professional standards authority
for health and social care

Protecting the public
HIGHLIGHTS 2018/19

Who we are

We are an independent body, accountable to the UK Parliament. We exist to protect the public by improving regulation and registration of health and care professionals.

How we work

We ensure that our values are at the core of our work: they are at the heart of who we are and how we would like to be seen by our partners. We are committed to being:

- focused on public interest
- independent
- fair
- transparent
- proportionate.

There are three main areas to our work:

- Reviewing the work of the regulators of health and care professionals
- Accrediting organisations that register health and care practitioners in unregulated occupations
- Giving policy advice to Ministers and others and encouraging research to improve regulation.

At the heart of everything we do

is a simple purpose...to protect patients, service users and the public by improving the regulation and registration of health and care professionals and practitioners.

2018/19 HEADLINES

STATE OF PROFESSIONAL HEALTH/CARE REGULATION

Most of the nine professional health/care regulators continue to meet the majority of our Standards of Good Regulation but their efforts to improve and innovate, especially in relation to their fitness to practise processes, continue to be restricted by their disjointed, outdated legislation.

FITNESS TO PRACTISE APPEALS

We have seen a 20% decrease in the number of fitness to practise determinations notified to us, but the the number of cases we referred to Court this year remains consistent – we appealed 11 cases during 2018/19 compared to eight in 2017/18.

MORE PEOPLE NEED TO KNOW ABOUT ACCREDITED REGISTERS

Every register we have accredited has been required to improve its practice in one or more areas to meet the Standards for Accredited Registers before gaining accreditation. However, the full potential of the Accredited Registers programme cannot be realised while awareness of the programme remains insufficient for it to deliver full benefit to the public.

THOUGHT LEADERSHIP

Our research report *Telling patients the truth when something has gone wrong* found that, though the regulators have made progress with initiatives to encourage candour, many of the barriers to professionals being candid remain the same as those we identified in 2014 – when we last did work in this area.

Protecting the public: reviewing the regulators

Scrutinising final fitness to practise decisions

2018 2019	2017 2018
3,621 notifications received	**4,095** notifications received
141 detailed case reviews	**265** detailed case reviews
21 case meetings	**35** case meetings
11 appeals	**8** appeals

20% decrease in the number of fitness to practise determinations notified to us (we believe this is mainly due to a decrease in the number of hearings at the NMC – relating to action taken to address a backlog)

Key stats appeals

How many cases appealed		How many cases per regulator	
11 cases	total cases referred to Court under S29 jurisdiction in 2018/19	NMC	**6**
4 cases	cases were upheld by Consent Order	GMC	**2**
1 case	case - we are waiting for the judgment	HCPC	**2**
6 cases	will be heard during 2019/20	GDC	**1**

Where we decided not to take forward an appeal, we sent learning points to the regulators – these focused on registrants' health, expert evidence and failing to bring full allegations.

Scrutiny of regulators' council appointments processes

We assist the Privy Council with appointments to the regulatory bodies' councils (except the PSNI) and in July 2018 we held a seminar on this topic. It was well-attended and well-received, covering a range of topics including the regulators' management of conflicts of interest and good practice in respect of diversity considerations. Feedback was positive and we committed to repeat the event at regular intervals.

The Bawa-Garba case

In August 2018, the Court of Appeal upheld an appeal by Dr Bawa-Garba against the decision by the High Court to erase her from the medical register. The doctor was convicted of Gross Negligence Manslaughter following the death of a child in her care. An MPTS panel suspended her registration with the GMC for 12 months and directed that she return for a review hearing before the MPTS. The GMC successfully appealed this decision to the High Court, which decided that she should be erased. Dr Bawa-Garba appealed that decision arguing that the original decision of the MPTS was the correct one. The Court of Appeal reinstated the original suspension order. The Authority took the decision to apply to be an interested party at the appeal hearing because important points of principle relating to fitness to practise proceedings were being raised and we took the view that as a neutral party we could give the Court an expert and valuable point of view. Dr Bawa-Garba's case attracted significant media attention. The case caused considerable concern because of the difficulties faced by practitioners in an over-stretched health service. The Secretary of State invited Professor Sir Norman Williams to undertake a review of gross negligence manslaughter in healthcare. We contributed to that review. We also gave evidence on the subject to the Health Select Committee. We were subsequently asked to take forward some of the recommendations from the Williams Review.

NMC Lessons learned review

In March 2017, the Secretary of State for Health asked us to review the NMC's handling of concerns about midwives at the Furness General Hospital, Morecambe Bay. We began our review in July 2017 and published the report in May 2018. The report identified some significant concerns about the way in which the NMC had handled the concerns and, in particular, its approach to dealing with patients and families and their evidence, and about its approach to transparency. We noted that the NMC acted swiftly to prepare a plan to address our concerns and we are monitoring its work on this. Read the **full report** on our website.

Out and about

We are keen to provide support and expertise for those involved in Fitness to Practise hearings. Our team has provided presentations to the HCPC and PSNI and at conferences in London and Dublin. A conference for Chairs of Fitness to Practise panels was held in March 2019 and was attended by over 90 people, including representatives of all the regulators.

Find out more about:

- Our work scrutinising final fitness to practise decisions
- Lessons Learned Review
- Full Annual Report for 2018/19

Protecting the public: reviewing the regulators

we oversee: nine regulators

who are responsible for approximately **1.6 million** registrants

Regulator	Standards met
General Chiropractic Council	24
General Dental Council*	22
General Medical Council*	24
General Optical Council**	22
General Osteopathic Council	24
General Pharmaceutical Council	24
Health and Care Professions Council	18
Nursing and Midwifery Council*	22
Pharmaceutical Society of Northern Ireland*	24

*These reviews were published post financial-year end (in April, May and June).
** Review from 2016/17 cycle.

Meeting the Standards of Good Regulation

The regulators continue to meet most of the Standards of Good Regulation. For those regulators who did not meet all of the Standards, the issues and concerns we identified related mainly to the fitness to practise Standards:

GENERAL DENTAL COUNCIL

The GDC did not meet two of our fitness to practise standards as we noted a deterioration in the GDC's timeliness in progressing fitness to practise cases as well as failing to meet the Standard in relation to information security due to several serious data security breaches.

NURSING AND MIDWIFERY COUNCIL

The NMC has engaged with the findings of our lessons learned review and has made progress to address the concerns outlined– including the introduction of its Public Support Service – but it did not meet two of our fitness to practise standards relating to transparency and fairness of its processes and keeping parties updated. We had concerns about how the NMC handled complaints raised about registrants who have conducted Personal Independence Payment (PIP) assessments and that these issues created a barrier to vulnerable people raising potentially serious concerns.

GENERAL OPTICAL COUNCIL

The GOC also failed to meet two of the fitness to practise standards – it is is still taking too long to progress its fitness to practise cases and we also identified concerns around the GOC's new triage process for assessing complaints at the initial stages.

HEALTH AND CARE PROFESSIONS COUNCIL

We reported concerns about the HCPC's performance against six of the 10 fitness to practise Standards in our 2016/17 performance review. Although the HCPC instigated a wide-ranging action plan to address our concerns, there was not enough evidence of sustained improvement for it to meet these Standards in its 2017/18 review.

Find out more about:
- Our performance review process
- Read our performance reviews

Reviewing the Standards of Good Regulation

Our Standards had been in place since 2010 and we wanted to make sure that they were still fit for purpose. Following two consultations (June 2017 and June 2018), the revised Standards were approved by our Board in November 2018.

The new Standards rationalise our previous Standards – reducing them from 24 to 18, and making them more outcomes-focused. We still have Standards for Guidance and Standards, Education and Training, Registration and Fitness to Practise.

However, we have introduced five new General Standards covering areas such as:

- regulators addressing concerns about themselves
- working with relevant stakeholders to identify and manage risks to the public
- equality and diversity.

We have developed an accompanying evidence framework for the new Standards. We plan to pilot the revised Standards during 2019, and implement them fully for the next performance review cycle from January 2020.

Find out more about: Our revised Standards of Good Regulation

Other issues

Following a high-profile historic case about someone who fraudulently obtained registration as a doctor by forging qualifications, we contacted the regulators to find out how they ensure the validity of applicants' qualifications. The information provided demonstrated that the majority of regulators had reviewed their processes and had confidence in these. Some regulators committed to undertaking detailed reviews of their processes to improve confidence in these.

There were also concerns that a 'no deal' Brexit might have significant effects on the regulators – we wrote to them in January 2019 to understand their readiness for this. It was clear that all the regulators had taken stops to consider the implications for them and their registrants.

Accredited Registers

We have a statutory role in strengthening quality and patient safety by setting standards and accrediting registers of people working in occupations not regulated by law.

26
accredited registers

55
occupations

87k
practitioners

More resources required

In line with government policy, we promoted the message that, where practitioners do not have to be registered by law, the public should choose practitioners on accredited registers due to the additional confidence this provides.

However, given the modest resources available to the programme it is not possible for the Authority alone to raise awareness amongst a population of over 60 million people. It requires concerted effort by us, accredited registers, and other stakeholders with an interest in ensuring public protection, delivering services and promoting public health.

Awareness of the programme remains insufficient for it to deliver full benefit to the public. We are grateful to NHS Employers for their continued promotion of the programme and will be contacting other stakeholders in the forthcoming year to ask for their support.

Exclusion from key legislation

We have again asked the Department of Health and Social Care to assist with securing changes to the Rehabilitation of Offenders Act and the Safeguarding Vulnerable Groups Act (SVGA) to strengthen the protection accredited registers can offer. At present, their exclusion from those Acts constrains their ability to protect the public as fully as they might.

Their exclusion means that they cannot check spent convictions; or receive information from the Disclosure and Barring Service. Their omission from the SVGA means that they are not covered by the exemptions offered to data protection legislation which either prevents or makes it difficult for them to act on safeguarding matters involving either children or adults.

Out and about

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

We have continued to raise awareness of the accredited registers programme and the importance of using registrants on them. The **www.checkapractitioner.com** facility on our website allows people to search for practitioners on accredited registers. We have also conducted social media campaigns including to raise awareness of the importance of choosing practitioners on an accredited register.

Accredited Registers conference

Taking its inspiration from our ***Untapped Resources*** report, our conference in June 2018 welcomed many delegates from the accredited registers and featured a mix of presentations and breakout sessions looking at a range of themes.

2018/19 Accreditation/re-accreditation

9 Conditions

41 Recommendations

27 Instructions

33 Learning points

The impact on registers who become accredited is clear. Every register we have accredited has been required to improve its practice in one or more areas to meet the *Standards for Accredited Registers* before gaining accreditation/re-accreditation. Our accreditation panels will issue conditions, recommendations, instructions and learning points for registers to improve their practice against the Standards and gain/maintain accreditation. We listened to feedback from registers about the process and in response, we have developed a new annual renewal process – streamling it to now include conditions and recommendations.

Find out more about the Accredited Registers programme.

improving regulation

WHAT IS IT TO BE A GOOD REGULATOR?

This was the question posed for this year's annual academic and research conference. This continues to grow every year. Our academic partner for the event was Professor Deborah Bowman, Professor of Bioethics, Clinical Ethics and Medical Law, St George's, University of London. Attendees came from academic institutions, regulators, accredited registers, research organisations, professional bodies, consultants working in this field, government officials, clinicians, professionals, accredited registers and law firms.

Find out more about the conference, including the presentations or watch our highlights video.

- **7-8 March 2019**
- **110 attendees**
- **45 presentations**
- **all 4 UK countries as well as Australia, Belgium, Canada, Ireland and the Netherlands**

Around the UK

We promoted debate and discussion in the sector.

- **In February 2019 we held an an event in partnership with the Welsh Government on regulation and the Welsh context.**
- **At the Scottish Government Regulation Conference we contributed to a panel discussion on supporting professionals to speak up under pressure, and presented on the report that we had published for the Scottish Government.**
- **We have also presented in Northern Ireland on the duty of Candour.**

28 responded to 28 consultations

Social Work England

We have been working with HCPC and the new social work regulator for England, Social Work England (SWE) to work towards a smooth transition of responsibilities and ensure any public protection risks are being appropriately managed. We also sit on SWE's Professional Expert Advisory Group which has provided input to the development of rules and standards for SWE ahead of public consultation.

We conduct and commission research to increase our understanding of the role regulation plays in protecting the public. This year we focused on:

- **the professional duty of candour – and what progress regulators have made in embedding it; and**
- **whether crossing sexual boundaries with colleagues can have an impact on patient safety.**

Duty of Candour

Telling patients and their relatives the truth when something goes wrong with their care comes out time and again as a key issue in health and care failings.

In 2014 eight out of the nine regulators we oversee signed a joint statement on candour and undertook to embed candour in the professionals they register. We wanted to know what progress they have made over the last four years and what barriers remain to professionals being candid.

We published ***Telling patients the truth when things go wrong*** in January 2019. This report found that regulators have made progress with initiatives to encourage candour, however many barriers to professional candour remain the same as reported in our 2014 publication.

The findings of the report were based on discussion groups with regulatory staff and fitness to practise panellists conducted by Annie Sorbie, Lecturer in Medical Law and Ethics at Edinburgh University, and questionnaires from regulators and stakeholders across health and care.

Since the report was published, we have been on a whistle-stop tour delivering presentations about the duty of candour in Wales, Scotland and Northern Ireland. We are also going further afield – delivering a presentation on candour to the next CLEAR conference in the USA in September 2019.

Find out more about our other work on candour.

Does crossing sexual boundaries with colleagues impact patient safety?

Messages to profession as a whole

'Not enough examples are made and people think, oh it'll be fine. You know, they won't do anything. So I think an example and a standard need to be set that actually we are not accepting this.'
Professional participant

We noticed that professionals subject to fitness to practise proceedings for sexual misconduct towards colleagues may receive lesser sanctions than professionals who had crossed sexual boundaries with their patients. We referred three such cases to Court under our powers to appeal regulators' panel decisions but lost. We wanted to find out if our views on how seriously this behaviour should be treated were out-of-step with public opinion. **The research** conducted for us by Dr Simon Christmas explored both the views of health professionals and patients using scenarios based on real cases.

Three key questions are covered in the report:
1. When does behaviour towards/ with a colleague cross a boundary?
2. How is boundary-crossing behaviour relevant to fitness to practise?
3. How should regulators respond to such behaviour?

The research highlighted participants' views on how this type of behaviour can have a negative impact on patient safety and the quality of their care:

- it may point to deep-seated attitudinal problems and motivations – including a lack of empathy (which may pose a risk to patients)
- there may be wider impacts of boundary-crossing behaviour, including the effect it has on the colleague subject to it (stress, distraction, anxiety)
- it may create a culture where boundary-crossing behaviour becomes acceptable (potentially creating toxic working environments where bullying is normalised)
- it may affect public confidence and trust in health and care professionals where such behaviour is witnessed or heard about.

Watch our video where Dr Christmas explains more about the research and its findings.

Find out more:

- **Read the full report**
- **Find out more about our work on sexual misconduct**
- **Find out more about all our research**

Reforming Regulation

Fitness to practise processes

We have been pushing for regulatory reform and look forward to see how the government responds to its 2017 consultation *Promoting professionalisn, reforming regulation*. However, this does not mean that we have stood still – one area ripe for reform is the regulators' fitness to practise processes and we have taken forward a number of projects to contribute to the evidence base for reforming fitness to practise.

We have been working on reports assessing current practice in relation to the handling of fitness to practise cases in the early stages. We also commissioned an academic literature review on the impact on decision-makers of taking decisions in private from Dr Paul Sanderson of Anglia Ruskin University.

Williams Review into Gross Negligence Manslaughter in healthcare

We were also commissioned by the Department of Health and Social Care to take forward two recommendations from the Williams Review of gross negligence manslaughter. We published our report on how the impact on public confidence is assessed in reaching fitness to practise decisions. To progress the other report, we commissioned the Department of Medical Education, UCL to develop a methodology to assess the consistency of fitness to practise outcomes across regulators.Both these these reports were published just after the financial year end. Read the reports.

Other work

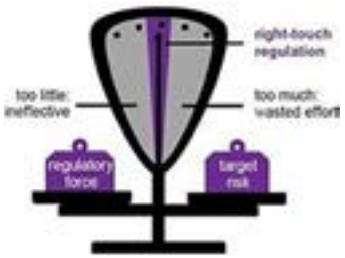
Advice to other organisations

We published the commission we undertook on behalf of the Scottish Government looking at the effects of regulating an occupation in fewer than all four UK countries. Read the report.

Can patients be effective in maintaining their own safety?

This was research commissioned in 2018/19 but published just after year-end. The research aimed to explore further the role of patients and service users in ensuring the safety of the care they receive. The research was qualitative, based on a mixture of focus groups plus face-to-face and telephone interviews. Read the report.

Right-touch regulation in practice: international perspectives



We published this report in September 2018 – it contains a series of essays from colleagues around the world about their experiences of implementing a right-touch approach. Experiences were shared from British Columbia, Ontario, Ireland, New Zealand, Australia and the UK.

You can find out more about right-touch regulation on our website.

Right-touch assurance - used to assess the role of sonographers

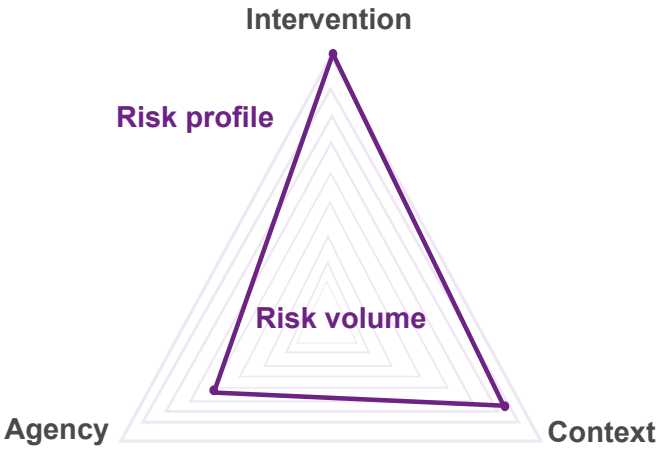
Right-touch assurance is the innovative tool that we developed. It is designed to assess the risk of harm arising from practice by different health and care occupations, the use of which we continue to promote. This year, commissioned by Health Education England, we undertook a review of the role of the sonographer and made recommendations as to the most appropriate form of assurance using our right-touch approach.

Right-touch assurance: a methodology for assessing and assuring occupational risk of harm

We developed *Right-touch assurance* in 2016 to assess risk of an occuation based on assessing the evidence related to the hazards and a judgement on the likelihood and severity of harms. A risk score will be allocated to each of the categories:

- intervention
- agency
- context.

This approach allows us to create a risk profile for each occupation and gain a clear picture of where the risks occur as well as indicate a risk volume from the area of the triangle.



International work

∗International reports

We also published reports for work we carried out on behalf of the:

- Report for the College of Dental Surgeons of British Columbia
- Report for the Saskatchewan Registered Nurses Association
- Report for the Engineers and Geoscientists of British Columbia.

∗International conferences

We contributed to several conferences including international regulatory conferences – IAMRA in Dubai and CLEAR in Philadelphia.

You can find out more about all our publications at: www.professionalstandards.org.uk/publications

Read our full Annual Report to find out more about our work in 2018/19.