hpc health professions council

Council – 25 March 2010

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

Executive summary and recommendations

Introduction

The Health and Social Care Act 2008 provided the Council for Healthcare Regulatory Excellence (CHRE) with powers to review decisions made by the healthcare regulators at the initial stages of their fitness to practise processes. Between April and December 2009, CHRE undertook the first audits of the nine regulatory bodies with the HPC audit taking place in December 2009. On 1 March 2010, CHRE published that report and a result the Executive has undertaken a review of that report and its recommendations to both identify any learning for the HPC from the CHRE's recommendations and to further specific information concerning the conduct of the HPC's fitness to practise function, to the Council.

Attached as an appendix to this cover paper is the results of that review.

Decision

The Council is requested to:

i Discuss the attached report; and

ii instruct the Executive to proceed with the recommendations outlined on page 21 of HPC's response and;

iii instruct the Executive to provide progress reports to future meetings of the Fitness to Practise committee.

Background information

PKF (HPC's Internal Auditors) undertook a series of reviews in relation to the work of the Fitness to Practise department over September and October 2009. That report was considered by the Audit Committee in December 2009 and by the Fitness to Practise Committee in February 2010.
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Resource implications

To be discussed in future papers

Financial implications

To be discussed in future papers

Appendices/Links

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

HPC response

Date of paper

15 March 2010

Fitness to practise audit report

Audit of health professional regulatory bodies' initial decisions

February 2010

council for healthcare regulatory excellence

About CHRE

The Council for Healthcare Regulatory Excellence (CHRE) 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), Health Professions Council (HPC), Nursing and Midwifery Council (NMC), Pharmaceutical Society of Northern Ireland (PSNI), Royal Pharmaceutical Society of Great Britain (RPSGB)

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1. Executive summary

1.1 Since 2003 we have reviewed every decision made by the final fitness to practise panels of the nine health professional regulatory bodies. Where a decision has been unduly lenient or has not protected the public, we have appealed the matter to court if we decided it was in the public interest to do so. We have also fed back learning points to improve the quality of fitness to practise panels' decisions.

1.2 Between April and December 2009, we carried out our first audit of the earlier stages of the regulators' casework. We looked at cases that had been closed without reference to a final fitness to practise panel. We took a sample of 100 cases or, at the smaller regulators where the overall caseload was fewer than 100, we looked at all such cases.

1.3 Our first audit has proved to be a valuable exercise. We have a much fuller view of the performance of the regulators. We have first hand evidence of areas of good practice and of areas of practice that present risks.

1.4 In the initial stages of their fitness to practise procedures, the regulators decide whether cases should be closed or referred to a final fitness to practise panel hearing. The vast majority of these closure decisions were reasonable and did not present any potential risk to the public. We found examples of good practice which we will encourage the regulators to consider adopting. However we have also found inconsistent standards of practice which create potential risks to public protection and confidence. We found examples of:

- Problems of policy
  - Inadequate guidance and delegations for decision makers
  - Failure to resource and manage case files and lack of adequate computer management systems
  - Differences between the standards expected of registrants by the regulators and the standards expected by employers.

- Problems of practice
  - Inadequate investigation and analysis leading to poor decisions to close cases
  - Poor judgement in individual decisions to close cases
  - Examples of failures to consider interim orders to protect the public.

1.5 **We recommend that each regulator should:**

- Review its processes and practices in the light of the risks we have identified in their own and other regulators' processes
- Look for opportunities to adopt the good practice we have identified in other regulators' reports
- Make sure that it has comprehensive guidance for staff who handle cases and for staff and committee members who make decisions
- Test the integrity and quality of systems for recording and storing information, for both paper and computerised formats

- Make sure that it has robust and clear systems for carrying out risk assessments and for applying for interim orders where appropriate
- Adopt as far as appropriate the practice of routine medical examinations of registrants who are convicted of drink driving or drug offences
- Develop guidance and practice to make sure that decision makers record and communicate clearly the full reasons for their decisions
- Take special care when analysing and using information from investigations carried out by other bodies. Although the other organisation may have taken no action, there may still be grounds for action or further investigation into fitness to practise matters
- Make sure there is a source of clinical advice for decision makers, and make sure that this is used when necessary
- Develop excellent relationships with employers. This will help in providing information during the investigation of a case and in managing risks after a case is closed
- Adopt our previous recommendation that registrants' responses be shared with complainants at an early stage.

1.6 We have seen that our findings have, in some cases, already led directly to improvement in practice. We are confident that this report will lead to further improvements, not least as it will provide new information from which regulators can learn.

SECTION ONE
Overall assessment

2. Introduction

2.1 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.[2]

The importance of the regulators' work in fitness to practise

2.2 Patients and the public are entitled to know whether the health professional regulatory bodies are protecting the public through the operation of their fitness to practise procedures. We carried out this audit of decisions made by the regulators in the initial stages of their fitness to practise processes to assure the public that this is happening.

2.3 The effective operation of fitness to practise procedures is crucial in protecting the public. Ensuring that fair, proportionate and timely action is taken where a registered professional's fitness to practise is impaired is essential for the following reasons:

- To ensure that the public are protected from professionals who present a risk of direct harm to them
- To maintain confidence in the regulated professions
- To maintain confidence in the systems of regulation
- To ensure that professionals are treated fairly
- To ensure that professionals have confidence in their regulatory body.

Why and how we carried out the audit

2.4 We undertake annual performance reviews of the health professional regulators to assess whether they are fulfilling their statutory duties to protect and promote the health, safety and wellbeing of members of the public. Until 2009 our power to scrutinize their fitness to practise decisions was confined to our review of decisions made by their final stage fitness to practise panels or committees. Where we consider that such decisions are too lenient and do not protect the public we can refer them to Court.

2 Department of Health, 2007. *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*. London: The Stationery Office. Chapter 1, para 1.2.

2.5 Most fitness to practise complaints or enquiries do not reach a final stage fitness to practise panel. In the Health and Social Care Act 2008 we were given additional power to review decisions made at the initial stages.

2.6 Further details about our powers to review fitness to practise decisions and how we developed the process for this audit can be found at Appendix A. Further details of how we selected the audit sample for each regulator are contained in Appendix B of this report.

Conducting the audits

2.7 The audits of the nine regulators took place between April 2009 and December 2009 according to the following timetable:

- General Medical Council (GMC) - April 2009
- General Chiropractic Council (GCC) – May 2009
- Nursing and Midwifery Council (NMC) – June 2009
- General Osteopathic Council (GOsC) – July 2009
- General Optical Council (GOC) – July 2009
- General Dental Council (GDC) – September 2009
- Pharmaceutical Society of Northern Ireland (PSNI)– October 2009
- Royal Pharmaceutical Society of Great Britain (RPSGB) – November 2009
- Health Professions Council (HPC) – December 2009.

2.8 We received complete co-operation from the staff in all of the regulators when conducting the audits. We are very grateful to them all for assisting our work and in particular for explaining their procedures and answering our queries.

Mystery shopping pilot project

2.9 During the course of the audit we invited all of the regulators to take part in a pilot 'mystery shopping' project. This was designed to assess how they deal with initial telephone queries about fitness to practise. The GDC, GOC, GOsC and PSNI agreed to take part in the project. CHRE also took part, so that our own response to telephone queries across the organisation could be tested.

2.10 We commissioned independent researchers to carry out the exercise. Posing as members of the public, the researchers phoned each regulator, and CHRE, and presented a variety of scenarios.

2.11 The researchers then assessed whether the regulator had dealt with their query appropriately. The calls were assessed to see whether the regulator encouraged and helped the complainant, and whether the regulators gave accurate information about their fitness to practise processes.

2.12 At the time of writing this report, we have not fully analysed the information from the research. However, an initial assessment shows encouraging results. We welcome these regulators' open approach to this project, and their time in helping us prepare the research. We believe that they and CHRE will find the mystery shopping exercise useful in assessing how they deal with such calls.

3. Our findings

Overview

3.1 In the initial stages of their fitness to practise procedures, the regulators decide whether cases should be closed or referred to a final fitness to practise panel hearing. The vast majority of these closure decisions were reasonable and did not present any potential risk to the public. However, the quality of protection provided by the regulators varied considerably. In a few regulators we found individual cases where we felt the regulator's handling of the case failed to ensure there was no potential risk to the public.

How do the regulators compare?

3.2 The regulators follow different processes for investigating and assessing cases. This is in part a result of the wide difference in number and type of cases they deal with. Generally these differences in approach are reasonable and appropriate and do not in themselves present risks.

3.3 In Section 2 of this report we give our detailed assessment of each of the regulators. We also draw attention to significant areas of good practice and risk that we identified during period covered by our audit.

3.4 In addition we want to draw particular attention to the following important concerns in particular regulators' performance in key areas of policy and practice:

Decision making and investigations

- At the HPC we found three cases where, in our view, decisions to close a case may not have protected the public or might undermine public confidence. We disagree with the decisions made, or think they were based on incomplete investigation
- At the NMC we found cases which were closed without adequate information, despite the fact that the allegations suggested that the registrant was a risk to the public through lack of competence or a health condition
- At more than one regulator we were concerned that decisions and investigations of external bodies, such as the police or NHS, were in some cases adopted too uncritically.

Failure to follow own processes

- At the NMC, some cases were closed by officers without proper authority.

Process and policy weakness

- We consider that the effectiveness of the PSNI is significantly undermined by its limited powers to investigate and impose a range of sanctions

- At the NMC, written delegations from the investigating committee to staff were poorly expressed. These aimed to describe when staff could close cases without committee approval. Written guidance for staff at the NMC was generally weak or non-existent
- At the NMC, serious inadequacies in information management during the period audited undermined the integrity of the casework system. We are hopeful that, as long as there are proper management controls and guidance, the NMC's new computerised casework management system will tackle many of these problems.

Good practice and risk

3.5 When auditing cases, we concentrated on identifying good practice and risks. The areas of risk we sought to identify were those where a regulator's processes and decisions may not protect the public, or where they may undermine public confidence in the regulated profession and the system of regulation.

3.6 We found examples of good practice by one or more regulators in all of the four areas of risk outlined in paragraph 4.1 below. We also found areas of risk where practices and performance had the potential to undermine the regulator's task of protecting the public and maintaining public confidence.

3.7 We give a more detailed assessment of each regulator's good practice and risks, later in this report. Here, however, we draw attention to the most significant areas of good practice and risk. This will enable all the regulators to compare them with their own practices and help them to challenge and improve their own performance.

3.8 As the individual reports show, some regulators have taken action to lessen some of these risks since the period we audited. Sometimes this was directly in response to our initial feedback at the end of each audit.

What is good practice?

3.9 We list a number of examples of good practice and good performance in our individual assessments of each of the regulators. Below, however, we draw attention to particularly important examples of good practice.

Drink driving convictions

3.10 The GMC always requires doctors convicted of drink driving, to undergo two health assessments. Two separate doctors, with an interest in addiction, separately carry out each assessment. We understand that, in the calendar year 2009, the GMC reached decisions on the cases of 35 doctors convicted of drink driving. Of these, the GMC dealt with approximately 60 per cent by giving a warning. The GMC says this implies there was no underlying health or performance issue. The remaining 40 per cent agreed undertakings, were referred to a health or conduct hearing or were granted voluntary erasure. The GMC says it is reasonable to assume that a high proportion of cases within this 40 per cent were dealt with in this way because of health or performance concerns.

3.11 Many of these health and performance concerns would not have come to the attention of the GMC if it did not routinely test convicted doctors for evidence of addiction.

3.12 We also understand that all applicants for registration with the GCC with a conviction for drink driving or possession of drugs are asked by the Registrar to undergo a psychiatric assessment and relevant laboratory tests, no matter how long prior to the application the offence occurred. This approach has been in place since the statutory register opened in 1999. Once registered, convictions or complaints about use of alcohol or drugs are considered by the Investigating Committee, which always asks the respondent to undergo the assessment/tests.

3.13 We think this a significant tool, which identifies underlying health difficulties that may pose a risk to the public. We think that other regulators should consider adopting this practice. We appreciate, however, that in doing so the regulators will need to take account of the cost of such medical examinations and adopt a proportionate approach, taking account of the circumstances of the case.

Quality assurance and continuous improvement

3.14 We are aware that two regulators, the GMC, and HPC regularly use internal auditors to check that casework complies with their procedures.

3.15 We think this is good practice and that all regulators should find ways to test compliance with processes and the quality of decisions throughout those processes.

3.16 We also found smaller-scale examples of systems aimed at commitment to quality. There are many ways in which a regulator may attempt to achieve high quality. Each regulator will make their own assessment of what is appropriate for them.

3.17 One example is the RPSGB's standard form which requires investigators to systematically divide up the elements of an allegation. They must then list the evidence gathered for that element, and assess any weaknesses in the evidence. We found examples where this had apparently led to more robust reasoning.

3.18 We have expressed concern that poor guidance to staff can affect quality. In contrast, we saw in the audit that the GMC has a clear commitment to producing comprehensive guidance for decision makers throughout its processes. This will contribute to consistency and to better decision making.

Showing registrants' responses to complainants

3.19 In December 2009 we published our report *Handling Complaints: sharing the registrant's response with the complaint*.[3] We recommended that, with certain safeguards and exceptions, a registrant's response to a complaint ought to be shared with the complainant. This would give the regulator further information to

3 CHRE, 2009. *Handling Complaints: sharing the registrant's response with the complainant*. London: CHRE. Available at http://www.chre.org.uk/_img/pics/library/091222_Report_on_handing_complaints.pdf [accessed 5 Feb 2010].

help decide whether the case should be referred to a fitness to practise committee.

3.20 Several regulators do this as a matter of routine and we consider this to be good practice.

3.21 During the audit we found examples at the GCC and GOC where this had helped provide further information, or had helped resolve a complaint more quickly.

Casework management system

3.22 We saw in the audits that a good casework management system is very important for maintaining quality. It was clear to us that high-volume casework organisations need systems that enable them to track cases and which provide comprehensive management information. This is so that progress can be monitored and to ensure that decisions are made by the right people at the right time. It also means that all relevant information is easily retrievable and can be clearly archived.

3.23 The GMC has a computerised system which makes paper files unnecessary. It stores all relevant information and links easily to open and historic cases connected to a registrant. Although we have not yet seen the NMC's new system working fully in practice, we expect that it will prove to be a major help in raising quality.

Liaison with employers

3.24 The audit showed that the GMC has particularly productive relationships with employers and commissioners of health services. It routinely seeks and shares information with employers. Where the GMC thinks a case does not merit a full investigation through its own processes, it can still bring the matter to the attention of the employer so that they are aware of potential risks.

3.25 We also saw that, when the RPSGB issues an advisory letter to one of its registrants, it sends a copy to the employer. Again, this ensures the employer is aware of potential risks.

4. What are the main areas of risk?

4.1 We have divided our findings into four areas:

- Dealing with complainants - how regulators respond to initial contact by complainants and whether regulators encourage and support complainants
- Gathering information - how well regulators gather the information they need to assess cases
- Quality of analysis and explanation of decisions
- Case and file management.

4.2 To achieve a consistent and high standard, regulators need to perform well in all of these areas. Good or poor performance in one of these areas is likely to have an impact on one or more of the other areas.

Dealing with complainants

4.3 We often found evidence of a helpful, encouraging and supportive approach to complainants. However, we were concerned that some regulators' standard letters and practices might deter complainants from persisting with their concerns.

4.4 The wording of the NMC's standard letters are likely to have deterred or discouraged complainants. Particularly in the early part of the period audited, the letters tended not to be adapted to the circumstances of the case. They often asked for information that the complainant had already supplied or that the complainant clearly would not have had.

4.5 The HPC uses a standard letter in response to most letters of complaint. In our view, the wording may discourage some complainants from pursuing a matter. It appears to ask the complainant to confirm again that they wish to make a complaint. It also appears to require the complainant to assess whether their allegation means that a registrant is not fit to practise. The HPC says that its use of standard letters is part of a continuing review.

Gathering information

Adopting other bodies' decisions

4.6 Some regulators adopt another organisation's decisions where there are overlapping facts. Typically, this would be where there has been a police investigation, NHS fraud or competence investigation, or employer's disciplinary investigation. The investigatory body may have decided not to pursue a prosecution or not to take disciplinary action. Adopting such decisions without very careful analysis can be risky, because the other bodies will have been investigating a matter for a different purpose.

4.7 This may be, for example:

- To establish whether a criminal offence could be proved ‘beyond reasonable doubt’
- To see whether there had been a breach of contract.

4.8 In contrast, the purpose of the regulators’ investigations is to assess whether there has been professional misconduct or evidence that a professional fitness to practise is impaired. They use different thresholds, different tests and a different standard of proof.

4.9 We found a few examples where we thought information in a discontinued investigation by police, employers or the NHS might have shown that a professional was not fit to practise. However, the regulator did not pursue this.

4.10 Later in this report we refer to examples where we had concerns in some cases handled by the GDC, GMC, HPC and NMC.

Inadequate investigation

4.11 We found that some complicated cases were not fully investigated. We saw examples where regulators did not fully investigate apparently significant issues. We refer to examples of this in our individual reports on the HPC and NMC. We had concerns that decisions they had made might not have protected the public.

Lack of clinical advice for caseworkers

4.12 We found cases where case officers should have sought expert clinical advice. In the processes of some regulators, only an investigating committee can close a case. These committees typically have one or more relevant professionals to give advice. At the GMC we regularly found examples where a clinically qualified case examiner was consulted on a decision or where an expert opinion was commissioned.

4.13 However at the NMC and HPC cases can be closed before they reach an investigating committee. We did not find evidence of clinical advice being sought by caseworkers before closure of cases. In most cases this was unnecessary but in some cases we believe it would have been helpful for the regulator’s staff to have had access to such clinical expertise.

Quality of analysis and explanation of decisions

Inadequate guidance to decision makers

4.14 We found examples of poor or incomplete guidance to decision makers. This included unclear delegations to close cases. This creates a risk of inconsistency and lack of proper checks and controls on the quality and reasonableness of decisions. We consider that this is a particular risk at the NMC.

Recording and communicating clear reasons

4.15 Recording clear and coherent reasons for decisions on the file is essential for any good casework organisation. Equally organisations must communicate these

reasons clearly to the people involved in a complaint. It is important for the following reasons:

- To maintain the confidence of complainants, the profession and the public
- To encourage disciplined and clear thinking
- To ensure all areas of a complaint are investigated and that none are overlooked, especially in complex cases
- To enable effective review, both internally by auditors, managers and lawyers and externally by CHRE or other auditors
- To lessen the risk of successful claims for judicial review of decisions, and criticism leading from this, which could potentially damage the reputation of regulators and the professions they regulate.

4.16 Even among the best performing regulators, we found examples of inadequate recording of reasons. In some instances it was not possible to understand, other than by inference, why the regulator had made the decision to close a case. Sometimes there would be analysis of some parts of a complaint and not others.

4.17 In some cases there appeared to have been a discussion, by an investigating committee or similar, of the reasons for closing a case. However, the reasons were not recorded on file, or were not transferred fully into the decision letter.

4.18 The registration committee of the HPC deals with self-referrals by professionals. Several of its decisions gave as a reason only that the professional's 'fitness to practise is not impaired', without saying why.

Interim orders

4.19 We were concerned that some regulators did not have clear procedures for either making or recording risk assessment procedures. Moreover, there was not always evidence on the file to show when and how these assessments had been carried out. We found examples at the HPC and GDC where we considered that the regulator should have considered an interim order based on initial information that had been received.

Case and file management

4.20 We found some cases where delay had not been actively managed, and there had not been a systematic regular review of delayed cases.

4.21 In some cases important documents were not on file. For instance at the NMC and GDC we found a few examples where it was clear that significant telephone conversations had taken place. However, there was no record of what was said.

4.22 In some regulators we found that all the information for one case was not in one place. There was no single file, either electronic or paper, that contained all the information. Where information is scattered between paper and electronic systems, there is a risk that something important may be overlooked. It also affects the quality of archiving, which may affect the quality of analysis if there is a future allegation against a professional. We have particular concerns about the NMC's inadequate archiving during the period covered by our audit.

4.23 We have referred above to the risks arising from unclear guidance and delegations. We came across some examples, in certain limited circumstances, where the process permitted a single caseworker to close a case. This was allowed without a double check and sign-off by a colleague. Any system that does not require checking by another person raises a risk of inappropriate closure.

5. Recommendations, future work and conclusions

Recommendations

5.1 We recommend that each regulator:

- Reviews its processes and practices to address the risks we have identified in its own report
- Reviews its own processes and practices against the risks we have identified in the other regulators' reports
- Looks for opportunities to adopt the good practice we have identified in other regulators' reports.

5.2 In particular, we recommend that, if it does not already do so, each regulator should:

- Make sure that it has comprehensive guidance for staff who handle cases and for staff and committee members who make decisions. This is to make sure that cases are handled consistently and to a high quality
- Test the integrity and quality of systems for recording and storing information, for both paper and computerised formats. There should be at least one single source of complete information for each case
- Make sure that it has robust and clear systems for carrying out risk assessments and for applying for interim orders where appropriate. Such systems should be put in place at the start of, and throughout, a case. These procedures should ensure that adequate information is collected promptly, and that proper records are made of how an assessment was reached and when it was made
- Adopt as far as appropriate the practice of routine medical examinations of registrants who are convicted of drink driving or drug offences
- Develop guidance and practice to make sure that decision makers record and communicate clearly the full reasons for their decisions
- Take special care when analysing and using information from investigations carried out by other bodies. Although the other organisation may have taken no action, there may still be grounds for action or further investigation into fitness to practise matters
- Make sure there is a source of clinical advice for decision makers, and make sure that this is used when necessary
- Develop excellent relationships with employers. This will help in providing information during the investigation of a case and in managing risks after a case is closed
- Adopt our previous recommendation that registrants' responses be shared with complainants at an early stage.

Future work

5.3 As part of our annual performance review we will ask regulators to tell us what they have done in response to our audit reports.

5.4 We will use the information gained in this first year of audits to focus on particular areas of risk in future audits. These will start after April 2010.

5.5 There are issues of policy raised by this report which need further consideration. These include the relationship between professional standards and terms and conditions of employment, and the difficulty of handling concerns about professionals with ‘temporary and occasional’ registration. We will work with the regulators and the Government to clarify these matters.

Conclusions

5.6 Our first audit has proved to be a valuable exercise. We have a much fuller view of the performance of the health professional regulatory bodies. We have first hand evidence of areas of good practice and of areas of practice that present risks.

5.7 We know that the vast majority of the regulators’ decisions, during the early fitness to practise stages, protect the public. However we have found inconsistent standards of practice and this leads to possible risks to public protection and confidence. We found examples of:

- Problems of policy
  - Inadequate guidance and delegations for decision makers
  - Failure to resource and manage case files and lack of adequate computer management systems
  - Differences between the standards expected of registrants by the regulators and the standards expected by employers.
- Problems of practice
  - Inadequate investigation and analysis leading to poor decisions to close cases
  - Poor judgement in individual decisions to close cases
  - Examples of failures to consider interim orders to protect the public.

5.8 We have seen that our findings have, in some cases, led directly to immediate improvement in practice. We are confident that this report will lead to further improvements, not least as it will provide new information from which regulators can learn.

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. Each report identifies good practice, risks and gives specific recommendations.

6. Audit of the General Chiropractic Council's initial stages of fitness to practise procedures

Overall assessment

Introduction

6.1 Based on the evidence from our audit of 22 cases, we consider that the General Chiropractic Council (GCC) deals with initial fitness to practise decisions effectively. It makes consistent decisions that are sound, that protect the public, and that should maintain public confidence in the regulation of the chiropractic profession.

6.2 The investigating committee's decisions were reasonable and were explained clearly. The GCC's written communications with people involved in the complaint were of a consistent high quality.

6.3 Case files were well managed. However, we had some concerns about a very small number of cases where there was significant delay for which there did not appear to be a clear reason. We understand from the GCC that such difficulties are historic and are unlikely to recur. The GCC has since introduced closer case monitoring and alerts, and has introduced a database for this purpose.

6.4 The GCC's process for assessing fitness to practise cases is described in Appendix C.

Good practice

6.5 We identified several areas of good practice during the course of the audit. The important areas of good practice include:

- Good communication with the people involved in the complaints
- Good and clear reasoning of the investigating committee which is then included in letters to the people involved in the complaint
- Active engagement with complainants to encourage them to follow up on initial complaints with supporting information
- Routinely sending a copy of registrant's observations to the complainant for comment

Risks

6.6 As well as this good practice, we did identify an area of potential risk in the historic cases that the GCC closed during the audited period. We found a lack of information on some files to explain some significant delays, which may be evidence of insufficient case monitoring. However the GCC informs us that, following discovery of this problem, it audited every file ever closed since 2000. This was to make sure there were no other similar problems. The GCC has introduced a database to monitor cases and it believes this has lowered this risk significantly.

Recommendations

6.7 The public can be reassured that the GCC is focused on protecting patients and other members of the public through the operation of its fitness to practise procedures. Its processes and procedures operate effectively and ensure that cases are dealt with appropriately and in a timely manner.

6.8 We are pleased that in response to our initial findings from this audit, the GCC has taken action to reassure us about the risks we identified. We consequently have no further recommendations to make arising from this audit.

Detailed assessment

Dealing with initial contacts from complainants, ensuring that they are assessed properly and assisting/encouraging complainants in making complaints

6.9 An active approach to assisting complainants is key in enabling a regulator to monitor the standards of the profession it regulates, in protecting the public and maintaining public confidence in the profession.

6.10 The cases audited showed good communication with complainants, with effective use of standard letters modified where necessary to ensure clear communication.

6.11 We found evidence that the GCC actively chases up complainants who have made an initial contact, but who have not taken the next step of submitting a formal complaint. We consider this very good practice.

6.12 We identified only one slight area of risk, which was the question of offering solicitors' statements of evidence.

6.13 The GCC's legislation requires it to offer complainants the opportunity to make a statement to a solicitor. The GCC routinely makes this offer, explaining in its standard letter that the GCC will pay for the solicitor and will reimburse the fee for having the statement sworn.

6.14 We considered, on the evidence of the audited files, that there was a slight risk that some complainants may be intimidated by the involvement of solicitors, and might think that their complaint could not be considered by the GCC without this statement. In addition, we considered that complainants might also not be aware of how much it would cost them initially to pay the reimbursable fee of having the statement sworn. We considered that this might be a deterrent to some complainants.

6.15 In response to our initial findings of this audit, the GCC has amended its standard letter further to explain the likely scale of reimbursable fees, and to make clearer to complainants that involvement of a solicitor is not compulsory.

Gathering information

6.16 We consider that the investigating committee closed cases on the basis of adequate information in all the cases we reviewed. In the few cases where the investigating committee asked for additional information before deciding whether to close a case, the information sought was appropriate and sufficient to inform their decision.

Quality of complaint analysis, decision making, recording and communication of decisions

6.17 The GCC performs well in this area. We found that the investigating committee provided clear and detailed explanations to the complainant and registrant when closing cases.

6.18 We found one case where the GCC chief executive sought clearer and fuller reasoning from the investigating committee, before sending the decision to the complainant and registrant. This resulted in a clearer and more detailed letter to those involved explaining the decision to close the case. We consider this to be evidence of commitment to high standards.

Case and file management

6.19 To protect the public effectively and for the interests of justice for the registrant it is essential that cases are dealt with promptly.

6.20 In addition good file management, and clear lines of responsibility in managing cases, are essential to:

- Achieve consistent good quality decisions
- Ensure that cases can be reviewed and audited when appropriate.

6.21 We consider that this all underpins a process which ultimately maintains public confidence and patient safety.

6.22 The GCC files that we audited were nearly all well managed, with good record keeping showing when and how decisions were made. Also the majority of cases were dealt with in a timely manner.

6.23 There was information in a few cases which suggested the following areas of risk, which the GCC may wish to consider reviewing:

- A risk that cases become delayed because there is insufficient review. There is also a related risk that failure to record reasons for delay may itself lead to a case not being properly monitored for progress. We found three cases where there were significant delays, and about which there was not a clear explanation on the file. The delays started several years ago with the cases being finally closed during the 2008/2009 period covered by our audit. In one case, some of the delay appears to have been caused by an error made by a former member of staff, who thought that action could not be taken against

a registrant who was out of the country. The GCC has explained that it believes the member of staff received legal advice to this effect but did not record it on the file; contrary legal advice was given at a later stage. One of these cases was not referred to the investigating committee, in breach of the GCC's policy. This error was corrected reasonably promptly by the GCC. We are however assured by the GCC that this risk is now very much lower. This is because the GCC now monitors all cases using a database and so such delays would be noticed sooner and acted upon.

6.24 A small risk that interim orders in cases of impaired health may not always be routinely considered, or at least that such consideration is not recorded on the file. This finding is, however, based on a concern relating to just one case in which the GCC did not have contact details for the registrant.

7. Audit of the General Dental Council's initial stages of fitness to practise procedures

Overall assessment

Introduction

7.1 Based on the evidence from our audit, we consider that the General Dental Council (GDC) deals with fitness to practise cases effectively. Patient and public safety, and maintaining public confidence in the profession and in regulation, are at the heart of its operations.

7.2 The GDC's process for assessing fitness to practise cases is described in Appendix C.

Good practice

7.3 We identified many areas of good practice during the course of the audit. The most important areas of good practice are as follows:

- The GDC has a reflective approach to developing its systems for assessing concerns about dental practitioners. It also actively assesses its own performance with a view to continuous improvement. The ways in which it does this include employing a mystery shopping firm to test its customer services, sending out customer feedback forms when it closes cases and employing staff dedicated to improving processes and learning lessons from previous actions
- In our performance review report 2008/09 we highlighted the GDC's focus on customer service. We saw evidence of this in practice during the audit in the way that the GDC encouraged and supported complainants
- We saw more than one example of the GDC making repeated efforts to ensure that they understood a complainant's concerns, including asking for more information. In one case this was despite the complainant expressing their complaint in a challenging and incoherent way
- In cases where GDC action was not appropriate, but there may still be a consumer rights issue, we also saw several examples of the GDC telling a complainant about the Dental Complaints Service.
- The GDC's system provides for all initial assessments of cases to be reviewed in a meeting with a manager and a fellow caseworker.

Risks

7.4 As well as this good practice, we did identify a few areas of potential risk in the way in which the GDC is currently considering cases. These are discussed later in this report. We hope that the GDC will review them and consider whether there are ways to improve its work. In the overall context of a well managed casework function, the main areas of potential risk are as follows:

- That, sometimes, too much reliance appears be placed on other agencies such as the police or primary care trusts (PCTs) to take action to protect the public. In such cases, the GDC needs to make immediate risk assessments and refer for an interim order where necessary
- On some occasions, that decision makers, or later reviewers of the file, may not have the fullest information for reaching an appropriate decision, or that cases may not always be actively managed. This risk was identified from a few files where we found that not all the information was in one place. Some potentially important information was not always captured, such as notes of relevant telephone conversations. In a few cases, it was not clear why delays had occurred and whether these were being managed
- That the system of peer and manager review, which we consider to be good practice, is not always applied. In a few cases we saw that the processes of recording decisions, and gaining appropriate sign-off, were not followed fully. The system is important to ensure that all cases are closed at the appropriate stage and with appropriate reasons
- That decision makers, such as the investigating committee, may not always be automatically given background information to enable them to make a full risk assessment when deciding on what action to take. There is a related risk that relevant information, such as general information from a PCT on a registrant's performance or complaint history, is not actively gathered
- That the GDC does not always actively consider alternative ways of gathering evidence, including using its statutory powers, when a complainant withdraws his or her co-operation
- That failure in communication between GDC departments may lead to failure to take enforcement action against non-registered practitioners.

Recommendations

7.5 The public can be reassured that the GDC is focused on protecting patients and other members of the public through the operation of its fitness to practise procedures. Its processes and procedures operate effectively and ensure that cases are usually dealt with appropriately.

7.6 We are confident that the GDC will continue to review and modify its processes. When we gave our initial results of our audit, we recommended that the GDC considers the following:

- Generally reviewing all the areas of risk that we have identified, to find opportunities to further strengthen its casework practice
- Ensuring consistent compliance with its own review and sign-off procedures, before closing a case
- Ensuring that, even when other agencies are taking related action, the GDC has actively assessed risks to public safety and taken its own action where appropriate, including consideration of an interim order. Where it considers such action unnecessary, it should ensure that it has gathered and recorded enough information to support this decision

- Considering appropriate ways, in which it can actively use its full powers and resources to gather information
- Considering further ways of gathering background information to inform risk assessments. This could include, for example, routinely contacting PCTs or employers for information, and ensuring all potentially relevant information is recorded and passed on to decision makers
- Ensuring that the fitness to practise department records and communicates the need for action to be taken when it discovers the use of a protected title by an unregistered practitioner.

7.7 We are pleased that the GDC has since taken a number of steps that are intended to address all the risks identified in our audit.

Detailed assessment

Dealing with initial contacts from complainants, ensuring that they are assessed properly and assisting/encouraging complainants in making complaints

7.8 In our performance review report 2008/09 we highlighted the GDC's focus on customer service. We saw evidence of this in practice in the way that the GDC encourages and supports complainants.

7.9 We saw more than one example of the GDC making repeated efforts to understand a complainant's concerns properly, including asking for more information. In one case this was despite the complainant expressing their complaint in a challenging and incoherent way.

7.10 Where GDC action was not appropriate but there may have been a consumer rights issue, we also saw several examples of the GDC telling a complainant about the Dental Complaints Service.

7.11 The GDC appears to have a good system for ensuring that all new concerns are properly assessed. All written complaints are considered by a caseworker who prepares an initial assessment sheet summarising the issues and making a recommendation. The future of the case is then assessed at a meeting involving the caseworker, the assessment manager and another caseworker. We consider this system of review to be an example of good practice.

Gathering information

7.12 The GDC routinely asks complainants to give their consent for medical records to be released, and to allow the GDC to send a copy of the complaint to the registrant for comment. If the registrant responds, their response is sent to the complainant. We consider this to be good practice as it improves the quality of information available to decision makers. These exchanges are included in the information given to the investigating committee to help it decide on how the case should be handled.

7.13 There was information in a very small number of cases which suggested the following areas of risk, which the GDC may wish to consider reviewing:

- That some cases are closed with too much reliance placed on other agencies, such as the police and PCTs, to keep the GDC informed or to take action to protect the public. This is in situations where these agencies have informed the GDC that they are investigating a matter. In one case the police informed the GDC that they were investigating allegations of sexual assault by a registrant. The GDC did not at that stage open a case and there was no evidence on the file that an interim order was considered. We understand that the GDC has in part addressed this in 2009 by creating a 'pending further information' case category. However, the GDC needs to ensure that it takes immediate action where it learns of serious allegations even when they are aware that another agency is taking action. The GDC says that in the light of our comments it now requires caseworkers to make telephone contact. The GDC will also consider introducing a requirement for registrants promptly to self declare cautions and convictions
- That some cases might be handled in a way that favours personal resolution for the complainant rather than gathering sufficient information to assess whether a registrant poses a risk to other patients. In two cases the GDC apparently closed cases on the basis that a complainant would be resolving their complaint either through direct contact with the registrant or through litigation. There did not appear to have been an assessment of whether the GDC should still pursue a fitness to practise investigation on patient safety grounds. The GDC says such decisions will in future be reviewed by a manager
- That the GDC might miss out on extra evidence that would help it assess the risk of a registrant who is possibly underperforming. This risk arises because the audited files did not show routine contact with employing PCTs to seek information about a registrant's general performance, in particular whether other complaints had been made. This information may be useful in assessing whether there is a wider pattern of poor performance or misconduct than shown in a single complaint. Alternatively, if the GDC does seek this information, the files do not show whether the information was sought and what the response from the PCT was. This raises a risk that decision makers do not have full information on which to assess risk. In response to our audit, the GDC says that will now routinely ask PCTs for information about complaints or other relevant information. It will create a system to make sure this is recorded on the file
- That the GDC might not always have full information to assess risk when closing a case, and that it might not give full consideration to using its statutory powers for gaining information without patient consent. This risk could occur when a complainant withdraws a complaint or refuses to give consent to release of medical records.

Quality of complaint analysis, decision making, recording and communication of decisions

7.14 The GDC performs well in this area. It normally communicates well when explaining decisions to close cases to those involved.

7.15 We have referred above to the GDC's good practice in its way of assessing new complaints. Under its initial assessment procedure, all written complaints are considered by a caseworker who prepares an initial assessment sheet, summarising the issues and making a recommendation. Decisions about how the case should proceed or whether it should be closed are then agreed at a meeting involving the caseworker, the assessment manager and another caseworker. This degree of peer review and management sign-off appears to provide a good system of quality assurance. In nearly all cases audited, this system was followed and this resulted in a clear written record of the decision making process.

7.16 There was information in a very small number of cases which suggested the following areas of risk which the GDC may wish to consider reviewing:

- A small risk that the GDC cannot always assure itself that decisions to close a case at initial assessment stage are rigorous in protecting the public or that public confidence would be maintained. This risk was suggested in a few cases where there was a failure to follow the initial assessment procedure. This meant variously:
  - Reasons for decisions were not clearly recorded on file
  - There was not a clear record that a decision was checked and approved in the way required by the procedure.
- A risk of inappropriate closure when a single caseworker closes a case, for example where a complainant has refused to give consent, without a case assessment meeting or management sign-off. The GDC says that since our audit, all cases will be signed off by managers who will also assure that full reasons have been recorded on file
- A small risk that failure in communication between GDC departments may lead to failure to take enforcement action against non-registered practitioners. This risk was identified from a case in which the fitness to practise department was unable to investigate alleged misconduct because the purported dental nurse was not in fact registered. The case was closed but was not passed to the fitness to practise legal team for potential legal action for unregistered practice
- A risk that the investigating committee may not be fully aware of either previous relevant complaints made against registrants, or of relevant sanctions previously imposed by an investigating committee or final fitness to practise panel. This raises a risk that the investigating committee may not properly assess the balance of risk between closing a case and continuing an investigation (for example in a matter that suggests poor performance). Similarly the investigating committee may not reach an appropriate balance when deciding on whether to close a case with advice or a warning, and whether this should be published. Such decisions could affect public

confidence
A small risk of loss of public confidence when the GDC's generally good standard of communications of decisions is not always maintained. This is based on a small number of cases where decisions to close cases (at initial assessment or investigating committee) were communicated with brief stock phrases and no real explanation.

Case and file management

7.17 Good file management, and clear lines of responsibility in managing cases, are essential in:

- Achieving consistent, good quality decisions
- Ensuring prompt management of investigations
- Ensuring that cases can be reviewed and audited when appropriate.

7.18 We consider that this underpins a process which ultimately maintains public confidence and patient safety.

7.19 Nearly all the GDC's case files were well maintained and we saw many examples of prompt and efficient handling of cases.

7.20 There was information in a small number of cases which suggested the following areas of risk, and which the GDC may wish to consider reviewing:

- A small risk that important information may be not be readily available on the file when a case is reviewed. Such a review may be required either whilst a case is active or later when further complaints are made against a registrant. The risk arises because in a very few cases:
    - Some records on the computer case management system were not replicated in the main paper file
    - Some apparently significant information about phone conversations was not recorded on the file, the existence of the phone conversations being referred to in other documents
    - Some original complaint forms or letters were not on the file.

The GDC says that it will explore a number of steps to mitigate these risks.

7.21 A small risk that delay may not be actively managed. This risk was suggested by a very small number of cases, where there were periods when it appeared no action was taken on a case, and where there was no clear explanation for this on file. The GDC says that it has now created management reports which will highlight cases where there has been a period of possible inaction.

8. Audit of the General Medical Council's initial stages of fitness to practise procedures

Overall assessment

Introduction

8.1 Based on the evidence from our audit, we consider that the General Medical Council (GMC) deals with fitness to practise cases effectively. Patient and public safety, and maintaining public confidence in the profession and in regulation, are at the heart of its operations. Its processes and procedures operate effectively and ensure that cases are usually dealt with appropriately and in a timely manner.

8.2 The GMC has a thorough approach to assessing concerns about doctors' fitness to practise. It has created high quality and robust procedures, including detailed guidance for its staff. These support appropriate and timely decision making. The GMC's process for assessing fitness to practise cases is described in Appendix C.

8.3 The public can be reassured that the GMC has achieved these high standards despite the particular challenges arising from the nature and work of the profession which it regulates. These challenges include the following:

- The medical profession deals with complex and difficult matters that require a high degree of knowledge and skill. Doctors often use procedures that carry high levels of risks of harm to patients. This makes the consequences of possible mistakes in regulation particularly significant
- The public has high expectations of doctors. However, some members of the public may lack the knowledge or expertise to make a fair assessment of whether a doctor's conduct has fallen below the expected standard
- Some people find it difficult to present legitimate concerns clearly and with full effect.

Good practice

8.4 We identified many areas of good practice during the course of the audit. The most important areas of good practice include:

- A comprehensive and effective IT-based case management system
- Detailed guidance for staff including a comprehensive *Investigations Manual*
- Internal quality assurance and audit processes which include a team of internal auditors to check compliance with systems and processes. We understand that lessons from these audits are fed back at management level
- Effective liaison with employers, in particular the standard procedure of referring certain complaints to employers. This happens when the GMC considers that it does not, on the information so far supplied, need to undertake an investigation. The GMC asks whether the employers have any

additional concerns, and gives the employers the opportunity to consider taking action themselves

- The standard procedure for dealing with drink driving offences. The GMC routinely requires doctors convicted of drink driving to be medically examined. This is to assess whether they are suffering from problems associated with alcohol or other substance misuse
- Where a complaint was not within the GMC's area of jurisdiction, there were several examples where the GMC actively gave the complainant information about alternative avenues of complaint, or offered to forward the complaint to another regulator.

Risks

8.5 As well as this good practice, we did identify some areas of potential risk in the way in which the GMC currently considers cases. We know that the GMC keeps its processes under continuous review and we hope that it will consider these issues as part of that review. These issues are discussed more fully in the relevant parts of this report. In summary, however, we consider that potential areas for further enhancement of the GMC's already high standards are as follows:

- Although generally the GMC performs well in this area, we consider that it needs to ensure that its decision makers have fully understood all the complainant's concerns, and that complainants feel that they are encouraged to submit a complaint
- The GMC should consider ways to make sure that all information supplied by third parties is consistently analysed with sufficient rigour, in particular information relating to investigations carried out for another purpose. We also consider that care should be taken when deciding on cases where the Crown Prosecution Service (CPS) has decided not to take action. The CPS generally adopts a higher threshold based on the criminal standard of proof, and the narrower issue of whether the individual has committed a criminal offence
- The GMC should consider ways of ensuring that all, rather than most, decisions are comprehensively explained and recorded. This should be considered in both its internal and external communications
- The GMC should also make full use of its case management system to improve further the effectiveness of its investigation process. Specifically, it should ensure that accountability for case actions is recorded fully, which should help to avoid potential failures of communication between departments.

Recommendations

8.6 We are confident that the GMC will continue to review and modify its processes and in doing so we recommend that it considers the following:

- Reviewing all the areas of risk that we have identified, to find opportunities to further strengthen its casework practice

- Altering the wording of its standard enquiry to employers. This is so that it asks for specific details of whether, when and how a doctor's work has been assessed. It should also ask for the actual results of any assessment, including whether these raised specific concerns
- Developing further the GMC's existing good practice of sharing information with employers. In particular it might do this by considering asking for more specific information about complaints that the employer has received against a doctor. This might include asking for copies of actual complaints received, and the reasoned responses the employer gave to the complainant. It might also mean giving the employer, at an early stage, more detailed information about the complaint the GMC is considering
- Developing further guidance for decision makers on recording how they have assessed an external investigation. They should record their assessment on an investigation's quality and whether it provides enough information for the GMC's purposes. This might include saying which aspects of the complaint the GMC considers have been satisfactorily dealt with by the external investigation, and whether it needs its own expert information to augment the external investigation. It might also include an assessment of the purpose of the external investigation and decision, and whether the purposes and standards (for example those adopted by the CPS) are fully applicable in a GMC case
- Exploring whether the case management system can be developed to ensure appropriate controls around administrative erasure. The purpose of this would be to make sure that there was the best exchange of information, and appropriate monitoring, between the registration and investigation departments.

Detailed assessment

Dealing with initial contacts from complainants, ensuring that they are assessed properly and assisting/encouraging complainants in making complaints

8.7 In our performance review report 2008/09 we highlighted the good practice of the GMC in assisting potential complainants. This active approach helps the GMC to monitor the standards of the professionals it regulates and to reassure the public.

8.8 During the audit we found practical examples of this positive approach to gathering information. For example, there was evidence of the GMC monitoring press reports for possible concerns about registrants. In one case a foreign English-language paper reported serious allegations against an unnamed doctor in a foreign country. The GMC took steps to try to establish his identity, in order to find out whether he was one of its registrants.

8.9 We also noted that the quality of initial correspondence with complainants was normally high. Letters were polite, and although based on standard letters, were tailored to the specific complaint. There was no evidence that people were being discouraged from making or pursuing complaints.

8.10 The audit evidence in a very small number of cases suggested two areas of risk.

8.11 First there was a risk that complaints might be closed because the complainant had not communicated their concerns clearly. In such circumstances, before closing a case, special care may be needed to confirm the real nature of the complainant's concerns. It may be necessary to seek further information from other sources. This risk was, however, identified from just one case.

8.12 Secondly there was a risk that an investigation may not be widened despite new potential areas of concern emerging. This risk was, however, identified from just two cases.

Gathering information

8.13 The GMC has a well developed system for gathering information. This enables it to reach an appropriate decision about whether to close a case. As well as using the clinical knowledge of its medical case examiners, it often commissions assessments from relevant experts. It also requests information about individuals' performance from their employers. It often receives and considers reports from local NHS investigations into complaints and concerns.

8.14 The GMC has a high volume of cases and some of its casework is complex and high-risk. In this context, it is reasonable for the GMC to make full use of information from investigations by other bodies. These include police investigations and local NHS investigations. We consider that giving weight to the decisions of reputable outside bodies is an acceptable practice. It will generally improve the quality of information available and lessen the risk of making an incorrect decision to close a case. This is a sensible use of resources which will enable the GMC to focus on areas of greatest risk.

8.15 When the GMC has assessed a complaint and decided it does not merit further investigation ('Stream 2' cases), it routinely asks the doctor's employers to confirm they have no current concerns about the doctor. In some cases the information from the employer leads the GMC to investigate the original complaint further. This provides a safety net against premature closure of cases that merit further investigation. This is very good practice.

8.16 We also consider it is good practice that the GMC regularly copies complaints to the doctor's employers and invites comment or information on the doctor's fitness to practise. The GMC does this after deciding that full investigation is merited ('Stream 1' cases).

8.17 There was information in a very small number of cases which suggested two areas of risk which the GMC may wish to consider reviewing.

8.18 First there is a risk that the GMC may sometimes put too much reliance on an external investigation. It may not always rigorously analyse whether the investigation has appropriately addressed all matters of concern to the GMC. In response to our initial feedback during the audit, the GMC has decided to develop further written guidance on this issue.

8.19 Secondly there is a risk that a GMC case examiner might misinterpret the meaning and significance of some of the information that an employer gives to the GMC. This may occur if an employer misunderstands what information the GMC requires. This in turn may affect the quality and clarity of information available to the GMC case examiner.

8.20 The employer’s misunderstanding may be because of a lack of clarity in the GMC’s questions. As a result the employer might not give enough detail in their response.

8.21 Further, in a small number of cases we considered that the GMC could have explained more clearly the complaint it was investigating. This may have encouraged the employer to give more information back to the GMC. Also, in some cases the employer itself would already have investigated a complaint from a member of the public. We considered that it might have been helpful to the GMC to ask to see the employer’s letter to the member of the public.

Quality of complaint analysis, decision making, recording and communication of decisions

8.22 Recording clear and coherent reasons for decisions on the case file, and communicating these clearly to the people involved in a complaint, is essential for any good casework organisation. It is important in the following ways:

- To maintain the confidence of complainants, the profession and the public
- To encourage disciplined and clear thinking
- To ensure all areas of a complaint are investigated and that none are overlooked, especially in complex multi-level cases
- To enable effective review, both internally by auditors, managers and lawyers and externally by CHRE or other auditors
- To lessen the risk of successful claims for judicial review of decisions, and criticism leading from this, which could potentially damage the reputation of the regulators and the professions they regulate.

8.23 The GMC performs well in this area. We found that in nearly all cases, case examiners analysed cases very thoroughly and appropriately. They provided clear and detailed explanations when closing cases. This was both in internal notes where decisions were recorded, and in correspondence to the people involved in a complaint.

8.24 The GMC’s investigation managers are responsible for assessing all new complaints and deciding whether an investigation should be launched. The GMC has wide-ranging guidance to its staff on how to investigate complaints and assess evidence at various stages. The main source of this guidance is the *Investigations Manual* and the 'triage script'. The triage script is a computer-based set of questions which helps the investigations manager analyse the complaint within the GMC’s policies. Through various steps the computer generates relevant questions, the answers to which generate further refining questions. These help the investigations manager decide whether the case should go to ‘Stream 1’ (full investigation) or ‘Stream 2' (limited investigation relying on the local employer taking action).

8.25 We consider the *Investigation Manual* and triage script to be examples of good practice which greatly assist the GMC’s staff in analysing cases thoroughly and making consistent decisions.

8.26 The audit evidence in a very small number of cases suggested two areas of risk which the GMC may wish to consider reviewing.

8.27 First there is a risk that all factors relevant to a case may not be taken into account. We found some cases where the case examiner's reasons did not cover all allegations from the complainant, or did not make clear the clinical basis for their conclusions, including the extent of their own specialist expertise. In response to our audit findings, the GMC has said it will review the way that decisions are recorded in its case management system.

8.28 Secondly there is a risk that a case examiner might be unduly influenced by a CPS decision not to prosecute a matter similar to that which the GMC is investigating. The standard of proof applied by the CPS and GMC is different, as are the reasons for potentially taking action. Also information from a discontinued criminal investigation, or from other sources, might still show that a doctor's fitness to practise is impaired. This risk was identified from one case, albeit a potentially serious one, and the GMC has assured us that it has well developed processes for dealing with cases where the CPS has been involved.

Case and file management

8.29 Good file management, and clear lines of responsibility in managing cases, are essential in:

- Achieving consistent, good quality decisions
- Ensuring prompt management of investigations
- Ensuring that cases can be reviewed and audited when appropriate.

8.30 We consider that this underpins a process which ultimately maintains public confidence and patient safety.

8.31 The GMC has an impressive integrated case management and filing system. The system is paperless, with all case information being held electronically. The system provides integrated information on individual doctors from the GMC's registration and fitness to practise departments. It enables the GMC to build a fuller profile of information relevant to a particular doctor's fitness to practise. This in turn strengthens its ability to make appropriate decisions whenever a concern is raised about a doctor. The system significantly reduces the risk of documents and other information being lost. It would appear to make it more difficult for any inappropriate alterations to be made to the file.

8.32 The GMC employs a team of internal auditors to check, amongst other things, that staff have complied with the system's processes. We consider this to be an example of good practice and evidence that the GMC is committed to continuous improvement.

8.33 We found that there was risk of miscommunication between departments leading to the erasure of a doctor for administrative reasons (such as failure to provide a current address) during a fitness to practise investigation. We found one case in the sample where this had happened. This meant that the GMC lost its jurisdiction to investigate and determine the allegation. This creates a risk that public confidence might be undermined. If the doctor sought restoration, the

matter could however be revived. A delay in starting an investigation would increase the risk that evidence gathering may be less effective.

9. Audit of the General Optical Council's initial stages of fitness to practise procedures

Overall assessment

Introduction

9.1 Based on the evidence from our audit of 84 cases, we consider that the General Optical Council (GOC) deals with fitness to practise cases well, with a commitment to quality and fairness and to protecting the public. Overall the files audited showed good management of cases and a helpful approach to the public.

9.2 The GOC's process for assessing fitness to practise cases is described in Appendix C.

Good practice

9.3 During the course of the audit we identified several examples of good practice:

- The investigation committee, when closing a case, giving advice to individual registrants and corporate registrants on how to improve the service they give, including how to handle complaints in a better way
- Investigation committee members being active in identifying good practice points to share with the rest of the profession, for instance through the College of Optometrists
- GOC staff actively helping complainants make statements, including arranging to meet them
- GOC staff giving complainants helpful information about the extent of the GOC's powers and about other potential sources of help
- The GOC referring matters to other regulators and investigatory bodies, such as the NHS counter fraud service.
- A GOC standard letter used when requesting information, such as hospital medical records, clearly states the statutory powers of the GOC and how the GOC may use these if necessary.

Risks

9.4 As well as this good practice, we did identify an area of potential risk in the way in which the GOC is currently considering cases. This was a potential risk that the public may not always have full confidence in the way decisions are reached. The risk is relatively small and was identified from three cases where the investigation committee's reasons were not fully recorded and passed on to the complainant and registrant. We understand that the GOC is reviewing its processes to address this issue.

Recommendations

9.5 The public can be reassured that the GOC is focused on protecting patients and other members of the public through the operation of its fitness to practise procedures. Its processes and procedures operate effectively and ensure that cases are usually dealt with appropriately and in a timely manner.

9.6 We are confident that the GOC will continue to review and modify its processes and in doing so we recommend the following:

- The GOC should assure itself that the investigation committee's decisions give full reasons for closing a case, and that these are conveyed fully to the people involved.

Detailed assessment

Dealing with initial contacts from complainants, ensuring that they are assessed properly and assisting/encouraging complainants in making complaints

9.7 The files that we reviewed suggested a helpful and open approach to people who had concerns about a GOC registrant. The helpfulness extended to carefully explaining the limits of the GOC's powers, and directing members of the public to other sources of help when a matter was not within the GOC's remit.

9.8 In one case we thought that the GOC could have been more active in responding to a request for information from a primary care trust (PCT). The PCT wished to know the reason for an investigation against a registrant who practised in their area. This was so that it could decide whether it should take its own action on public protection grounds, against the registrant. The GOC did assure the PCT that the matter had not been considered serious enough to merit an interim order, but did not in our view provide sufficient details about the complaint for the PCT to make a risk assessment. We also understand that the GOC has since developed a more sophisticated approach to deciding when it is appropriate in the public interest to give more information to employers and others.

Gathering information

9.9 The information available for the investigation committee was adequate for its purposes. The GOC takes a clear and firm line when gathering information necessary for the committee. A GOC standard letter used when requesting information, such as hospital medical records, clearly states the statutory powers of the GOC in requiring information and how it will use these powers if necessary.

9.10 The GOC routinely shares the registrant's comments on the complaint with the original complainant. This led to instances where the complainant was able to provide further information that in due course assisted the committee.

Quality of complaint analysis, decision making, recording and communication of decisions

9.11 The evidence of the files was that the investigation committee takes an active role, including taking the opportunity to identify learning points to share with the registrant or with the wider profession. Most decisions were clear and detailed.

9.12 There was information in four cases which suggested the following areas of risk:

- The investigation committee's reasons for closing cases are not always recorded fully and conveyed to the complainant. We found three cases where the investigation committee's minutes did not show how and why it reached certain decisions. We understand that the GOC is reviewing its processes to ensure that the full detail of each committee decision is captured
- We found one instance where a case was closed by the investigation committee, even though there was a conflict of evidence around a registrant's performance. We considered that the evidence should probably have been tested further. However, we note that recent proposed guidance for the committee would make it clearer that conflicts of evidence should be tested by referral to a final fitness to practise committee.

Case and file management

9.13 Good file management, and clear lines of responsibility in managing cases, are essential in:

- Achieving consistent, good quality decisions
- Ensuring prompt management of investigations
- Ensuring that cases can be reviewed and audited when appropriate.

9.14 We consider that this underpins a process which ultimately maintains public confidence and patient safety.

9.15 The evidence of our audit is that the GOC's quality of file management was good. We did find one case where there was a 10 month delay between the investigation committee's decision to refer a case and a subsequent decision, following investigation, to close the case. Much of this delay was because the external firm of investigating solicitors experienced difficulty in receiving information from a third party.

10. Audit of the General Osteopathic Council's initial stages of fitness to practise procedures

Overall assessment

Introduction

10.1 Based on the evidence from our audit of eight cases, we consider that the General Osteopathic Council (GOsC) deals with initial fitness to practise decisions effectively. It makes consistent decisions that are sound, that protect the public, and that should maintain public confidence in the regulation of the osteopathic profession.

10.2 The investigating committee's decisions were clearly reasonable in almost all the audited cases, although in one instance we think a decision to close a case may not have been sound.

10.3 The GOsC's standard written communications with the people involved in a case were of good quality.

10.4 Case files were well managed and cases were generally conducted in a timely fashion. We could not see, however, how the screeners stage contributed value to the process. In some cases it lengthened the time taken to conclude a case.

10.5 The GOsC's process for assessing fitness to practise cases is described in Appendix C.

Good practice

10.6 We identified several areas of good practice during the course of the audit. The important areas of good practice include:

- An active approach in assisting complainants who wish to make a complaint
- Sending evidence to the complainant and registrant for comment before the matter is considered by the investigating committee
- When closing a case, the investigating committee's practice, where appropriate, of giving advice to the registrant on improving areas of their practice.

Risks

10.7 As well as this good practice, we did identify some areas of risk in the way in which the GOsC is currently considering cases, and details of these are given in the report. We hope that the GoSC will consider these issues as part of any future review. The main areas of risk we identified, based on the small number of cases examined, are:

- A small risk that public confidence will not be maintained in the GOsC's decisions to protect the public when it closes cases. This arises from the brevity and lack of explanation of some of the investigating committee's decisions.
- A small risk that the investigating committee may make decisions which do not adequately protect the public or maintain public confidence. This risk is caused by the lack of proper explanation given for some decisions, which suggests that in such cases the committee itself is not clear of its reasons for closure. The risk is also amplified by evidence that the committee sometimes does not have the fullest information when it closes a case.

Recommendations

10.8 The public can be reassured that the GOsC is focused on protecting patients and other members of the public through the operation of its fitness to practise procedures. Its processes and procedures operate effectively and ensure that cases are usually dealt with appropriately and in a timely manner.

10.9 We recommend that the GOsC consider the following issues:

- Whether, and how, the investigating committee's reasons for decisions can be improved
- How the investigating committee can assure itself that it has all relevant information before closing a case
- The contribution of screeners to the process and whether their current role, if needed at all, could be fulfilled by the GOsC's fitness to practise team staff.

Detailed assessment

Dealing with initial contact from complainants, ensuring that they are assessed properly and assisting/encouraging complainants in making complaints

10.10 An active approach to assisting complainants is key in enabling a regulator to monitor the standards of the profession it regulates, to protect the public and to maintain public confidence in the profession.

10.11 From the small number of cases examined, we saw evidence of good communication with complainants, with effective use of standard letters. This was in the stage leading up to consideration of a case by the investigating committee.

10.12 We found one case in which the GOsC made particular efforts to take information from the complainant by telephone, in order to draft a witness statement. We consider this to be a positive and helpful approach to encouraging complainants to supply information.

Gathering information

10.13 Gathering sufficient relevant information before deciding to close a case is essential to good decision making. In nearly all of the cases closed by the investigating committee, we consider that the committee had enough information.

10.14 However, in two cases we consider that the committee should have ensured that it had received fuller information. In one of these cases it may have been relevant for the committee to have known, before closing a case, what action the police were taking. However, this information was not made available to it.

10.15 In another, more serious case, we consider that the committee should have either requested fuller witness information or simply referred the matter to a professional conduct committee hearing. This is so that the witness' evidence would be tested by a panel. In the next section we also comment on what we consider to be a flaw in the assessment of this case.

10.16 We were assured by the GOsC that, when a complaint is made about an osteopath, fitness to practise staff examine the history of that osteopath to see if there are any relevant previous complaints. There was no evidence in the files, however, to indicate that this had happened, or that in all cases the investigating committee had been given information about any previous complaints that involved the same osteopath.

10.17 However, there was clear evidence on the file that the GOsC regularly sends copies of its evidence to the complainant and the registrant osteopath. It then invites comments, before sending a case to the investigating committee. We think this makes the information gathering process more robust and is an area of good practice.

10.18 From the small number of cases examined, we identified a risk that the investigating committee may not have been provided with, or have requested, enough information to make a rigorous decision.

Quality of complaint analysis, decision making, recording and communication of decisions

10.19 We considered that the decisions to close cases were clearly reasonable in all but one of the cases. However in some of the cases, we considered that the reasons given by the committee for its decisions were too brief. This could have given the impression that the committee had not fully considered the complaint. In one case the complainant was told that there was not sufficient evidence of professional incompetence, but the osteopath in question was told in a little more detail how the committee rated the osteopath's treatment plan, advice given and quality of communication. However, the committee still did not explain the basis for this assessment.

10.20 We found one case in which we considered that the committee's reasons for discounting the complainant's assertions were not sound. The decision to close the case was not clearly unreasonable, but the seriousness of the allegation meant the evidence should have been tested by the professional conduct committee.

10.21 We did find several cases where the committee had resolved to send informal advice to an osteopath in respect of areas of their practice. We consider this active approach to be an example of good practice.

10.22 There was information in a few cases which suggested the following areas of risk, which the GOsC may wish to consider reviewing:

- A risk that some evidence may not be fully tested before closure of a case
- A risk that people involved in the complaint will not understand how the committee reached its decision and may doubt the quality of the decision
- A risk that, by not expressing its decisions more fully, the committee may not see errors in its own reasons for closing a case.

Case and file management

10.23 To protect the public effectively, and in the interests of justice for the registrant, it is essential that cases are dealt with promptly. In addition good file management, and clear lines of responsibility in managing cases, are essential to:

- Achieve consistent, good quality decisions
- Ensure that cases can be reviewed and audited when appropriate.

10.24 We consider that these are necessary to underpin a process that ultimately maintains public confidence and patient safety.

10.25 The GOsC files that we audited were generally well managed. Also cases were dealt with in a reasonably timely manner.

10.26 However, we found however a couple of cases where telephone notes were not made or were not complete. There was also one case where a letter of advice, which the investigating committee had resolved to send to an osteopath, was not on file.

10.27 We did not find evidence that the screeners contributed to the consideration of cases. The inclusion of the screener stage will, however, have added to the overall time taken to deal with some of the cases. The screeners have the power to close a case, but they did not use this power in any of the cases. Instead they referred all the cases on to the investigating committee. One case, which might reasonably have been closed without reference to the committee, was still sent forward to the committee. The screeners do not appear to have contributed clearly to the investigating committee's ability to consider the case, nor did they provide guidance on possible draft charges.

11. Audit of the Health Professions Council's initial stages of fitness to practise procedures

Overall assessment

Introduction

11.1 Based on the evidence from our audit, we consider that the Health Professions Council (HPC) deals with fitness to practise cases efficiently and effectively. The vast majority of decisions taken on cases were reasonable and protected the public. However, we had concerns about three cases where we felt that the decision to close the case might present a risk to patient and public safety or public confidence in the relevant profession and the system of regulation. One of these cases raises an important matter of principle which we and the HPC intend to discuss further.

11.2 Although these three cases raise particular questions of practice and decision-making they do not affect our overall conclusion that the HPC's fitness to practise process and procedures do protect the public

11.3 The HPC's process for assessing fitness to practise cases is described in Appendix C.

Good practice

11.4 We identified many areas of good practice during the course of the audit, including:

- Examples of thorough information gathering and regular communication with those involved in a complaint
- When a case is closed by an investigating committee the HPC's letter to the registrant and complainant is usually detailed, clear and easy to understand. It usually includes a full explanation of reasons for the decision along with the guidance that the committee used to arrive at its conclusion. (We do, however, refer in the report to some cases where explanations were not adequate)
- Nearly all the HPC's case files were well maintained, with systems in place to facilitate recording of actions and decisions. We saw many examples of prompt and efficient handling of cases
- We understand that the HPC carries out regular audits of closed cases to check compliance with its own procedures and to identify areas for improvement

Risks

11.5 As well as this good practice, we did identify some areas of potential risk in the way in which the HPC is currently considering cases. We identified these potential risks from only a small number of cases within the overall sample.

11.6 We considered that three cases had been closed prematurely and that the circumstances of these cases meant there was a possible risk to public safety and/or to public confidence in the profession concerned and the system of regulation. In the course of this audit we raised our concerns with the HPC about these cases. In two of the cases the HPC did not accept that the cases had been closed with insufficient action.

11.7 One concerned an alleged serious clinical error by a short-term agency employee. In reporting the matter to the HPC, a clinician on behalf of the employing hospital said that, if the registrant continued to practise, another incident of the same nature would inevitably occur. The HPC commented to us that 'it was highly doubtful that the employer could substantiate such a claim'. However, we consider that the strong statement of risk from a clinician was sufficient for the case to have proceeded to an investigation or for an interim suspension order to have been considered. This may have included calling for the clinical evidence and gaining an expert opinion on evidence that may been produced. Instead this case was closed without referral to an investigating committee, which in turn meant it was not referred to a final conduct and competence committee panel. The HPC considers that it made sufficient attempts to gather evidence, which was not forthcoming from either the Trust or the employing agency. By placing the registrant on a watch list it ensured they cannot return to practice. This case raises questions about the risks associated with 'Occasional and Temporary' registration and the difficulty of investigating such workers.

11.8 Another case concerned a potential difference between professional standards and terms of employment. A paramedic had refused to go to the assistance of a member of the public as he was on his unpaid lunch-break. The employer had taken no action because it accepted that the registrant's failure to assist a member of the public had not involved a breach of contract. The HPC commented to us that the registrant was not contractually obliged to act in the situation and that 'whilst we may feel morally uncomfortable with the course of action taken by this [registrant], it [was] neither improper, illegal or unethical'. We accept that it was not illegal but believe that it was unethical. Registrants have an ethical duty to act in the best interests of service users, and this is reflected in the HPC's *Standards of Proficiency*. The HPC says that to pursue this case would be to challenge the validity of the nationally agreed terms and conditions of employment for paramedics. We consider that it was a matter that needed careful adjudication at the highest level within HPC's processes and think that it should have been brought to the attention of the HPC Council as a matter of principle. The HPC has agreed with us that the issue of conflicts between professional standards and terms of employment is worthy of further discussion.

11.9 In the third case, we considered that further investigation should have been carried out into an allegation which suggested that a registered professional may have been stealing addictive drugs and may have had a serious health problem.

In response to our feedback on this case, the HPC has said 'we will review the learning from this case in order to ensure all our cases are managed appropriately'.

11.10 In the overall context of a well managed casework function, we also identified the following potential risks, which we discuss in more detail later in this report:

- That the standard letter used by the HPC in response to initial letters of complaint may discourage some complainants from pursuing a matter. We think it is reasonable for a complainant to expect the regulator to assess the allegation against the criteria for impaired fitness to practise, and for the regulator to decide whether to investigate further. However the standard letter, in our view, appears effectively to require resubmission of many complaints.

  It also appears to put the onus on the complainant to assess the fitness to practise question. This creates a risk that some serious cases will not be resubmitted by a complainant. The HPC informed us that they are currently undertaking a review of their standard letters
- That a decision to close one case without clinical advice may, we believe, sometimes mean the HPC prematurely closes cases
- That not showing a registrant's response to a complainant may contribute to an inappropriate decision to close
- That some cases may be closed without a sufficiently wide investigation
- That one case, in which an employer was allowed to delay providing information, suggests a risk that the HPC may sometimes not make a suitably prompt risk assessment
- That despite the normal good practice of giving clear explanations, some cases are closed without the investigating committee providing proper explanation to the complainant
- That an employer's decision to take no action in two cases may mean the HPC are adopting employer decisions inappropriately
- That an interim order may not always be applied for promptly. This risk is based on two cases where we believe an interim order should have been applied for, but the HPC did not make such an application
- That there may, in our view, be an inconsistent approach between the registration panel and the fitness to practise department, and that this may lead to inadequate investigation or reasoning in some cases.

11.11 We hope that the HPC will review these matters and consider whether there are ways to improve its work further.

Recommendations

11.12 Based on the evidence from our audit, we consider that the HPC deals with fitness to practise cases efficiently. Its process and procedures operate effectively and ensure that cases are usually dealt with appropriately and in a

timely manner. However, we have concerns about a small number of cases where the decision to close a case might mean that there are risks to patient and public safety.

11.13 We are confident that the HPC will continue to review and modify its processes and in doing so we recommend that it considers the following:

- Reviewing all the areas of risk that we have identified, to find opportunities to further strengthen its casework practice
- Reviewing its standard letter sent in response to most new complaints, and any procedures that this letter reflects
- Ensuring that the information necessary for risk assessments is gathered promptly and that current thresholds are appropriate for deciding to request an interim order of suspension
- Reviewing the approach to adopting an employer's resolution of a case where the issues and options for the HPC may not be the same as for the employer. This is especially important where there is a potential risk to the public, or to the public's confidence in professional standards
- Reviewing the approach of the registration panel in assessing self-referred allegations. This is to ensure consistency of investigation standards and of decisions within the HPC
- Ensuring that an appropriate level of information is collected where there is a potential risk of substance abuse by a registrant
- Ensuring that, where appropriate, proper consideration is given to showing a registrant's defensive assertions to a complainant (or other principle witness). This is in order to increase the chance of appropriate counter-challenge and thereby to assist the investigating committee.

Detailed assessment

Dealing with initial contacts from complainants, ensuring that they are assessed properly and assisting/encouraging complainants in making complaints

11.14 We found several examples that show that caseworkers aim to be helpful to complainants. Examples included:

- Some very quick responses and clear explanations given to complainants and employers raising concerns about a registrant
- Advising complainants of other bodies that may be able to assist
- Clear and helpful letters encouraging complainants to submit information.

11.15 There was information in a small number of cases which suggested the following areas of risk, which the HPC may wish to consider reviewing:

- We consider that there is a risk arising from the standard procedure and letter used by the HPC in response to initial letters of complaint. We consider that there is a risk that this may discourage some complainants

- Where a complaint is not made on the official HPC form, the HPC usually sends a standard letter which says 'If you are of the view that [registrant name's] conduct may impair [their] fitness to practise, you can make a complaint to the HPC. I have enclosed a brochure which explains the HPC's Fitness to Practise investigation process, including how to make a complaint'. We saw some examples where we considered that the original letter was clearly a complaint about a registrant and where the complainant believed that the registrant had acted unprofessionally. We consider that asking a complainant effectively to resubmit their complaint may be a deterrent. We also consider that asking a complainant to understand the technical term 'impaired fitness to practise', and to assess the alleged actions against this term, may also be a deterrent.

  We think it is reasonable for a complainant to expect the regulator to assess the allegation against the criteria for impaired fitness to practise, and for the regulator to decide whether to investigate further.

Gathering information

11.16 Gathering an appropriate level of information is an essential step that allows proper decision making, and clear explanations, to assure and protect the public.

11.17 We found several examples of the HPC actively pursuing full information to assist decision makers. This good practice includes the following examples of cases where:

- The HPC made further enquiries, including obtaining hospital scan records, in order to provide the investigation committee with as full a picture as possible
- The HPC made several attempts to obtain information from an uncommunicative and reluctant complainant
- The HPC pursued a matter very thoroughly with regular updates requested from the employer and reluctance to close the case without full documentation
- There were a number of chaser letters sent at each stage to the employer requesting updates.

11.18 There was information in a small number of cases which suggested the following areas of risk, which the HPC may wish to consider reviewing:

- That some cases may be closed without sufficient investigation and where certain important factors, such as a registrant's motivation for certain actions, can only properly be tested at a fitness to practise panel hearing. We identified this risk in a case where we considered that enquiries should have been made to previous employers about behaviour suggesting substance abuse. We also considered that the HPC should have considered requesting inviting the registrant to undergo a medical examination to assess if there was any evidence of substance misuse, and whether the registrant therefore posed a risk to the public

- That failing to show a registrant's response to a complainant may contribute to an inappropriate decision to close. We found an example where a registrant challenged some of the evidence of the employer. The employer was not invited to rebut this challenge and it is possible that the registrant's untested claims influenced the investigating committee's decision to find no impairment
- That some cases may be closed without appropriate clinical advice and there is a risk that this may lead to premature closure of a case. We considered that in one case we reviewed it was likely that the case officer, who closed the case without referral to an investigating committee, did not have clinical expertise to assess a matter
- That if employers are allowed to delay in providing information, the HPC may not make a suitably prompt risk assessment. A risk assessment is particularly important so that the HPC can decide whether it should impose an interim order of suspension on the registrant to protect the public. We identified this risk from one case where the HPC waited several months before an employer gave details of the concerns it had reported about a registrant it employed. We consider that, when the employer first informed the HPC of their concerns, the HPC should have considered using its statutory investigative powers to require the employer to give more detail of the allegations against the registrant. The HPC says that it now reviews cases on a monthly basis to ensure appropriate actions are taken.

Quality of complaint analysis, decision making, recording and communication of decisions

11.19 Recording clear and coherent reasons for decisions on the file, and communicating these clearly to the people involved in a complaint, is essential for any good casework organisation. It is important in the following ways:

- To maintain the confidence of complainants, the profession and the public
- To encourage disciplined and clear thinking
- To ensure all areas of a complaint are investigated and that none are overlooked, especially in complex multi-level cases
- To enable effective review, both internally by auditors, managers and lawyers and externally by CHRE or other auditors
- To lessen the risk of successful claims for judicial review of decisions, and criticism leading from this, which could potentially damage the reputation of the regulators and the professions they regulate.

11.20 The HPC normally communicates well when explaining decisions to close cases. When an investigating committee closes a case, the HPC's letter to the registrant and complainant is usually detailed, clear and easy to understand. It usually includes a full explanation of reasons for the decision along with the guidance that the committee had used to arrive at its conclusion. This is very good practice.

11.21 There was information in a very small number of cases which suggested the following areas of risk which the HPC may wish to consider reviewing:

- Despite the normal good practice, some cases are closed without proper explanation to the complainant. This may undermine confidence in the regulatory system
- An employer's decision to take no employment disciplinary action, may be adopted inappropriately by the HPC. We identified this risk in two very different cases that we reviewed. In one case, the employer had taken no action because there had been no breach of contract by the registrant. However we considered that the registrant's failure to take certain actions raised questions about acceptable professional standards
- In a different case an employer had taken no action, in part because the registrant had been a very short term temporary worker that it had decided not to re-engage
- Where a registrant is alleged to present a direct risk to the public, in some cases the HPC may not consider seeking an interim order of suspension. We identified two cases where initial allegations suggested that the registrants may have been a risk to the public, but where the HPC did not appear to have considered an interim order of suspension
- An inconsistent approach to dealing with different classes of concern about a registrant may lead to inadequate reasoning, and thus potentially inadequate analysis and investigation. There was evidence that cases of self-referral by a registrant sometimes received a lower standard of review than those where another party referred a matter. Sometimes chance determines whether the HPC learn of a matter first from a registrant or from another party such as an employer. Where a registrant is the first to inform the HPC of a possible breach of professional standards, the matter is first assessed by the HPC's registration panel. This panel decides if it should then be passed to the HPC's fitness to practise department for investigation. We found several cases that had been considered by the HPC's registration panel which had brief and inadequate reasons for closure. Without adequate reasoning, there is a risk of poor decision making and that public confidence may be undermined. In response to discussions during this audit, the HPC says it will address issues about the quality of reasoning through training and additional support
- Cases that are closed by just one caseworker, without considered review by a colleague, may lead to inconsistent or poor quality decision making. The HPC processes, in the period audited, allowed in some situations for one person to close a case. We found one example where this had happened. We consider that, however senior the person closing a case, this is not good practice. We are pleased to learn from the HPC that allocation of caseloads has changed and that this means this situation is unlikely to recur.

Case and file management

11.22 Good file management, and clear lines of responsibility in managing cases, are essential in:

- Achieving consistent, good quality decisions

- Ensuring prompt management of investigations
- Ensuring that cases can be reviewed and audited when appropriate.

11.23 We consider that this underpins a process which ultimately maintains public confidence and patient safety.

11.24 Nearly all the HPC's case files were well maintained and we saw many examples of prompt and efficient handling of cases.

12. Audit of the Nursing and Midwifery Council's initial stages of fitness to practise procedures

Overall assessment

Introduction

12.1 Based on the evidence from our audit, we have identified serious weaknesses in the Nursing and Midwifery Council's (NMC's) operation of its fitness to practise processes during the period 1 April 2008 to 31 March 2009. We are concerned that the NMC has not always acted in ways that have protected the public or that would fully maintain public confidence in the professions which it regulates. We consider that this reinforces the conclusion in our report, *Special Report to the Minister of State*[4] published in June 2008. It is clear that in response to that report the NMC has taken substantial measures to improve its performance in this area of its work over this period. We refer to some of these improvements in this report.

12.2 Because of the timing of some of the improvements that have been made, and because of the NMC's former policy of not retaining documents during the period which limited our ability to conduct a full audit, we are unable to give a firm view on the effect of these improvements at this stage.

12.3 Our audit covered cases closed in the period 1 April 2008 to 31 March 2009. This means that many of the cases were closed before, or shortly after, we published our *Special report to the Minister of State for Health Services on the Nursing and Midwifery Council* in June 2008. The judgements we make in this audit report must be considered in that context.

12.4 It is clear that the NMC has taken substantial measures to improve its performance in this area of its work, in response to the special report. In December 2009 we understand that the NMC's new computerised case management system came into operation. We were given a demonstration of this system during its development and were impressed with its apparent capabilities. The NMC has also started to address its seriously deficient document retention practices. We also understand that in the last few months of the audited period, the NMC introduced a new structure in its casework teams, creating new caseworker posts and new supervisory roles to support and guide individual caseworkers. In January 2010 it appointed a quality assurance manager. We are aware that it is taken other steps to address its problems.

12.5 We also understand that, within weeks of receiving initial feedback from us on this audit in July 2009, the NMC's fitness to practise department developed plans to address our concerns.

4 CHRE, 208. *Special report to the Minister of State for Health Services on the Nursing and Midwifery Council*. London: CHRE.

12.6 However, we are unable to give a firm view on the effect of these plans at this stage. This is because some of the intended improvements happened towards the end of the period audited, or later. Also, we understand the NMC has continued to have administrative difficulties in its new archiving process. It was apparent that files were frequently not properly scanned for much of the period that we audited. This limited our ability to conduct a full audit. We refer to these problems in Appendix B.

12.7 During the period audited, there appeared to be very poor file and case management, with poor control of delegated decision making, and poor practices in gathering and analysing information. The NMC closed some cases without enough information to assure it that certain registrants did not present a risk to patients.

12.8 We have identified a number of areas where we feel there is a particularly strong risk to public protection. These are discussed in detail in this report. We hope that the NMC will continue to review these issues as a matter of priority, and take account of them in their ongoing review of their fitness to practise processes and procedures. The main areas are 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, when and why.

Recommendations

12.9 We welcome the steps that the NMC has already taken. However, in view of the serious concerns we have identified when auditing cases, we strongly recommend that the NMC closely monitors its action plan and ensures that developing plans fully respond to the following points:

- The need to develop comprehensive guidance for staff and investigating committee members on how to handle all aspects of cases. This should include guidance on matters such as:
    - How to gather sufficient information
    - How to assess information
    - The criteria to use when reaching decisions
    - The use and full description of delegated powers

- The need to create a mechanism for staff to have access to expert advice on acceptable nursing and midwifery practice. This might be used when deciding whether to close a case under delegated authority, particularly in cases involving complex clinical issues or when preparing a brief for an investigating committee
- Reviewing how it handles information, such as drink driving convictions, that may suggest substance misuse problems by registrants. This includes exploring whether there is a need to seek medical examinations of registrants in more cases. We recommend that the NMC consult the GMC and other regulators on how it handles such cases
- Considering ways to improve information gathering from statutory bodies and employers, by building relationships, and by understanding and explaining its own statutory powers of investigation.

Detailed assessment

Case and file management

12.10 Good file management, and clear lines of responsibility in managing cases, are essential in:

- Achieving consistent, good quality decisions
- Ensuring prompt management of investigations
- Ensuring that cases can be reviewed and audited when appropriate.

12.11 We consider that these are necessary to underpin a process that ultimately maintains public confidence and patient safety.

12.12 In this area of activity, there was information which suggested the following areas of risk which the NMC should consider reviewing urgently:

- A risk that, due to poor file archiving, all the information received by the NMC about a registrant may not be available. This information may be needed if a subsequent concern arises about the same registrant
- A risk that staff do not have sufficient guidance to enable consistent, high quality decisions. This includes lack of written guidance and procedures, and a lack of formal systems for gaining internal or external advice on appropriate nursing practice
- A risk that decisions may be made by unauthorised officers
- A risk that cases may be closed that should have been considered by the investigating committee
- A risk that during the introduction of the new case management system, cases may be left unattended as a result of falsely being recorded as 'closed'.

12.13 The NMC's management of documents on closed cases was often inadequate. Until July 2008 the NMC's standard practice was to destroy all files within a few months of closure. Original complaint documents submitted by complainants were routinely sent back to them.

12.14 After July 2008 the NMC started a programme of scanning all cases after closure and retaining an electronic copy of the full file. Whilst we fully support this change of practice, we found many post-July 2008 cases where the original complaint had not been retained or scanned. In most of the cases where this had happened, we were unable to audit the file.

12.15 We found many cases where some key documents were missing. These included memos recording why a caseworker had closed a case, the decision letter to the people involved in the complaint, and file notes of important phone conversations. For example we found one case where it was apparent that a complainant withdrew their complaint in a phone conversation and this led to the closure of the case. There was, however, no note of the phone conversation on file.

12.16 We cannot say for certain whether, in such cases, the documents had existed previously but had not been scanned properly for archiving. Scanning was clearly inadequate in many cases. We found several instances where documents from one or more unrelated cases had been scanned under the wrong reference on the computer document management system.

12.17 The pattern of missing information also suggested that basic practices were not followed. Very few cases closed by staff without reference to the investigating committee had clear records of why a decision had been made, under what authority, and by whom. Frequently a draft of a letter was the only information that recorded a reason for a closure. There was no indication whether the letter had finally been sent in that form, or whether it had been sent to registrant and complainant at all. Copies of final, signed closure letters were rarely present.

12.18 We understand that in 2007 the NMC's investigating committee agreed to delegate to staff the power to close cases in certain circumstances. We understand also that the NMC started to use this delegated power in about October 2008. An internal document records the delegation as follows:

> *'The Investigating Committee has agreed that cases which meet particular criteria can be closed by NMC officers without referral to the IC. (Minute IC/07/11 amended by minute IC/07/27)*
>
> *Cases **cannot** be closed by officers if:*
> - *there is a public interest reason for pursuing the allegation or*
> - *the registrant has a previous FtP history*
>
> *Cases **can** be closed by NMC officers without referral to an IC panel if they fit the following criteria:*
>
> *1 local complaints procedures (where they exist) have not been exhausted*
>
> *2 traffic offences incurring fixed penalty points and a fine and not involving drugs and/or alcohol or leading to a disqualification*
>
> *3 the registrant's profession is incidental to the matter e.g. a dispute between neighbours*

4 a registrant's immigration status prevents them from working (e.g. a work permit has expired or is no longer valid or their permission to remain in the UK has expired), where no dishonesty is involved

5 the level of quality of service provided by a healthcare organisation where there is no suggestion that an NMC registrant is directly responsible

6 correspondence copied to the NMC, but addressed to another body, and there is no suggestion that patients/the public are at risk

7 correspondent is explicitly seeking an apology only and there is no suggestion that patients/the public are at risk.'

[Emphasis is as given in original document]

12.19 We consider the description of some of these delegated powers to be vague and poorly expressed. There is a risk that, by applying these criteria strictly according to these wordings, staff could close a case in which there was a serious risk of harm. For example, we would be concerned if all cases were automatically closed if local procedures had not been exhausted. A case might have been referred to the NMC because it required urgent action, such as an interim order, before local procedures could be completed. There is no other guidance available to officers explaining how to interpret this delegation. We found many cases closed by officers that we could not clearly identify as falling within any of these categories.

12.20 Under these delegated powers, all decisions must be authorised by a manager. However, we found very few cases where the prescribed form was used to record which category was being applied and which authorised manager was confirming the closure. In most of these cases this information was not clearly available in any other format either. We do understand, though, that the NMC is addressing this issue and that the new IT-based case management system will require a manager to confirm closure by ticking a box, and by writing a reason explaining the closure decision.

12.21 Rule 22 (5) of the NMC's statutory rules *(The Nursing and Midwifery Order 2001 as amended)* says that the Council must refer to the relevant committee or person any allegation that is made to it 'in the form required by the Council'. The rules do not define what this 'form' is. However, the Council has defined this to include the need for an allegation to 'be supported by appropriate evidence'.

12.22 Again there is no guidance to staff on what is 'appropriate evidence' and when Rule 22 has not been met. Staff do not, therefore, have proper guidance on when they may close a case on these grounds, instead of sending it to an investigating committee. There is also no guidance on how far the staff should go in finding out whether such evidence is likely to be available. Some of the cases we reviewed may have legitimately been closed under the rule relating to sufficiency of evidence, but we could not see which of seven delegated criteria applied. However, we consider that the formulation of the phrase 'supported by appropriate evidence' is too loose. It raises considerable risk that cases may be

closed by staff when they should instead have the careful assessment of the investigating committee.

12.23 The lack of effective guidance to staff is a serious deficiency in the NMC's procedures. Staff need a comprehensive manual of guidance covering all aspects of their consideration of cases.

12.24 Comprehensive guidance and advice on the effective management of cases should be available for all decision makers, both staff and investigation committee members. This should be consistent throughout the process.

12.25 We noted that the new computerised case management system (CMS) was being introduced and tested whilst we were on site to conduct the audit. This is encouraging not least because it was one of the main recommendations in our special report on the NMC. Cases open since February 2009 had been added to the CMS system, which was being used during its development stage for storing new documents. However, we were concerned to discover that many of the cases that were marked as closed on the CMS system were in fact still open. They had been registered as 'closed' as a result of an inputting error which we understand arose from a design fault. We believe this is due to be rectified on the final CMS. However, we were concerned that there was a risk that many cases may have been not dealt with due to this error.

Dealing with initial contacts from complainants, ensuring that they are assessed properly and assisting/encouraging complainants in making complaints

12.26 In this area of activity, we identified information which suggested the following particular areas of risk which the NMC may wish to consider reviewing:

- That anonymous information that casts doubts on a registrant's fitness to practise may not be investigated by the NMC
- That complainants may be deterred from submitting further information in support of complaints after the NMC has returned their original documentation
- That complainants may be deterred from pursuing a complaint where the NMC asks for information that has already been supplied or where the information is clearly not accessible to the complainant.

12.27 In most cases we saw evidence that the NMC acknowledged receipt of complaints promptly.

12.28 However, we saw many cases dealt with earlier in the period covered by the audit in which the NMC sent members of the public inappropriate and confusing letters. This included letters asking for information that only an employer would have had, or for information that had already been supplied with the original complaint. We think this is likely to have discouraged some complainants from pursuing their complaints. We understand that staff underwent training and were encouraged to consider the appropriateness of some parts of this standard letter. In more recent cases that we audited, there was evidence that staff were less likely to send out such untailored standard letters.

12.29 We found no direct evidence from the cases audited that anonymous complaints were handled inappropriately. However we were concerned that the guidance to

staff on how to deal with anonymous complaints does not sufficiently highlight the possibility that the NMC may need to pursue a serious anonymous allegation without a named complainant.
It appeared that there was previously a misunderstanding amongst staff that they could not pursue a case in the absence of a named complainant.

12.30 When staff close a case, the NMC now routinely offers complainants the opportunity to write to the triage manager. This enables them to say if they are dissatisfied with the way a case has been handled. We found examples where this led to a fuller explanation of how the NMC had reached its decision. This also gives the staff the opportunity to consider again whether the delegated authority to close a case has been used appropriately. This is in itself good practice. However we considered that, in some of the cases, the NMC should have given fuller explanations to complainants earlier in the process.

12.31 We consider that the NMC's practice of routinely returning the original correspondence to complainants to be poor practice. Its standard letter says *'I am returning all the documents you have sent to us. If you find any more information that might alter this decision [to close the case], you may write to us and we can see whether that changes the position'.*

12.32 We consider that many complainants will consider it discourteous to have their original letter returned to them and not retained by the NMC. Further, many will be deterred from writing with further information or concerns if they have to resubmit all the documentation they previously submitted.

Gathering information

12.33 In this area of activity, there was information from the audit which suggested the following areas of risk:

- The risk that cases are closed in the absence of proper information to assess the case
- The risk that registrants who are unfit to practise are allowed to continue working and that patient safety is endangered. This is because of delays, and failure to refer for interim orders.

12.34 Gathering sufficient relevant information before deciding to close a case, is essential to good decision making. We consider that the NMC's practice in gathering information is deficient in many respects:

- We found several cases where the NMC failed to ask for further information before closing cases. These were cases where there appeared to be a serious risk to patient safety from the reported behaviour or competence of a registrant. These included cases where there were serious allegations about the registrant's mental health, conduct or competence. For example, in one case the NMC said to a complainant that they would not be interested in pursuing a case against a nurse who had been convicted of assault, and that they would not want any further information
- The NMC regularly receives from the police, and other sources, information that a registrant has been cautioned or convicted of an offence. There appears to be no consistency around when the NMC seeks further information on criminal records after receiving such information. Such

information can show whether there was a wider pattern of criminal misconduct. In one case where the NMC did carry out such a check, other relevant convictions were brought to its attention

- We were concerned about delays in conducting investigations where complaints involved a criminal allegation. In one case we looked at, the registrant had been referred to the NMC after being arrested for a very serious crime involving sexual violence. Although the referral was quickly acknowledged, no further investigative action was taken for eight months, during which period the registrant's registration was unaffected. In this instance, the registrant had been found not guilty five months after the initial referral, but the NMC did not become aware of this until it resumed the investigation
- In drink driving cases or drug-related offences, it appears very rare for the NMC to seek further information about the registrant's health. Such information might show whether the registrant suffers from an addiction or substance misuse problem. We know that the GMC, which regulates doctors, finds that further medical checks on doctors cautioned or convicted for drink driving reveals a significant proportion have previously undisclosed substance misuse problems. However, from the evidence of this audit, the NMC investigating committee routinely assumes that an offence or caution was a 'one off' offence. It takes no further action other than allowing the complaint to remain on file for three years. In one case, an investigating committee did impose an interim order after evidence of a registrant's alleged drinking problem. However, it later decided there was no case to answer because the registrant refused to take part in a medical assessment
- We found several cases where the NMC had closed a case on the strength of an employer's investigation, without considering whether the investigation addressed the individual registrant's alleged impaired fitness to practise. In some cases we considered that the employers' investigations addressed only hospital system failures or identified training needs. They did not reach a view on the registrant's general fitness to practise
- We found some cases where the NMC had difficulty obtaining information, but did not consider quoting, or using, its statutory powers of investigation. There is no reference to these powers in its standard letters, despite the fact that this might enable other statutory agencies to release the information quickly. Similarly, there were cases where the NMC could have requested information direct from other statutory investigating bodies. Instead it requested it unsuccessfully only from a third party, such as the registrant's employer.

Quality of complaint analysis, decision making, recording and communication of decisions

12.35 In this area of activity, there was information which suggested the following areas of risk:

- That inadequate recording of decision reasons may reflect poor case analysis

- That members of the public will not have confidence that their concerns have been addressed by the NMC or that the NMC is properly protecting patients.

12.36 Recording clear and coherent reasons for decisions on the case file, and communicating these clearly to the people involved in a complaint, is essential for any good casework organisation. It is important in the following ways:

- To maintain the confidence of complainants, the profession and the public
- To encourage disciplined and clear thinking
- To ensure all areas of a complaint are investigated and are that none are overlooked, especially in complex multi-level cases
- To enable effective review, both internally by auditors, managers and lawyers and externally by CHRE or other auditors
- To lessen the risk of successful claims for judicial review of decisions, and criticism leading from this, which could potentially damage the reputation of the regulators and the professions they regulate.

12.37 The NMC appears to perform poorly in these areas, although it was difficult to reach a full view as document retention was inadequate. In very many cases closed by staff, rather than the investigating committee, there was no clear explanation on file of why the case was closed or how the information available had been analysed. Where there was a decision letter on file, we found that the NMC often used standard phrases which were not sufficient. These did not properly explain how the NMC had assessed information, nor how this information contributed to the decision to close the case. We did note an improvement in many of the standard letters in the latter half of the year. However we consider there is probably still much room for improvement in the way these are used. For example, we reviewed a case closed towards the end of the audited period. In this, a complainant had accused a registrant of missing a symptom, thereby causing a patient's death. The standard phrase in the closure letter said 'the matters you wrote to us about… do not raise a question of impaired fitness to practise'. This was clearly untrue, whether or not the question raised by the complainant was justified.

12.38 Most cases that the investigating committee closed at the beginning of the audited period had very brief reasons for a closure. We understand that, during the audited period, committee members were trained in decision writing. We did find evidence that this has led to more detailed explanations of decisions.

13. Audit of the Pharmaceutical Society of Northern Ireland's initial stages of fitness to practise procedures

Overall assessment

Introduction

13.1 In October 2009 CHRE audited the initial stages of the fitness to practise procedures of the Pharmaceutical Society of Northern Ireland (PSNI). We audited all the 20 cases that the PSNI had closed between 1 April 2008 and 31 March 2009 in the initial stages of its fitness to practise process. The audit concerned only cases that had been closed without being referred to a final stage fitness to practise panel hearing by the Statutory Committee. More details about how we carried out the audit are at Appendix A.

13.2 We would like to thank the PSNI's staff for their helpful approach and practical assistance during our audit.

Statutory limits on powers to act

13.3 The PSNI's process for assessing fitness to practise cases is described in Appendix B.

13.4 The PSNI has limited powers in dealing with fitness to practise matters. This is because of the limits of its statutory framework. First, this gives the PSNI no specific investigatory powers. For matters raising a potential question of a registrant's fitness practise, it typically refers cases to be investigated by the Department of Health, Social Services and Public Safety's (DHSSPS) Medicines Inspection and Investigation Team ('the inspectorate').

13.5 Secondly the only sanction available to the PSNI, in matters of impaired fitness to practise is removal of the registrant's name from the register by the statutory committee for misconduct. It does not have any other sanctions, such as the power to temporarily restrict a registrant's practise through imposing conditions on their registration. Nor does it have the power to suspend a registrant, or to impose a warning.

13.6 The DHSSPS has the power to remove a registrant because of ill health where there is no misconduct. These powers come from the *Pharmacy (Northern Ireland) Order 1976*. The terms of such removal are set out in paragraph 18 of the order and are to be exercised after consultation with the Council. We understand that doubts have been expressed as to whether this provision would comply with modern Human Rights legislation.

13.7 Unlike other health professional regulators, neither the DHSSPS nor the PSNI has the power to impose an interim order of suspension during an investigation, where a registrant presents a risk to the public.

13.8 Several of the cases closed in the initial stages may have merited referral to a final hearing. This would have been possible if the PSNI had powers, similar to the other eight health professional regulators, to impose sanctions less severe than striking off.

13.9 In three cases, even if the PSNI had had the full range of sanctions, realistically it would not have been able to use these sanctions. This was because the matter had been investigated by the inspectorate who had independently decided that there should either be no further action or had issued a warning or letter of advice.

13.10 Our findings from the audit are limited because of the small number of cases handled by the PSNI during the year. Within this small sample of 20 cases, several cases involved complainants who wished to be anonymous, failed to provide information or withdrew their complaints. As a result, there were only 13 cases where the PSNI took any action at all. In three of these the PSNI referred the matter to the inspectorate. In most of these remaining ten cases, the PSNI's action consisted of passing on concerns or advice to a pharmacy.

Case handling

13.11 There was only one formal decision that fell within the remit of this audit. This was the one case during the year that was closed after consideration by the scrutiny committee.

13.12 However, we did find evidence that the PSNI has taken a creative and positive approach in making itself as effective as possible, within the limits of its statutory powers. This included:

- Taking an active approach to referring concerns to the pharmacist, or their supervisor if they had one, in an attempt to resolve matters informally, and by giving advice to improve safety and public confidence
- In two cases which concerned registrants who suffered with a health condition that potentially presented a risk to patients, engaging sensitively with the registrants and their employers to limit any potential risk. In one case the registrant voluntarily accepted restrictions through undertakings and eventually sought voluntary removal from the register.

13.13 The PSNI has also taken steps that would appear partly to have lessened the effect of some of the other limitations created by its statutory framework.

- From January 2009 it has created an advisory scrutiny committee. This has no statutory powers but has been given the role of recommending to the chair of the statutory committee whether a matter should go forward to that committee. We consider that the creation of the scrutiny committee brings some of the structural benefits of the investigating committees or equivalents found in most of the other regulators. This should ensure formal consideration of matters at an earlier stage, and instil discipline in case preparation as well as encouraging the development of case-handling guidance. In the one case we reviewed from this committee, there had been careful preparation and review, and this resulted in a considered and well explained decision to close the case

- From the spring of 2009, and so after the period audited, the PSNI helped set up a Pharmacy Network Group. This consists of representatives of the PSNI, DHSSPS, Business Services Organisation and the Regional Health and Social Care Board. Each of these partners will bring concerns and complaints, about pharmacists and pharmacies, to a regular meeting. Where a matter has been brought to the meeting for the purposes of action, the matter will be referred to the most suitable body or bodies for handling. This is likely to improve the co-ordination of complaint investigation. We consider that this should counteract to some extent the PSNI's limitations in not having its own investigative arm through which it can directly control and quality assure investigations into cases. However, while this is a pragmatic solution to some of the difficulties, it does not remove the need for the reform of the law in relation to regulation of pharmacy in Northern Ireland.

13.14 We also found that the PSNI took a supportive approach to complainants, giving information on how to complain and keeping them regularly updated on progress.

13.15 We considered that there was a small risk that complainants may have their identity inadvertently revealed before they had given their consent, and that this might undermine their confidence in the system of regulation. We identified this risk from a small number of cases. In these cases, the PSNI had acted quickly in bringing a concern to the attention of a pharmacy. However it had not received written consent from the complainant, and there was no record on file of verbal consent given by telephone. It appeared the pharmacists were often able to identify the complainant from the facts given.

13.16 Record keeping and logging of actions on files was of a good standard. On a very few cases we considered that some conversations with complainants or other sources of information were not always fully documented. Recording such information is important for the integrity of the file and for accountability.

Conclusion and recommendations

13.17 The public can be reassured that the operation of PSNI's fitness to practise procedures is focused on protecting patients and other members of the public. However, the PSNI is severely restricted through the lack of sanctions available to it. Also, the Society can gather information to help in its casework, but it does not have direct control over the majority of investigations on which it relies for the most significant matters. These are carried out by the DHSSPS's inspectorate, whose investigations may have a different primary focus.

13.18 In our 2008/09 performance review, we commented on the difficulties that the legislative framework created for the PSNI. Now that we have examined in detail the cases closed in the year from April 2008, we are satisfied that the regulation of pharmacy in Northern Ireland will not fully protect the public, and the reputation of the pharmacy profession, unless:

- It is carried out under a statutory framework similar to the fitness-to-practise processes of the other health professional regulators; and
- The regulator is able to conduct and manage its own investigations.

13.19 We recommend that these issues should be addressed as a priority.

13.20 We also recommend that the PSNI considers all the comments made in this report, including ensuring that it protects the identity of complainants where necessary. It should also make sure that it has full notes of telephone conversations with complainants and other providers of information. This would include ensuring that it fully records on the file when a complainant has given verbal consent for their concern to be relayed to a pharmacy.

14. Audit of the Royal Pharmaceutical Society of Great Britain's initial stages of fitness to practise procedures

Overall assessment

Introduction

14.1 Based on the evidence from our audit, we consider that the Royal Pharmacteutical Society of Great Britain (RPSGB) deals with fitness to practise cases effectively. Patient and public safety, and maintaining public confidence in the profession and in regulation, is at the heart of its operations.

14.2 The RPSGB's process for assessing fitness to practise cases is described in Appendix C.

Good practice

14.3 We identified many areas of good practice during the course of the audit. Important areas of good practice include:

- Good liaison between the RPSGB's fitness to practise department and its Inspectorate, which is able to gather information on pharmacists at the local level. This enables the RPSGB to take an active and pragmatic approach to dealing with concerns
- Thorough explanations given to the people involved about decisions on closing cases
- Well reasoned investigation reports, based on structured templates, which lead to well reasoned decisions
- Well maintained case files with evidence of a systematic approach to file and case management, with checklists and other forms nearly always filled in appropriately. There were normally very good audit trails on files, including action logs and internal emails showing when and why actions were taken. We saw many examples of prompt and efficient handling of cases.

Risks

14.4 In the overall context of a well managed casework function, we did identify a potential risk arising from the system of filing and casework management. This is partly related to the three different casework management systems that the RPSGB has employed in recent years, with some case management information also being held on a separate spreadsheet. There is a risk that caseworkers and decision makers may not have easy access to all relevant information, which may affect the quality of their decision making and case management. This may be when a case is open, or if it is later referred to after it is closed.

Recommendations

14.5 The public can be reassured that the RPSGB is focused on protecting patients and other members of the public through the operation of its fitness to practise procedures. Its processes and procedures operate effectively and ensure that cases are usually dealt with appropriately and in a timely manner.

14.6 We hope that the RPSGB will continue to review and modify its processes and in doing so we recommend that it considers the following:

- Reviewing the areas of risk that we have identified, to find opportunities to further strengthen its casework practice
- Considering ways in which all information on a case can be held in one place
- Considering whether there are additional safeguards that can be put in place to avoid accidental premature closure of a case on the case management system.

Detailed assessment

Dealing with initial contacts from complainants and assisting/encouraging complainants in making complaints

14.7 The evidence from the audited cases shows that the RPSGB aims to assist people who express concerns, and does not create barriers to complaining. We saw more than one example of the RPSGB making considerable effort to provide a good standard of customer service to complainants. Examples included:

- Responding quickly to a particular complaint, to explain why it was not appropriate to take action
- Responding thoughtfully and helpfully to a difficult and persistent complainant, and directing him appropriately to another body
- Regularly referring complainants to other organisations when a matter fell outside the RPSGB's remit.

Gathering information

14.8 The cases we examined showed evidence of a strong link between the RPSGB's fitness to practise department and its inspectorate. This provides the fitness to practise department with good locally-gathered information, from a variety of sources, about possible concerns with a registrant. It also enables the RPSGB to engage constructively at a local level to improve practices and protect the public.

Quality of complaint analysis, decision making, recording and communication of decisions

14.9 The RPSGB performs well in this area. We saw many instances of good practice in the analysis and communication of decisions:

- On the basis of our audit, the RPSGB normally communicates well when explaining a decision to close a case

- The RPSGB provides to the registrant and the complainant the fully reasoned determination made by the investigation committee
- Investigators' reports, which are supplied to the investigation committee, are generally well reasoned. The investigators are required to fill in a well-designed form which facilitates a systematic ordering of evidence, including an assessment of any weakness. On the evidence of the files we examined, this leads to well reasoned decisions and comprehensive accounts
- We found cases where advisory letters sent to registrants were also copied to the employer's superintendent pharmacist. We consider this good practice which protects the public by encouraging the employer to put in place appropriate supervision and monitoring following incidents such as dispensing errors
- We found one case where an inspector considered that there was no evidence of misconduct. However, in view of the very serious nature of the allegations, the case manager decided to refer the matter for a final decision by the investigation committee. We consider this to be evidence of application of a proper approach to public protection.

14.10 There was information in a very small number of cases which suggested the following area of risk which the RPSGB may wish to consider reviewing:

- The investigation committee often requires the RPSGB to give advice to a registrant when it is closing a case. Often there are detailed instructions on what this should be. On several cases we found that this had been translated into general advice about adhering to the code of ethics. Although the registrant and complainant would have seen the investigation committee's full determination, any other party sent a copy of the advice letter would not see this. We consider that there is a small risk that this does not promote public confidence that investigations were having a full effect in improving registrants' practice and enabling third parties, such as employers, to make fully-informed risk assessments. However, we understand that the RPSGB has now created a process to ensure that letters of advice better reflect the full investigating committee decision.

Case and file management

14.11 Good file management, and clear lines of responsibility in managing cases, are essential in:

- Achieving consistent, good quality decisions
- Ensuring prompt management of investigations
- Ensuring that cases can be reviewed and audited when appropriate.

14.12 We consider that this underpins a process which ultimately maintains public confidence and patient safety.

14.13 The RPSGB's case files were well maintained. There was evidence of a systematic approach to file and case management with checklists and other forms nearly always filled in appropriately. There were normally very good audit trails on files, including action logs and internal emails showing when and why

actions were taken. We saw many examples of prompt and efficient handling of cases.

14.14 There was information in a small number of cases which suggested the following areas of risk, and which we hope the RPSGB will review:

- During the life of cases closed during the audit period, the RPSGB had used three different casework management systems. We also understand that some case management information is stored on separate spreadsheets. The RPSGB will need to take special care to ensure that all casework and management information is available. This will be needed to ensure monitoring of case progress. It is also so that all necessary information is available for caseworkers, decision makers and reviewers during the life of the case, and if the case is referred to in future. This risk was in part identified in the following way:
    - We found several cases where documents were available on the computer system but not on the paper file
    - We found one case which had been recorded as 'closed' on a spreadsheet but which should have remained opened and some further action taken. Although in the particular case the error was corrected and the matter had progressed to a hearing, this suggests that there is a small risk of cases not being properly managed.

15. Appendix A: Why and how did we carry out the audit of initial fitness to practise decisions?

Background

15.1 Until the relevant provisions contained in the Health and Social Care Act 2008 came into force in January 2009, CHRE's involvement in scrutinising the regulators' fitness to practise cases was confined to its powers contained in Section 29 of the National Health Service Reform and Health Care Professions Act 2002. That legislation gives us the power to review final decisions made by the fitness to practise panels of the health professional regulators. Where we consider such a decision is unduly lenient and that it is necessary for the protection of members of the public we can refer the case to court.

15.2 Although we refer relatively few cases to court we have succeeded in protecting the public in a number of important cases. In addition, we provide feedback to the regulators on cases which we do not refer to court. We believe that, partly as a result of our work under Section 29, the quality of decisions made by fitness to practise panels has improved considerably in recent years. This has resulted in fewer cases being referred to court.

15.3 Our Section 29 powers only apply to those cases which have reached a full fitness to practise panel hearing. However, the majority of complaints or enquiries which the regulators deal with about the fitness to practise of people on their registers do not get as far as a fitness to practise panel. Most cases are closed at an earlier stage either by staff, case examiners or an initial stage committee, often called an investigating committee. In many respects it seemed inappropriate that our scrutiny of fitness to practise only applied to a relatively small proportion of cases right at the end of the procedures. Indeed these were the cases that were already predominately in the public domain, as most of the fitness to practise panel hearing decisions are published by the regulators. However, decisions not to refer cases to a fitness to practise panel are not published.

15.4 The suggestion that we should audit the regulators' initial fitness to practise was included in the White Paper, *Trust, Assurance and Safety - The Regulation of Health Professionals in the 21st Century.* This set out an intention for CHRE to set up a new auditing process to assess whether patient safety interests have been properly considered in the decisions and operations of the regulators on fitness to practise cases.

15.5 Specifically, paragraph 4.16 states that: '……for all the professional regulators, the Government will ask CHRE to review a sample of cases that the regulators have not taken to full fitness to practise panels. The Government will consider whether CHRE has the necessary powers to review the different fitness to practise cases, both their processes and application. CHRE will report annually to Parliament on whether patient safety interests have been properly considered in the decisions and operations of the regulators on fitness to practise cases.'[5]

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5 Department of Health, 2007. *Trust, Assurance and Safety - The Regulation of Health Professionals in the 21st Century*. London: The Stationery Office. Paragraph 4.16

15.6 The necessary changes to the NHS Reform and Health Care Professions 2002 to enable us to have the powers to perform the audit were made by the Health and Social Care Act 2008. The relevant part of the Health and Social Care Act 2008 (Section 115) came into force on 1 January 2009.

The audit process

15.7 In 2008, we set up a working group which included representatives from the regulators and a patient and public representative to develop a process for auditing the regulators' initial fitness to practise decisions. We also obtained legal advice from the University of Reading Statistical Department on the methodology for sampling of cases. We undertook a full public consultation on the proposed process from December 2008 to February 2009. The process was finalised in March 2009 and can be found on our website.

15.8 Taking account of the advice of the University of Reading Statistical Department, we decided in the first year to audit 100 cases that each of the regulators had closed without referral to a final fitness to practise panel. For those regulators who had closed fewer than 100 cases we audited all of their closed cases. The sample was selected from cases closed between 1 April 2008 and 31 March 2009. Cases were randomly selected but we used a stratified random sample to ensure that we audited a proportionate selection of cases at each closure point in each of regulators' process.

16. Appendix B: How we carried out the audit and selected the sample of cases

16.1 The audit of regulators was carried out under our new powers in Section 115 of the Health and Social Care Act 2008 and in accordance with a process which we had developed in consultation with the regulatory bodies and other stakeholders. The process and guidelines document can be found on our website: www.chre.org.uk/Audit_Process_and_guidelines_April_2009.pdf

16.2 There were two main questions which we considered in reviewing the handling of cases:

- Whether each regulator's staff had followed their own guidance and procedures
- Whether any decision to close a case failed, or risked failing, to protect the public, either through presenting a direct risk to members of the public or failing to maintain public confidence in the profession and the system of regulation.

16.3 To assess this we looked at:

- The reasonableness of the handling and the outcomes of the sampled cases
- The information each case gave about the processes and supporting environment in which cases are handled, and the risk that future cases might not be handled appropriately.

16.4 Regulators provided us with the reference numbers of all cases closed during the period 1 April 2008 to 31 March 2009. This covered all cases where an investigation had been considered but not carried out, or had been started but concluded without reaching a final fitness to practise panel. We were advised by statisticians to select where possible 100 cases from each regulator in our first year of conducting the audits. Where the number of total cases closed was less than 100, we should audit all the closed cases. Further detail of this statistical advice is available on our website in our Audit Process and Guidelines April 2009 document.

General Chiropractic Council

16.5 As the GCC closed less than 100 cases at the initial stages during the period 1 April 2008 to 31 March 2009, it provided us with the files for all of its cases closed during the period. All the cases were closed by its investigating committee.

General Dental Council

16.6 From the case closure information given to us by the GDC, we identified five main closure points in the early stages of the GDC's procedures (see Appendix C). We were provided with statistics on the number of cases closed within each of these closure points. We therefore weighted our sample to reflect these proportions, rounding up to the nearest whole number and subtracting from the largest groups. We then selected the numbers for auditing at roughly equal intervals from the list to ensure a random sample, as illustrated in the table below.

Decision type	Number of closures in year from April 2008	Intended audit sample	Actual audit sample
Closure point 1	**333 (28.61%)**	**28**	**28**
Closure point 2	**309 (26.55%)**	**27**	**27**
Closure point 3	**31 (2.66%)**	**3**	**3**
Closure point 4	**407 (34.97%)**	**35**	**35**
Closure point 5	**84 (7.22%)**	**7**	**7**
TOTAL	**1,164 (100%)**	**100**	**100**

General Medical Council

16.7 From the case closure information given to us by the GMC, we identified eight main closure points in the early stages of the GMC procedures, several of these having subdivisions within the type of closure depending on the decision made. We were provided with statistics on the number of cases closed within each of these closure points. We therefore weighted our sample to reflect these proportions, rounding up to the nearest whole number and subtracting from the largest groups. We then selected the numbers for auditing at roughly equal intervals from the list to ensure a random sample.

Decision type	Outcome	Number of decisions	%	Audit sample
Triage	Closed	**1,788**	35.9%	**32**
Triage	Referred	**141**	2.8%	**3**
Stream 2 second assessment	Conclude	**1,446**	29.0%	**28**
Public interest test	Conclude - not in public interest to continue	**570**	11.4%	**12**
Case examiner (CE)	Conclude	**357**	7.2%	**7**
CE	Conclude with advice	**318**	6.4%	**6**
CE	Issue warning	**88**	1.8%	**2**
CE - criminal conviction	Issue warning	**77**	1.5%	**2**
CE - criminal conviction	Conclude with advice	**23**	0.5%	**1**
CE - criminal conviction	Conclude	**10**	0.2%	**1**
Section 30 (5) (non-effective address erasure)	Close case	**4**	0.1%	**1**
CE - voluntary erasure	Grant application	**113**	2.3%	**2**
Investigation committee	Conclude	**12**	0.2%	**1**
Investigation committee	Issue warning	**16**	0.3%	**1**
Rule 28 (withdraw reference to FTP panel)	Cancel hearing	**20**	0.4%	**1**
TOTAL		**4,983**	100	**100**

General Optical Council

16.8 As the GOC closed less than 100 cases at the initial stages during the period 1 April 2008 to 31 March 2009, it provided us with the files for all of its cases closed during the period, which amounted to 84 in total.

General Osteopathic Council

16.9 As the GOsC closed less than 100 cases at the initial stages during the period 1 April 2008 to 31 March 2009, it provided us with the files for all of its cases closed during the period, which amounted to eight in total. All the cases were closed by its investigating committee.

Health Professions Council

16.10 From the case closure information given to us by the HPC, we identified five main closure points in the early stages of the HPC's procedures (see Appendix C). We were provided with statistics on the number of cases closed within each of these closure points. We therefore weighted our sample to reflect these proportions, rounding up to the nearest whole number and subtracting from the largest groups. We then selected the numbers for auditing at roughly equal intervals from the list to ensure a random sample, as illustrated in the table below.

16.11

Decision Type	Number of closures in year from April 2008	Intended audit sample	Actual audit sample
Closure point 1 Closed - self referral	**94 (22.6%)**	**23**	**23**
Closure point 2 & 3 Initial enquiry	**60 (14.4%)**	**14**	**14**
Closure point 4	**113 (27.2%)**	**27**	**27**
Closure point 5	**149 (35.8%)**	**36**	**36**
TOTAL	**416 (100%)**	**100**	**100**

Nursing and Midwifery Council

16.12 From the case closure information given to us by the NMC, we identified five main closure points in the early stages of the NMC's procedures. We were provided with statistics on the number of cases closed within each of these closure points. We therefore weighted our sample to reflect these proportions, rounding up to the nearest whole number and subtracting from the largest groups. We then selected the numbers for auditing at roughly equal intervals from the list to ensure a random sample.

16.13 However, because of the NMC's previous policy of destroying all case documents after a case was closed, and despite previously discarding from the list the cases where no scanned documents existed, we were still unable in a large number of

cases to locate certain key documents within certain files. This made it impossible for us to audit those cases sufficiently. Therefore, once we had ascertained how many cases from each decision type we were unable to audit, we selected further numbers for auditing at roughly equal intervals from the list. Where this process continued to produce case numbers of files that we were unable to audit, we picked further numbers from the very bottom of the list – that is, cases that were closed at the end of the audit period. We did this because we deduced, from the cases we had audited, that those in the latter part of the audit period were more likely to have the relevant documents scanned into the case. This methodology proved successful, but due to time constraints we were only able to identify 96 auditable cases instead of the intended 100 cases.

Decision type	Number of closures in year from April 2008	Intended audit sample	Actual audit sample
Preliminary enquiry/ triage	**589 (44.4%)**	**44**	**40**
Investigating committee section 1	**2 (0.15%)**	**1**	**1**
Investigating committee section 2	**557 (42%)**	**41**	**42**
Investigating committee section 4	**177 (13.3%)**	**13**	**12**
Screeners	**2 (0.15%)**	**1**	**1**
TOTAL	**1,327 (100%)**	**100**	**96**

The Pharmaceutical Society of Northern Ireland

16.14 As the PSNI closed less than 100 cases at the initial stages during the period 1 April 2008 to 31 March 2009, it provided us with the files for all of its cases closed during the period, which amounted to 20 in total.

Royal Pharmaceutical Society of Great Britain

16.15 From the case closure information given to us by the RPSGB we identified six main closure points in the early stages of the RPSGB's procedures. We were provided with statistics on the number of cases closed within each of these closure points. We therefore weighted our sample to reflect these proportions, rounding up to the nearest whole number and subtracting from the largest groups. We then selected the numbers for auditing at roughly equal intervals from the list to ensure a random sample. Some of the cases were disposed of by means of more than one decision type if the case involved more than one registrant.

16.16 Some of the cases in the sample indicated they had been closed at different decisions points than they actually had. We therefore had to reshuffle the sample a number of times to ensure the correct balance of cases were audited. This resulted in a small number of cases from the original sample being superfluous and therefore not audited, and further case numbers being selected at roughly equal intervals from the list to make up the correct sample size within each decision type.

One case listed as a decision type 5 case was audited but was found to have been referred to the disciplinary committee so should not have fallen within the sample. This resulted in 101 cases being audited in total.

Decision type	Number of closures in year from April 2008	Intended audit sample	Actual audit sample
1. Complaint not about a registrant/out of jurisdiction	**80 (10.60%)**	**11**	**11**
2. Complaint does not constitute impairment but letter of advice may be issued	**186 (24.64%)**	**25**	**25**
3. Further investigation - complaint does not indicate impairment	**135 (17.88%)**	**18**	**18**
3 & 4	**1 (0.13%)**	**1**	**1**
4. Investigation committee dismiss allegations	**124 (16.42%)**	**16**	**16**
4 & 5	**9 (1.19%)**	**1**	**1**
5. Investigation committee issue letter of advice or warning	**220 (29.14%)**	**28**	**29**
6. Case referred to DC or HC but withdrawn	**0 (0%)**	**0**	**0**
TOTAL	**755**	**100**	**101**

17. Appendix C: Process for handling complaints

The following descriptions of processes are based on information provided to us by the regulators.

General Chiropractic Council

17.1 GCC leaflet *How to complain about a chiropractor* is available in ten languages. It provides full details of the regulatory process and the support GCC offers to complainants

17.2 GCC is required to offer complainants the opportunity to make a statement of evidence. GCC commissions solicitors to take such statements. The GCC sends any statement and the original letter of complaint to the respondent, who is given 28 days to submit a response. The response is sent to the complainant, inviting comments. Any comments are sent to the respondent. The case file is then referred to the Investigating Committee for consideration.

17.3 All complaints about registered chiropractors received by the GCC must be put before its investigating committee.

17.4 The committee must decide whether there is ‘a case to answer’. If it considers that there is no case to answer, it closes the case and its reasons are given to the complainant and registrant chiropractor.

17.5 The committee may reach a decision on a complaint at its first meeting or decide that it wants to have further information before deciding whether or not there is a case to answer. If the committee decides that it would like further information, it instructs officers to gather that information. Case files may go before the investigating committee on a number of occasions before a final decision is reached.

17.6 The investigating committee considers complaints on paper – neither complainants nor respondents have the right to appear or be represented before the committee.

17.7 If the matters alleged are serious enough, officers will alert the chairman to consider the need for an interim suspension hearing. The committee has the power to impose an interim suspension order whilst it concludes its investigation.

17.8 Where the investigating committee has concluded that there is a case to answer, it is responsible for drafting the formal allegations to be referred to the relevant committee. Formal allegations relating to unacceptable professional conduct, incompetence or criminal conviction will be referred to the professional conduct committee. Formal allegations relating to the physical or mental health of a respondent will be referred to the health committee.

General Dental Council

17.9 Callers to fitness to practise or the customer advice and information team are taken through the fitness to practise process and told about the minimum information the GDC needs to make an assessment. Callers are given as much information as they feel is relevant to their enquiry. At this stage, the team has no written information to assess, so callers are provided only with advice about processes and procedures.

17.10 A leaflet entitled *How to Report a Dental Professional to Us,* which describes how the public can report concerns about dental registrants to the GDC, is available at

http://www.gdc-uk.org/General+public/Reporting+unfitness+to+practise/Reporting+a+dental+professional.html

17.11 It outlines the GDC complaints procedures and the various outcomes at each stage and is used as a basis for briefing potential complainants. The leaflet and website include a form but informants are not required to use it. Full contact details of the fitness to practise team are provided on the form, including a dedicated email address. The GDC website also has a dedicated customer service page which details how the public can make a complaint about the standard of administration or other service provided in response to a contact made with members of the GDC staff.

17.12 All fitness to practise complaints need to be made in writing and although the GDC will accept an initial email, it must be able to confirm the authenticity of the complainant shortly afterwards by means of a physical address and original signature. Complaints can only be considered against current GDC registrants. Information about illegal practice is referred to the GDC's fitness to practise legal services team.

17.13 Complaints and information can originate from any person or organisation, within the UK or anywhere else in the world and relate to matters either current or which occurred at any time in the past of the registrant concerned. Governing legislation does not provide for the investigation of anonymous complaints but, where the matter is entirely within the public domain, the GDC itself may act as the complainant.

17.14 All mail received by the fitness to practise team is logged onto the GDC's Postlog Database, for assessment by a fitness to practise operations manager. The manager decides whether the information raises a question about a registrant's fitness to practise and whether it requires urgent action, ie to be sent to the interim orders committee via the registrar. New fitness to practise complaints are then allocated to caseworkers. The admin team input contact details into the GDC's organisation-wide information system (CARE). Where the matter is not within the GDC or fitness to practise remit, for example it does not concern a GDC registrant, or dentistry, or could be dealt with by another body, this is explained to the complainant who is referred to the appropriate organisation, if applicable.

17.15 New cases are allocated to a fitness to practise caseworker who checks to ensure the GDC has the minimum necessary information to conduct the assessment, ie the registrant can be identified with certainty and details and circumstances surrounding the complaint are clear. The caseworker then prepares an assessment sheet. This details the factual aspects of the complaint, identifying how any alleged failings read across to the GDC's standards guidance, whether any more information is needed and if other organisations or regulators should be contacted. The first assessment is then made. The caseworker presents his/her case to another caseworker and an operations manager. All three discuss the matter. The operations manager authorises any decision to refer the matter on, defer for further

information or close the case. The decision is recorded on the assessment sheet which is signed off by all three present

17.16 Where a complaint is taken to the next stage, it becomes an allegation (in accordance with the GDC's fitness to practise rules). At this point the GDC is required to inform the registrant and certain third parties, for example primary care trusts. The registrant receives a copy of the allegation and the caseworker assessment sheet, the date and composition of the investigating committee and is advised to contact their defence organisation to help them formulate a response. If further information is received which affects the viability of the case after the allegation has been referred on, a second caseworker assessment meeting is held with a new assessment sheet which is signed off as before. Once the registrant's response has been received, this is sent to the informant for their comments, which are added to the bundle for the investigating committee to consider. Details of the case, such as names of parties, dates, outcomes, etc are entered into the fitness to practise casework database. If the informant does not give consent or withdraws, the case is not referred to the investigating committee, unless the GDC itself acts as the complainant

17.17 The investigating committee meets twice a month and consists of a total of five lay and dental members; the latter being a mix of dentists and dental care professionals. The registrant is advised who will be sitting, in order that any potential conflicts of interest can be declared. Similarly, the investigating committee panel is given its agenda two weeks in advance for the same purpose. Any subsequent conflicts identified on the day of the committee itself are discussed and decided by the chair. If a member is required to leave the room for any particular case, that fact is recorded.

17.18 The test for the investigating committee is to 'investigate the allegation and determine whether the allegation ought to be considered by a practice committee' [Dentists Act 1984, (27A)(1)]. If the investigating committee refers to a practice committee (health, conduct or performance), it can also send the case to the interim orders committee for urgent action. If the investigating committee does not refer the matter on, it may issue an advice letter or a warning letter to the registrant (which may or may not be published against the registrant's entry on the web-register).

17.19 The investigating committee may also defer its decision and direct that further enquiries be made about specific factual matters or reports about the health or performance of the registrant.

17.20 The relevant fitness to practise operations manager who was secretary to the investigating committee provides the initial instructions to one of the three fitness to practise legal support teams. The support team conducts a conflict of interest check within 24 hours and produces a detailed case plan in seven working days. From this point, contact is primarily between caseworkers in the fitness to practise team and the team's solicitors.

17.21 The fitness to practise operations managers monitor case progress. Where the investigating committee has directed that further information be procured, the committee secretary will arrange this and reschedule the case once such information is received. Fitness to practise caseworkers deal with case handling, providing on-going instructions to the solicitors, attending case conferences, checking and approving notifications of hearing and attending the hearings. The

solicitors meet with the head of fitness to practise and operations managers on a monthly basis to discuss case progress, in particular any limiting factors preventing any case being listed for a hearing or whether a case should be returned to the investigating committee for re-consideration.

17.22 The investigating committee is responsible for the case until it comes before a practice committee so, where further investigation fails to reveal sufficient evidence to support the allegations, fitness to practise solicitors prepare a report for the investigating committee. The committee then decides whether to dispose of the case.

17.23 The GDC, registrant or informant may apply for a review of an investigating committee decision.

17.24 Where a practice committee considers that an allegation should not have been referred, it may refer the case back to the investigating committee.

General Medical Council

17.25 All new correspondence to the GMC, expressing a concern about a doctor, is assessed by an investigation manager. The investigation manager considers whether the matter is one that should be investigated and, if so, in what way.

17.26 Where an investigation is appropriate, the GMC asks the complainant for permission to disclose the complaint to the doctor and his or her employers. They also ask for permission to see medical records.

17.27 Where the complainant does not give permission for disclosure, or where the complainant withdraws a complaint, one of the members of staff designated as an 'assistant registrar' (typically an investigation manager) applies the 'public interest test' – that is the GMC considers whether it is in the public interest to close the case.

17.28 Complaints that do not appear to raise serious concerns about a doctor's fitness to practise are allocated to 'Stream 2'. If the doctor is employed by the NHS, the case is closed and referred to the doctor's employer for possible investigation and so that the employer can report back to the GMC any relevant concerns it is aware of about that doctor. Where the doctor is not employed by the NHS, the GMC seeks this information from the private sector employers first. When it has received confirmation of no ongoing concerns, the GMC closes the case.

17.29 All other investigations go into 'Stream 1', with the investigation manager setting out the information that needs to be collected. The results of the investigation are eventually assessed by a case examiner. The case examiner must decide whether there is a reasonable prospect of a fitness to practise panel (FTP panel) finding that a doctor's fitness to practise is impaired. If the case examiner decides that this test is met, the matter will be prepared for an FTP panel which has a range of sanctions available to it, including erasing the doctor from the register so that they may no longer practise medicine. If the case examiner is not satisfied that the test is met, he or she will recommend closure of the case, giving detailed reasons. The decision and reasoning is then given to a second case examiner. If they agree, the case is closed. There is always one medically qualified and one lay case examiner involved in each decision.

17.30 If the case examiners disagree with each other, the matter is referred to an investigation committee which makes the decision instead.

17.31 The case examiners, when closing a case, have the power to impose a warning on a doctor, or require the doctor to give certain undertakings about their future activities. Such warnings and undertakings are visible for a period of years on the doctor's registration details on the GMC website. If a doctor refuses to accept the warnings or undertakings, the case is referred to an investigation committee which hears any submissions the doctor wishes to make. The committee then decides whether to close the case – either with or without a warning or undertakings as it sees fit.

17.32 In certain circumstances the case examiners issue advice to a doctor when closing a case with no further action. The issuing of such advice is not recorded against the doctor's registration on the GMC website.

General Optical Council

17.33 If a complaint is received by telephone or email, the complainant is provided with advice and where appropriate asked to complete and submit an investigation form. English and Welsh versions of the investigation forms, along with the GOC's explanatory booklet *How to Complain About an Optician* and optical record consent forms are available to download from: http://www.optical.org/en/our_work/Investigating_complaints/How_to_make_a_complaint/index.cfm .

17.34 The GOC will post forms to complainants by request. The same webpage gives contact details for the Optical Consumer Complaints Service and also advises complainants how to make a complaint about the GOC itself.

17.35 Upon receipt of a complaint, the GOC checks that it has jurisdiction to consider it. This requires confirmation that the allegation relates to a GOC registrant, either individual or corporate. This information may be provided by the complainant. If the complaint does not relate to a registrant, it is closed and the complainant referred to another relevant authority or body

17.36 Where the allegation is one of deficient professional performance, even if the GOC is provided with the name of the registrant, it requires that any optical outlets involved must disclose the names of all registrants who have provided relevant treatment. The GOC also checks that the complaint falls within the scope of section 13D(2) of the Opticians Act 1989, ie that the facts alleged, if true, could amount to a ground upon which a registrant's fitness to practise is impaired. Jurisdiction is determined by an analysis of the complainant's allegations. Where the GOC has no jurisdiction, the complaint is closed and a closure letter is sent to the complainant giving reasons.

17.37 Once jurisdiction is confirmed, the registrant is informed that a complaint has been made. S/he is requested not to make representations until specifically invited to do so. All relevant information is then collated including, where required, patient consent for the disclosure of all relevant patient records. Upon receipt of patient consent, the GOC requires those records to be supplied by the bodies that hold them. Copies are taken and the originals returned by recorded delivery.

17.38 Once all relevant documentation, including patient records, has been collated it is sent to the registrant who is invited to make representations upon the complaint in accordance with Rule 6 of the GOC Fitness to Practise Rules 2005. The registrant has 28 days to provide such representations. It should be noted that the GOC does

not grant extensions. If representations are late it is in the discretion of the Investigation committee whether to consider them.

17.39 Upon receipt of representations, the GOC may obtain a formal witness statement from the complainant. The bulk of these are taken by the investigations manager. Some are taken by external solicitors.

17.40 The witness statement is disclosed to the registrant in advance of the case being considered by the investigation committee. Registrants may comment on witness statements, even if they are not invited to make further formal representations (which only occurs if the statement raises new issues). Representations made by registrants are disclosed to complainants who are invited to comment. Any comments received will be passed to the investigation committee for consideration.

17.41 The case papers are then presented to the GOC's investigation committee which, during the period audited, met six times a year (it now meets more frequently). All new cases are considered at a full meeting. Legal advice is provided to the committee by a legally qualified member of GOC staff. The meetings are held in private and are not transcribed. The reasons for each decision are recorded within the minutes document and disclosed to the parties involved in the letter that reports the committee's decision.

17.42 The investigation committee's options with each case are as follows:

- To take no action
- To take no action but issue an advisory letter
- To issue a formal warning (following completion of the 'minded to warn' procedure which permits the registrant to make representations about any suggested warning before the committee makes a final decision as to whether or not to issue it)
- To refer the case to the fitness to practise committee for a formal hearing or an interim order hearing
- To direct further investigation before reaching its decision (including a performance or health assessment if appropriate).

17.43 The committee sometimes requests a registrant to attend a voluntary performance review. Health or performance assessments are arranged by the fitness to practise department and reports are placed before a subsequent meeting of the investigation committee which then has the same options available as above.

General Osteopathic Council

17.44 Advice is provided in response to all enquiries received. Guidance for the public and employers on how to complain is available from the GOsC website at http://www.osteopathy.org.uk/information/complaints/. A complaint form can also be downloaded. No decision to close an enquiry is made at this stage.

17.45 Information given in response to all telephone enquiries is limited to explaining the GOsC complaints process and if appropriate, an explanation of the types of issues that are dealt with by the GOsC.

17.46 The fitness to practise procedure starts with the receipt of an enquiry, which can be made by a patient, fellow osteopath or any member of the public, or with the receipt of notification from the police of a conviction of a registrant. The initial enquiry is

logged on the database if the GOsC is provided with the registrant's name. The complainant is either sent a complaint form to complete, sign and date, and return, or the GOsC may take a statement from him or her at the outset. If an initial complaint has been logged, and a form is sent out for completion but not returned, a chaser letter is sent.

17.47 On receipt of the complaint, or where a statement has been taken, a staff member in the regulation department is assigned to the case and will be identified to all parties involved as the contact point. There is no decision making on the merits at this stage; the only issue for consideration is jurisdiction. Provided the complaint is about an osteopath (ie they are on the register), the GOsC will consider the complaint.

17.48 Once the completed form or statement has been received, and before complaints are forwarded to the investigating committee, they are considered by a screener (an osteopathic member of the committee), in accordance with section 20 (4) to (7) of the Osteopaths Act 1993 (the Act) and sections 3 to 6 of the General Osteopathic Council (Investigation of Complaints) (Procedure) Rules Order of Council 1999 (the 1999 IC Rules), to determine whether the GOsC has the power, under the Act, to consider the complaint.

17.49 Administrative staff prepare a draft screener's report and send this to the screener. The screener must first confirm that he/she does not know the registrant concerned or have any conflicts of interest. In addition, the screener cannot sit as a member of the investigating committee on any case he/she has previously considered as a screener. The screener is asked to establish whether there is power to investigate and therefore to recommend whether the complaint should be closed or referred to the investigating committee. The complainant is informed accordingly.

17.50 If the screener decides that there is no power to investigate, GOsC seeks a second opinion from a lay member of the investigating committee. (However, this should be seen in the context that the number of complaints which fall into this category is minimal – perhaps one or two over the last few years.) The screener is also asked to consider whether an interim suspension should be considered by the investigating committee. If the screener decides that the complaint is not within the GOsC's jurisdiction, the registrant is not generally notified at this stage.

17.51 Following the screening process, and assuming the screener has referred the complaint to the investigating committee, the registrant will be provided with a copy of the complainant's written statement of complaint and supporting evidence. The registrant will be invited to respond to the allegations in writing, within 28 days. If further information is required from/about the complaint (for example, GP notes), as identified by the caseworker, the complainant is asked to give consent for that information to be obtained. Once consent has been provided, letters are sent to the relevant parties requesting the information. On receipt of this information, the complaint may then be considered by the investigating committee.

17.52 The investigating committee's terms of reference are set out in Section 20 of the Act and its procedures are governed by the 1999 IC Rules. The committee at the GOsC meets, on average, five times a year; meetings are scheduled approximately a year in advance by the clerk to the council.

17.53 At the investigating committee meeting, each case is considered in turn. Guidance contained within the *Investigating Committee Decision Making Process* sets out the required actions to be followed when determining whether there is a case to

answer. The guidance was developed and implemented by committee members during 2007, with assistance from in-house and external legal advisors. It consists of a flow chart, which is referred to at the committee meetings. If committee members conclude that there is a case to answer, it will refer the complaint to the professional conduct committee or to the health committee in accordance with section 20 (1) (d) of the Act.

17.54 The investigating committee may formulate reasons for referral to the professional conduct committee, which may differ from the allegations made by the complainant. If the case is not referred to the professional conduct or health committee, the parties are notified of the investigating committee's reasons for the decision by letter, and the complaint is closed.

17.55 If the case is referred to the professional conduct or health committee, the parties are again notified, and the registrant will be provided with all the evidence that has been gathered during the investigation. The investigating committee will provide its reasons for referral, and the charges to be made are drawn up by external solicitors.

17.56 The investigating committee can also instruct the GOsC to send an informal advisory letter to the registrant regarding any issues concerning their practice which were identified during the investigating committee hearing.

17.57 Both the investigating committee and the professional conduct committee may make interim suspension orders. The screener and regulation department staff will identify serious allegations as requiring immediate steps to protect the public. Allegations of violence, sexual misconduct, alcohol abuse and drug offences typically give rise to the necessity to consider an interim suspension order. An interim suspension order may be made in the first instance by the investigating committee, for a period of up to two months. The professional conduct committee may then impose its own interim suspension order.

17.58 Once a case has been referred to the professional conduct or health committee, the decision to close the case can only be made by the relevant committee.

Health Professions Council

17.59 The HPC's Standard of Acceptance means that in order to proceed, all fitness to practise allegations must:

- Be made in writing
- Sufficiently identify the registrant who is the subject of the allegation
- Identify the person who is making the allegation, and
- Be signed by or on behalf of that person.

17.60 Allegations can be made by anyone. The HPC itself has the power to make an allegation under Article 22(6) of the Health Professions Order 2001. This is used if the complaint is anonymous (in line with the HPC's allegations practice note) or where the HPC becomes aware of potential fitness to practise issues relating to a registrant. Cases of self referral which are serious enough to warrant an interim order are also considered under Article 22(6) at this stage.

17.61 Cases of self referral which do not require an interim order at the receipt stage are considered by the registration panel, which decides whether to advance the case

through to the full FTP process. If there is no fitness to practise concern the case is closed (closure point 1 – see Appendix B). If there is a fitness to practise concern, following legal advice the matter becomes an article 22(6) fitness to practise allegation and proceeds through the standard process.

17.62 When information is received by the fitness to practise department, it is initially considered by a manager to determine what it relates to. Where the complaint does not relate to a registrant it is closed and a letter is sent to the complainant (closure point 2).

17.63 Where the complaint does refer to a registrant and the information provided does not meet the HPC's Standard of Acceptance, the case is closed and a letter is sent to the complainant (closure point 3).

17.64 Where the complaint does refer to a registrant and the information provided meets the HPC's Standard of Acceptance for an fitness to practise allegation, it is logged on the fitness to practise database as an allegation**.** Where the complaint does refer to a registrant and the information provided does not meet the HPC's Standard of Acceptance, but is likely that with further information it will do so, it is logged on the fitness to practise database as an enquiry.

17.65 The HPC has provided us with the following description of its risk assessment process:

> *'The HPC's fitness to practise process involves the risk assessment of cases at various stages. When a complaint is received it is initially assessed by a manager within the department and given a risk category depending on the seriousness of the allegation and the risk posed to the public or the registrant themselves. Consideration is also given to the need for an interim order at this stage. Once a case is assigned to a Case Manager a further case assessment is undertaken including a review of the risk category and rationale for whether or not an interim order is required. When new information is received or the case reaches a particular stage in the investigation, further consideration is given to risk posed and what action may need to be taken. Operational guidance is in place to assist Case Managers in their assessment of cases and the importance of ongoing assessment forms part of Case Manager inductions and ongoing training.'*

17.66 All cases are allocated to a case manager who will undertake the necessary investigations. An assessment of the information is completed to formally determine how the investigation should proceed.

17.67 If on receipt of further information an enquiry fails to meet the Standard of Acceptance, the case is closed. Advice is sought from a manager and reasons provided and documented on a file note or the case assessment form and counter signed by the case manager and a manager (Closure point 4). In some cases legal advice will be sought.

17.68 Allegations may be closed prior to an investigating committee if further information is provided which means the case no longer meets the standard of acceptance – this is a rare occurrence. All decisions taken on this are signed off by a manager. (closure point 4.) In some cases legal advice will be sought.

17.69 Once all relevant information has been obtained, the case manager will formulate the allegations and send this to the registrant providing an opportunity for them to respond. The particulars of the allegation are signed off by a manager.

17.70 An investigating committee panel meets to determine whether there is a case to answer. If there is no case to answer the case is closed and kept on record for three years (closure point 5). Should further similar allegations be received in that time this information can be taken into account if relevant.

17.71 If there is a case to answer the matter is referred to a final hearing panel of the health committee, conduct and competence committee or, in cases of incorrect or fraudulent entry to the register, a further investigating committee. The committee may also request further information and the case will then remain in the remit of the investigating committee and be considered by a further panel once the information has been sought.

17.72 A case manager instructs HPC-appointed solicitors to prepare the case for a committee. The appointed solicitors prepare the case for a health or conduct and competence committee. If on further investigation there appears to be further particulars that should be alleged, the additional elements of the allegation may be sent to the registrant for comment and to the investigating committee to consider if there is a case to answer in relation to any new allegation.

Nursing and Midwifery Council

17.73 The NMC publishes advisory leaflets Complaints about Unfitness to Practise: a guide for members of the public and Reporting Unfitness to Practise: a guide for employers and managers. These give information to members of the public, profession and employers. These and many other sources of advice and information are available at the fitness to practise section of the NMC website at http://www.nmc-uk.org/aSection.aspx?SectionID=7. The employers guide in particular gives numbers to call for those seeking advice.

17.74 Information given in response to all telephone enquiries is limited to explaining the NMC complaints process and if appropriate, an explanation of the types of issues that are dealt with by NMC.

17.75 For a case to progress, the enquiry or complaint should normally be received in writing. On receipt, the fitness to practise (FTP) administration team gives each referral a correspondence reference number and adds a review sheet. The team then determines whether the correspondence refers to a registrant. If not, the team writes back to the referrer advising of the reasons why the NMC cannot deal with the complaint.

17.76 If the referral relates to an NMC registrant, it is passed to the appropriate case manager who determines whether the referral is 'in the form required' (see paragraph 3.11 above) and completes a further review sheet.

17.77 Where the referral is not in the form required, reasons should be detailed on the case review form and the FTP admin team will refer the case to the preliminary enquiry team to be assigned to a case officer. The case officer should follow the instructions on the case review form and sends a letter to the complainant/referrer – this requests any further information required as well as consent to disclose the referral to the registrant at the appropriate time.

17.78 The referrer is given 14 days in which to respond. If there has been no response after two chaser letters, a letter can be sent informing the referrer of their professional duty to comply with the NMC investigation. A case manager will authorise closure of a preliminary investigation if there is insufficient information to

progress the matter or the referrer has failed to respond to the two further information requests.

17.79 Where the referral is ‘in the form required’, the FTP admin team create a case file and refer the case on to the pre investigation team. At this point the case manager undertakes an initial review to decide if it should be taken forward. The case manager will confirm that the case is ‘in the form required’ and should consider the closure criteria that is set out in the guidance note *Devolved Decision Making from the Investigation Committee to NMC Officers (Minute IC/07/11 amended by minute IC/0727)*. If it does not meet the criteria for closure, the case will be prepared for the investigation committee section 2 decision by a case manager.

17.80 The case manager may also decide that further information is required. Once all relevant information is collected, the case manager will again consider whether the case is in the form required and will consider the criteria that is set out in the guidance note *Devolved Decision Making from the Investigation Committee to NMC Officers (Minute IC/07/11 amended by minute IC/0727)*. Again, If the complaint does not meet the criteria for closure, the case will be assigned to a case manager to prepare for the investigation committee section 2 decision. Once prepared, the complaint is passed to the investigation committee for a section 2 decision.

17.81 The investigation committee decide whether there is a case to answer by referring to the *Advice on Case to Answer Test for Panellists* document and the *Referral of Cases Direct to the Conduct and Competence Committee* document. If the Committee decides that there is no case to answer, the case is closed and a decision letter is sent to the registrant and the referrer.

17.82 If the committee finds that there is a case to answer they will set out what information will be gathered and refer to the case back to the investigation team. Once the required information has been obtained, the complaint is passed to the investigation committee for a section 4 decision.

17.83 The investigation committee will once again decide if there is a case to answer by referring to the *Advice on Case to Answer Test for Panellists* document and the *Referral of Cases Direct to the Conduct and Competence Committee* document. If the committee decides that there is no case to answer, the case is closed and a decision letter is sent to the registrant and the referrer. If the committee decides there is a case to answer, it refers the complaint to the conduct and competence committee or health committee for a final decision.

17.84 Having been referred to either the conduct and competence committee or the health committee, a case cannot be closed or sent back to the investigation committee.

Pharmaceutical Society of Northern Ireland

17.85 Guidance for the public and employers on the type of complaints that PSNI can and cannot deal with, along with details of how to make a complaint are available from the PSNI website at: http://www.psni.org.uk/consumers/complaints/complaints.php

17.86 Any complaint made to the PSNI in relation to a pharmacist is initially acknowledged and logged on the PSNI complaints management system.

Complaints may come from:

- A patient

- A carer
- A relative
- A support group/organisation
- A HPSS board or trust
- A pharmacist/pharmacy
- A health professional
- Another enforcement agency
- Regulation and Quality Improvement Authority (RQIA)
- Other regulators
- Central Services Agency (CSA)
- Department of Health, Social Services and Public Safety (DHSSPS).

17.87 Monthly meetings are held between the PSNI registrar and the head of inspection and enforcement of the DHSSPS to facilitate the sharing of intelligence and outcomes, to ensure that a comprehensive overview is being considered by all parties in relation to complaints.

17.88 The registrar will decide whether the matter relates to a registrant or to pharmacy premises. Where the matter relates to another professional or a pharmacist who is registered outside Northern Ireland, the registrar will advise the complainant to take the matter to the appropriate body.

17.89 After a complaint is received by the PSNI, the registrar will decide if –

- No further action is required
- The complaint can be resolved locally
- The complaint should be referred to another body or enforcement agency for further investigation, for example:
  - DHSSPS
  - CSA
  - HPSS Board
  - Police Service

17.90 Investigations are taken forward by the registrar, the DHSSPS or appropriate agencies, particularly where witness statements need to be taken or on site investigations occur. A report is then produced by the investigating body. Where the Public Prosecution Service recommends prosecution post-investigation, this takes precedence over any PSNI statutory committee processes. Any professional hearings or further investigation by the PSNI are only considered at the conclusion of the criminal proceedings. Where the PSNI is made aware of a health related issue the pharmacist may be asked to voluntarily undertake an occupational health assessment and may also be asked to enter into a voluntary undertaking with the PSNI. There is also the option of an Article 18 case being considered by the DHSSPS in regard to a registrant in relation to health issues. The outcomes of all cases investigated are reported back to the PSNI by the investigating body.

17.91 On receipt of investigations carried out by the inspectorate, the registrar consults with the director and PSNI's solicitors before determining any action that will be

taken. On receipt of the investigation the registrar, director and solicitor will decide whether:

- No further action is required
- The complaint can be resolved locally
- The complaint is referred to the statutory committee.

17.92 From January 2009 the registrar has used a scrutiny committee to help assess cases where further investigation is necessary.

17.93 Where a conviction has been sought but has not been obtained, PSNI makes an assessment of whether the case should be considered at a statutory committee hearing. The registrar and director consult with inspectors and act on the advice of the PSNI's solicitors in this instance. Where a relevant conviction has been handed down to a pharmacist, a statutory committee hearing will normally be convened on this notification. A hearing can also be conducted into the conduct of former members of the PSNI who apply to be restored to membership at any point.

17.94 The PSNI will seek a medical report from the registrant's physician. Where appropriate, further specialist medical advice may also be sought, for example an occupational health assessment. The pharmacist may be referred for further assessment if required. The assessment will detail any recommendations with regard to the pharmacist's fitness to practise or to any practise undertakings that may be appropriate. Undertakings are voluntary. Neither the PSNI nor the DHSSPS have powers to impose these on a practitioner. The DHSSPS has the power under Article 18 of the Pharmacy Northern Ireland Order 1976 to instruct the removal of the pharmacist from the register, after consultation with the council of the PSNI.

17.95 If, after any decision to refer a pharmacist to the statutory committee and following further legal advice, it appears that there is insufficient evidence the registrar will reconsider their original decision.

Royal Pharmaceutical Society of Great Britain

17.96 The RPSGB encourages people to make a complaint by filling in an online complaints form. Where a complainant is unable to complete a complaints form (for example due to psychological or physical incapacity) then a member of the investigations team will assist in documenting the complaint in writing. If a caller contacts the investigations team, the inspectorate or the legal and ethical advisory service, they are informed that they need to complete a complaints form or otherwise put their complaint in writing. Comprehensive background information about fitness to practise, as well as information and guidance about how to make a complaint and the type of complaints the RPSGB can deal with is available on the RPSGB's website at: http://www.rpsgb.org.uk/protectingthepublic/complaints/

17.97 A booklet entitled Guidance on Making Complaints Against Registrants and Owners of Pharmacies can also be downloaded.

17.98 Complaints are commonly received from members of the public, pharmacists, patients, primary care trusts, other health professionals and other regulatory bodies. Complaints or allegations are also often conveyed to a RPSGB inspector in the first instance.

17.99 Anonymous complaints will be accepted and preliminary assessment/inquiries undertaken. However, there must be an alternative avenue of inquiry in order for the RPSGB to compile a case which has a real prospect of referral.

17.100 All complaint information is forwarded to the fitness to practise manager (investigations) for triage/assessment. A complaint is logged as an 'out of jurisdiction' complaint if it does not involve a registrant and/or a registered pharmacy premises. A letter explaining that the complaint is out of jurisdiction is sent to the complainant. Where appropriate the complainant is referred on to the relevant body.

17.101 Where the complaint refers to a registrant and/or a registered pharmacy premises but doesn't involve an allegation of impairment of practise of a registrant, or information calling into question the fitness to practise of a registrant, the case is logged as an 'out of jurisdiction' complaint and a letter is sent to the complainant.

17.102 Where the complaint falls within the published threshold criteria and is managed through the non-referral process, such cases are logged on the case management system and either result in:

- A letter of advice being issued by the chief inspector (where the registrant admits the allegation and accepts the advice)
- Referral to the investigating committee at the request of the registrant
- The complaint being logged as an 'out of jurisdiction' complaint and a letter being sent to the complainant.

17.103 Where the complaint does refer to a registrant and the information provided could constitute an allegation of impairment of fitness to practise, or information which calls into question the fitness to practise of a registrant, the case is logged on the electronic case management system.

17.104 All cases are allocated to a case manager and an inspector who will undertake the necessary investigations. If on receipt of further information it is identified that the case does not involve a registrant or does not involve allegations of impairment of fitness to practise, the case is closed in accordance with the policy entitled *Policy for the Closure of Cases Without Referral to the Investigating Committee*.

17.105 Once all relevant information has been obtained, the Inspector or the case manager will submit an investigation report. The case manager and/or inspector will then formulate allegations and prepare the evidence bundle.

17.106 An investigation committee panel meets to determine whether there is a real prospect of impairment of fitness to practise and/or whether the committee's referral criteria have been met. The test applies to both the factual allegations and the question whether, if established, the facts would amount to impairment of the registrant's fitness to practise.

17.107 If the investigating committee determines that there is no real prospect of a finding that the registrant's fitness to practise is impaired it will not refer the case to the disciplinary or health committee.

17.108 The investigating committee may decide:

- That no further action should be taken
- That the allegations should be dismissed

- To issue a letter of advice or a warning, but not refer the case to the disciplinary committee or health committee.

17.109 If the investigating committee determines that there is a real prospect that the disciplinary or health committee will make a finding of impairment of fitness to practise, it will refer the matter to the appropriate committee for a hearing.

17.110 Before being heard by the disciplinary or health committee, the case is referred to the fitness to practise manager (hearings), who will either instruct a fitness to practise manager (advocacy) or one of the RPSGB's external panel legal firms to prepare the case for a hearing.

17.111 The appointed case presenter prepares the case for the committee. If on further investigation, the case presenter determines that, on the evidence, the hearing should not be held, they will refer the matter back to the investigating committee with an application to rescind the referral. The investigating committee, after consultation with the complainant will then determine whether the referral should be rescinded.

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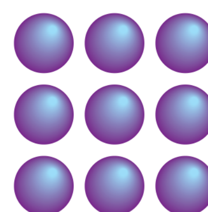

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CHRE Fitness to practise audit report: Audit of health professional regulatory bodies' initial decisions

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1 Introduction

1.1 On 1 March 2010, the Council for Healthcare Regulatory Excellence (CHRE) published their report into their first audit of initial stages of the nine health professional regulatory bodies' fitness to practise processes. As a result, the Health Professions Council (HPC) Executive has reviewed the report and its recommendations. In addition, we have reviewed our own 'processes and practices in the light of the risks CHRE have identified in their own and other regulators' processes and looked for opportunities to adopt the good practice that has been identified in other regulator's reports.

1.2 This report is structured by first looking at and providing comment on the recommendations and conclusions made by CHRE in the overall summary, then looking at the good practice and risk identified by CHRE in respect of the other eight regulators, before specifically moving on to review the report by CHRE on the performance of the HPC. Finally, we make a number of suggestions and recommendations as to how HPC can progress its fitness to practise work further.

2 Overall Summary

2.1 CHRE makes a number of recommendations and conclusions at page 14 and 15 of their report. They are listed and commented upon below.

2.2. Make sure it has comprehensive guidance for staff who handle cases and for staff and committee members who make decisions. This is to make sure that cases are handled consistently and to a high quality.

2.2.1 CHRE have particularly commented on the good practice of the General Medical Council (GMC) in this area; commenting that the '*GMC has a clear commitment to producing comprehensive guidance for decision makers throughout its processes*' and '*that this will contribute to consistency and to better decision making.*'

2.2.2 HPC has the same commitment to the production of comprehensive guidance for employees and for committee members who make decisions. This can be evidenced through the range of operating guidance that is available for fitness to practise department members which includes, for example, operating guidance on:

- Investigations and Allegations
- Investigative Report Writing
- Requiring disclosure of information
- Risk profiling
- Witness management
- Adjournment requests
- Taking complaints over the telephone
- Instructing and seeking advice

2.2.3 The Council and Fitness to Practise Committee have also clearly demonstrated their commitment to providing guidance for decisions makers through production of a comprehensive series of Practice Notes which include, for example, guidance on:

- The Standard of Acceptance for Allegations
- Barring Allegations
- Case Management and Directions
- Case to Answer Determinations
- Concurrent Court Proceedings
- Conviction and Caution Allegations
- Drafting Fitness to Practise Decisions
- Finding that Fitness to Practise is Impaired
- Health Allegations
- Joinder.

2.2.4 The Fitness to Practise Committee also approved at its 25 February 2010 meeting an approach to auditing decisions which will help to ensure that the quality of decision making is consistent and of a high quality. The HPC Executive also ensures that any learning from cases is fed back to decisions makers to ensure a continual improvement to the quality of reasoning and decision making. The audit of decisions sits alongside other work undertaken

by HPC lead case managers who regularly audit all ‘no case to answer’ decisions and a sample of ‘case to answer decisions’ to ensure that policy and procedure is being complied with.

2.3 Test the integrity and quality of systems for recording and storing information, for both paper and computerised formats. There should be at least one single source of complete information for each case

2.3.1 The CHRE comment at page 9 paragraph 3.2.3 of their report that ‘*The GMC has a computerised system which makes paper files unnecessary. It stores all relevant information and links easily to open and historic cases to a registrant. Although we have not yet seen the NMC’s new system working fully in practice, we expect that it will prove a major help in raising quality.’*

2.3.2 HPC have just started phase II of the Case Management System project. During phase I of the project we undertook a full scale review of the existing processes and procedures and identified areas for development. Vendor(s) for the fourth iteration of the case management system have now been selected and over the course of the next year, we will be entering into the design, build, test and migration phase of the project. It is anticipated that as result of this project, HPC will not use paper files.

2.3.3 HPC currently has three sources of information for cases. All case files have physical as well as an electronic cases and all case information is logged on the relevant database. Our move to a new solution for the management of cases is to ensure that our processes and procedures remain fit for purpose as we grow and develop as an organisation.

2.4 Make sure that is has robust and clear systems for carrying out risk assessments and for applying for interim orders where appropriate. Such systems should be put in place at the start of, and throughout, a case. These procedures should ensure that adequate information is collected promptly, and that proper records are made of how an assessment was reached and when it was made.

2.4.1 CHRE comment at page 12, paragraph 4.19 of the overall summary that *‘We were concerned that some regulators did not have clear procedures for either making or recording risk assessment procedures. Moreover, there was not always evidence on the file to show when and how these assessments had been carried out. We found examples at the HPC and GDC where we considered that the regulator should have considered an interim order based on initial information that had been received.’*

2.4.2 More comment on the cases that CHRE refer to regarding the HPC is provided later in this commentary (see HPC section of the report). However, information is provided here on the approach HPC takes in relation to the risk assessment of cases.

2.4.3 All new allegations are risk assessed on receipt as a matter of course. Before a case is logged on the case management system, the lead case manager will assess the allegation to determine whether the standard of acceptance for allegations has been met, whether any other information is required any whether it is appropriate for an interim order to be applied. If an assessment in

the affirmative that such an order should be applied for, this has to be authorised by either the Head of Case Management or the Director of Fitness to Practise. HPC operating guidance on risk profiling provides the case managers with further guidance on this process and furthermore we have an initial logging form and a case assessment form which is completed for every new case. When a decision is made to apply for an interim order, the application before a panel to make such a decision is generally heard within seven days of the decision to make such an application.

2.4.4 The risk assessment process is a dynamic process and all new material received is reviewed on receipt to determine whether there is any change in the position as to whether an interim order is necessary. To further aid in ensuring this takes place, case meetings take place once a month between the Lead Case Managers and the Case Managers within their team to discuss case load and any issues arising out of that case load.

2.5 Adopt as far as appropriate the practice of routine medical examinations of registrants who are convicted of drink driving or drug offences.

2.5.1 CHRE comment at page 9, paragraph 3.11 that

> *'Many of these health and performance concerns would not have come to the attention of the GMC if it did not routinely test convicted doctors for evidence of addiction'* and at paragraph 3.12 that *'We understand that all applicants for registration with the GCC with a conviction for drink driving or possession of drugs are asked by the Registrar to undergo a psychiatric assessment and relevant laboratory tests, no matter how long prior to the application the offence occurred and (sic) once registered, convictions or complaints about use of alcohol or drugs are considered by the Investigating Committee, which always asks the respondent to undergo the assessment/tests.'*

CHRE say that *'this is a significant tool, which identifies underlying health difficulties that may pose a risk to the public and that (sic) we think that other regulators should consider adopting this practice.'*

2.5.2 There are a number of points to consider in relation to this recommendation and it perhaps a point that requires further consultation and discussion. The HPC's Executive's position is that taking such an approach in all cases is not reasonable, proportionate or appropriate and even if that were the case, our legislation does not provide us with the ability to do so. Article 25 of the Health Professions Order 2001 (the 2001 Order) provides that

> '*For the purpose of assisting them in carrying out functions in respect of fitness to practise, a person authorised by the Council may require any person* ***(other than the person concerned)*** *who in his opinion is able to supply information or produce any document which appears relevant to the discharge of any such function, to supply such information or produce such a document.'* It is important to recognise here that the only person who can not be ordered to provide information or documents is the registrant concerned.

2.5.3 It is also important to understand that it does not automatically follow that all registrants or applicants who are convicted of drug and drink related offences have an alcohol or drug dependency. The approach that HPC takes in this area endeavours to be fair, balanced and appropriate. Panels consider all allegations thoroughly, but in cases such as these, also take into account whether the evidence provided demonstrates that the registrants' ability to practice safely and effectively has been compromised. The brochure '*Managing your fitness to practise*' provides further guidance on this subject.

2.5.4 The Fitness to Practise department work plan for 2010-2011 provides that we will review how such an approach could be adopted by the HPC and an update on the work the HPC Executive has undertaken in this area will be provided to the Fitness to Practise Committee in October 2010.

2.6 Develop guidance and practice to make sure that decision makers record and communicate clearly the full reasons for their decisions

2.6.1 At paragraphs 4.14 to 4.18 of their report, CHRE highlight a number of concerns they have regarding all of the regulators about the quality of analysis and explanation of decisions. They comment on why recording clear and cogent reasons are important and how where in some cases '*the reasons were not recorded on file or were not transferred fully into the decision letter.'* CHRE also comment more particularly on the HPC's self referral's process where they say at paragraph 4.18 that *'Several of its decisions gave a reason only that the professional's fitness to practise is not impaired without saying why.'* More comment on this issue is provided in the HPC specific section of this report.

2.6.2 HPC has produced a range of practice notes to aid panels in their drafting and at the final hearing stage, the Practice Note 'Drafting Fitness to Practise decisions' is available for panels to refer to. A Practice Note on Case to Answer and a decision template and guidance is available for panels at this stage in the fitness to practise process. The HPC Executive proposes that the template and guidance that is available to those that make decisions on whether there is a case to answer and whether a recommendation should be made to refer a case (or not) is reviewed to ensure that it remains fit for purpose. It is also proposed that decision making remains a key topic at refresher training for those partners who are involved in the fitness to practise process.

2.6.3 At its meeting on 25 February 2010, the Fitness to Practise Committee approved mechanisms by which decisions made as to whether there is a case to answer could be quality assured. The learning from the review and audit of those cases will be fed back to those who are involved in the decision making process.

2.7 Take special care when analysing and using information from investigations carried out by other bodies. Although the other organisation may have taken no action, there may still be grounds for action or further investigation into fitness to practise matters.

2.7.1 At page 10, paragraph 4.6, CHRE comment that *'Some regulators adopt another organisation's decisions where there are overlapping facts. Typically,*

this would be where there has been a police investigation, NHS fraud or competence investigation, or employer's disciplinary investigation. The investigatory body may have decided not to purse a prosecution or not to take disciplinary action. Adopting such decisions without very careful analysis can be risky, because the other bodies will have been investigating a matter for a different purpose.

2.7.2 Comment is made in the report that CHRE had concerns about some cases where this appeared to be the position for the HPC. More comment on those specific cases will be provided later in the report however it would be helpful to comment on the approach that HPC takes in this area.

2.7.3 The Practice Note 'Concurrent Court Proceedings' was approved by the Council in October 2009 and formalised pre-existing policy in this area. The practice note provides that 'acquittal in the criminal courts will not always mean that no regulatory action will follow, as the grounds for acquittal may be irrelevant for the purpose of fitness to practise proceedings. For example, a registrant who is charged with a sexual offence against a service user may be acquitted on the basis of doubts about the service user's consent or lack of it, but may still face an allegation of misconduct based upon the inappropriate nature of the relationship with the service user.'

2.7.4 In order for a case to be considered by an Investigating Committee, it has to meet the standard of acceptance for allegations and most importantly it has to be about the fitness to practise of a registrant. The practice note referred to above makes clear what the HPC's approach in this area is and careful consideration is given to what impact another organisations decision should have on the fitness to practise process.

2.7.5 The IPSOS Mori report recently commissioned by the HPC on the expectation of complainants highlighted the concerns of employers in this area. IPSOS Mori comment on page 33 of their report that '*There was also an expectation amongst employers that although the HPC would conduct their own independent investigation, the outcome of any pervious disciplinary hearings conducted by the employers in question should be noted.'* The HPC Executive proposes to take forward further improving employer understanding about the purpose of HPC's fitness to practise processes.

2.8 Make sure there is a source or clinical advice for decision makers, and make sure that is used when necessary.

2.8.1 CHRE comment at page 11, paragraphs 4.11 and 4.12 that *'we found cases where case officers should have sought expert clinical advice'* and that (sic) at '*the HPC and NMC it would have been helpful for the regulator's staff to have access to such clinical expertise.'*

2.8.2 The Standard of acceptance of allegations (referred to previously) sets out when an allegation about fitness to practise can be considered by the Council. The HPC Executive has also further developed its mechanisms for allocating and logging cases which particularly provides for an assessment to be made as to whether there is a need for expert advice. Expert advice is much wider than clinical advice as there are cases where non clinical but still expert advice is required. The HPC Executive propose to produce further operating

guidance for employees within fitness to practise department to further aid them in identifying where expert or clinical advice is necessary.

2.8.3 The Article 22(6) process also provides that legal advice is sought before an allegation is dealt with through this route.

2.8.4 All panels considering an allegation concerning a registrant include one panel member from the same profession as the registrant concerned. The Practice Note 'Assessors and Expert Witnesses' also provides guidance on when expert advice should be sought.

2.9 Develop excellent relationships with employers. This will help in providing information during the investigation of a case and in managing risks after a case is closed.

2.9.1 CHRE identified in their performance review of the HPC in 2008-2009 that our relationship and engagement with employers was an example of excellent practice by a regulator. This engagement includes an ongoing series of employer events where there is a workshop particularly focused on the fitness to practise process.

2.9.2 HPC plans to undertake further improvements in this area. As part of the work plan for expectations of complainants, the HPC Executive will be undertaking a review of the material that is available for employers. This will include a review of the brochures, standard letters and information available on the website. The HPC Executive also proposes to produce a referral form particularly for employers.

2.9.3 The audit identifies concerns the CHRE have around the ongoing management of risk after a case is closed. Rule 4(7) of the Health Professions Council (Investigating Committee)(Procedure) Rules 2003 provides that '*An earlier allegation in respect of which a Practice Committee previously determined that there was no case to answer may only be taken into account in accordance with paragraph (6) if, when the health professional is notified that no further action is to be taken in connection with the earlier allegation, the notification contains a statement that the case may be taken into account in the consideration of any subsequent allegation*.' Operating guidance has been produced which sets out the process that case managers should follow when a further allegation about a registrant is received within three years of receiving an allegation about the same registrant.

2.10 Adopt our previous recommendation that registrants' responses be shared with complainants at an early stage

2.10.1 The Fitness to Practise Committee considered at its meeting on 25 February 2010 a report from the HPC Executive on this subject and has recommended that no change to existing policy in this area is made. The Council was asked to approve this recommendation at its March 2010 meeting. The Committee felt that the current approach struck the right balance and was a reasonable and proportionate approach. It felt that the work that was being done as part of the expectations of complainants work would aid in improving understanding about the difference between a complaints resolution process and the purpose of a fitness to practise process.

3 Good Practice and Risk relating to the other regulatory bodies

3.1 This section provides particular comment on the good practice and risk that the CHRE raise in relation to the other eight regulatory bodies. It provides the HPC Executive's comment on that good practice and any learning from it that is relevant to the HPC.

3.2 General Chiropractic Council (GCC)

3.2.2 CHRE's report on the GCC begins at page 17 of the report and covers 22 GCC cases. It highlights GCC good practice in:

- communicating decisions;
- clear reasoning;
- active engagement with complainants; and
- routinely sending a copy of the registrant's observations to the complainant for comment.

3.2.2 At its February 2010 meeting, the Fitness to Practise Committee considered a proposal on quality assuring decisions and a report analysing cases where it had been determined that an allegation was not well founded. That report made a number of recommendations including an ongoing focus on reasoning at refresher training for panel members.

3.2.3 As noted previously, the HPC do not send complainants a copy of the registrant's observations to the complainant for comment..

3.3 General Dental Council (GDC)

3.3.1 CHRE's report on the GDC begins at page 21 of the report. It highlights GDC good practice in:

- its reflective approach to developing systems for assessing concerns about dental practitioners;
- how GDC actively assesses its own performance with a view to continuous improvement,
- its focus on customer service in how it encourages and supports complainants, making repeated efforts to ensure they understood a complainants concerns; and
- its systems for providing all initial assessment of cases to be reviewed in a meeting with a manager and a fellow caseworker.

3.3.2 The HPC continually reviews its processes and procedures to ensure that they are both improved and remain fit for purpose. A key feature of the Fitness to practise department work plan for 2010-2011 is continuous improvement. The work plan on expectations of complainants includes improving complainants and registrants understanding of the purpose of the fitness to practise process.

3.3.3 When HPC is in receipt of an allegation it is initially assessed by the lead case manager before it is allocated to the case manager. As part of the monthly

meetings that take place between lead case managers and their case teams, cases are reviewed to ensure they are being progressed appropriately.

3.4 General Medical Council (GMC)

3.4.1 CHRE's audit of the GMC begins at page 27 of the report and highlights the most important areas of GMC good practice as its:

- comprehensive and effective IT-based case management system;
- detailed guidance for staff;
- internal audit and quality assurance processes;
- effective engagement with employers; and
- standard procedures for dealing with drink driving offences.

3.4.2 Many of the areas of good practice highlighted by the CHRE as good practice for the GMC are also commented on as areas of good practice in the overall summary for the GMC and are not repeated in this section of the report.

3.5 General Optical Council (GOC)

3.5.1 CHRE's report on the GOC begins at page 34 of the report and covers 84 cases. It highlights GOC practice in:

- giving advice to individual registrants and corporate registrants on how to improve the service they give;
- staff actively helping complainants and referring matters to other regulators; and
- standard letters when requesting information

3.5.2 At its 25 February 2010 meeting, the Fitness to Practise Committee considered a work plan from the HPC Executive on alternative mechanisms to resolve disputes. This work plan includes reviewing the feasibility of providing learning points to registrants when it is determined that there is no case to answer or where the allegation is not well founded

3.5.3 The HPC endeavour to ensure that its process are as open and accessible as possible and the work that is being done as part of the expectations of complainants work, aims to improve this and understanding of the fitness to practise process still further. HPC also has processes where by a statement of complaint can be taken over the phone and a free phone telephone number is available for complainants.

3.5.4 When in receipt of a complaint about fitness to practise, the lead case manager will first of all assess whether the complaint concerns an HPC registrant. If it does not and relates to a registrant of another regulatory body, HPC will refer the complainant to that regulatory body. There is also operating guidance on signposting complainants which will direct them to other sources of support and where a complaint can be made.

3.5.5 The HPC standard letter which requests information from complainants or third parties clearly sets out the HPC's statutory powers. Standard letters are kept under continual review to ensure that they remain fit for purpose and this

review forms an ongoing part of the Fitness to Practise department work plan for 2010-2011.

3.6 General Osteopathic Council (GOSC)

3.6.1 CHRE's report on their audit of eight GOSC cases begins on page 37 of the report and highlights the GOSC's good practice in:

- its active approach to complainants who wish to make a complaint;
- sending evidence to the complainant and registrant for comment before the matter is considered by the investigating committee; and
- where appropriate, giving advice to the registrant on improving areas of their practice.

3.6.2 Comment is made previously in this report on HPC's approach in the areas above. HPC can not provide information to the investigating committee which the registrant subject to the complaint has not been provided with an opportunity to comment upon.

3.7 Nursing and Midwifery Council (NMC)

3.7.1 CHRE's report on their audit of the NMC begins on page 49 of the report. It comments that CHRE have *'identified serious weaknesses in the Nursing and Midwifery Council's (NMC's) operation of its fitness to practise processes during the period 1 April 2008 to 31 March 2009.'* Instead of commenting on the good practice highlighted by the CHRE, the HPC Executive has instead reviewed the recommendations made by the CHRE on how the NMC should further progress it's fitness to practise function. It recommends that the NMC should:

- produce comprehensive guidance for staff and investigating committee members on how to handle all aspects of cases;
- create a mechanism for staff to have access to expert advice on nursing and midwifery practice,
- review how it handles drink driving convictions; and
- consider ways to improve information gathering from statutory bodies and employers.

3.7.2 HPC has produced guidance for all those involved in it's fitness to practise process and in complaints management. The HPC Executive proposes that the recommendations CHRE make in relation to further guidance should be looked at to ensure it is incorporated into HPC guidance.

3.7.3 Comment has been made previously on mechanisms for staff to have access to expert and clinical advice and as part of the work plan for 2010-2011 the HPC Executive will review the recommendations made in relation to drink driving convictions.

3.7.4 As part of the expectations of complainants work plan, the HPC Executive will look to consider improving the relationship it has with those who interact with the fitness to practise process. This particularly includes developing referral

forms for registrants and employers which set out in clear detail the statutory framework within which the HPC operates.

3.8 Pharmaceutical Society of Northern Ireland (PSNI)

3.8.1 CHRE’s report on their audit of the 20 cases closed by the PSNI begins on page 58 of the report. It particularly highlights the limited powers the PSNI has in dealing with fitness to practise matters. The HPC has a wider range of powers to ensure that is able to deal with allegations concerning the fitness to practise of the health professionals it regulates.

3.9 Royal Pharmaceutical Society of Great Britain (RPSGB)

3.9.1 CHRE’s report on their audit of the RPSGB begins at page 62 of the report with comment particularly made on the RPSGB’s good practice in:

- the liaison between the RPSGB’s fitness to practise department and its inspectorate; thorough explanations given to the people involved about decisions on closing cases;
- its well reasoned investigative reports; and
- its well maintained case files with evidence of a systematic approach to file and case management with very good audit trails on files.

3.9.2 The HPC Executive proposes to further develop it’s templates for investigative reports and risk assessment to further improve the quality of reasons given when a case is closed. The approach the HPC takes in auditing ensuring cases are properly maintained and managed is provided earlier in this report.

4 Health Professions Council (HPC)_

4.1 CHRE's report on their audit of HPC's initial fitness to practise processes begins at page 41 of the report. CHRE state at paragraph 11.1 that

> *'Based on the evidence from our audit, we considered that the Health Professions Council (HPC) deals with fitness to practise cases efficiently and effectively. The vast majority of decisions taken on cases were reasonable and protected the public. However we had concerns about three cases where we felt that the decision to close the case might present a risk to patient and public safety or public confidence in the relevant profession and the system of regulation.'*

CHRE have provided comment on a number of areas of good practice at the HPC and provided recommendations as to how HPC can improve the operation of its fitness to practise processes. This section of the report reviews those recommendations and risks and as part of this process, the HPC Executive will continue to look for mechanisms to continue to improve the operations of the HPC's fitness to practise function.

4.2 Risks

Case One

4.2.1 CHRE comment that they believe there are some areas of potential risks in the way in which HPC is currently considering cases and at page 42, paragraph 11.7 cite a case concerning an alleged serious clinical error by a short-term agency employee and that *'this case raises questions about the risks associated with Occasional and Temporary' registration and the difficulty of investigating such workers.'* The HPC Executive's position is at odds with CHRE's assessment of this case. The circumstances of one case does not necessarily mean that there is a risk associated with investigating complaints about individuals who have occasional and temporary registration.

4.2.1 This case concerned a clinical error by a short-term agency employee where the clinician in reporting the case said that in her belief 'if the registrant continued to practise, another incident of the same nature would inevitably occur.' CHRE comment that they consider that the strong statement of risk from a clinician was sufficient for the case to have proceeded to an investigation or for an interim suspension order to have been considered and that the investigation should have included calling for clinical evidence and gaining an expert opinion on the advice that may have been produced. CHRE have noted that the HPC did not agree with their assessment of this and one other case. It may help the Council to have further detail on the circumstances

4.2.2 This case concerned an individual who was on the temporary register in accordance with the relevant EC directive and who has subsequently been placed on the HPC watch list. No evidence was provided to substantiate the claim that, based upon a single incident that occurred only a few days after joining the employer, the person concerned was likely to repeat the same error. CHRE suggested to the HPC that contact should have been made with other employment agencies, but HPC had no contact details for said

employment agencies or the means to obtain that information. It was therefore considered doubtful that the employer could substantiate such a claim and for the realistic prospect test that there was a case to answer to be met.

4.2.3 The chronology of this case and the actions taken by the Fitness to Practise department is as follows:

June 2008 – Registrant entered onto temporary register

October 2008 - Letter received from Trust, very brief (9 lines long) with no supporting information.

October to December 2008 – Three letters were sent to the Trust requesting further information between October and December 2008 with no responses received.

January 2009 – Fourth chasing letter sent to Trust. Trust called HPC and confirmed that:
"The registrant was employed through an agency and only worked at the hospital for 4 days." It was further confirmed by the Trust that although an incident report form would have been completed, there was no further investigation or documentation she could forward to us. The employer confirmed that the registrant failed to comply with the Trust protocols and this may have been down to the difference in languages

March 2009 – Case Manager wrote to the employment agency to establish: *"whether you have any further information in regards to any complaints or disciplinary action taken against the registrant"*

March 2009 – Employment Agency telephone call and confirm that:
"The registrant was only on their books for a very short period of time and (sic) confirmed that the registrant was employed at the Hospital for 3 days but they have no record of any concerns being raised in regards to the registrants' clinical competence."

4.2.4 This case was closed before consideration by the Investigating Committee because it was felt that it did not meet the standard of acceptance for allegations. No other evidence was received, nor in the view of the HPC Executive, could have received, in order to substantiate an allegation that the registrant's fitness to practise was impaired. The CHRE report also suggested that the HPC should have considered applying for an interim suspension order. Article 31 of the Health Professions Order and the Practice Note on interim orders provides that an interim should be imposed if it is felt that there is an immediate risk to the public, it is in the interest of the person concerned or it is otherwise in the public interest. The HPC Executive concluded at the time that this case did not meet the test set out in the order and accompanying Practice Note.

4.2.5 Although this registrant was a temporary and occasional registrant, similar challenges in gathering evidence are faced across all registrants. In order for a case to proceed, there has to be evidence of impaired fitness to practise.

4.2.6 This registrant is no longer on the temporary and occasional register and the HPC Executive is not aware of the registrants' whereabouts. If the registrant concerned were to apply for registration in the future, the facts of the case would be considered in accordance with Rule 5 of the Health Professions Council Registration and Fees rules to determine if registration should be granted.

4.2.7 There is of course learning from this case which the HPC Executive proposes to take forward. The quality of the correspondence between the HPC and the employer was perhaps not the standard that should be expected. Furthermore, the reasoning provided when closing the case should have included more explanation as to why the case was being closed. Lead case manager audits of closed cases has been implemented to ensure that processes and procedures have been followed and this will be extended to review the quality of correspondence. The Fitness to Practise Committee have also approved mechanisms to quality assure decisions and learning from cases such as the one highlighted by HPC will help to improve the quality of HPC processes and decision making.

Case Two

4.2.8 CHRE comment at paragraph 11.8 that another case concerned a 'potential difference between professional standards and terms of employment' and provide more detail of the circumstances of that case in that same paragraph and that the case concerned a matter 'that needed careful adjudication at the highest levels within HPC's processes and that (sic) it should have been brought to the attention of the HPC Council as a matter of principal.'

4.2.9 There are wider implications resulting from this case which the HPC Executive, with the CHRE, proposes to take forward. It may assist the Council to be briefed on the particular issue that this case has highlighted.

4.2.10 In early 2007, under the Agenda for Change proposals, agreement was reached between the UK and Welsh Assembly Governments and Unison on national guidelines for paramedics' rest breaks. That agreement allows paramedics to either take an unpaid and uninterrupted rest break or to be available for calls during their rest break and receive a special payment in return. Some NHS Ambulance Trusts, adopted a policy that all rest breaks would be unpaid and, in consequence, that staff would have no obligation to respond to calls during such breaks.

4.2.11 The case in question concerned a failure to act during such a break and, the HPC Executive indicated in responding to CHRE about this case that, whilst we may feel morally uncomfortable with the course of action taken by the paramedic concerned, it was not improper, illegal or unethical.

4.2.12 Neither the HPC standards or the common law impose a general 'duty of rescue' and, in some situations (such as where the EC Working Time Directive applies), suggesting that a registrant must work beyond their contracted hours would be unlawful.

4.2.13 As this case did not meet the standard of acceptance for allegations, it was not referred for consideration to an Investigating Committee and subsequently

to substantive hearing for consideration as to whether the registrant's concerned fitness to practise was impaired. The mechanisms to review decisions agreed by the Fitness to Practise Committee in February 2010 also provides that consideration should be given to whether the case highlights wider policy implications. A report on the review of cases will be produced every six months and will form part of the work that contributes to producing the Fitness to Practise Annual Report.

Case Three

4.2.14 The final case to which CHRE refer to in this section and which they assessed as having been closed prematurely concerned an allegation which suggested that a 'registered professional may been stealing addictive drugs and may have had a serious health problem'. This case was considered by a panel of the Investigating Committee which determined there was no case to answer.

4.2.15 This case concerned a registrant working as a locum. The hospital at which he was working contacted the HPC with information about a high number of ampoules being recorded as broken where the registrant was involved. They also stated that another hospital recently had similar concerns and there was an incident dating back a number of years recorded on a CRB.

4.2.16 The Case Manager allocated to the case undertook an investigation, contacting the two hospitals and local police. No investigation was undertaken by either the employer or the police in relation to the most recent two incidents. The allegations were drafted and sent to the registrant who provided a full response. The case was considered by the Investigating Committee who concluded there was no case to answer.

4.2.17 The HPC has no power to require a registrant to undergo a health assessment. The registrant had been previously employed by the hospital raising the concerns, and since returned to work there as a locum. Although the employer did state that during the registrants permanent employment with the hospital there had been a high sickness level, they further stated that there were no concerns in relation to the broken ampoules at that time and no connection was made by the employer to the current allegations and previous sickness absence.

4.2.18 In references provided by the registrant's colleagues, including a Consultant Anaesthetist, it was stated that there were no concerns relating to his health. The registrant stated in their response that the HPC should obtain copied of their health records from the occupational health department to confirm the nature of the sickness absence. This was not done.

4.2.19 Enquires were made with the second hospital where the registrant had recently worked. No investigation was undertaken by that hospital, and therefore no evidence was available. Copies of the correspondence confirming this were provided to the Investigating Committee.

4.2.20 The HPC were aware that the registrant was employed by an agency but they were not contacted. Generally in cases where the registrant is an agency worker, they would be contacted as part of the investigation. Furthermore, allegations dating back a number of years which had not been substantiated

were raised as part of the complaint, and it may have assisted the Investigating Committee if that previous employer or the police had been contacted.

4.3 Recommendations

4.3.1 CHRE make (recommendations page 44 paragraph 11.13); as to how HPC can continue to review and modify its processes. Comment on the recommendations made are provided below:

4.4 Reviewing its standard letter sent in response to most new complaints, and any process that this letter reflects

4.4.1 We have a range of standard letters for use by Case Managers in responding to complainants. There are three letters in particular which are drafted for use on receipt of a new case. The letter to which CHRE refer in their report is drafted for the purpose of asking a complainant to clarify their intention to make a complaint. It is not always evident on receipt of a letter that the complaint intends to make a fitness to practise allegation and we therefore ask them to confirm their intention. If a complainant does not respond to the initial letter confirming their intention to make an allegation, the Case Manager will follow this up and pursue all avenues prior to closing a case. There are two other letters available for Case Managers. These are used in cases where it is clear that a fitness to practise allegation is being made. These letters either ask for specific further information, or summarise the complaint in order to ensure that it is fully understood by the Case Manager.

4.4.2 The Expectations of complainants' research highlighted a mismatch in understanding between complainant understanding of a fitness to practise process and a complaints resolution process and recommended that HPC should take forward work in improving understanding in this area. The HPC Executive will take this work and work in improving the quality of its standard letters forward as part of the work plan for 2010-2011. It is important to continually review standard correspondence used by the department to ensure that it remains fit for purpose. The work being done to further explore the meaning of impairment in the HPC context will inform the review of both the standard correspondence and other literature produced to aid understanding of the fitness to practise process.

4.5 Ensuring that information necessary for risk assessments is gathered promptly and that current thresholds are appropriate for deciding to request an interim order of suspension

4.5.1 CHRE comment that '*one case, in which an employer was allowed to delay providing information, suggests a risk that the HPC may sometimes not make a suitably prompt risk assessment.*' CHRE comment at paragraph 11.18 that '*when the employer first notified the HPC of their concerns, the HPC should have considered using its statutory investigative powers to require the employer to give more details of the allegation against the registrant.'*

4.5.2 On reviewing this case, it is clear that more action in terms of requesting an update from the employer should have been undertaken by the case manager. However, this situation has now been addressed through the

monthly review of case files which requires a “chaser” letter to be sent if correspondence has not been responded to or the information requested received within month. There is always a fine balance to be struck between asking for information and waiting for employers to provide HPC with relevant information and to conclude their own proceedings. Often there is a judgement to be made in determining whether to the powers under Article 25 of the Health Professions Order. That power can only be used to request specific information and can not be use demand information when there is no information available. There is operating guidance on this subject for case managers on using this power.

4.5.3 Nevertheless, the learning from this case does indicates that HPC case managers do need to record more fully why a decision has been made not to compel the production of information and the relevant guidance will be updated to this effect. Training for case managers in 2010-2011 will particularly include a seminar on the use of powers under Article 25. This ongoing training is part of wider initiative to continue to deliver a high quality investigative process.

4.5.4 Cases are reviewed on receipt and on receipt of each piece of new information to determine whether it is necessary to apply for an interim order. There is operating guidance on risk profiling and this guidance will be kept under review. The HPC Executive proposes that the Fitness to Practise Committee should consider the guidance on this subject at its next meeting and consider whether it remains fit for purpose.

4.6 Reviewing the approach for adopting an employer’s resolution of case where the issues and options for the HPC may not be the same as for the employer. This is especially important where there is a potential risk to the public, or to the public’s confidence in professional standards

4.6.1 Comment is made on the substance of this recommendation earlier in this report and the HPC Executive will take forward work suggested in this area.

4.7 Reviewing the approach of the registration panel in assessing self-referred allegations. This is to ensure consistency of investigation standards and of decisions within the HPC

4.7.1 The revised Health and Character policy was approved by the Education and Training Committee in December 2008 and sets out how the HPC deals with health or character declarations on admission, readmission and renewal to the register and outside of this cycle when registrants “self-refer” issues to the HPC.

4.7.2 The Health Professions Order 2001 provides that registration decisions, including on whether a person meets the prescribed requirements as to good health and good character within the responsibility of the Education and Training Committee.

4.7.3 The policy provides that in respect of self referrals, the declarations made by registrants in accordance with paragraph 4 of the Standards of Conduct, Performance and Ethics are, in the first instance, to be treated as registration rather than fitness to practise issues unless:

- the same information is received from another source prior to, or around the same time as, receipt of a written declaration from the registrant; or
- in the opinion of the Director of Fitness to Practise, the matter declared is of such a serious nature that it should be referred directly to the Investigating Committee.

If a matter is referred to a Registration Panel, the registrant is advised that the panel will consider the information that has been provided, and any other observations the registrant wishes to make. The role of the Panel is to make a recommendation to the Council as to whether or not the issue declared is of such a nature that it should be considered as a fitness to practise allegation. Registrants are advised that if, on the basis of the Panel's recommendation, the Council considers that the registrant's fitness to practise has been brought into question, the matter may be referred to the Investigating Committee. At that point the matter becomes a fitness to practise allegation by virtue of Article 22(6) of the Order and the procedures under Part V of that Order then apply.

4.7.4 The self referral policy has been designed to ensure that registrants are not dissuaded from acting in accordance with standard 4 from fear that the matter will be immediately dealt with as an allegation. Furthermore, in order for an allegation to be made, it has to be made by someone, and natural justice provides that a registrant can not make an allegation against themselves. If material was brought to the HPC's attention by a registrant, in order for it to be dealt with as an allegation, Article 22(6) powers need to be applied.

4.7.5 CHRE have highlighted a number of concerns they have regarding the quality of reasoning provided by registration panels. The HPC Executive proposes that this is addressed through ongoing refresher training and the production of assessment forms to aid panels in their deliberations.

4.8 Ensuring that an appropriate level of information is collected where there is a potential risk of substance abuse by a registrant

4.8.2 As part of the Fitness to Practise department work plan for 2010-2011, the HPC Executive will be reviewing the what information is gathered when there is evidence of substance misuse or where a registrant has been convicted or cautioned for drug or alcohol related offences.

4.9 Ensure that, where appropriate, proper consideration is given to showing a registrant's defensive assertions to a complainant (or other principle witness). This is in order to increase the chance of appropriate counter-challenge and thereby to assist the investigating committee

4.9.1 If a registrant provides a response to an allegation, that response should be reviewed to determine whether any further information is required to clarify certain aspects of the response. This does arise occasionally but will vary significantly from case-to-case. It may range from requiring verification of a single date to answering a substantial list of questions.

4.9.2 If an Investigating Committee, when considering whether there is a case to answer, are of the view that there is not enough information to make that decision, they can ask for further information. This further information is then provided to the registrant to comment upon. More information on the approach the HPC takes in this area can be found in the report on ‘Sharing the registrant’s response.’

4.10 Good practice and overall summary

4.11 CHRE highlight a number of areas of good practice relating to HPC’s performance and the HPC Executive will ensure that those areas are further maintained and improved to ensure that this high quality is continuously developed.

5 Conclusions

5.1 A number of recommendations and suggestions for future work are made throughout this report. The Council is therefore asked to agree with those recommendations and instruct the Executive to undertake the following work, with a progress report provided to future meetings of the Fitness to Practise Committee:

i. review the approach to how HPC deals with allegations where a registrant has been convicted of drink or drug related offences;

ii. review the template and guidance that is available to those who make a decision as to whether there is a 'case to answer';

iii. focus on decision making at refresher training for panel members;

iv. continue to take forward work aimed at improving employer understanding about the purpose of the HPC's fitness to practice processes;

v. produce operating guidance for fitness to practise employees on when and how to seek expert or clinical advice;

vi. further develop templates for investigative reports and risk assessments;

vii. develop audit mechanisms to review the quality of correspondence that has been produced as part of a fitness to practise investigation;

viii. take forward with CHRE the wider implications resulting from the CHRE review of the paramedic case; and

ix. further explore the meaning of impairment in the context of regulation.

The Council is also asked to consider whether the current approach taken to deal with self-referrals is appropriate and if necessary instruct the HPC Executive to produce a report detailing the approach taken in this area.