. However we were concerned about the standard of the GDC's fitness to practise casework in a number of areas. We found examples of the following:

- Cases where we considered that there had been inadequate risk assessment before the case was closed
- Investigating committee decisions that were insufficiently detailed, creating a risk that complainants would not understand why their complaint had not been referred for a final fitness to practise panel hearing
- Weak record keeping, with documents missing from some files, and unco-ordinated duplicated files for some matters
- A closure of a case by one caseworker without the authorisation or countersignature of a colleague. We were disappointed to find that this had occurred, because we raised our concerns about allowing one person to close a case in our first audit, and the GDC had said that it would take action to prevent this happening again
- Two examples of long delays.

3.13 We shared our audit findings with the GDC. It says that it has, or will be, introducing a number of changes to its fitness to practise processes that will address the concerns we have raised in this year's audit findings.

4. Recommendations and conclusions

Recommendations

4.1 We recommend that each regulator:

- Reviews its processes and practices in the light of the risks we have identified in its own and other regulators' processes
- Considers whether its key performance indicators relating to the timescales between receipt of a complaint and closure of the case are sufficiently demanding
- Where this does not already exist, actively considers introducing a computerised casework management system that links into the regulator's computerised registration system. We consider that this is especially important for the larger regulators
- Ensures that investigating committees, and equivalent decision makers, have relevant previous fitness to practise history available to them. Such information may assist committees in any finely balanced decision about whether or not to require further investigation. Information about previous history may also be relevant when an investigating committee considers whether or not it should authorise an application for an interim order.

Conclusions

4.2 This year's audit demonstrated that all the regulators, with the exception of the NMC and GDC, have achieved good standards of handling of fitness to practise casework. In some areas this represents a continuation of the good practice we identified last year, and in others it represents significant improvement.

4.3 We were pleased that several regulators took immediate action to improve their processes during the course of last year's audit process, and that others took account of our findings and improved their practices as a result.

4.4 The HPC presented a paper to its Council in March 2010 setting out potential changes to its fitness to practise processes, following a systematic review of our first audit report. We commend the HPC for using our findings about other regulators to help identify potential improvements it could make to its own processes. We would encourage other regulators to carry out a similar exercise, looking at good practice in this area across the different regulators, and using that information to identify any areas for potential improvement to their own processes.

4.5 We are concerned that our audit found significant weaknesses in case handling processes at the NMC (audited in July and August 2010) for a second year. The

NMC has already committed to providing quarterly progress updates on its actions to deal with the concerns identified in our recent progress review.[8]

4.6 We are also concerned that this year's audit identified new concerns about the GDC's handling of its casework, as well as one area of concern that we had previously raised with the GDC. The GDC, under its new chief executive, has assured us that it is taking steps to resolve the problems that we identified during our audit.

4.7 Both these regulators are already taking steps to address the problems that we identified during the audit this year, and in the next audit we will expect to see evidence that these problems have been resolved.

4.8 We will use our annual performance review process as an opportunity to review the progress both regulators have made in addressing our concerns since the date of publication of this report.

Future audits

4.9 We are pleased that regulators have taken action in response to our first audit in 2009/10. Our second audit has shown a pattern of continued good standards and improvement.

4.10 In keeping with our commitment to 'right touch' regulation, we will review how we can make our future audits more risk-based, targeted and proportionate.

[8] CHRE, 2011. *NMC progress review - A review of the NMC's fitness to practise directorate's progress since 2008*. London: CHRE. Available at www.chre.org.uk/_img/pics/library/110124_NMC_Progress_Review_Report.pdf

SECTION TWO
Individual reports

At the end of each individual audit, we wrote a report on our findings. We sent a draft of this report to the regulator and asked them to comment on the factual accuracy of our findings and the validity of our opinions. Where necessary we made amendments.

The following reports give our detailed findings on each regulator.

5. GCC[9] fitness to practise audit report

Introduction

5.1 In June 2010 CHRE audited the initial stages of the fitness to practise procedures of the General Chiropractic Council (GCC). We did this by auditing cases that the GCC had closed without referral to a final stage fitness to practise panel hearing during the six months ending 31 May 2010.

5.2 This meant we reviewed 47 cases. In the previous year's audit we reviewed all cases closed during the financial year 2008/09 (22 cases in total).

5.3 The nature of the cases closed in the six month period was significantly different to the cases reviewed in 2009. Despite covering a shorter period, the number of cases closed was much higher, and all of the cases came from just three complainants. Only one complaint concerned the quality of treatment that a patient had received. The other 46 cases were complaints about chiropractors' websites. One of the complainants made almost identical allegations about 40 individual chiropractors' websites and the direct or indirect claims they had made about the treatments they offered and their use of the title 'Dr'.

5.4 The third complainant made allegations against five chiropractors. Again the complaints were almost identical, and concerned direct or indirect claims that the chiropractors had made on websites about treatments they offered.

5.5 The legislation governing the GCC's fitness to practise procedures means that each complaint has to be considered individually by the investigating committee, which decides whether there is a 'case to answer' (in which event the case is referred to the professional conduct committee). If the investigating committee decides that there is no 'case to answer', the case is closed. We understand that the total number of cases received by the GCC as a result of these two bulk complaints was approximately 600. Many of these fell outside the scope of this audit. This is because they were closed outside our sampling period, or were referred to the professional conduct committee because the investigating committee decided that there was a case to answer. We know that the number of complaints has presented a great administrative challenge to the GCC, which it has managed effectively.

Assessment

5.6 The GCC's investigating committee agreed case handling principles to ensure consistency of its decision making in relation to the cases arising from the two bulk complaints. The GCC commissioned a review of the research on the effectiveness of manual therapies for a wide range of conditions. This review was provided to the investigating committee to assist it in maintaining a consistent approach in its consideration of the cases arising from the two bulk complaints. In deciding whether or not there was a case to answer, the investigating committee frequently referred to the review to ascertain whether or not there was sufficiently strong research to support advertised claims by the chiropractor.

[9] Updated on 26/4/11 for factual clarification at paragraph 5.13

5.7 We consider that the cases we reviewed show that the GCC's approach was proportionate, targeted and fair and that its investigating committee took a consistent approach to decision making. This confirms the positive conclusions we reached in last year's audit.

5.8 In all the cases we reviewed in this audit, the investigating committee made reasonable decisions and in our view gave clear logical reasons for its decisions.

5.9 We identified one concern about the clarity, from the complainant's perspective, of the committee's reasoning in a small number of cases. These were cases in which the investigating committee had identified that one or two claims made by particular websites were not appropriately supported by evidence, but the threshold for referral to the professional conduct committee was not met. The outcome of these cases was that the investigating committee decided to provide advice to the relevant registrants about the claims that were not supported by 'high or moderate positive' evidence.

5.10 Our concern was that the complainant might not understand why the case did not meet the threshold for referral to the professional conduct committee, in circumstances where one or two claims had been identified as not being adequately supported by evidence. The GCC's letter to the complainant explained the investigating committee's function and the evidence that was considered by the committee in relation to the complaint. It concluded by stating '…having taken all the information before it into consideration, the investigating committee has concluded that the facts of this complaint, taken at their highest, would not be capable of amounting to unacceptable professional conduct…'. In our view, expanding this statement might have assisted the complainant in understanding the committee's decision. The committee could have explained further why those particular website claims were not, in the committee's judgment, serious enough to amount to 'conduct which falls short of the standard required of a registered chiropractor'. For example this may have been because its concerns about the claims were too minor in nature or too few in number for the website to be regarded as misleading overall.

5.11 Some additional explanation might also reduce any risk of a complainant considering that their complaint had not been properly addressed. We regard this as important for public confidence in regulation.

5.12 The GCC's practice, as at several other regulators, is to send a copy of the complaint letter to each registrant who is under investigation. We identified one situation in which this practice appeared to have led to the complainant's email address being misused (not by the GCC).

5.13 We have seen evidence that the GCC reacted quickly and appropriately once the complainant notified them of this. [10] The GCC reported the matter to the Information Commissioner and commissioned a solicitor's investigation to try to identify whether any of the GCC's registrants had misused the complainant's personal data, and to ensure that no member of the GCC's staff had done so. The GCC also took immediate action to review its own processes, to remove any potential risk of complainants' contact details being disclosed. The GCC

[10] The rest of this paragraph was changed on 26/4/11 to reflect new information received after publication about the Information Commissioner's response to the complaint.

explained to the complainant what action it had taken. The complainant made a complaint to the Information Commissioner, who concluded that while it was unlikely that the GCC had complied with the DPA principles in relation to the 'preliminary notification' the GCC had sent to the registrants under investigation, the GCC had subsequently taken appropriate remedial action. We consider that the GCC took a proportionate and responsible approach to dealing with this situation.

5.14 We consider that, overall, the GCC dealt thoroughly and carefully with the cases we reviewed.

5.15 We would also like to commend the approach taken by the GCC's investigating committee in dealing with the cases arising from the two bulk complaints. Not only did the committee take steps to ensure that it dealt consistently with the cases, it also undertook a detailed investigation of each website that formed the subject of a complaint, in order to ensure that all potential concerns (not just those specifically highlighted by the complainant) were considered.

Conclusion and recommendations

5.16 The nature of the complaints made to the GCC during the period we reviewed in this audit was atypical, as the vast majority of cases originated from two bulk complaints which concerned website information rather than allegations about competence and conduct during the treatment of patients. However the GCC's professional approach, which was displayed in the cases we reviewed, supports the positive findings in our previous audit, and we conclude that the GCC has continued to protect the public and the reputation of the profession. This is particularly impressive in light of the significant increase in the volume of cases that the GCC has had to deal with during this period.

6. GDC fitness to practise audit report

Overall assessment

Introduction

6.1 In October 2010 CHRE audited the initial stages of the fitness to practise procedures of the General Dental Council (GDC). We audited a sample of cases that had been closed without being considered by a final stage fitness to practise panel.

6.2 Our overriding aim in conducting audits is to seek assurance that the health professional regulators are protecting patients and the public, and maintaining the reputation of the professions and the system of regulation. We assessed whether the GDC achieved these aims in the particular cases we reviewed. We considered whether weaknesses in handling any of these cases might also suggest that the public might not be protected, or confidence not maintained, in future cases.

Summary of findings

6.3 The cases we reviewed showed examples of the GDC taking a helpful approach to complainants. However, we found several weaknesses in its record keeping system, with documents missing from some files and uncoordinated duplicated files for some matters. Poor record keeping may make proper management of cases more difficult, which in turn creates risks for patient protection and public confidence. Outcomes of individual cases may also be more difficult to explain and defend if the files do not contain complete audit trails that document every decision in each case.

6.4 We also found examples of cases where we considered the GDC had not investigated thoroughly enough to ensure that it had made sound decisions.

6.5 We found that some investigating committee decisions lacked detailed explanation. We are concerned that this may mean that some complainants might not understand why their complaints had not been referred for further investigation or a hearing. This risks undermining public confidence in the regulator.

Method of auditing

6.6 We reviewed a sample of 100 cases closed at the initial stages. We drew our sample from the 709 cases that the GDC closed at the initial stages in the six month period ending 31 August 2010. We selected the first 50 cases at random, in proportion to the different closure points within the GDC's processes. Our original intention was to select the remaining 50 cases from a sub-set of those cases that we considered were likely to involve higher risk factors, as identified in last year's audit report. However the GDC's case management information was not detailed enough to allow us to identify all the cases within that sub-set. We

therefore selected a further 25 cases at random, and the final 25 cases from those which had been closed at points within the process that meant they were more likely, in our view, to involve the higher risk factors.

Detailed findings

Receipt of information stage and customer service

6.7 We found several examples of a helpful approach by GDC staff to complainants. For example:

- A case in which there was notable good communication with the complainant and active case management, with the GDC chasing up consent forms several times
- A case in which the GDC made several attempts to contact the complainant and gather the necessary information, despite a continued lack of response
- A case in which the closure letter stated that if the Dental Complaints Service (DCS) which deals with private fee disputes, was unable to resolve the matter, the complainant should write or call the caseworker for further advice. This helpful approach however does not appear to be followed uniformly by GDC staff, as we found two other cases concerning private fee disputes in which the GDC did not advise complainants to approach the DCS. We consider that a consistent approach should be taken.

6.8 Redirecting inquirers to other sources of help is a useful function that regulators can perform. However, it is also important that regulators ensure that staff do not suggest that a complainant should instead approach a different body if the complaint concerns a registrant's fitness to practise. In one case we found that the GDC had referred a complainant to the DCS because part of the complaint related to fees. However, part of the complaint concerned an allegation that the dentist had failed to carry out a full assessment before commencing treatment, and that the dentist had gone on to carry out unnecessary treatment on the patient. We consider that this complaint clearly raised issues relating to the registrant's fitness to practise, and that it therefore should have been progressed through the GDC's investigation processes. However the complaint was passed over to the DCS in its entirety. It appeared that the GDC neither informed the complainant that their complaint had been received, nor explained that it had decided to pass the matter to the DCS and the reasons for doing so. We also noted that the file did not contain a record showing who had taken the decision to pass the matter to the DCS. We regard this as demonstrating failings not only in the GDC's decision making and record keeping, but also in their customer service.

Risk assessment

6.9 We noted one case where the GDC had made a particularly prompt referral of a matter for consideration by an interim orders committee. We considered that this was an appropriate response, in view of the potentially serious adverse impact on patient safety raised by the allegation in question.

6.10 However, in two other cases we reviewed we were concerned about the process of risk assessment used by the GDC. In one case there was no evidence on the file that any risk assessment had been carried out. In another case GDC caseworkers had recommended consideration for an interim order. The case was potentially serious as it concerned allegations of poor infection control and storage of clinical waste. However, it appeared that this recommendation had not been followed up, and there was no record on the file to show why the case had not been referred to an interim orders committee.

Gathering information

6.11 We found six cases that we considered demonstrated weaknesses in the GDC's processes for assessing and investigating complaints and for gathering relevant information. These were as follows:

- A case in which the GDC did not ask a complainant to identify the registrant, and appeared to treat the complaint (which concerned alleged discrimination) as a customer service issue rather than as a potential breach of Standards for Dental Practitioners
- One case in which the GDC did not seek appropriate clarification from a complainant who had alleged that their dentist had provided them with inadequate treatment. The GDC instead treated the complaint as concerning difficulty in registering with a dental practice – which the GDC told the complainant was an issue that was better dealt with by the primary care trust (PCT)
- A case in which the GDC did not appear to have considered using its statutory powers to obtain information, following the complainant's withdrawal of co-operation. The case concerned a serious issue which might have impacted on public protection
- One case closed by the investigating committee because there was insufficient evidence available to prove the allegation. This was because the patient records were missing. Our examination of the file showed that the GDC had not obtained formal confirmation that the relevant patient records had definitely been destroyed. Instead it had relied upon a verbal statement given by a potentially interested party. We consider this to be poor practice
- In one case, concerning allegations of poor clinical work, the complainant had made reference to a second opinion he had received. This allegedly supported his complaint. The GDC did not enquire about this nor seek its own expert opinion, and instead closed the case without referral to the investigating committee. We think this was poor practice, as a potential conflict in evidence had not been explored. We consider that it created a risk of undermining confidence in the regulator
- In one case, the GDC referred an allegation of poor infection control to the PCT and requested that it refer any fitness to practise matters that emerged back to the GDC. However the GDC then closed their file without waiting for the PCT's response. This practice would create a risk that important information about a registrant's fitness to practise might not be chased up.

This appeared to be contrary to the GDC's usual practice, as we found other cases in which the GDC had kept files open until PCT responses had been received.

Evaluation and giving reasons for decisions

6.12 We found several cases in which the investigating committee had failed to explain why it was not referring a matter to the professional conduct committee (PCC). This creates a risk that complainants may think that the investigating committee has not properly assessed their complaints.

6.13 The referral test that the GDC's investigating committee applies is to 'assess whether there are grounds to say that an allegation, if proven at a practice committee, would amount to impairment of fitness to practise such that [a sanction would be imposed]'.[11] (We call this the 'referral test' in this report.) We consider that a complainant should be given enough information to understand why any complaint which is not referred to the PCC for a hearing has not met the referral test. We had concerns about the decisions communicated to complainants in the following cases:

- In one case the investigating committee considered that there was supporting evidence for four out of the five allegations made, but did not explain why, despite this, the case did not meet the referral test
- In two separate cases the investigating committee did not explain adequately to the complainants why the cases were not being referred to the PCC, despite the fact that they involved serious allegations. In one of these cases the committee had decided that the matter merited a warning letter. In the other case the committee described the allegations as 'serious' and commented that the registrant had not shown insight.

6.14 In one case the investigating committee had decided to issue a warning letter. Again the committee did not explain why the case did not meet the referral test. This was despite the case being potentially serious, as it concerned allegations of poor quality work and pain management and unhygienic practices. We were concerned that concluding this case with a warning letter may have been inappropriate and that the case should have passed the referral test. This is because of the seriousness of the allegations and the lack of evidence of any remediation by the registrant. We were also concerned about the lack of any mechanism by which the GDC could monitor the registrant's adherence to the advice given, and we considered that the recommendation for training in the warning letter was too non-specific, referring only to 'appropriate training' without providing further details about what would be appropriate.

6.15 In one case we considered that the GDC had not taken appropriate action to reduce risk to an acceptable level and to maintain confidence in the system of regulation. The case concerned an allegation that a registrant had failed on two occasions to comply with conditions that had previously been imposed (specifically a condition that the registrant must inform prospective employers of the conditions). The case was not sent for an early review of the conditions.

[11] GDC, 2009. *Guidance for the Investigating Committee November 2009*. London: GDC. [Guidance document withdrawn 21 July 2010]

Further, there was evidence that only one of the registrant's two current employers were aware of the conditions.

6.16 The investigating committee has the power to issue advice to any party on any issue arising during the course of an investigation. We noted one case where we considered that the investigating committee had made good use of this power. The committee asked the GDC to write to a PCT to advise that the PCT was the appropriate body to deal with contractual issues in the case, and suggesting that it should have commissioned an appropriate National Clinical Assessment Service (NCAS) assessment rather than awaiting the outcome of the GDC's consideration of the case.

6.17 In one case we consider that the investigating committee's written advice created a risk of loss of confidence in the process. The case concerned allegations that advertising on a registrant's website about the need for prescriptions for certain types of dental devices was misleading. We consider that the written advice that was issued by the committee to the registrant was itself misleading and incomplete.

6.18 In one case, we considered that a letter sent to the complainant contained a statement that might have discouraged the complainant from making complaints to the GDC. The letter told the complainant that the committee considered that the complainant should have addressed their concerns to the dentist at an earlier stage. The letter did not providing any explanation as to why this would have been helpful.

Quality control in decision making

6.19 In one case the file appeared to show that an individual caseworker had closed a case without the decision being validated by another authorised member of staff. Closure of cases by a single person creates risks in terms of probity and quality control. We raised the same issue in our audit of the GDC last year and reported that the GDC had, as a result, decided that all case closure decisions would be signed off by managers.

6.20 The case in question had been closed by the caseworker on the grounds that there was 'no complaint', following the complainant's withdrawal of the complaint. The complainant had withdrawn their complaint in the course of a phone call and had said it was because the matter was also being dealt with by the local PCT and the health services ombudsman. The GDC agreed with us that it would have been better practice to have waited for receipt of the PCT's and ombudsman's reports before closing the GDC file. This would have given the GDC an opportunity to assess any ongoing patient risk before making a decision about whether to close the case.

6.21 As a result of our review of this case, the GDC says it will make explicit in its procedure that, where a case is closed by staff, there must be a record on all files that the decision has been approved by a second authorised person.

Record keeping

6.22 We found several instances where the case files were incomplete. This meant that we could not always tell whether certain actions had been carried out.

Inadequate case records create a number of risks, including lack of clarity about whether all necessary evidence has been gathered and which investigative steps remain to be completed. Poor record keeping can also cause difficulties in establishing at a later date what was done and why certain decisions were made. This information may be needed at a fitness to practise panel hearing or for any future review of the case. We found the following examples:

- Three cases in which investigation correspondence was missing. In one case this was because of incomplete cross-referencing with a linked file
- One case where there was no record on file of the closure decision
- One case that had two files, one marked 'closed' and the other 'open'. We audited the 'closed' file. When we asked why the matter had been closed, the GDC said that this was an error and that there was another 'open' file
- One case with two files, both of which were marked as 'closed'. When we asked why the audited file had important documents missing, the GDC told us that another complete file existed
- One file in which documents were missing and where some important case information was recorded only on 'post it' notes. Using 'post it' notes as the only way to record key information on a file is not good practice.

Timeliness

6.23 In two cases we found examples of unexplained long delays in the investigation process:

- In one case there was a five month delay between receipt of the complaint and its initial assessment by the GDC. The case (mentioned above at paragraph 6.15) concerned an alleged breach of conditions that had been imposed on the registrant by the GDC's professional conduct committee. We consider the matter should have been treated as a priority, in order to uphold confidence in the regulation of the dental professions. It took two months for the GDC to acknowledge receipt of the complaint about the breach of conditions. Prompt contact with complainants is important in order to build trust and confidence in the regulatory system
- In another case there was a period of eight months before an enquiry was made of a PCT. The need to make the enquiry had been agreed by staff soon after the complaint had been received. There was no explanation for this delay on the file.

Conclusion and recommendations

6.24 We are aware that, in the year before our audit, the GDC fitness to practise team went through a period of structural and management changes. The GDC says that it has recently appointed a new senior casework manager in the fitness to practise department, with responsibility for the performance of caseworkers and for the quality assurance of their work. It says that there will be a new training programme for caseworkers starting soon, and that a new comprehensive casework guidance manual is planned for summer 2011. The GDC also says that

a project led by the chief executive to improve the casework management system is already well advanced.

6.25 In the light of the findings from our audit, we recommend that the GDC reviews the areas of concern that we have identified in this report, and considers ways in which these can be addressed.

6.26 In summary we refer in this report to the following areas of concern:

- Concerns about the standard of the GDC's casework files and the risks this may create for effective case management
- Concern that there was some delay in progressing a small number of the cases that we audited
- We found that several letters sent to complainants to report the decisions of the investigating committee contained insufficient details to ensure that complainants could understand why their complaints were not being referred for a hearing
- We consider that there was inadequate investigation and information gathering in some cases that we reviewed
- We also have a continued concern in relation to a case where there was no evidence that a decision to close the case had been endorsed by a second authorised member of staff. We are disappointed that the GDC still displays weaknesses in this area despite the assurance given to us when we raised the issue in last year's audit.

6.27 In addition we recommend that the GDC:

- Continues to pursue the implementation of a comprehensive and robust casework management system, ensures that staff are trained in proper file management, and ensure that there is monitoring and quality assurance of staff's adherence to the casework management procedures
- Takes action to improve the quality of the explanations provided to complainants about investigating committee decisions
- Ensures that all cases closed by staff are authorised by a second person, and that a clear record of this is kept on file.

7. GMC fitness to practise audit report

Overall assessment

Introduction

7.1 In May and June 2010 CHRE audited the initial stages of the fitness to practise procedures of the General Medical Council (GMC). We audited a sample of cases that had been closed without being considered by a final stage fitness to practise panel.

7.2 Our overriding aim in conducting audits is to seek assurance that the health professional regulators are protecting patients and the public, and maintaining the reputation of the professions and the system of regulation. We assessed whether the GMC achieved these aims in the particular cases we reviewed. We considered whether weaknesses in handling any of these cases might also suggest that the public might not be protected, or confidence not maintained, in future cases.

Summary of findings

7.3 The 100 cases we reviewed showed that the GMC has a robust initial-stages casework system leading to good decisions that were properly recorded and communicated. In a very small number of cases we found slightly weaker handling of some aspects of cases, and two decisions that created slightly higher than normal risks to public confidence.

Method of auditing

7.4 We reviewed a sample of 100 cases closed at the initial stages. We drew our sample from the 2,733 cases that the GMC closed at the initial stages in the six month period ending 30 April 2010. We selected 50 cases randomly in proportion to the different closure points within the GMC's processes. We selected the other 50 cases at random from those categories of case that we considered were more likely to have elements of higher risk. We identified these risk areas from the findings of our previous year's audit and other information available to us.

Detailed findings

7.5 We found that the GMC has robust systems and processes in place in all essential areas of initial-stage casework. The computerised casework management system is a secure system for comprehensive storage of information, including all correspondence and documentary evidence. The system includes a full audit trail of actions and decisions made on a case. The system links together all relevant information about all those involved in each case, and allows the GMC to make risk assessments based on the full information available to it.

7.6 Most of the health professional regulators rely on investigating committees to make the majority of the decisions about whether individual cases should be referred for a formal hearing by a fitness to practise panel. At the GMC, the

majority of such decisions are taken by its 'case examiners'. Two case examiners (one medically qualified, and one lay person) consider the reports and recommendations made by staff about whether each case should be closed or referred for a formal hearing. If both case examiners do not agree on the outcome for a particular case, it is referred to the GMC's investigating committee.

7.7 Our audit showed that this system results in consistent high-quality decisions, which the GMC communicates to parties in a professional way. The GMC's employment of medically qualified case examiners means that there is a ready source of clinical advice available to investigative staff when carrying out initial investigations. We also saw regular examples of the GMC commissioning clinical expert advice as part of its initial investigation when a matter fell outside a case examiner's area of expertise. This ensures that the decision makers have sufficient information available to them.

7.8 We also commend the GMC for its active approach to quality control, which is exemplified in its internal audit and review process. This process continually checks samples of cases for compliance with the GMC's policies and procedures.

7.9 We found several examples of strengths in case handling, including:

- Detailed notes of telephone conversations with witnesses and others being kept in case files
- One case file which contained a note of a meeting of investigative staff, held to decide how to deal with additional submissions from a complainant in a particularly complex case
- Examples of prompt referral to an interim orders panel where registrants presented a particular risk to the public or themselves.

7.10 We found a few instances where we considered the GMC had handled an aspect of a case slightly less well than usual, and this might have led to minor risks:

- In one case we considered that the GMC could have provided a fuller explanation in the letter sent to the complainant. The complainant believed that the prescription of a drug had caused a series of serious physical side effects. The GMC's letter simply said that the allegations were not sufficiently serious for the GMC to investigate, but did not explain why. We consider that the complainant would not necessarily have known or understood the criteria that the GMC applies when considering whether or not to investigate an allegation. We consider that a complainant should be given sufficient information so that they can understand why their complaint has not been taken further
- In this case the GMC had categorised the complaint as 'Stream 2', and had sent the complainant a factsheet, *Stream 2: guidance for complainants*. This factsheet explained that Stream 2 cases are ones which the GMC does not consider raise 'potentially serious' issues. The factsheet explained that because the concerns raised, on their own, were 'unlikely to require us to take formal action against the doctor's registration' and that the matter would instead be referred to the doctor's employer to decide whether to investigate and to ask for additional relevant information. We acknowledge that the GMC

deals with a large volume of complaints which means that it would not be a proportionate use of the GMC's resources to customise standard letters for each complaint. However, we consider that the GMC's relationship with complainants would be enhanced if it were able to provide a more case-specific explanation to a complainant if the complainant clearly believes that serious errors or misconduct have occurred. The GMC told us that they will review the factsheet and assess whether it is possible to include additional information for complainants

- We found one case in which a case examiner (relying on a summary prepared by a GMC investigating officer) had misinterpreted one of the secondary allegations made against a doctor. However this did not affect the quality of the decision on the overall case.

7.11 Good record keeping is important to ensure that there is sufficient information for decision makers to rely on in reaching their decisions, as well as to ensure that those decisions can be shown to be reasonable if challenged. We found consistent high quality record keeping in almost all of the cases we reviewed, with only one exception:

- In one case we found that an internal memo recording a decision about the GMC's application of its 'five year rule'[12] was not on file. The memo should have recorded the reasons for the GMC assistant registrar's decision about the application of the rule in the circumstances of the case. The missing memo was needed subsequently when a complainant made a 'rule 12' application asking for the assistant registrar's decision to be reviewed. This lapse in record keeping did not affect the decisions made about the case.

7.12 We found two cases in which there had been a long delay in the GMC acknowledging letters of complaint:

- In the first case the GMC did not write to the complainant until ten weeks after it had received the letter of complaint. The GMC told us that it did not at that time routinely send acknowledgments to complainants as in most circumstances contact with the complainant would be made soon after receipt in any event. The GMC told us that it had taken longer than usual to contact the complainant in this case because, unusually, it was not necessary to contact the complainant straight away to obtain further information about the complaint, because all the information was already available. Unfortunately therefore the complainant was not contacted until several weeks after receipt of the complaint. In response to our audit finding the GMC has amended its process to avoid a recurrence of this situation
- In the second case, the complainant wrote to ask for a review of a GMC decision not to refer an allegation for a hearing. The GMC took seven months to reply to that request. The GMC explained to us that the complainant's request was received during a period in which the GMC was seeking an amendment of the relevant rule, and at the date of receipt of the request, the GMC had no statutory authority to deal with it due to the 'gap' in the rules that were in operation at the time. This circumstance will not recur as the rules

[12] The 'five year rule' means that generally a matter that occurred more than five years earlier is not investigated by the GMC.

have now been amended. The GMC had apologised to the complainant and we saw that it subsequently dealt with the matter promptly.

7.13 We are pleased that the GMC has taken action in response to our audit findings on those two cases as we consider that a failure to ensure prompt communication with complainants following receipt of their complaints could create a risk of undermining public confidence in the system of regulation. Complainants (who often will have complained about a matter that has caused them anxiety) will want to know that their communication has arrived safely and has not been ignored.

7.14 We found one case in which we considered that the GMC's decision created a small risk to public confidence:

- The GMC has a system of 'consensual disposal'. This means that a matter can be concluded at the case examiner stage with the registrant doctor giving formal undertakings about future practice. Often the doctor will undertake to restrict their practice or in certain circumstances, practise only under supervision. The GMC's guidance says that if a case is to be concluded by the use of undertakings, the doctor must demonstrate personal insight into their previous failings, which means that they must accept that those failings happened. Without such insight the GMC cannot be satisfied that there is minimal risk of the doctor repeating the behaviour or errors
- In one case the doctor (through their representative) refused to admit that he had made any errors. If the case had been referred for a formal hearing by a fitness to practise panel, the panel would have heard the evidence in an open forum and decided whether or not the errors occurred, and if so whether or not the doctor's fitness to practise was impaired and whether their practice needed to be restricted. We consider that if the GMC's guidance on the use of undertakings is not followed in individual cases, there is a risk that this could undermine public confidence in the GMC's role as a regulator
- In May 2010 the GMC revised its policy on undertakings to give clearer guidance to decision makers when considering 'insight'. We understand from the GMC that this was as a direct result of its own review of this case, which took place prior to our audit.

Conclusion and recommendations

7.15 Our audit found a well managed system of casework with no evidence of significant risks to patients or to the maintenance of public confidence in the system of regulation and the profession. We are pleased that the GMC has, through revision of its policies and procedures, addressed the few issues of slight concern that we found in our audit.

8. GOC fitness to practise audit report

Overall assessment

Introduction

8.1 In August 2010 CHRE audited the initial stages of the fitness to practise procedures of the General Optical Council (GOC).[13] We audited all 75 cases that the GOC had closed between 1 February 2010 and 31 July 2010 in the initial stages of its fitness to practise processes. These cases were closed without being referred to a final stage fitness to practise panel hearing.

8.2 Our overriding aim in conducting audits is to seek assurance that the health professional regulators are protecting patients and the public, and maintaining the reputation of the professions and the system of regulation. We assessed whether the GOC achieved these aims in the cases we reviewed. We considered whether weaknesses in handling any of these cases might also suggest that the public might not be protected, or confidence not maintained, in future cases.

Summary of findings

8.3 The 75 cases we reviewed in our audit showed that the GOC has a good initial-stages risk assessment and investigation system leading to safe decisions. These decisions were communicated to interested parties in a thorough, helpful and articulate way. In three cases we found evidence of weaknesses in case management, or in co-ordination between GOC departments. We considered that these created a risk of loss of public confidence in the profession and system of regulation. We note that the GOC has, since these incidents, put in place monitoring measures to ensure that cases are efficiently investigated and proactively progressed through the investigation process. We also note that the GOC is considering an electronic case management system as part of an overall programme of IT modernisation.

8.4 We make three recommendations: on the application of key performance indicators; on ensuring progress on the implementation of a case management system; and on information that is given to investigation committees about a registrant's previous fitness to practise history.

Detailed findings

8.5 We found that the GOC has strong systems and processes in place in many areas of initial-stage casework.

8.6 The GOC, like many of the regulators, has an investigation committee which makes the final decisions about whether individual cases should be referred for a

13 In August 2010, Rosalyn Hayles became director of scrutiny and quality at CHRE. In recent years she has worked in the fitness to practise departments of the GOC and RPSGB. For this reason she took no part in the audits of the GOC, RPSGB and GPhC, and did not help in the production of the relevant audit reports. The chief executive of CHRE had personal oversight of these reports.

formal hearing by a fitness to practise panel. The GOC's legislative framework does not provide delegated authority for officers of the GOC to make decisions on allegations relating to a registrant's fitness to practise, and therefore all allegations must be heard by the investigation committee. The committee is compromised of optometrists, dispensing opticians, an ophthalmogist and members of the public.

8.7 As well as relying on the expertise of investigation committee members, there were also examples where the GOC obtained expert reports in cases when a matter fell outside of the investigation committee's expertise. This assures us that the investigation committee has access to relevant information on which to base its decisions.

8.8 We were pleased to note that the GOC had addressed an area of risk identified in last year's audit report. This was regarding the GOC not fully recording and relaying, to the complainant and registrant, the investigation committee's reasons for its decisions. Our audit this year showed that the GOC's system results in high-quality decisions which are now consistently well reasoned, and which the GOC communicates to parties in a helpful, coherent way.

Case handling strengths

8.9 We found several examples of strengths in case handling, including the following:

- Excellent written communication, including articulate, detailed and explanatory responses and full reasons for the GOC's actions
- Evidence of comprehensive telephone notes being taken
- Consideration of people with disabilities, especially poor eyesight, in communications
- In one case the GOC, after an investigation, reasonably took no action against a registrant. However, it still examined possible shortcomings in the procedures and policies of the registrant's corporate employer
- Effective proformas for assessing the requirement for interim orders and for regular monitoring of case progression, resulting in action where necessary
- In one case the GOC noted, during an investigation of a registrant, that the registrant's employer itself was a non-registered business. The GOC therefore opened a new case looking into unlawful use of a protected title by the registrant's employer. The new case was opened under the GOC's protocol for the investigation and prosecution of criminal offences.

Internal communication and case management

8.10 In three cases, we found evidence of weaknesses in case management, or in co-ordination between GOC departments. This created risks of undermining public protection and confidence.

8.11 One case concerned allegations of serious misconduct by a registrant. The GOC had imposed an interim suspension order on the practitioner's registration and the investigation committee had referred the matter to the fitness to practise panel for a formal hearing. However, during the investigation, the registrations

department twice removed the registrant from the register for administrative reasons, and twice allowed him to re-register. This was done without the knowledge of the fitness to practise department. During the periods of non-registration the GOC had no power to investigate. After the second restoration the GOC resumed its investigation. The resultant delay appears to have contributed to the GOC's difficulty in gathering evidence from witnesses and other third parties.

8.12 The GOC has told us that the staff members who dealt with the notification when it was originally received in November 2006 have now left. The GOC says, therefore, that it is unable to comment further on the way in which this particular notification was dealt with. The GOC reports that it has formalised its process in this area to ensure that every notification and declaration of a criminal case is dealt with appropriately.

8.13 We consider that these errors could have had consequences for public protection, especially given the serious allegations in this case. There should be systems in place to allow for a registrant's fitness to practise history to be accessed by all staff, in addition to alerts being in place to prevent inappropriate registration action.

8.14 The GOC conceded that there had been errors in the handling of this case in 2007 and 2008. The GOC commented that it has learnt from this case and improved its processes to prevent any such errors from recurring, by placing an alert on a registrant's record on the GOC's registrations database at the outset of any investigation. The GOC also told us that a registrant is not permitted to voluntarily remove themselves from a register, nor will a registrant be administratively removed from a register, once a fitness to practise investigation has been opened against them.

8.15 This is in line with the process that many of the regulators adopt to mitigate against this risk. We were pleased to note the GOC has addressed this risk.

8.16 In another case, the GOC was notified by the police that a registrant had been cautioned for two offences of common assault. An entry was made on the GOC's system but no action was taken in relation to it. The notification was only picked up by the registrations department almost two years later, when the registrant sent in her application for retention. The case was then passed to the fitness to practise team to investigate the caution and the registrant's failure to disclose this to the GOC.

8.17 In a third case, a complainant informed the GOC that a registrant had received a police caution a number of years previously. The complainant, a primary care trust (PCT), asked what action the GOC had taken in respect of this. The GOC had had no notification of the caution before this. The GOC's registrations department sent the complainant a 'letter of good standing' regarding the registrant, on the basis that there was no adverse fitness to practise history. This was done without any liaison with the fitness to practise department. The matter was then passed to the fitness to practise department and they subsequently opened a case and wrote to the complainant for further information.

8.18 We considered that this may have caused confusion to the complainant who, on receipt of the letter of good standing, may initially have thought that the GOC had

reached the view that no action needed to be taken on the previously undisclosed caution. We accept, however, that there was a period of only two weeks between the GOC sending the letter of good standing and the letter requesting further information about the reprimand.

8.19 The above cases illustrate why it is essential to have robust systems for recording and monitoring progress, and good communication between all relevant parts of a regulator. We note that the GOC has, since these incidents, put in place monitoring measures to ensure that cases are efficiently investigated and proactively progressed through the investigation process. We also note that the GOC is considering an electronic case management system as part of an overall programme of IT modernisation. We would support this move in order to further reduce the risk of incidents such as those identified above.

Information provided to the investigation committee

8.20 We found two cases where information provided to the investigation committee fell slightly below the expected standard.

8.21 In one case, the patient's name was not requested on receipt of a complaint from a PCT and therefore no steps were taken to obtain the patient's medical records in advance of the investigation committee meeting. The investigation committee then had to request the records and this led to a delay in the case concluding.

8.22 In another case we found that neither the legal advice given to the investigation committee, nor the committee's decision itself, appeared to make any reference to the registrant's previous fitness to practise history or whether this was relevant to the new allegation. In response to our comment during the audit, the GOC said that it thought it was not appropriate for the investigation committee to be advised of previous fitness to practise history. It considered that the role of the investigation committee is to consider the current allegation only. However, we think that relevant history should be brought to the investigation committee's attention. This may in some circumstances include similar complaints that were not taken forward. In a finely-balanced decision about whether to require further investigation, such information may assist the committee.

8.23 This information is also relevant when the investigation committee considers whether it should authorise an application for an interim order. Evidence of previous fitness to practise history would help the committee in its risk assessment.

8.24 In the case that we reviewed, our view was that the registrant's previous fitness to practise history may have been relevant to the new allegation. The investigation committee might have come to a different conclusion had it believed the registrant's past behaviour was ongoing.

Decision letters

8.25 In one case, the investigation committee minutes included a statement which was not relayed in the closure letter to the patient, but was included in the closure letter to the registrant. The GOC commented to us that it would be their usual practice for the full investigation committee minute to be included in both the

decision letter to the complainant and the registrant, and this was evidenced through our review of the remaining cases.

Timescales

8.26 We found five cases where there had been a slight delay in the GOC concluding a case following its receipt. In October 2009 the GOC adopted a key performance indicator (KPI) for cases to reach the first investigation committee meeting within nine months of the date the investigation is opened. All of these cases, including the two opened before the adoption of the new KPI, met this KPI. However, many of the cases were delayed by the fact that if the investigation committee is minded to issue a warning to the registrant, a statutory process must then be followed. This involves notifying the registrant of the investigation committee's decision and inviting written representations within a period of 28 days. Where this happens, it can sometimes then take a further two to three months for the case to reach the final investigation committee. The GOC should therefore consider whether its KPIs are sufficiently demanding and reflect the actual timescale for the conclusion of many of these cases.

8.27 Another case took two years and four months to reach a conclusion and we considered that this was an unreasonable length of time for a case which was not complex. The GOC explained this was partly due to delays caused by the registrant and also by difficulties commissioning expert evidence. The length of time taken to consider this case did not pose a risk to the public, as the GOC had carried out the appropriate risk assessments. Nevertheless, we considered that if cases are not being dealt with as quickly and efficiently as possible there is a risk that this might undermine public confidence in the system of regulation.

8.28 In some cases there was a gap of several months between receipt and consideration by the investigation committee. In part this was because of lack of capacity within the investigation committee. There was a period, between November 2008 and February 2009 when the investigation committee did not meet while a new committee was recruited. The GOC has increased the number of investigation committee meetings: there were six meetings in 2008, eight in 2009 and ten meetings in 2010.

Conclusion and recommendations

8.29 Our audit found that the GOC made well reasoned decisions which were communicated to parties appropriately. Overall our audit found a well managed current system of casework. In nearly all cases the GOC dealt well with risk to patients and the maintenance of public confidence.

8.30 We recommend that the GOC:

- Considers whether its KPIs for the timescales for cases reaching an investigation committee meeting are sufficiently demanding
- Ensures continuing progress is made on the introduction of a case management system, with links to the registration system, to enhance case management and internal communication

- Reviews its policy of not bringing relevant previous fitness to practise history to the attention of the investigation committee.

9. GOsC fitness to practise audit report

Overall assessment

Introduction

9.1 In September 2010 CHRE audited the initial stages of the fitness to practise procedures of the General Osteopathic Council (GOsC). We audited all the cases that had been closed without being considered by a final stage fitness to practise panel in the six months from March until August 2010.

9.2 Our overriding aim in conducting audits is to seek assurance that the health professional regulators are protecting patients and the public, and maintaining the reputation of the professions and the system of regulation. We assessed whether the GOsC achieved these aims in the particular cases we reviewed. We considered whether weaknesses in handling any of these cases might also suggest that the public might not be protected, or confidence not maintained, in future cases.

Summary of findings

9.3 The cases we reviewed in our audit showed that the GOsC has a robust initial-stages casework system leading to good decisions that are properly recorded and communicated.

Detailed findings

9.4 At the GOsC, all decisions about whether or not individual cases should be referred for a formal hearing by a fitness to practise panel are taken by an investigating committee.

9.5 We found that the GOsC employs robust systems and processes in all essential areas of initial-stage casework. Case files were well maintained and comprehensive. All the necessary information appeared to be accessible in one place. File notes were clear and comprehensive and provided an accurate chronology of cases as they progressed through the initial stages of the fitness to practise process.

9.6 We found several examples of strengths in case handling that we believe reinforce public protection and maintain confidence in the regulator, including:

- An example of prompt referral to an interim orders panel, when further evidence submitted by the complainant suggested that the registrant might present a particular risk to the public
- A case where the investigating committee continued its consideration of whether there was a case to answer, even though the complainant had accepted the registrant's explanation and withdrawn his complaint. The GOsC advised us that in similar circumstances in the past the investigating committee had found that there was a case to answer. This was because the

issues uncovered went beyond the complainant's concerns or evidence. We believe that this approach offers an added level of public protection

- Detailed notes of telephone conversations with witnesses and others being kept in case files
- The provision of detailed explanations setting out the reasoning behind the investigating committee's decisions in communications sent to the registrants and complainants. We are pleased to note that the GOsC has made improvements in this area in line with the recommendations made last year in our initial stages audit report.[14] We consider that it is important for public confidence in the system of regulation that complainants and registrants understand why a complaint has not been taken further
- Formal complainants' questionnaires and registrants' complaints questionnaires were sent to registrants and complainants. We acknowledge that the number of complaints received by the GOsC each year is low and that it will take some time for enough feedback to be gathered to allow a meaningful analysis. However, from the feedback so far the GOsC has identified that registrants' understanding of the fitness to practise process is not as clear as it could be. The GOsC is therefore reviewing its communication with registrants and taking steps to improve the information it provides
- The reintroduction, as of 1 March 2010, of a policy to share registrants' responses with complainants, subject to appropriate safeguards and written guidelines. In our previous audit report in February 2010,[15] we identified the GOsC's policy to provide complainants with registrant responses prior to the investigating committee hearing as an example of good practice. We understand that this was temporarily halted on legal advice, but welcome the reintroduction of this practice after further consideration.

9.7 We acknowledge that all cases were handled to an acceptable standard and in line with GOsC processes applicable at the time. Almost all cases had been decided by the investigating committee within four months of initial receipt of the complaint.

Conclusion

9.8 We consider that the decisions to close the cases we reviewed were reasonable and the reasons given were clear and comprehensive. Our audit showed that the GOsC's systems consistently help to deliver high-quality decisions, which are communicated to parties in a professional way. Overall, our audit found a well-managed system of casework with no evidence of significant risks to patients or to the maintenance of public confidence.

[14] CHRE, 2010. *Fitness to Practise Audit Report: Audit of health professional regulatory bodies' initial decisions*, p 49, 10.9. London: CHRE.

[15] CHRE, 2010. *Fitness to Practise Audit Report: Audit of health professional regulatory bodies' initial decisions*, p48, 10.6 London: CHRE.

10. GPhC fitness to practise audit report

Overall assessment

Introduction

10.1 In January 2011 CHRE audited the initial stages of the fitness to practise procedures of the General Pharmaceutical Council (GPhC). We did this by auditing cases that the GPhC had closed without referral to a final stage fitness to practise panel hearing between 27 September 2010 and 21 January 2011.[16]

10.2 Our overriding aim in conducting audits is to seek assurance that the health professional regulators are protecting patients and the public, and maintaining the reputation of the professions and the system of regulation. We assessed whether the GPhC achieved these aims in the particular cases we reviewed.

10.3 On 27 September 2010 the GPhC took over responsibility for the regulation of pharmacists and pharmacy premises in Great Britain from the Royal Pharmaceutical Society of Great Britain (RPSGB). At that date, all open fitness to practise cases were transferred from the RPSGB to the GPhC. Under its new legislation, the GPhC registrar was empowered to assess such inherited cases under its 'legacy criteria' (see annex 2) and close cases under that criteria. Some of these cases had been progressed beyond the investigating committee stage by the RPSGB, including some that were nearly at the point of being heard by a fitness to practise panel. Cases that were not closed by the GPhC registrar under the legacy criteria were instead processed under the GPhC's new standard procedures.

10.4 Nearly all of the 50 cases that we audited had been inherited from the RPSGB. Only six were received after 27 September 2010, and these were all closed because they were out of the GPhC's jurisdiction.

10.5 In our audit we assessed whether closures under the legacy criteria:

- Complied with those criteria
- Adequately protected patients and would maintain public confidence in the profession and system of regulation.

10.6 We assessed whether the other cases, closed other than by application of the legacy criteria, were closed in compliance with GPhC's procedures. Similarly we checked whether the closures protected patients and maintained public confidence.

[16] In August 2010, Rosalyn Hayles became director of scrutiny and quality at CHRE. In recent years she has worked in the fitness to practise departments of the GOC and RPSGB. For this reason she took no part in the audits of the GOC, RPSGB and GPhC, and did not help in the production of the relevant audit reports. The chief executive of CHRE had personal oversight of these reports.

Method of auditing

10.7 We reviewed a sample of 50 cases. We drew our sample from the 165 cases that the GPhC closed, other than by determination of a final fitness to practise panel, in the period 27 September 2010 to 21 January 2011.

10.8 Of these, the GPhC closed 27 cases under the legacy criteria. We audited all of these closures as we considered these raised the highest theoretical risk of inappropriate closure.

10.9 We selected the remaining 23 cases at random, in proportion to the different closure points, adjusting the final figures to ensure where possible there were at least five cases within each category.

Findings

10.10 We considered that all the cases that we assessed in our audit were closed appropriately under the legacy criteria or other GPhC procedures. None of the decisions were unreasonable in terms of public protection and confidence.

Recommendations

10.11 The legacy criteria cases we reviewed had been closed promptly, once subject to the GPhC legacy criteria processes. However, several of the cases closed under the legacy criteria showed evidence of considerable delay after referral by the RPSGB investigating committee. This delay had happened in the years before the cases were transferred from the RPSGB to the GPhC. The GPhC has told us that it would have dealt with these cases more quickly under its new rules and procedures. We recommend that the GPhC take note of the risks revealed in these delayed cases.

11. HPC fitness to practise audit report

Overall assessment

Introduction

11.1 In December 2010 CHRE audited the initial stages of the fitness to practise procedures of the Health Professions Council (HPC). We audited a sample of cases that had been closed without being considered by a final stage fitness to practise panel.

11.2 Our overriding aim in conducting audits is to seek assurance that the health professional regulators are protecting patients and the public, and maintaining the reputation of the professions and the system of regulation. We assessed whether the HPC achieved these aims in the particular cases we reviewed. We considered whether weaknesses in handling any of these cases might also suggest that the public might not be protected, or confidence not maintained, in future cases.

Summary of findings

11.3 The 100 cases we reviewed in our audit showed that the HPC has a robust initial-stages casework system leading to good decisions that were properly recorded and communicated.

11.4 In one case we thought that the HPC should have carried out a more detailed investigation in order to reduce the risk to patients and public confidence. We also explain that in our view the HPC could take more active steps to investigate registrants' ill-health when notified of drink or drugs convictions and cautions. We comment on the closure process followed in two cases. We also refer to some minor administrative shortcomings in a very few cases.

Method of auditing

11.5 We reviewed a sample of 100 cases. We drew our sample from the 433 cases that the HPC closed at the initial stages in the six month period ending 31 October 2010. We selected 50 cases at random in proportion to the different closure points within the HPC's processes. We selected the other 50 cases at random from those categories of case that we considered were more likely to have elements of higher risk. We identified these risk areas from the findings of our previous year's audit and other information available to us, including the HPC's own risk assessment and our knowledge of the HPC's new areas of work.

Detailed findings

11.6 We found that the HPC has robust systems and processes in place in all essential areas of initial-stage casework.

11.7 We found several examples of strengths in case handling, including:

- Several cases that demonstrated that the HPC has a practice of chasing complainants and employers (where appropriate) for further information

- Several examples that demonstrated the HPC's practice of trying to assist complainants. These included:
  - Telling complainants how they could make their complaint and the types of issues the HPC could consider
  - Sending correspondence to the complainant that clearly stated what further information the HPC required in order to investigate their complaint
  - Explaining other possible avenues of complaint
- Good systems for managing cases, for example the use of closure forms that include a checklist to ensure that all the necessary actions have been carried out, and that proper reasons are recorded and signed off by the appropriate person before the case is closed.

11.8 Good record keeping is important to ensure that there is sufficient information for decision makers to rely upon in reaching their decisions, as well as to ensure that those decisions can be shown to be reasonable if challenged. We found record keeping of a consistently high quality in almost all of the cases we reviewed.

11.9 We found two cases where the paper files were incomplete. In one case the paper file did not contain copies of all the emails sent and received. In the other case the paper file did not contain copies of the closure letters that had been sent.

11.10 We also found some minor administrative errors which, if repeated across the caseload, might lead to minor risks to public confidence:

- The HPC opened an investigation into a registrant following notification from the police of their criminal conviction. However, the caseworker had not checked the relevant HPC database before opening the investigation. This would have shown that the HPC had already dealt with the conviction because the registrant had already referred it to the HPC himself. The HPC has assured us that the system for dealing with self-referrals has since been changed, and that this error could not recur
- A member of HPC staff made a mistake when checking the HPC's register and wrongly told a complainant that the person they wished to complain about was not registered with the HPC (and that therefore they could not investigate the matter). The error was only discovered and corrected when the complainant's solicitor queried it. The HPC has said that all cases which are closed without consideration by an investigating committee are now reviewed by a senior manager each week. This is to check that the closure is appropriate.

11.11 In response to our comments on these cases the HPC referred to the fact that it undertakes random audits of case files. We regard this as good practice. The HPC also says that a new case management system will be introduced in September 2011 to further strengthen its file management.

11.12 We found a few instances where we considered that the HPC had handled a particular aspect of a case slightly less well than usual, and we considered that it might have led to some minor risks to public confidence or patient safety.

- In one case the police had closed an investigation into the alleged sexual misconduct of an HPC registrant during a consultation with a patient. Based on the evidence gathered during the police investigation, the HPC decided that it was unlikely that it would be able to establish that the registrant's fitness to practise was impaired in relation to this alleged misconduct. The factors that the HPC took into account were the absence of independent witness evidence to the alleged incident and the fact that the registrant had put forward a clinical justification for his actions during the patient consultation. We think that the HPC's decision was probably correct in this case and that it is unlikely that impairment of fitness to practise could have been established on the basis of the evidence. However, given the seriousness of the allegation and the evidence provided by the patient, we think that the HPC should have assessed whether it needed to gather further evidence before making a decision to close the investigation
- In particular, our view is that the HPC should have considered obtaining an expert opinion from a fellow professional as to whether or not the registrant's explanation for his actions during the patient consultation was plausible by reference to acceptable professional standards. Doing so would have enabled the HPC to assure itself that it had fully addressed the risks to patients, and to maintain public confidence in its regulatory activities
- We also consider that it would have been more appropriate if the decision to close the investigation had been made by the HPC's investigating committee rather than by HPC staff acting under delegated authority. Closure of such an investigation by staff does not appear to us to comply with the HPC's own guidance; its practice note, *Standard of Acceptance for Allegations*, requires complaints related to a registrant's fitness to practise to be considered by the investigating committee
- We noted one case in which a decision to close an investigation had been made by one person (a manager). The HPC says that this should not have happened under their procedures. We consider that the particular decision was reasonable. However closure by a single member of staff, without review of that decision by a colleague, means that the HPC loses the opportunity to assure itself that all closure decisions have been taken in compliance with its guidance and policies. The HPC says that its new weekly check of closures by a senior manager will help it to identify any similar breaches of procedure.

11.13 In last year's fitness to practise audit report we commented on the varying approaches taken by different regulators to investigating convictions or cautions for drink or drug-related offences. We recommended that, as far as appropriate, the regulators adopt the practice of routine medical examinations of registrants who have received such convictions or cautions. We made this recommendation because we were aware that early adoption of such a practice by some regulators had meant that they were able to take prompt action to protect the public from registrants who had underlying dependency problems that impaired their fitness to practise.

11.14 We are pleased that the HPC, in response to our recommendation, asked its fitness to practise panel in October 2010 to consider whether to start adopting the practice of routine medical examinations of registrants in such circumstances.

However, the committee decided that the HPC's current practice should not be changed.

11.15 During the current audit we identified two cases that concerned drink driving by registrants which the investigating committee decided to close. It closed the cases even though it did not have any information about the registrants' health and so was not in a position to evaluate whether there was any evidence that they had underlying dependency problems. In one case, there was no evidence to suggest that the registrant might have an underlying dependency problem, other than the nature of the conviction itself. In the other case, given the severity of the court's sentence (a suspended custodial sentence) as well as the registrant's own admission that his drinking had become problematic, we considered that it would have been better practice for the HPC to have undertaken further investigation before making a decision to close the case. Such investigation could have included a medical examination of the registrant, seeking background information from the courts and the police, and establishing whether or not the registrant had other undeclared convictions or cautions for similar offences.

11.16 We were concerned that the case officer in one of these two cases gave the registrant advice about what should be included in a mitigating submission to the registration panel. The HPC agrees that the case officer's advice was inappropriate and tells us that it has addressed the problem.

11.17 Under the HPC's current legislative framework only its health committee has the power to request that a registrant attend a medical examination (or 'health assessment').[17] We consider that the HPC should keep under review whether its legislative framework provides it with sufficient powers to protect the public in such cases, and whether it is using its existing powers to maximum effect.

Conclusion and recommendations

11.18 Our audit found that the HPC has a well managed system of casework with no evidence of unacceptable risks to patients or to the maintenance of public confidence.

11.19 We recommend that the HPC:

- Further reviews its practice relating to the identification of registrants who may have underlying drink or drug dependency problems that may impair their fitness to practise. This may include considering whether the HPC is using its existing powers effectively, and whether it might wish to seek amendments to its legislative framework
- Reviews all the cases referred to in this report, to see whether there are opportunities for improving its processes.

[17] HPC, 2010. Paper to HPC Investigating Committee 10 October 2010, *Mechanisms for Dealing with Alcohol or Drug Related Criminal Offences.* London: HPC. Available at www.hpc-uk.org

12. NMC fitness to practise audit report

Overall assessment

Introduction

12.1 In July and August 2010 CHRE audited the initial stages of the fitness to practise procedures of the Nursing and Midwifery Council (NMC).

12.2 Our overriding aim in conducting audits is to seek assurance that the health professional regulators are protecting patients and the public, and maintaining the reputation of the professions and the system of regulation. We assessed whether the NMC achieved these aims in the particular cases we reviewed. We considered whether weaknesses in handling any of these cases might also suggest that the public might not be protected in future cases.

Summary of findings

12.3 In this year's audit of the NMC we found continuing significant weaknesses in the NMC's handling of fitness to practise matters. These weaknesses create significant risks that the NMC will not always protect the public or maintain confidence in the professions.

12.4 It is disappointing that several of the issues we found were the same as those raised following our audit last year. However it was apparent to us that, in recent months, the NMC had engaged in a great deal of activity to attempt to improve its performance. In our meetings and correspondence with managers we encountered a positive response to the issues we that we were raising.

12.5 Further details of our findings are given below. However, in summary we found the following weaknesses that give rise to risks that the NMC will not properly fulfil its role:

- Inconsistent review of new cases to identify risks, and inconsistent consideration of prioritising high risk cases and referral of cases for interim orders
- Inadequate information gathering in some cases, affecting the quality and safety of the decision to close the case. We found cases where employer decisions were adopted by the NMC without full background information. We found cases where the NMC relied on a registrant's word without corroborating evidence
- Poor or no analysis in some final decisions. This was sometimes affected by poor information gathering. We considered that further information should have been gathered before a decision was made to close some cases, or that some should have been referred to a final hearing
- Poor record keeping and electronic case management. In some cases, key documents were missing on the electronic case management system (CMS). We also found that it was possible for case officers to close cases in some circumstances without management agreement and before all actions were completed

- Poor linkage between the CMS and WISER (the computer system that runs the NMC registration system). This creates a risk that allegations would not be investigated and that registrants might avoid action against them by temporarily removing themselves from the register
- Poor customer service. There were examples of poor standard letters and adaptations of these letters. We found several examples of poor liaison with employers, in particular one case where the NMC did not tell the employer the result of an investigation into one of their staff. We consider that this is a missed opportunity to build trusting relationships with employers to mutually enhance the NMC's and employers' public protection roles
- Delays. There were several examples of cases where there appeared to have been little active case management leading to significant delays. This would have been avoided with proper management and staff resources. We also found some significant delays in referring potentially serious cases for interim orders. There were long delays in some cases which had been referred to external solicitors for investigation.

Method of auditing

12.6 We reviewed a sample of 100 cases closed at the initial stages – that is without being considered by a final stage fitness to practise panel. We drew our sample from the 779 cases that the NMC closed at the initial stages in the six month period ending 30 June 2010. We selected 50 cases at random in proportion to the different closure points within the NMC's processes. We selected the other 50 cases at random from those that we considered had elements of higher risk. We identified these risk areas from the findings of our previous year's audit and other information available to us.

Detailed findings

Risk assessment

12.7 A regulator can seek to suspend a registrant's registration or impose a restriction on their permitted professional activities by applying for an interim order. The suspension or restriction is made on a temporary basis to enable the regulator to gather more information. An interim order should be considered if a regulator thinks that it is necessary to protect the public, or is in the public's or registrant's own interests.

12.8 In the cases we examined, we did not find evidence of a consistent system for considering whether to apply for an interim order or of prioritising cases according to risk. The NMC has told us that it is addressing this issue by introducing an assessment sheet for each new case, and that it will carry out audits of its use. It is also introducing standard operating procedures to ensure consistent case handling.

12.9 We know that cases are referred for interim orders, and this tells us that risk assessment does take place in at least some cases. However we found several cases involving potentially serious allegations where there was no evidence of a risk assessment, or consideration of early prioritisation or of applying for an

interim order. These cases variously involved allegations of assault on an ex-patient, domestic violence, clinical incompetence, incompetence allegedly contributing to a patient's death, child abuse and child pornography. The fact that these cases were eventually appropriately closed by the investigating committee shows that the public and patients were not endangered by the lack of interim orders in these particular cases. However, the NMC did not know at the time that the actual risks were low.

12.10 Because this audit looks only at cases closed in the initial stages, it does not give us information about whether there are cases still open that should have been considered for an interim order. The audit also does not tell us whether there have been cases that reached a final hearing, and which resulted in a suspension or striking off order, but which were never considered for an interim order. In such a situation, patient safety and public confidence would have been put at risk.

Gathering information

12.11 Proper gathering of all relevant information is vital if decision makers are to protect the public and uphold the reputation of the professions and the system of regulation.

12.12 In several instances we consider that the NMC did not gather sufficient evidence before deciding to close a case. In some of these cases we consider that there was a risk that these cases had been closed prematurely. We found the following examples of insufficient information gathering.

12.13 We found four cases where the NMC failed to get corroboration of a registrant's mitigating arguments or account of events:

- In one case, decisions not to seek an interim order, and eventually to close the case, were based on the registrant's untested assertion that the police had dropped an investigation. The allegation was of indecent assault
- A case where a decision to close was partly based on a registrant's untested assertion that his employers were investigating the allegation and dealing with it
- A drink drive conviction case where the registrant's representatives described the employer's alleged supportive attitude, and how this supported the registrant's mitigation. However none of these assertions were tested by seeking further information from the employer or the police
- A case of police giving a caution for domestic violence in which the NMC appear to have accepted the registrant's version of events without seeking independent police evidence
- An allegation of physical and psychological abuse of a vulnerable patient which the NMC closed before receiving the final outcome of the employer's disciplinary investigation.

12.14 We found three cases where the NMC adopted an employer's decision without seeking further evidence to enable it to reach its own independent view. This creates a risk because an employer may be basing its decisions on criteria that

differ from the NMC's. The NMC has no means of quality-assuring the employer's investigation.

12.15 We considered these particular decisions to close did not pose a significant risk. However, the failure to gather a proper level of information shows a lack of rigour and increases the risk that other cases may be closed inappropriately. The three cases were as follows:

- In an indecent assault allegation, the NMC in closing the case relied on the fact that the police and employers had taken no action. The NMC did not seek further information on police and employer investigations, or evidence from the alleged victim, or request that the employer give information about any other concerns they may have had
- In an allegation of misuse of illegal drugs by staff, the NMC relied on an employer investigation. However, we consider that this investigation was possibly inadequate for the NMC's purposes. It did not identify which staff the employer had investigated, or whether those staff were NMC registered, or what degree of investigation the employer had undertaken
- An allegation of rowdy misbehaviour against two registrants, which received media attention. The NMC appears to have relied on the employer's decision to take no action, and to have assumed the incident was unrelated to the registrant's professional practice. But the NMC did not first seek information on where the incident had taken place, whether the registrants had been on duty, and whether patients were put at risk.

12.16 We found several cases of convictions and police cautions where there appeared to have been no further check with the police that the registrant had not committed other offences. We also did not always see evidence that checks were made of previous allegations made to the NMC. Information about other offences and allegations may assist the NMC's risk assessment, and consideration of whether an offence is a 'one off' uncharacteristic of the registrant.

Making and communicating decisions

12.17 We found several cases in which we consider that the analysis was inadequate. We have referred already to cases where there was insufficient information gathered, and where this may have affected the rigour of the reasoning.

12.18 We consider that failings in gathering information and rigorously analysing the case led to unsafe closures in the following cases:

- A conviction for child neglect in which the investigating committee did not seek background information about what led to the conviction
- A serious allegation of patient abuse that the investigating committee considered incapable of proof, despite the fact that the registrant had admitted key facts to the police
- Serious allegations of incompetence and repeated dishonesty which the investigating committee closed on the basis that the employer had put arrangements in place to deal with the registrant's failings. However we could not see enough evidence that the registrant had dealt with their failings or that the employer had fully investigated the allegations.

12.19 We found some cases where the investigating committee's reasons were no more than that there was insufficient evidence to prove allegations, or that a finding of impairment was unlikely. There were no reasons given for why this was the case.

12.20 The decisions given in some cases suggested that the investigating committee had not considered certain allegations in some cases which involved multiple allegations.

12.21 Some final decision letters contained inaccuracies which would have undermined the recipient's confidence in the NMC as a regulator. One letter had several errors including a reference to the wrong registrant. Two cases were closed with adaptations of standard letters that did not make much sense.

Record keeping

12.22 We found many cases where the CMS computerised record was incomplete or unclear:

- A case where a police notification of a conviction of a registrant was filed in the wrong file. It appears that this conviction was not investigated by the NMC until our auditors drew this to its attention
- Key documents were not on the electronic file. In several cases there was no final decision letter on file
- The NMC does not scan the signed letters that it sends and there were some cases where it was unclear which version of a draft letter was the final one, and whether it was actually sent. In response to our initial comments the NMC says it will introduce 'version control' but that in the meantime all file copies will now be countersigned by a manager
- We found one case where some papers were filed under an old case number, and some were filed under a new case number.

12.23 We are concerned that controls within the structure of the CMS might allow closure of a case by a case officer without all actions being completed. We found one case that was recorded as 'closed' but in which it appears closure letters were not sent until we drew this to the attention of the NMC. Another case was recorded as 'closed' although it appeared to still be active. This suggests that controls within the system may not yet be sufficiently robust.

12.24 We are concerned about the effectiveness of safeguards in the interaction of the NMC's two main computer systems, and the implication this has for ensuring that the NMC deals adequately with all allegations. WISER is the system that stores information about the registration status of each registrant. The NMC may only investigate allegations against people currently registered. If a registrant has left the register when the NMC is informed of an allegation, an 'under investigation' flag should be put on the WISER record. This is so that the investigation can be resumed if the registrant rejoins the register.

12.25 The following cases caused us concern:

- A case had been flagged as 'under investigation' on WISER but no action was taken when a registrant rejoined the register. The employer who had

made the original complaint alerted the NMC to this and the NMC wrote to apologise to the employer. However the case was still showing as 'closed' on the CMS when we audited three weeks later

- A case that should have had an 'under investigation' flag but did not have one. This would mean that, if the registrant re-registered, the registrations department would not have known to alert the fitness to practise department
- A case wrongly flagged for investigation if a registrant should re-register, which she subsequently did. She was then told that she was under investigation when in fact no allegation had been made against her.

12.26 We are concerned that this exposes a considerable area of administrative weakness and a lack of fail-safe systems. This in turn creates substantial risks that serious cases may not be investigated before a registrant rejoins the register, or that registration may be allowed to lapse during an investigation, removing the NMC's power to act.

Customer service

12.27 We found several examples of poorly adapted standard letters, typically asking for information that the complainant had already provided or said they did not have. This will have undermined confidence in the NMC as a regulator.

12.28 We noted a standard letter asking the complainant to contact the NMC if they had not heard from the NMC within a certain time. We consider this poor customer service which would not sustain confidence in the NMC.

12.29 We noted several examples where an employer, although not the complainant, had been involved in a case, but where the NMC had not told them of the outcome. We think that this is discourteous, fails to assist employers in their public protection role, and is a missed opportunity for the NMC to build relations with employers. Keeping employers informed would improve their confidence in the NMC and the flow of information for future cases.

Timeliness and monitoring of progress

12.30 We found the following cases where there appeared to be a lack of active case management leading to significant delay. This creates risks to patients and to confidence in the system of regulation. In most of these cases the NMC was unable to give us an explanation for the delay.

- A 13 month delay between the receipt of allegation and an investigating committee hearing, at which it was noted that the incidents had occurred before the registrant was registered and that they were now considered competent
- A 10 month delay when the NMC did not chase information it had requested
- A nine month delay in referring a case to the investigating committee. The NMC says the triage case officer in question had a high workload
- A five month delay due to an administrative error which meant employer information was not chased

- A delay caused by the fact that the NMC took nine months to establish that the subject of a complaint was in fact a Health Professions Council registrant rather than an NMC registrant. This was in part due to lack of communication by the complainant, but this could have been avoided if the NMC had been more proactive.

12.31 We identified cases in which there appeared to have been poor oversight of external solicitors appointed by the NMC to conduct investigations. This resulted in some significant delays. The NMC says that it has adopted more active management of outsourced investigations, including introducing a more formal process for agreeing extensions.

12.32 We reviewed one case concerning the recruitment and adaptation of overseas nurses. There appeared to have been an unexplained period of three years in which no action was taken. From the documents available to us, there was no clear reason for the investigating committee's decision to close the case. However the legal advice it had received suggested that the long delay had made the gathering of sufficient evidence too difficult.

12.33 We were concerned about delays in the referral of some serious cases for interim orders or in prioritising investigations, resulting in potential risks to patients and public confidence:

- In one case where sexual offences were alleged, there was no action for the first seven months, leading to delays before the matter was considered for an interim order
- In a case involving child pornography allegations it took eight weeks before the case was allocated and another six weeks before the investigating committee considered the case
- Following the cancellation of two hearings, an interim order panel did not consider a case of alleged incompetence leading to patient harm until six months after it was received by the NMC
- A potentially serious case involving alleged incompetence took three months to reach an interim order panel after being referred by an investigating committee. The NMC says that these delays experienced in 2009 have now been reduced
- A case of alleged mistreatment of a patient was not referred an interim order panel until six months after receipt by the NMC.

Recommendations

12.34 We are aware that the NMC is taking action to address many of the concerns described in this report. It has told us of action it has taken or will take. We recommend that the NMC ensures that its future plans fully address each of the weaknesses and risks we have identified. These actions will need to be properly resourced and the effectiveness of changes continually reviewed.

13. PSNI fitness to practise audit report

Overall assessment

Introduction

13.1 In November 2010 CHRE audited the initial stages of the fitness to practise procedures of the Pharmaceutical Society of Northern Ireland (PSNI). We audited all the cases (17) that had been closed in the six months to 31 September 2010 but that had not been considered by a final stage fitness to practise panel.

13.2 Our overriding aim in conducting audits is to seek assurance that the health professional regulators are protecting patients and the public, and maintaining the reputation of the professions and the system of regulation. We assessed whether the PSNI achieved these aims in the particular cases we reviewed. We considered whether weaknesses in handling any of these cases might also suggest that the public might not be protected, or confidence not maintained, in future cases.

Summary of findings

13.3 We reviewed 17 cases, five of which were closed after consideration by the scrutiny committee. All of the cases reviewed showed that, within the significant limitations of its powers, the PSNI handled cases in a timely and professional manner, and endeavoured to protect the public and maintain confidence in the profession. However, as we discuss below, the PSNI's ability to achieve this is limited by its lack of statutory powers and resources.

13.4 The development of the scrutiny committee (which is a non-statutory equivalent of the investigation committee in other health professional regulators) has contributed to the effectiveness of the PSNI. In our audit we found that the committee reviewed cases competently and provided thorough and detailed reasoning for its decisions. These reasons were relayed fully in closure letters to the registrant and complainants.

13.5 We have made three recommendations to the PSNI relating to clarification of the role and procedure of the scrutiny committee.

Statutory limits on powers to act

13.6 In last year's audit report we commented that the PSNI has limited powers in dealing with fitness to practise matters, as a result of the current limitations of its statutory framework. The current framework gives the PSNI no specific investigatory powers, although it may investigate cases where investigation does not require use of statutory powers, for example, where it can be done by correspondence. PSNI typically refers complaints that raise a concern about a registrant's fitness to practise to the Department of Health Social Services and

Public Safety (DHSSPS) Medicines Inspection and Investigation Team ('the inspectorate') for investigation.

13.7 In addition, the only sanction available to the PSNI (if a registrant's fitness to practise is found to be impaired) is removal of the registrant's name from the register by the statutory committee for misconduct. Unlike the fitness to practise panels of other health professional regulators, the PSNI's statutory committee does not have any other sanctions available to it (such as the power to temporarily restrict a registrant's practice by imposing conditions on their registration, or the power of suspension, or the power to impose a warning).

13.8 Unlike other health professional regulators, neither the DHSSPS nor the PSNI have the power to impose an interim order either suspending a registrant from practice or placing conditions restricting their practice during the period of any investigation – even where a registrant presents a risk to the public.

Detailed findings

13.9 We found several examples of strengths in case handling that we believe reinforce public protection and maintain confidence in the regulator. These included the following:

- In one case the PSNI actively intervened to encourage a pharmacy chain to investigate. This was after a patient reported an adverse incident to the PSNI. This led to the pharmacy chain changing its good practice guidance for all its branches. The PSNI reported this back to the patient and undertook to publicise the issue in a forthcoming newsletter
- General good file management. Case files were indexed and included checklists, and closure reasons were documented at the front of case files
- In one case, the PSNI registrar told a patient that a complaint was not suitable for PSNI investigation (because it did not concern policy on the supply of certain drugs). However the registrar explained the regulatory context and the alternative avenues of complaint open to the patient
- In one case, a letter sent by the PSNI to a superintendent pharmacist, informing them of a decision to close a case, recommended that there could be some value in sharing the learning from the incident among all their pharmacies. We considered this to be demonstrative of the PSNI taking an active approach to ensure good practice.

13.10 We noted that the PSNI has changed its procedures since the completion of our 2009 audit, to include a risk assessment on each case file. The PSNI informed us that where a case is identified as being high or extreme risk, it will be prioritised, particularly where a registrant's conduct may have resulted in patient harm. We regard this as an enhancement to the PSNI's previous processes.

13.11 In January 2009 the PSNI created an advisory scrutiny committee. Whilst the scrutiny committee does not have any statutory powers, it is intended to replicate the investigation committee of most other health professional regulators. It considers cases and its decisions take the form of advice to the registrar. In our view the creation of the scrutiny committee has enabled the PSNI to carry out a more formalised consideration of complaints. We found that the written advice

given by the scrutiny committee to the registrar on cases was detailed and well reasoned. The committee's reasons for recommending no further action were relayed fully to the complainant and registrant.

13.12 In one case the scrutiny committee criticised deficiencies in the evidence presented in the inspectorate's report which had been submitted to the committee in evidence. On the basis of the information available in the inspectorate's report, we consider that the committee's concerns were understandable. However we sought further information from the DHSSPS and, as a result, we were satisfied that the matter had been thoroughly investigated. We understand that the DHSSPS has, since the date of this investigation, also further developed its own case management processes to ensure that there is a clear record of all investigative actions taken in each case. We understand that the establishment of the monthly Pharmacy Networking Group meetings means that the PSNI and DHSSPS now share information about cases more effectively. We would encourage the two organisations to further develop protocols for information sharing so that the scrutiny committee can be provided with sufficient information.

13.13 In one case the scrutiny committee adjourned its consideration and asked for further investigation. However, there is no evidence that the case was then referred back to the scrutiny committee to reconsider. Nor is there evidence of any discussion having taken place at a later date between the registrar and the chair of the committee about whether the case could be closed. Further, the rules of the scrutiny committee currently require the reasons for its decisions to be reported to the chair of the statutory committee. We consider that closure of the case following further investigation was merited in the circumstances. However, we think that the failure to refer the matter back to the scrutiny committee for a final decision was an error. Although the committee does not have a statutory standing, failure to follow the existing rules could potentially undermine public confidence in the committee.

13.14 In reviewing the PSNI's guidance and the *Scrutiny Committee Rules 2009*, we considered that there was not comprehensive, clear guidance about the circumstances or specific criteria under which the registrar should refer cases to the scrutiny committee for consideration. In practice, in the cases we reviewed in our audit, we did not find any failure by the registrar to refer appropriate cases to the scrutiny committee. However, we recommend that clearer written referral criteria is developed. In addition we also noted that there was a lack of guidance for the registrar when considering how to handle a complaint where the complainant wishes to withdraw from the process, but where there may be a public interest in the complaint proceeding. Again we recommend that this is addressed in written guidance.

13.15 We found that some paper files had some documents missing. In one case we found that a note of a telephone conversation had not been made and kept in the case file. In one case a copy of the final letter to the complainant was not available. In a further case there was no file record of communication with the DHSSPS although we know from discussions with the PSNI that contact was made with the DHSSPS regarding this case.

13.16 Records of case actions and communications should be documented to ensure a chronological record and for the purposes of transparency and accountability. We understand that a new case management system will help to ensure that complete case records are kept electronically and that records of all emails and telephone calls will be saved to the appropriate case.

Conclusion and recommendations

13.17 We consider that in the cases we reviewed, the decisions to close the cases were reasonable, and the reasons given to the registrant and the complainant were clear and sufficiently detailed. However we remain concerned that the PSNI continues to be restricted as a result of its lack of investigative powers and its very limited sanctions. We understand, that a consultation on extending the PSNI's fitness to practise powers will commence shortly.

13.18 We recommend that the PSNI:

- Ensures that its new case management system is used to capture and retain in one place all relevant information about each case
- Considers producing written guidance which sets out criteria for the referral of cases to the scrutiny committee
- Considers producing written guidance for the handling of complaints in which the complainant withdraws either their complaint or their consent to proceed
- Further explores information-sharing protocols with the inspectorate.

14. RPSGB fitness to practise audit report

Overall assessment

Introduction

14.1 In November 2010 CHRE audited the initial stages of the fitness to practise procedures of the Royal Pharmaceutical Society of Great Britain (RPSGB).[18] We audited a sample of cases that had been closed without being considered by a final stage fitness to practise panel.

14.2 Our overriding aim in conducting audits is to seek assurance that the health professional regulators are protecting patients and the public, and maintaining the reputation of the professions and the system of regulation. We assessed whether the RPSGB achieved these aims in the particular cases we reviewed.

14.3 The RPSGB's fitness to practise functions were transferred to the new General Pharmaceutical Council (GPhC) on 27 September 2010. We would therefore encourage the GPhC to consider whether lessons from this audit should inform the approach it will take to its own casework.

Summary of findings

14.4 The cases we reviewed produced many examples of strengths in case handling. We however also found several examples in which there had been unexplained long delays in progressing matters. In these cases there was insufficient evidence of active case management.

Method of auditing

14.5 We reviewed a sample of 50 cases closed at the initial stages. We drew our sample from the 215 cases that the RPSGB closed at the initial stages in the three month period ending 27 September 2010. We selected the 50 cases at random, in proportion to the different closure points within the RPSGB's processes.

14.6 In this year's audits of the other regulators we have taken as our sample period the six months immediately preceding the start of each audit. For the RPSGB, however, we chose the period of the final three months before the fitness to practise function was passed to the GPhC. This was in order to address a theoretical risk that cases may have been closed to different standards, because of the imminent transfer of powers to the GPhC.

[18] In August 2010, Rosalyn Hayles became director of scrutiny and quality at CHRE. In recent years she has worked in the fitness to practise departments of the GOC and RPSGB. For this reason she took no part in the audits of the GOC, RPSGB and GPhC, and did not help in the production of the relevant audit reports. The chief executive of CHRE had personal oversight of these reports.

Detailed findings

Case handling strengths

14.7 We found several examples of strengths in case handling. These included the following systems for checking and reinforcing quality:

- A clear form for carrying out initial assessments of cases. This included checklists to remind staff to consider relevant issues
- A form for the investigation team to review timeframes in order to check that key performance indicators were met (although we comment below on examples of unexplained failures to make progress on some cases)
- Systems in which managers and inspectors checked and approved closure letters.

14.8 We found examples of clear internal reports, with a useful case summary and inspectors' structured findings and recommendations for case closure.

14.9 We found several examples of good quality closure letters to complainants, giving clear explanations of why a matter was not being taken forward.

Timeliness

14.10 Delays may lead a member of the public to believe that the regulator is not dealing with concerns seriously and competently, and may lead to unfairness to the parties involved. Delays can also make evidence more difficult to gather and less reliable once gathered, and this may affect the regulator's ability to protect patients and the public. We found several examples where there was unexplained delay in a case, or where there was evidence of weak case management:

- In a relatively simple case concerning out-of-date medication, and requiring straightforward evidence, there were delays of several months in requesting and chasing up requests for evidence. There was a further delay of several months before a decision to close the case was communicated to the complainant. The RPSGB did apologise to the complainant, blaming an administrative error prior to reallocation of the case
- A case in which there was a delay of 17 months between an inspector's visit to a pharmacy in response to a complaint, and the referral of the matter to the investigating committee. There was no information on file to explain this delay, and we could see no evidence on the file of active case monitoring
- A case in which there was a one year delay between the police notifying the RPSGB of a caution given to a registrant, and the RPSGB requesting further information from the police. There was no evidence on file that there had been systems in place to monitor case progression. We also found that, four months after notification was received from the police, the registrant also wrote to the RPSGB to declare the caution. The registrations department passed this to the fitness to practise department, but no record was made on the electronic or paper file

- In a relatively simple case of a single dispensing error, there was a year's delay before the inspector submitted a report to the fitness to practise department. There was no explanation for this on file, and no evidence that the fitness to practise department had chased progress with the inspector
- We also found two cases in which there was a delay in acknowledging the initial complaint. In one, the complaint letter took four weeks to reach the fitness to practise department from the chief executive's department. In the other there was an unexplained ten week delay in acknowledgement. We consider that a failure to communicate with a complainant promptly creates a risk of undermining public confidence in the system of regulation. Complainants, who often will have complained about a matter that has caused them anxiety, will want to know that their communication has safely arrived and has not been ignored.

Conclusion and recommendations

14.11 We recommend that the GPhC assesses any systems it has inherited from the RPSGB to ensure:

- That the strengths in case handling that we have identified are taken forward into new GPhC processes where appropriate
- That weaknesses in case monitoring leading to delay are tackled.

Annex 1

Fitness to practise casework framework – a CHRE audit tool

The purpose of this document is to provide CHRE with a standard framework as an aid in reviewing the quality of regulators' casework and related processes. The framework will be adapted and reviewed on an ongoing basis.

Stage specific principles

Stage	Essential elements
Receipt of information	• There are no unnecessary tasks or hurdles for complainants/informants • Complaints/concerns are not screened out for unjustifiable procedural reasons • Provide clear information • Give a timely response, including acknowledgements • Seek clarification where necessary.
Risk assessment	*Documents/tools* • Guidance for caseworkers/decision makers • Clear indication of the nature of decisions that can be made by caseworkers and managers, including clear guidance and criteria describing categories of cases that can be closed by caseworkers, if this applies • Tools available for identifying interim orders/risk. *Actions* • Make appropriate and timely referral to Interim Order panel or equivalent • Make appropriate prioritisation • Consider any other previous information on registrant as far as powers permit • Record decisions and reasons for actions or for no action • Clear record of who decided to take action/no action.

Stage	Essential elements
Gathering information/ evidence	*Documents/tools* • Guidance for caseworkers/decision makers • Tools for investigation planning. *Actions* • Plan investigation/prioritise time frames • Gather sufficient, proportionate information to judge public interest • Give staff and decision makers access to appropriate expert advice where necessary • Liaise with parties (registrant/complainant/key witnesses/employers/other stakeholders) to gather/share/validate information as appropriate.
Evaluation/decision	*Documents/tools* • Guidance for decision makers, appropriately applied. *Actions* • Apply appropriate test to information, including when evaluating third party decisions and reports • Consider need for further information/advice. • Record and give sufficient reasons • Address all allegations and identified issues • Use clear plain English • Communicate decision to parties and other stakeholders as appropriate • Take any appropriate follow-up action (eg warnings/advice/link to registration record).

Overarching principles

Stage	Essential elements
Protecting the public	• Every stage should be focused on protecting the public and maintaining confidence in the profession and system of regulation.
Customer care	• Explain what the regulator can do and how, and what it means for each person • Create realistic expectations. • Treat all parties with courtesy and respect • Assist complainants who have language, literacy and health difficultie • Inform parties of progress at appropriate stages.

Risk assessment	• Systems, timeframes and guidance exist to ensure ongoing risk assessment during life of case • Take appropriate action in response to risk.
Guidance	• Comprehensive and appropriate guidance and tools exist for caseworkers and decision makers, to cover the whole process • Evidence of use by decision makers resulting in appropriate judgements.
Record keeping	• All information on a case is accessible in a single place. • There is a comprehensive, clear and coherent case record • There are links to the registration process to prevent inappropriate registration action • Previous history on registrant is easily accessible.
Timeliness and monitoring of progress	• Timely completion of casework at all stages • Systems for, and evidence of, active case management, including systems to track case progress and to address any delays or backlogs.

Annex 2

GPhC legacy criteria

THE GPhC produced the following guidance on how it would deal with cases inherited from the RPSGB:[19]

Just Disposal of Legacy Cases Guidance

1. Purpose

On the 21 July 2010 the Council of the General Pharmaceutical Council (GPhC) agreed the Just Disposal of Legacy Cases Policy.

The objective of this guidance document is to detail the procedure as to how the Fitness to Practise Division (FtP) will handle cases it inherits from the Royal Pharmaceutical Society of Great Britain (RPSGB) under the transitional provisions set out in the Pharmacy Order 2010 ("the 2010 Order").

2. Scope

The Just Disposal of Legacy Cases Policy applies to the following cases that must be transferred to the GPhC:

- all cases that have not yet progressed to Investigating Committee including cases awaiting listing before the Investigating Committee;
- all cases where a decision has been taken by the Investigating Committee; or Disciplinary
- Committee (DC)/Health Committee (HC) in respect of interim order applications or
- otherwise by way of direct referral from the Registrar;
- all part-heard cases where the final decision has not been communicated to the pharmacy professional; including Disciplinary Committee and Health Committee decisions.

According to Schedule 5, paragraph 12 of the Pharmacy Order 2010 the GPhC can dispose of the cases described above:

- by using the relevant provisions in the Pharmacist and Pharmacy Technician Order 2007 ("the 2007 Order") or
- in line with the relevant provisions in the Pharmacy Order 2010 or
- in such other manner as it considers just.

3. Procedure

3.1. Our approach to transitional cases relating to those on the practising register

The Just Disposal of Legacy Cases Policy will only apply to those cases the GPhC inherits from the RPSGB. It will not apply to those Fitness to Practise cases that GPhC receives after the appointed day.

3.1.1. Applying the criteria

The application of the legacy criteria will be entirely separate from the standard procedure for progressing Fitness to Practise cases as set out in the 2010 Order and the GPhC (Fitness to Practise and Disqualification etc Rules) Order of Council 2010 ("the 2010 Rules"). As such it

[19] This is a reproduction of the GPhC document available at www.pharmacyregulation.org

sits outside the threshold criteria for determining whether a new case should proceed to the Investigating Committee and the decision to close a case because it is out of GPhC Fitness to Practise jurisdiction.

Pre IC Cases
The Case Manager / Investigator should review the case against the legacy criteria at the various decision making point at which the case has reached. For example, this could be at the point where the investigation has been completed but **before** the application of the threshold criteria has taken place.

The case manager / FtP Manager will determine whether the allegation / or information should be discontinued without referral to the IC. A record of this decision and the reasons must be recorded in the Just Disposal of Legacy Cases record of decision form (Practising Register at Appendix 1).

Post IC Cases
A review will take place by the FtP Manager / Case Manager of the case and a decision taken as to whether the case should be discontinued.
The criteria set out below are designed to assist with making this decision of both IC and DC cases. However, it is essential that each case should be considered individually and all relevant circumstances should be taken into consideration. The following should not be applied as a rigid set of rules or criteria when determining to proceed with the case to a hearing before either an Investigating Committee or a Fitness to Practise Committee of the GPhC, or having proceeded to a hearing, whether the case should nevertheless be discontinued.

The Case Manager / FtP Manager should consider that there is a presumption that there is a public interest in the ventilation in public of complaints that have a real prospect of establishing impairment of fitness to practise.

The following (non-exhaustive criteria) should be applied when determining whether a case may be discontinued or referred back to the Investigating Committee for rescission:

- the length of any delay since the original allegation, and the reasons for the delay;
- the seriousness of risk of harm to the health and safety of the public
- the nature, gravity and seriousness of the allegations;
- the extent to which the pharmacy professional may have been prejudiced by the delay;
- whether the facts of the case involve important points of practice or principle;
- the state of the evidence and the likelihood of the charge(s) being proved;
- any witness difficulties and whether the evidence is likely to be weakened by the passage of time
- the individual circumstances of the pharmacy professional, including their health (for example have they retired etc)
- the complainants' response (if any) to the proposed course of action
- whether there is a real prospect of establishing that the pharmacy professionals' fitness to practise is currently impaired.

3.1.2. Cases that will not proceed to a hearing
It is important that the decision and reasons to discontinue a case is recorded by the Case Manager / Fitness to Practise Manager and is approved by the Registrar or his Delegated Officer. This should be recorded on the Just Disposal of Legacy Cases record of decision form (Practising Register at Appendix 1).

3.1.3. Cases that will proceed to a hearing

If the decision has been taken that the case should proceed to a hearing then the following procedure describes which cases will be conducted in accordance with the relevant provisions of the 2007 Order or the 2010 Order as follows:

Where before the appointed day of the transfer:

1. An allegation of impairment of fitness to practise or disqualification has been brought to the attention of the Society and:
   (i) The notice of referral to the Investigating Committee has been sent to the registrant concerned in accordance with rule 10 of the 2007 FtP Rules;

It shall be dealt with in accordance with the provisions under the 2007 Order and the associated rules there under.

Where before the appointed day of the transfer:

2. An allegation of fitness to practise or disqualification has been brought to the attention of the Society and:
   (i) Has not been referred to the Investigating Committee (or in the case of an interim order application, the Disciplinary Committee or Health Committee / or otherwise by direct referral from the Registrar) or
   (ii) The notice of referral to the Investigating Committee has not been sent to the registrant concerned (where relevant)

It shall be dealt with in accordance with the provisions of the 2010 Order and the associated rules there under.

Where before the appointed day of the transfer:

3. (i) A case where the allegation of impairment of fitness to practise / disqualification has been referred from the Investigating Committee to the Disciplinary Committee (DC) or Health Committee (HC), (or in the DC or HC as a result of an interim order application or direct referral by the Registrar) and
   (ii) The case has been listed for a hearing before the DC or HC (including those cases which have been adjourned or postponed)

The Fitness to Practise Committee of the GPhC will dispose of the case in accordance with the 2007 Order and the associated rules there under.

Where before the appointed day of the transfer:

4. (i) A case where the allegation of impairment of fitness to practise / disqualification has been referred from the Investigating Committee (or the DC or HC in an interim order application or direct referral by the Registrar) and
   (ii) The case has not been listed for a hearing before either the DC or HC, then unless the person concerned has submitted written submissions requesting otherwise;

The Fitness to Practise Committee of the GPhC shall dispose of the case in accordance with the GPhC 2010 Order and the associated rules there under.

5. On the appointed day all existing review cases shall be dealt with in accordance with the 2007 Order and the associated rules there under with all subsequent reviews being dealt with under the 2010 Order and the associated rules there under.

If a decision has been taken to proceed with a case, then the standard procedure for progressing Fitness to Practise cases as set out in the 2010 Order and the GPhC (Fitness to Practise and Disqualification etc Rules) Order of Council 2010 (“the 2010 Rules”) will apply.

Date Guidance came into effect: 27 September 2010

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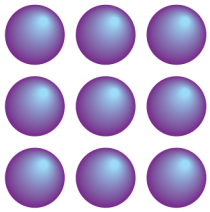

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CHRE Fitness to practise audit report: Audit of health professional regulatory bodies' initial decisions

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