Regulatory good practice of relevance to voluntary registers

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About the Professional Standards Authority

The Professional Standards Authority for Health and Social Care\(^1\) promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and voluntary registration of people working in health and care. We are an independent body, accountable to the UK Parliament.

We oversee the work of nine statutory bodies that regulate health professionals in the UK and social workers in England. We review the regulators’ performance and audit and scrutinise their decisions about whether people on their registers are fit to practise.

We also set standards for organisations holding voluntary registers for people in unregulated health and care occupations and accredit those organisations that meet our standards.

To encourage improvement we share good practice and knowledge, conduct research and introduce new ideas including our concept of right-touch regulation.\(^2\) We monitor policy developments in the UK and internationally and provide advice to governments and others on matters relating to people working in health and care. We also undertake some international commissions to extend our understanding of regulation and to promote safety in the mobility of the health and care workforce.

We are committed to being independent, impartial, fair, accessible and consistent. More information about our work and the approach we take is available at www.professionalstandards.org.uk.

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\(^1\) The Professional Standards Authority for Health and Social Care was previously known as the Council for Healthcare Regulatory Excellence

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1. Introduction

1.1 This paper summarises good practice advice developed by the Professional Standards Authority (and CHRE) on statutory regulation over the last six years. We hope these summaries, with signposts to further reading, will be useful to current register holders of the AVR scheme and to those who are interested in applying for accreditation in the future.

1.2 Please note accredited voluntary registration differs from statutory professional regulation because it is voluntary, not compulsory. Practitioners can work in occupations covered by the AVR scheme without being on a register. However, we consider that it is useful to highlight areas of good practice where they may assist AVRs in meeting the accreditation standards.

1.3 The paper provides advice in four functional areas - standard setting, education and training, registration and complaints and concerns – and governance, against the Authority’s standards for accredited voluntary registers (AVRs).

1.4 The Authority’s good practice advice featured in this paper has been developed in response to:
- A request for advice from the Secretary of State, or
- A general issue emerging from the Authority’s in-depth scrutiny of the regulators.

1.5 Other sources of good practice are available from the Authority. From time to time the Authority responds to public consultations, carried out by regulators, Government departments and other organisations. Our responses are necessarily specific and focus on issues arising at that time, so details of these are not summarised here. Links to specific responses to individual consultations can be found on our website:

1.6 Our annual performance review reports, audits of the early stages of fitness to practise, special investigations and reports, and learning points bulletins will also highlight good practice and make recommendations. More information can be found here:

Principles of good regulation

1.7 Beyond the main functional areas covered by this paper, we have also offered guidance on good practice in regulatory policy and approaches to regulation. We have summarised this in *Right-touch regulation* (2010) as ‘right-touch regulation’. This is the minimum regulatory force required to achieve the desired result. Right-touch regulation recognises that there is usually more than one way to solve a problem and that regulatory activity is not always the best answer. It may be more proportionate, for instance, to promote greater co-operation and sharing of good practice.
1.8 The concept of right-touch regulation emerges from the application of the principles of good regulation identified by the Better Regulation Executive in 2000:

- Proportionate: regulators should only intervene when necessary. Remedies should be appropriate to the risk posed, and costs identified and minimised
- Consistent: rules and standards must be joined up and implemented fairly
- Targeted: regulation should be focused on the problem, and minimise side effects
- Transparent: regulators should be open, and keep regulations simple and user friendly
- Accountable: regulators must be able to justify decisions, and be subject to public scrutiny.

1.9 To these five we have added a sixth principle, agility. Agility in regulation means looking forward to anticipate change rather than looking back to prevent the last crisis from happening again.

1.10 Alongside the results of regular research work with patients, service users and the public across the UK, and the Authority’s scrutiny work, these concepts and principles underpin the recommendations we make on good practice in regulation.
2. Setting standards for registrants

2.1 The Authority’s accreditation requirements about setting standards relate to the content, publication, promotion and reviews of the standards a voluntary register sets for its registrants.

2.2 These requirements have some similarities to the Authority’s standards of good regulation relating to guidance and standards:

- Standards of competence and conduct reflect up-to-date practice and legislation. They prioritise patient and service user safety and patient and service user centred care
- Additional guidance helps registrants apply the regulators’ standards of competence and conduct to specialist or specific issues including addressing diverse needs arising from patient and service user centered care
- In development and revision of guidance and standards, the regulator takes account of stakeholders’ views and experiences, external events, developments in the four UK countries, European and international regulation and learning from other areas of the regulators’ work
- The standards and guidance are published in accessible formats. Registrants, potential registrants, employers, patients, service users and members of the public are able to find the standards and guidance published by the regulator and can find out about the action that can be taken if the standards and guidance are not followed.

2.3 We have completed a range of policy work in this area. The issues and findings of relevance are described below, with links to the full reports.

Clear sexual boundaries: professionals’ responsibilities (2008)

2.4 In 2008 we published guidance aimed at preventing health professionals from violating the sexual boundaries that should exist between them and their patients/clients. The Department of Health commissioned us to develop this guidance because despite a number of high profile public inquiries, including Ayling, Kerr-Haslam and Peter Green, health regulators were continuing to receive allegations of sexual misconduct towards patients or their carers.

2.5 Health professionals must not display sexualised behaviour towards patients or their carers, because doing so can cause significant and enduring harm. The health professional–patient relationship depends on confidence and

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trust. A health professional who displays sexualised behaviour towards a patient breaches that trust, acts unprofessionally, and may, additionally, be committing a criminal act. Breaches of sexual boundaries by health professionals can damage confidence in professionals generally and leads to a diminution in trust between patients, their families and the professions.

More info: http://www.professionalstandards.org.uk/publications/detail/clear-sexual-boundaries

Professional duty of candour (2013)

2.6 The Francis Inquiry Report into Mid Staffordshire NHS Trust recommended that ‘any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it’. In response to this, in 2013 the Department of Health asked for our advice on what more statutory professional regulation can do to encourage professionals to deliver this ‘duty of candour’.

2.7 The professional duty of candour focuses on the individual’s reaction (and, where appropriate, the team’s reaction) when a mistake happens and harm occurs. There are three aspects to this:

- Recognising that harm has occurred or may have occurred
- Proactively informing the patient or service user about what has happened
- Offering an appropriate remedy and support.

2.8 To these we add a complementary obligation on all professionals to support their peers when they need to be candid and to play an active role in creating a climate where professionals feel able and supported to be candid. This reflects the reality that care is often delivered by multi-professional teams. These four actions are integral to candour, and in our view, a professional duty of candour cannot be said to be met if one or more is absent.

2.9 Please note, our advice did not take a view on what level of harm warrants candour as this issue was beyond the scope of this advice. However we observed that different views exist about the appropriate trigger point.


Providing references about colleagues: the role of the regulator (2009)

2.10 Our 2009 report considered the adequacy of guidance on the ethical responsibility of health professionals to provide objective and transparent references.
2.11 The actions of providing a reference are covered by the core standards of conduct, performance and ethics that apply across all health professions, and within each regulator. Providing a reference should maintain the overriding interests of public protection and patient safety.

2.12 However it is important to note that while the referee has a duty to provide an honest and accurate reference it is for the employer to assure themselves of the qualification and competence of those they propose to employ.

2.13 If at some point in the future such reference guidance were found to be necessary it should require the referee to:
- Act with honesty and integrity
- Include all information relevant to professional competence
- Provide comments which can be substantiated
- Provide comments which are objective, fair, and unambiguous
- Provide information about conduct including matters which might affect trust in a candidate or the profession as a whole, including matters that could put patients at risk.

2.14 The individual should not base comments on personal views about the individual which have no bearing on suitability for the role.


Managing extended practice (2010)

2.15 This 2010 report looked at how regulators manage risks when health professionals extend their practice, either into areas overseen by other regulators or into currently unregulated areas.

2.16 The report identified two main risks associated with this kind of extended practice:
- Professionals being unclear as to the standards they should be working to
- Regulators not being equipped to manage fitness to practise issues in these areas.

2.17 We concluded that these potential risks could be managed using existing approaches. We recommended that the following principles are followed at the individual, employer, regulator and Government level when managing areas of extended practice:
- Registered health professionals should only practice in areas that they are competent to do so; they are responsible for the care that they provide to patients
• Employers should have the appropriate support and performance management systems in place if it employs health professionals in extended roles

• Regulators should ensure their codes of conduct adequately reflect the requirement for health professionals to stay up to date and to operate safely within their areas of competence

• Regulators should only pursue the option of creating a specialist list or annotation on the register when all other approaches have been exhausted

• All parties should demonstrate an active commitment to cooperating and sharing information to manage risks to patient safety and public protection.


Healthcare for people with disabilities – role of regulators (2009)

2.18 Legislation places duties on public bodies to promote disability equality. This 2009 report described how health professional regulators can influence the standards of healthcare experienced by people with disabilities and meet this duty.

2.19 Regulators are one of a number of influences on the quality of care and the report recommends action is taken by other organisations, including governments, service providers and professional leadership bodies. In particular, these organisations should work with agencies representing the interests of disabled people to facilitate the sharing of good practice in the delivery of healthcare to people with disabilities, through training and service improvements.

2.20 The specific recommendations for regulators are:

• As regulators review their standards and codes of conduct and competence, they should address issues raised by patients, service users and carers, through surveys and other research, as well as new statutory developments. Supplementary guidance should focus on the ways and means of practising in a safe and effective manner for groups of people with different disabilities as this may be the most effective way of improving care

• Regulators make certain that education and training programmes throughout a registrant’s professional life provides skills and competencies necessary for meeting the healthcare needs of people with disabilities

• Regulators’ plans for revalidation should consider risks of poor care from patients’ perspectives. This could inform a targeted approach, and help to
remedy the threat of failing to meet the healthcare needs of people with disabilities.

3. **Education and training**

3.1 The Authority’s accreditation standards around education and training require voluntary registers to set appropriate educational standards for competent practice and assure that registrants and training programmes meet those standards.

3.2 The Authority sets similar standards of good regulation for the statutory regulators:

- *Standards for education and training are linked to standards for registrants. They prioritise patient safety and patient centred care. The process for reviewing or developing standards for education and training should incorporate the views and experiences of key stakeholders, external events and the learning from the quality assurance process*

- *The process for quality assuring education programmes is proportionate and takes account of the views of patients, students and trainees. It is also focused on ensuring the education providers can develop students and trainees so that they meet the regulator’s standards for registration*

- *Action is taken if the quality assurance process identifies concerns about education and training establishments*

- *Information on approved programmes and the approval process is publicly available.*

3.3 We have completed a number of good practice projects in this area. The relevant issues and findings are described below, with links to the full reports.

**Learning about clear sexual boundaries (2008)**

3.4 We published recommendations around learning about sexual boundaries as part of the 2008 project mentioned above (see 2.4). The recommendations were directed towards those organisations that have a key role in health professional education and training.

*Recommendations to regulators*

3.5 Regulators should strongly encourage the inclusion of training on sexual boundaries within curriculum and validation mechanisms, and specifically question providers as a routine part of quality assurance.

3.6 Regulators should work with Royal Colleges and professional associations to ensure that an appropriate balance is struck between what might best be imparted at a pre-registration level, and what should be taught as part of post-registration education and training or continuing professional development.

3.7 Regulators should make available to education and training establishments, including colleges and schools, examples of previous fitness to practise cases and relevant legal challenges, for use as part of learning about boundaries.
3.8 Regulators should consider opportunities for synergy between the creation of materials for use in training, and the creation of materials for use within their fitness to practise processes. Training programmes could, in the future, form part of remedial/rehabilitative sanctions for health professionals who have breached sexual boundaries, but who demonstrate a degree of insight, consent to remediation, and are considered to be of sufficiently low risk to be allowed to remain on the professional register. Attendance on such a programme could also be a prerequisite for re-admittance after a period of suspension.

3.9 Regulators should work together to ensure that codes of conduct and other guidance about sexual boundaries emphasise the shared, core responsibilities of all regulated health professions.

Recommendations to Royal Colleges and professional associations

3.10 The sensitive nature of teaching of sexual boundaries means that in-depth teaching of this subject (and certainly the specialty-specific dimensions) may be more usefully included as part of specialist training. Even if students have been taught about boundaries pre-registration, this will need to be reinforced once they are registered. Medical specialties which have the highest reported incidences of sexual boundary transgressions can reasonably be expected to take a lead on training provision (psychiatry, general practice and obstetrics and gynaecology). Professional bodies within other health professions should also demonstrate a commitment to training provision in this area, for example, by making boundaries training a compulsory element of continuing professional development (CPD). As identified above, effective supervision is an important part of the strategy for preventing abuse. Royal Colleges and professional associations might wish to consider formal mechanisms for widening access to supervision. In smaller professions one suggestion might be to encourage or require more senior health professionals to supervise newly-registered colleagues.

3.11 Royal Colleges and professional associations should ensure that they use information from data collection (of disciplinary and fitness to practise cases) to make sure that educational content is informed and up-to-date.


Quality assurance of undergraduate education programmes (2009)

3.12 One of the key responsibilities for statutory regulators is to assure the quality of education and training courses for students. In 2009 we were asked to advise on the different approaches taken by the regulators.

3.13 The report describes how the regulators’ involvement in quality assurance is valued by education providers for the confidence and specific expertise it provides. However, regulators are only one of a number of parties with an interest in undergraduate health programmes. Funders and commissioners,
and professional organisations, are also involved. Therefore concern has been expressed about the total impact and possible overlap of different quality assurance type processes on higher education. We conclude it would be impractical to try to seek a definitive solution to these different interests and it may be more productive to focus on establishing ways to live with change and manage any tensions that arise.

3.14 Therefore all regulators must be willing and able to demonstrate how their processes link proportionately to patient safety and public protection, maintaining the focus on the issue of being fit to join the register, or making further progress towards this point, is essential. Demonstrating the contribution of quality assurance to the main duty to protect the public would be valuable, both in improving education and in assuring the public of the competency of newly qualified health professionals.


### Sharing outcomes of student fitness to practise hearings (2010)

3.15 This 2010 report makes recommendations on handling outcomes of student fitness to practise panels held by education providers. We consider that it is in the interests of public protection to share an individual student’s fitness to practise sanctions with a regulator.

3.16 We recommend that the student and the education provider should declare information about student fitness to practise sanctions to the regulator. It is for regulators to decide how and when they seek this information prior to registration.

3.17 Regulators should collect data about student fitness to practise in their role in quality assuring the provision of pre-registration education and training. This should be used to improve standards of education and training and to improve the provision of guidance to students about professional conduct and competence.

3.18 Regulators should work with education providers to share good practice in the management of student fitness to practise issues.

4. Keeping a register

4.1 The Authority’s accreditation standards around registration cover the purpose of the register, maintenance of the register, access to the register, entry standards for registration, maintaining and checking continuing fitness to practise, recognising other organisations’ registration decisions, and how decisions about admissions and removal will be reviewed.

4.2 The Authority sets similar standards of good regulation for the statutory regulators.

- Only those who meet the regulator’s requirements are registered
- The registration process, including the management of appeals, is fair, based on the regulators’ standards, efficient, transparent, secure, and continuously improving
- Through the regulators’ registers, everyone can easily access information about registrants, except in relation to their health, including whether there are restrictions on their practice
- Employers are aware of the importance of checking a health professional’s registration. Patients and members of the public can find and check a health professional’s registration
- Risk of harm to the public and of damage to public confidence in the profession related to non-registrants using a protected title or undertaking a protected act is managed in a proportionate and risk based manner
- Through the regulator’s continuing professional development/revalidation systems, registrants maintain the standards required to stay fit to practise.

4.3 We have completed a number of good practice projects in this area. The relevant issues and findings are described below, with links to the full reports.

Maximising registers contribution to public protection (2010)

4.4 Our 2010 report on registers established that registers should be easily accessible to members of the public, and that sanctions should be made clearly visible to the public on the register. This is important for voluntary registers, as those who are struck off a voluntary register can legally continue to practise without registration.

4.5 This project confirmed our understanding that if a member of the public is going to the trouble of checking a regulator’s register, this should be straightforward and the information should be useful. The recommendations we made for online registers should be complemented with other effective enquiry routes for members of the public, such as by post and telephone. We also recommended that regulators should also encourage their registrants to make wider use of registration numbers in correspondence and practice environments.
4.6 At the time, only some of the regulators provided access through their online registers to information about health professionals currently prevented from practising because of fitness to practise sanctions. The absence of this information can be confusing for members of the public searching for a health professional. We recommended that regulators should provide information about all current fitness to practise sanctions on the online register. We believe that existing legislation should not be a barrier to introducing this as there is discretion for many of the regulators to make information available if it is in the public interest.

4.7 There is a public protection issue when individuals who have been struck off the register continue to provide services to the public under a different, unregulated title. Such instances indicate that fitness to practise sanctions remain relevant long after the panel has issued its determination. We recommend that regulators should publish information about health professionals who have been struck off on their online register for at least five years.

4.8 The benefits and disadvantages of making fitness to practise sanctions that are no longer in force available to the public are finely balanced. We accept that the purpose of the fitness to practise process is not to punish a health professional, and that a professional with an expired sanction has been judged to be fit to practise. However, in line with the principle of regulators operating transparently, we have given more weight to the rights of patients than those of professionals. Information that is already available should be made as accessible as possible. We recommend that regulators who do not currently publish fitness to practise histories should begin to take a proportionate approach to making this information available against a register entry.

4.9 For online registers to be credible, useful and accessible, we recommend that they should have the following features:

- Clear signposting from the regulator’s homepage to the register search page
- Search functionality that supports some flexibility, such as the ‘sounds like’ option on the GMC register
- A comprehensive listing that reflects all current sanctions including suspensions and those who have been struck off
- Links to information about previous fitness to practise sanctions
- Ease of navigation to greater levels of detail where available, such as direct links to fitness to practise determinations
- Provide an indication of location of practice to help to identify an individual professional
- Provide a glossary to aid understanding of the terms used in registers
- The absence of material that could compromise the credibility of the data, such as advertising.
Advanced practice (2009)

4.10 Where the nature of a profession’s practice changes for some individual registrants to such a significant extent that their scope of practice is fundamentally different from that at initial registration – rather than more subtly evolving over time – regulatory bodies may need to consider whether action is necessary to assure the professional’s fitness to practise in the context of a very different nature of practice where risk to the public is evident.

4.11 Such cases would be where the standards for practising proficiently in these roles are significantly different to those assessed against at initial registration, going far beyond ordinary progression within a given scope of practice, and where the risks to patients from these roles are of a qualitatively different nature from those ordinarily associated with the practice of the profession.

4.12 However, much of what is often called advanced practice appears to represent career development within a profession over time and not a fundamental shift in a profession’s practice such that the risks to patient safety are not adequately captured by the existing standards of proficiency and ethical duties.

Health conditions at registration (2009)

4.13 The work on health conditions concluded that health should only be of interest to the regulator insofar as it affects a registrant’s fitness to practise.

4.14 We believe that there is an important distinction between formal health requirements and fitness to practise requirements. Regulatory bodies do not need health requirements that go beyond determining whether someone is fit to practise, either at registration or during fitness to practise procedures. Health issues may be material in determining whether a person meets the competence and conduct standards, but should not be a separate requirement.

4.15 However, health needs to be one of the grounds on which a regulatory body can find a person’s fitness to practise to be impaired. This is because if issues around the person’s health are an underlying reason for their practice not meeting the competence and conduct standards, it is the health issues that are a ground for establishing this and then finding fitness to practise to be impaired (failure to meet standards does not itself ground a finding of impairment).
4.16 We recommend that the language regarding the health of registrants reflects this position. For both registration and fitness to practise procedures the concern of the regulatory body is whether the person is fit to practise – whether their practice meets the necessary competence and conduct standards. However, in some cases the particular circumstances of an individual’s health and their approach to their practice may be of material relevance to the question of whether their practice meets these standards, and regulatory bodies need the ability to access and consider such information. We believe that there should be single requirement of fitness to practise for registration and that consideration be given to reordering regulatory bodies’ fitness to practise procedures so that there is a single committee with responsibility for all fitness to practise hearings. The purpose of these changes would be to make clear that health is not considered in isolation, but only insofar as it relates whether a person’s practice meets the necessary competence and conduct standards.

More info: http://www.professionalstandards.org.uk/publications/detail/health-conditions-at-registration

Common approach to good character (2008)

4.17 This report proposed a standard definition and approach to good character across the regulatory bodies. The purpose of ‘good character’ assessments is to establish whether someone would practise safely and effectively if registered. Our common approach emphasises public protection, public confidence, acting in accordance with professional standards, and honesty and trustworthiness.

4.18 We have identified four key elements which we believe form a basis on which good character can be approached. These are whether an applicant has acted, or there is reason to believe they are liable in future to act:

- In such a way that puts at risk the health, safety or wellbeing of a patient or other member of the public
- In such a way that his/her registration would undermine public confidence in the profession
- In such a way that indicates an unwillingness to act in accordance with the standards of the profession
- In a dishonest manner.

4.19 When it comes to making a judgement on good character, the regulators can only affirm that, given the evidence available to them, they are not aware of any factor that would call into question the good character of the applicant. References to good character should reflect this as it is important that the public are not misled on the level of assurance that the regulators can give regarding their registrants. The regulators cannot assure that an individual possess particular traits, only that given the evidence available it is not reasonable to believe the individual lacks them.
Lapses in professional registration (2013)

4.20 We looked at issues related to lapsing registration following concerns that emerged in the 2011/2012 performance review. It is in the interests of registrants and the regulators themselves to preserve the integrity of the register and ensure that it displays the names of those who have met the requirements of continuing registration. Increasingly registration is linked to indemnity insurance cover. ‘Unwanted’ registration lapses could challenge both of these objectives.

4.21 A register should be a reliable and up to date list of those practitioners who have met the relevant requirements; members of the public and employers should be able to place their trust in them as such. Lapsed registrations have the potential to undermine the integrity of these registers along with people’s trust in them.

4.22 Lapsing can create a public protection risk if the registrant is allowed to lapse inadvertently by the regulator while they are under a fitness to practise investigation, or while they are under conditions of practice.

4.23 Some of the regulators compromise the integrity of their register by waiting several weeks before removing registrants if they have failed to renew or pay the fee, meaning that for a time, some people who should not be registered are. Conversely, sometimes people who should be registered are not because of mistakes by the regulator in processing payments and applications.

4.24 All registrants have a professional responsibility to meet their regulator’s requirements whatever they may be. The regulator should support and enable registrants to meet its requirements; and it is in its interests to do so, to help it meet its statutory requirements to maintain the register.

4.25 We picked out some areas that regulators could work on to reduce lapsing rates, such as communication, online facilities, and facilitating fee payment. For more information see section 5 of the report.

More info: http://www.professionalstandards.org.uk/publications/detail/lapses-in-professional-registration

Right-touch approach to continuing fitness to practise (2012)

4.26 This report built on the general principles of right-touch regulation and applied it to the question of continuing fitness to practise. We concluded that a register holder should understand the risks presented by its registrants, and
respond appropriately with measures to keep registrants fit to practise and up-to-date.

- Continuing fitness to practise should focus on both conduct and competence
- There is a range of possible responses to the challenge of assuring continuing fitness to practise; revalidation is just one of them
- Regulators need to understand and quantify the risks presented by the professions they regulate in order to develop proportionate and targeted continuing fitness to practise measures
- How reliable a regulator’s continuing fitness to practise measures need to be should depend on the level of risk presented by the professions they regulate.

5. Complaints and concerns

5.1 The Authority’s accreditation standards around complaints and concern cover the provision of information about complaints processes, encouraging early resolution of complaints, providing advice and support to those involved in cases, focusing on public and service user protection, quality of decision making, and liaison with other agencies with similar aims, where appropriate.

5.2 The Authority sets similar standards of good regulation for the statutory regulators:

- Anybody can raise a concern, including the regulator, about the fitness to practise of a registrant
- Information about fitness to practise concerns is shared by the regulator with employers/local arbitrators, system and other professional regulators within the relevant legal frameworks
- Where necessary, the regulator will determine if there is a case to answer and if so, whether the registrant’s fitness to practise is impaired or, where appropriate, direct the person to another relevant organisation
- All fitness to practise complaints are reviewed on receipt and serious cases are prioritised and where appropriate referred to an interim orders panel
- The fitness to practise process is transparent, fair, proportionate and focused on public protection
- Fitness to practise cases are dealt with as quickly as possible taking into account the complexity and type of case and the conduct of both sides. Delays do not result in harm or potential harm to patients. Where necessary the regulator protects the public by means of interim orders
- All parties to a fitness to practise case are kept updated on the progress of their case and supported to participate effectively in the process
- All fitness to practise decisions made at the initial and final stages of the process are well reasoned, consistent, protect the public and maintain confidence in the profession
- All final fitness to practise decisions, apart from matters relating to the health of a professional, are published and communicated to relevant stakeholders
- Information about fitness to practise cases is securely retained.

5.3 We have completed a number of good practice projects in this area. The relevant issues and findings are described below, with links to the full reports.
Modern and efficient fitness to practise adjudication (2011)

5.4 In 2011 we were asked to provide advice on modernising and improving the efficiency of fitness to practise adjudication among the health professional regulators.

5.5 We concluded that although adjudication has improved over recent years, a number of issues remain. There is a strong sense of inconsistency in outcomes both within and between regulators. Good practice is not consistently demonstrated. People who raise a concern to a professional regulator find the process stressful and daunting. There remains confusion about the purpose of fitness to practise.

5.6 We made a number of recommendations to the regulators, based upon common issues highlighted in our scrutiny work. We consider these represent good practice and lead to good quality adjudication outcomes. These are summarised below.

Getting the best from panels and panellists
- Recruiting against competencies, providing training, regular appraisal and feedback
- Providing clear and comprehensive indicative sanctions guidance to help in decision making

Getting the best from staff
- Training, appraisal and performance management
- Providing guidance on operations and decision-making
- Bespoke training on investigation skills
- Manageable caseloads

Widening understanding of the process with external stakeholders
- Information for patients and the public about fitness to practise process and nature of concerns investigated
- Guidance for employers on thresholds for referral
- Working with groups representing registrants and patient advocates
- Effectively administering and hearing cases
- Service standards for case progression to encourage timely adjudication and avoid delays
- Using IT to improve administration and record keeping of cases, and to provide accurate management information
- Dedicated accommodation for hearings

Communicating clearly with all parties about case progress and decision making
- Training staff in good communication skills
• Corresponding with all parties at regular intervals and after panel decisions
• Disclosing decisions to third parties, including overseas regulators

**Good stakeholder relationships**
• Working with employers to build relationships and deliver faster resolution of complaints
• Working with primary care organisations at a local level
• Increasing focus on customer service
• Supporting witnesses through the process
• Virtual hearing room and patient information websites
• Vulnerable witness support scheme
• Witness guidance and information packs

**Learning from experience for continuous improvement**
• Customer satisfaction survey of those who go through the process
• Mystery shopping
• Learning from complaints
• Quality assurance audits of decisions
• Sharing learning points from individual cases.


**Harmonising sanctions (2008)**

5.7 We completed a project in 2008 to identify a harmonised set of sanctions for all regulatory bodies, and the public’s preferred terms for different sanctions. Alongside undertakings, which are not sanctions, the project concluded that the following would be the ideal sanction set:

• ‘Warning’ – appropriate in cases in which there is a need to indicate to a registrant, and more widely to the profession and the public, that their conduct or behaviour fell below acceptable standards, but when there is no need to take action to remove or restrict a registrant’s right to practise. This term was preferred to ‘caution’

• ‘Conditions of practice’ – conditions enable registrants to take steps to remedy any deficiencies in their practice while placing restrictions on the types of work that they may undertake. Conditions might be appropriate when there is evidence of incompetence or significant shortcomings in a registrant’s practice, but the panel is satisfied that there is potential for the registrant to respond positively to retraining and supervision. Conditions
are also likely to be appropriate when a registrant’s fitness to practise is impaired by ill health, but they demonstrate sufficient insight to comply with conditions

- ‘Suspension’ – the registrant is not able to practise for a specified period of time. Suspension can be used to send out a signal to the registrant, the profession and public about what is regarded as unacceptable behaviour. Suspension from the register also has a punitive effect (if not intention), in that it prevents the registrant from practising and may therefore prevent them from earning a living in that profession during the period of suspension.

- ‘Striking Off’ – the most severe sanction, removing the registrant from the register. When this happens there is a general expectation that it will normally be for life and that the registrant will not be able to practise again. This term was preferred to ‘erasure’ and ‘removal’

- ‘Fines’ – a contentious option, but on balance, the need to ensure that a sanction can be imposed against all types of registrant, including businesses, when there is a fall in standards has led us to conclude that fines have a place in a common sanction set.


### Sharing registrant’s response with the complainant (2010)

5.8 This report arose from the 2008/2009 Performance Review which found there was variation across the regulators about sharing the registrant’s response to a complaint with the complainant.

5.9 We consider that the benefits to sharing the response outweigh the risks, as it can help to bring information to light, establish an accurate record of events to decide if a case should proceed to a fitness to practise hearing and lead to the early resolution of a case by providing clarification to the complainant. While there are circumstances when a response would not be shared in full, there should be a presumption of sharing and registrants should be informed of this at the outset.

5.10 We make the following recommendations from the perspective of fairness and transparency, rather than of statutory duty:

- In cases where the regulator has requested a response from the registrant, this ought to be shared with the complainant while deciding if a case should be referred to a fitness to practise committee

- When a registrant includes comments of a personal nature not relevant to the case, details that reveal the identity of a whistleblower, or reference to sensitive personal information about the registrant (e.g. their health or finances), this should not be shared
• Regulators ought to provide clear guidance to registrants on what is expected of them, and what should be included in their response, when a complaint is made against them

• Regulators ought to provide clear guidance to complainants on the purpose and potential outcomes of the fitness to practise process, and details of the independent advocacy services available to them.

More info:

Clear sexual boundaries – guidance for fitness to practise panels (2008)

5.11 We published recommendations and guidance for fitness to practise panels on sexual boundary violation as part of the 2008 project mentioned above (see 2.4). It is important that fitness to practise (FtP) panel members are adequately informed about this subject so that they can fulfil their public protection function.

5.12 Panels need to be aware of certain critical factors when adjudicating cases involving sexual boundary breaches. These include the following:

• Sexual boundary breaches commonly involve vulnerable people

• Health professionals who breach sexual boundaries tend to abuse more than one patient, and use strategies such as minimisation, normalisation and denial when challenged about their behaviour

• Contrary to stereotypes, healthcare professionals who abuse patients may be personable and charismatic, highly regarded by their colleagues and held in high esteem by other patients

• Confusion about boundaries can impair clinical judgement

• Patients themselves may have a poor sense of appropriate boundaries. Setting boundaries is important for the protection of the professional as well as the safety of the patient.

5.13 Research shows that people who have been seriously abused respond in a number of ways that may have a bearing on how they appear as witnesses before panels. Dissociative identity disorder (DID) is a common symptom of having been sexually abused. This may result in complainants becoming frozen or withdrawn under stress, and appearing to lose concentration whilst giving evidence. Victims of abuse may also demonstrate passive compliance or learned helplessness, or blame themselves for what has happened. In short, witnesses may not present as strongly as panel members might expect, given the nature of their allegations. Abused patients may, alternatively, present as hostile and angry with a disdain for authority and misgivings as to whether they will get a fair hearing. Panel members need to bear this in mind when evaluating a witness’s demeanour and the reliability of their evidence.
Panel members need to appreciate that a complaint may not have been lodged immediately. It may be several years before the complainant came forward. This is entirely consistent with a post-traumatic shock disorder diagnosis, and may be exacerbated if the patient has previous experience of abuse. It may take many years for a patient to be able to pin-point the source of their problems, or to appreciate that what they experienced constituted abuse. This needs to be borne in mind if a professional raises in mitigation that no other complaints have been raised in the years since the alleged events.

6. Governance

6.1 The Authority’s accreditation standards cover the commitment to protecting the public and promoting public confidence, good practice in governance including adhering to a set of principles and values, service user and public involvement along with more general stakeholder engagement and cooperation, and effective communication.

6.2 The Authority does not have equivalent standards for the statutory regulators it oversees. However, we have completed a number of good practice projects in this area. The issues and findings are described below, with links to the full reports.

‘Fit and proper’: governance in the public interest (2013)

6.3 Our paper on governance sets out what we believe to be the central characteristics of an effective board that works in the public interest.

6.4 This report discusses how responsibility is both individual and collective. Individual responsibility requires people to be sure they understand, to have the courage to challenge and be challenged, and to give voice to their issues and concerns. Collective responsibility follows on from this: it requires them to acknowledge the decision of the board and uphold it whether or not they personally agree with it.

- Board members are responsible for their organisation and accountable for its performance
- Board members must demonstrate both behaviours and values appropriate for the holding of public office. They must demonstrate seriousness of purpose, probity, integrity, resilience and courage
- Recruitment procedures should focus on the competences required for the membership of the particular board in question, rather than looking narrowly at time served on seemingly similar boards
- Organisations need to support their board members to play their role fully and effectively, including through induction and development opportunities and effective appraisal
- Disagreements are part of the proper process of thorough scrutiny. The Chair has a vital role to play in steering the board through disagreements, ensuring different sides to an argument are explored and examined and that business disagreements do not become personal conflicts. It is necessary to have escalation measures in place, but they should not be used as a distraction or substitute for the rigorous exploration of different opinions assumptions and ideas
- Board members should take responsibility for their own behaviour, and all board members must challenge others when they see casual and irresponsible attitudes, discourteous language or disingenuous and manipulative behaviour
• Chairs and chief executives needs to appreciate each other's role and work in partnership

• The Chair should lead and develop the board to chart the organisation’s strategic direction, prioritise the organisation’s resources and enable a culture in which the chief executive and staff can succeed

• The chief executive leads and develops the staff team

• Individual members of boards should not be representative of the interests of any particular group or constituency

• Members should commit to declaring any personal, professional or financial interests and ensuring that they do not interfere with my actions, transactions, communication, behaviours or decision-making, and removing myself from decision-making when they might be perceived to do so

• The importance of identifying and managing conflicts of interest extends to panels and committees within the regulatory bodies

• A proper degree of formality should be observed in boards to prevent any perceptions of conflicts of interest where there are none

• Boards should be transparent, for example by holding meetings in public unless there is a compelling reason not to. There should be clear decision-making processes at every level of the organisation and information should be made public proactively

• Boards should receive performance information that tells them enough so that they can make judgements about what is going on without being overwhelmed by non-essential detail. They should assure themselves of the quality of the information and challenge it where necessary. They should follow up on action points, and seek performance information as opposed to descriptions of process. Proper oversight of corporate complaints should be part of this information.


Board size and effectiveness (2011)

6.5 In this report we found that smaller boards appeared to be more effective and that boards should move away from representativeness in membership if they are to govern effectively in the public interest.

6.6 We suggest that smaller boards, in the range of 8 to 12 members, are associated with greater effectiveness. It appears that smaller sized groups are able to communicate more effectively and reach decisions more quickly than larger ones. In addition, they are less likely to suffer from fragmentation and clique-formation and more likely to develop a culture of inclusiveness than their larger counterparts. Finally, since smaller boards struggle to
involve themselves in issues that should be delegated to the executive, a smaller size helps them to focus their efforts on core governance issues.

6.7 There is an important shift in thinking required in the governance of regulatory bodies in moving away from the concept of representativeness in membership. Small boards cannot ‘represent’ all relevant constituencies or stakeholders nor should they attempt to do so. Rather boards should demonstrate the knowledge, understanding and awareness to properly take into account relevant interests, such as those of different groups of professionals or the different health systems in the UK, but they should not attempt to ‘represent’ them.


Patient and public participation in regulation (2011)

6.8 We have developed a set of principles for regulators to consider when planning and carrying out their patient and public participation and involvement activities. These are:
- Be clear and focused
- Use existing knowledge, networks and expertise
- Make it easy for people to participate
- Listen, act, and provide feedback
- Make patient and public participation part of everyday business.


Advice on establishing the GPhC (2008)

6.9 In 2008 we provided advice on the establishment of the General Pharmaceutical Council. We felt that the GPhC had the potential to become an exemplar of modern professional regulation: effective in protecting patients, agile in identifying and responding to change, and balanced in its approach to risk and regulation.

6.10 We recommended that a new regulator would need to
- Allocate its resources according to assessment of risk to patient safety, taking a light touch where risk to patient safety is low and focusing on areas where risk is highest
- Establish a horizon-scanning function capable of anticipating the changes in practice which will occur over the next decade
- Be able to adapt quickly to reflect change in its standards, structures and processes
- Be flexible in setting standards, with new areas of practice being anticipated and standards developed and promulgated quickly.

6.11 These recommendations were based on the following good governance principles:

- The council should uphold the purpose of the organisation as established by parliament, determine its values and keep both its purpose and values in mind at all times, with mechanisms in place for annual review
- The council should be forward- and outward-looking, focussing on the future, assessing the environment, engaging with the outside world, and setting strategy
- The council should determine the desired outcomes and outputs of the organisation in support of its purpose and values
- For each of the desired outcomes the council should decide the level of detail to which it wishes to set the organisation’s policy – any greater level of detail of policy formulation should then be a matter for the determination of the chief executive and staff
- The means by which the outcomes and outputs of the organisation are achieved should be a matter for the chief executive and staff; the council should not distract itself with operational matters
- The chief executive should be accountable to the council for the achievement of the organisation’s outcomes and outputs
- In assessing the extent to which the outcomes have been achieved, the council must have a framework of pre-determined criteria against which performance is reported both internally and externally
- The council should engage with its key interest groups including patients, the public, registrants, employers, educators and the devolved administrations, and be confident that it understands their views and priorities
- The membership of the council should have the capacity and skill to understand the priorities of each of these key constituents
- Information received and considered by the council should support one of three goals – to allow informed decision making, to fulfil control and monitoring processes or to enable the council to co-operate with CHRE and to be accountable to parliament
- The council must govern itself effectively, with clear role descriptions for itself, its chair, and its members, with agreed methods of working and self-discipline to ensure that time is used efficiently
- The council must ensure that issues of equality and diversity are considered as part of all its work.

Good practice in making council member appointments (2014)

6.12 Since July 2012 the Authority has been responsible for advising the Privy Council on the quality of the processes the health and care professional regulators (excluding the Pharmaceutical Society of Northern Ireland) use to recommend candidates for appointment as chairs and members of their councils. It is the Privy Council which makes these appointments, but the regulators are responsible for running a suitable process to select candidates to recommend to the Privy Council. Our role is to scrutinise the process the regulator has used, and assess whether it is fair, whether it is transparent and open, whether it inspires confidence, and whether it ensures all selection decisions are based on evidence of merit.

6.13 To support the regulators’ work in this area, we published good practice guidance.


7. Document Control

Version Control

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