

First Rate Regulator Initiative

Best Regulatory Practice

On behalf of the Royal College of Veterinary Surgeons



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Executive summary

This report is the fourth in a series of research reports prepared on behalf of the Royal College of Veterinary Surgeons (RCVS) as part of its *First Rate Regulator Initiative*. This seeks to deliver improvements across the organisation to ensure that the RCVS is regulating as effectively as possible.

This report is informed by a literature search about best practice in professional regulation, as well as internet based research of the following:

- the UK's nine health and care professional regulators (covering thirty-one regulated professions)
- two of the eight legal services regulators
- four international regulators of veterinary surgeons.

Details of how the health and legal regulators discharge their regulatory responsibilities and undertake related activities, are contained in [Appendices A1-A8](#). Four case studies of arrangements for regulating veterinary surgeons in the United States, Canada, Australia and New Zealand are contained in [Appendix B](#).

Key messages:

Principles of better regulation

- The following principles for good regulation are widely accepted: transparent, accountable, proportionate, consistent and targeted. Other principles identified as key to good regulation are agility and flexibility.
- These principles align with approaches for 'smart' or 'right-touch' regulation.
- A number of regulators adopt fairness as an underpinning organisational principle. Other principles include being forward thinking or progressive.
- A shift towards risk-based approaches to regulation is evident in the mission statements of a number of regulators. For legal services regulation, this shift reflects a stronger focus on consumer expectations and outcomes (for example, the Solicitors Regulation Authority has moved towards what it calls 'consumer-based regulation').

Governance

- The governing bodies of the professional regulators examined for this report have (with two exceptions) councils that range in size from 7 to 14 members – the direction of travel is 8 to 12 members.
- All the governing bodies of health professional regulators have parity of lay and professional members. The regulators of legal services are required to have a lay majority. All board

members are appointed. The international veterinary regulators have only a minority of lay members.

- The regulators examined here have all separated regulation from representation, except for one veterinary regulator in Canada. The regulator of pharmacists in Northern Ireland has delegated its professional and leadership role to another body.
- Most of the UK regulators are London-based; however the General Medical Council has established offices in each of the four countries to enable it to respond effectively to devolution.

Standards and guidance

- All professional regulators set standards of conduct, competence and ethics.
- Regulators with responsibility for more than one profession tend to have a single code that covers all regulated professionals, however they may produce supplementary guidance specific to each profession.
- The codes of the health professional regulators place a strong emphasis on making the care of the public the first concern, on respect and shared decision-making, on being honest and trustworthy, and on maintaining knowledge and skills.
- The codes for the two legal services regulators considered for this report include business-related standards. The General Optical Council stands out for having two codes of conduct – one for individual registrants and one for business registrants.
- A range of learning materials developed by the General Medical Council to help doctors apply standards guidance are an example of innovative practice in this area.

Registration

- There is enormous variation in the size of registers, from around 2,000 to over 670,000.
- Registration requirements generally include providing evidence of health, good character and professional indemnity, in addition to the appropriate qualifications. Some regulators require proof of identity or a police check.
- The introduction of key performance indicators or targets has focused attention on improving customer service responsiveness of registration departments. Another trend is around the use of e-billing and online accounts to enable registrants to pay their fees swiftly and conveniently.
- Fees for registration vary widely – from £76 to £800 for health and care professions (and more than £1,000 for some barristers). A number of regulators have a lower fee rate for the first year of registration and one has established a lower income category. A number of regulators have reduced their registration fees.

- There is a growing emphasis on the need for professions to demonstrate continued fitness to remain on the register. The General Medical Council is the first regulator to implement a system of revalidation. The other health professional regulators have been developing their own systems, but they are unlikely to introduce revalidation for several years.

Education and training

- Quality assurance (QA) of education and training tends to revolve around self-assessment against set standards, external assessment or validation, and public reporting of the outcome (typically on regulators' websites).
- The emphasis of QA is shifting towards more outcome-focused, risk-based approaches – reflecting a more proportionate and risk-based approach to regulation. The more progressive regulators are combining this with a thematic approach to QA activity.
- The health professional regulators involve lay people (and sometimes students) in QA visiting teams. Some also seek views from the public as part of QA visits.
- Requirements in terms of continuing professional development (CPD) hours vary, as does the length of time over which CPD has to be carried out (ranging from yearly to five-yearly cycles). Some regulators make explicit requirements around spending CPD hours on learning with other professionals.
- A number of regulators have introduced online recording of CPD, making audit programmes easier to manage.
- Some regulators are currently reviewing their QA arrangements for education and training and many are reviewing their CPD requirements and processes.

Handling complaints

- The numbers of complaints received by regulators varies enormously. For some regulators, the majority of complaints come from employers and the police; others are receiving year-on-year increases in complaints from the public.
- Some regulators have timeframes for responding to complaints about their services. There is no evidence of timeframes for responding to complaints about registrants.
- Regulators can only consider complaints that raise issues about fitness to practise – this generally includes competence or performance, as well as conduct, health and criminal convictions.
- Most regulators advise complainants to raise concerns locally first. The General Dental Council and the General Optical Council have responded to gaps in redress arrangements by setting up or contracting with complaints services.
- Some regulators are actively working to improve the way they explain their processes and outcomes to complainants.

Fitness to practise

- The main statutory grounds for impairment of fitness to practise are generally: misconduct, deficient professional performance, criminal convictions (and cautions), and adverse health. The processes regulators have in place to investigate and hear cases vary quite significantly.
- The direction of travel for health professional regulators is for the following powers at investigation stage: warnings, interim orders, undertakings, voluntary erasure, and advice.
- A common set of sanctions has been proposed for adjudication by the health professional regulators: warnings, conditions of practice, suspension, striking off and fines.
- Many regulators are seeking to streamline their fitness to practise processes, making them swifter and more proportionate, for example, through making greater use of case examiners to reduce cases going before investigating committees, allowing for consensual panel determinations, and also voluntary removal from the register.
- The General Medical Council is driving forward more independent adjudication with the creation of its Medical Practitioners Tribunal Service. Independent adjudication arrangements already exist for solicitors and barristers.

Engaging with stakeholders

- Professional regulators engage with a wide range of stakeholders, although the level and approach to engagement is variable.
- Engagement with registrants tends to be through electronic newsletters and regional events focused on consultations. More innovative approaches include engaging hospital ward staff during a night shift.
- A number of health professional regulators have established reference groups or panels with members of the public, and some carry out annual surveys of public perceptions.
- Regulators are increasingly using social media as a tool for engagement – examples include live Twitter feeds of council meetings and YouTube for information videos and interviews.
- The General Medical Council's employer and regional liaison services will be of interest to regulators seeking to increase their presence with registrants and employers at a local level.
- It has been proposed that health professional regulators should be given a duty to cooperate with employers, education and training providers, other regulators, and service providers.

Introduction

The Royal College of Veterinary Surgeons (RCVS) announced its *First-Rate Regulator Initiative* in November 2012. This seeks to deliver improvements across the organisation to ensure that the RCVS is regulating as effectively as possible. To assist in this, the RCVS has commissioned research to better understand how it is perceived and where opportunities for change may lie.

This report is the fourth in a series of research reports prepared on behalf of the RCVS. Three research studies explored how the RCVS is perceived by veterinary surgeons, veterinary nurses, practice managers, RCVS staff, and a range of external stakeholders, including members of the public who complained about a veterinary surgeon. Reported here are the findings of desk research exploring best practice in professional regulation, particularly relating to the health and legal professions, together with four case studies of international veterinary regulation.

LEARNING FROM OTHER SECTORS

The relevance for the RCVS of learning from international regulators of veterinary surgeons is quite clear. However, the health and legal professions also offer the RCVS a rich source of learning about professional regulation. Both sectors have attracted considerable public scrutiny over the previous ten to fifteen years. Serious failings in healthcare damaged the reputation of self-regulation of the medical profession and culminated in the Shipman inquiry between 2001 and 2005. More recently, the Nursing and Midwifery Council has been subject to close parliamentary scrutiny, amongst other things, of its annual registration fee and increase in fitness to practise cases (Health Select Committee 2012).

Concern about the rising numbers of complaints about solicitors, a bewildering regulatory maze and a lack of independence prompted reform of the regulation of the legal profession in 2007.

Regulatory reform for the health and legal professions highlights a direction of travel that is relevant to veterinary surgeons and veterinary nurses. It reflects a wider shift in public expectations of professionals. A societal decline in deference has meant a growing reluctance to trust professionals unquestioningly. A better educated and informed public expects more of professionals and the bodies charged with regulating them. Regulatory reform has been underpinned by a need to sustain or boost public confidence in the way professions are regulated. For example, regulators have accepted and even embraced sharing responsibility for regulation between professionals and the public, with parity of lay people and registrants on governing boards.

The Professional Standards Authority (PSA), previously the Council for Healthcare Regulatory Excellence (CHRE), oversees the UK's nine health and care professional regulators¹. These regulate nearly 1.4 million staff across thirty-one professions (Department of Health 2011). These regulators are referred to here as 'health professional regulators', however since August 2012 the regulation of

¹ General Chiropractic Council, General Dental Council, General Medical Council, General Optical Council, General Osteopathic Council, Health and Care Professions Council, Nursing and Midwifery Council, General Pharmaceutical Council, Pharmaceutical Society of Northern Ireland

social workers in England has come under this umbrella (with the dismantling of the General Social Care Council, the regulation of social workers in England moved to the Health and Care Professions Council).

The Legal Services Board (LSB) oversees eight 'approved regulators'², which in turn regulate nearly 150,000 members of the legal profession.³

The Law Commissions of the UK have made proposals to simplify and modernise the law and establish a streamlined, transparent and responsive system of regulation of healthcare professionals and, in England only, the regulation of social workers (Law Commission et al 2012). The proposals address the four main regulatory functions: registration, standard setting, education and training, and fitness to practise, as well as the governance arrangements of regulators.

The Law Commission consultation closed in May 2012. The analysis of consultation responses was published in February 2013 and the Law Commission's final report is pending. The proposals are limited in scope to the health professional regulators, however they set out a direction of travel that regulators in other sectors may find useful to consider.

THIS REPORT

This report is informed by the following research activities:

- **Literature search:** The King's Fund Information and Library Service was commissioned to undertake a search for literature about best practice in health professional regulation. Literature about professional regulation in other sectors was identified mainly through internet searches. The aim of the literature search was to identify learning about best practice, together with themes and trends in professional regulation. The search revealed little by way of evaluative studies of regulatory practice, and was instead dominated by policy and strategy documents.
- **Web-based research of regulators:** profiles were compiled of the UK's nine health and care professional regulators (covering thirty-one regulated professions), two regulators of legal professions, and four international regulators of veterinary surgeons (one each in the United States, Canada, Australia and New Zealand). The aim was to identify good or innovative practice that may be of interest to the RCVS.

Section 1 draws on a review of the literature and the values adopted by professional regulators to identify the principles of better regulation. **Section 2** considers governance arrangements, including the direction of travel relating to the size and constitution of the governing boards or councils of regulators. **Sections 3, 4 and 5** examine themes across three of the main regulatory functions: standards and guidance (section 3), registration, including revalidation (section 4), and education

² The Law Society, the Bar Council, the Master of the Faculties, the Institute of Legal Executives, the Council for Licensed Conveyancers, the Chartered Institute of Patent Attorneys, the Institute of Trade Mark Attorneys and the Association of Costs Lawyers. The Institute of Chartered Accountants in Scotland and the Association of Chartered Certified Accountants are also approved regulators in relation only to reserved probate activities.

³ The legal profession consists of around 15,000 barristers, 119,000 solicitors and 12,000 individuals operating in other aspects of the legal profession such as conveyancing.

and training (section 5). The next two sections address complaints handling (**section 6**) and fitness to practise (**section 7**). Finally, this report considers how regulators engage with their main stakeholders, particularly members of the public (**section 8**).

This report was prepared by Sally Williams, with supporting research analysis by Marie Bunby.

1: Principles of better regulation

Key messages:

- The following principles for good regulation are widely accepted: transparent, accountable, proportionate, consistent and targeted. Other principles identified as key to good regulation are agility and flexibility.
- These principles align with approaches for 'smart' or 'right-touch' regulation.
- A number of regulators adopt fairness as an underpinning organisational principle. Other principles include being forward thinking or progressive.
- A shift towards risk-based approaches to regulation is evident in the mission statements of a number of regulators. For legal services regulation this shift reflects a stronger focus on consumer expectations and outcomes (for example, the Solicitors Regulation Authority has moved towards what it calls 'consumer-based regulation').

BETTER REGULATION PRINCIPLES

Many of the regulators considered for this report have explicitly adopted the principles for good regulation identified by the Better Regulation Task Force (2005). This identified five principles:

- Transparent
- Accountable
- Proportionate
- Consistent
- Targeted where action is needed.

The Council for Healthcare Regulatory Excellence (CHRE), now the Professional Standards Authority, adds a sixth principle to those identified by the Better Regulation Taskforce:

'Agility in regulation means looking forward to anticipate change rather than looking back to prevent the last crisis from happening again. We consider that an agile regulator would foresee changes that are going to occur in its field, anticipate the risks that will arise as a result of those changes, and take timely action to mitigate those risks.' (CHRE 2010a)

Fairness is frequently mentioned by regulators as an underpinning organisational principle. Other principles include being forward thinking or progressive. The Health and Care Professions Council stands out for seeking to demonstrate value for money.

The *Legislative and Regulatory Reform Act* 2006 came into force in January 2007 to ensure that regulatory activities reflect the Better Regulation Task Force principles. Reducing the quantity and improving the quality of regulation is a key priority for the Coalition Government (HM Government 2010).

Reducing the burden of unnecessary regulatory is a common aspiration across the literature. For example, what are known as 'The Hampton Principles' emerged from Sir Philip Hampton's review into reducing unnecessary administration for business (Hampton 2005). The Hampton Principles were designed with the regulation of business in mind, but are transferable to professional regulation. The principles require regulators to:

- Use comprehensive risk assessment to concentrate resource on areas of most need
- Be accountable for efficiency and effectiveness, while remaining independent
- Justify the reason for inspection
- Avoid asking business to give unnecessary information
- Implement proportionate and meaningful sanctions
- Provide authoritative, accessible advice easily and cheaply
- Be of the right size and scope
- Allow, or even encourage, economic progress and only to intervene when there is a clear case for protection

The best practice principles adopted by the New Zealand Government echo the emphasis on supporting economic growth, proportionality and transparency (New Zealand Treasury 2012). They do not reflect the emphasis on risk assessment, but instead seek regulatory mechanisms that are 'certain and predictable', 'durable', 'flexible' and 'capable'. This aligns with the UK Government's principles for economic regulation, which are: accountability, predictability, coherence, adaptability, and efficiency (Department for Business Innovation and Skills 2011).

The White Paper *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century* (Department of Health 2007a) identified a number of key principles that should underpin statutory professional regulation of the health professions:

- First, its overriding interest should be the safety and quality of the care that patients receive from health professionals.
- Second, professional regulation needs to sustain the confidence of both the public and the professions through demonstrable impartiality. Regulators need to be independent of government, the professionals themselves, employers, educators and all the other interest groups involved in healthcare.
- Third, professional regulation should be as much about sustaining, improving and assuring the professional standards of the overwhelming majority of health professionals as it is about identifying and addressing poor practice or bad behaviour.
- Fourth, professional regulation should not create unnecessary burdens, but be proportionate to the risk it addresses and the benefit it brings.
- Finally, a system is needed that ensures the strength and integrity of health professionals within the United Kingdom, but is sufficiently flexible to work effectively for the different health needs and healthcare approaches within and outwith the NHS in England, Scotland, Wales and Northern Ireland and to adapt to future changes.

RIGHT-TOUCH OR SMART REGULATION

From the Better Regulation Task Force principles, and the principle of agility, emerges CHRE's concept of 'right-touch' regulation. It defines this as follows:

'Right-touch regulation is based on a proper evaluation of risk, is proportionate and outcome focused; it creates a framework in which professionalism can flourish and organisations can be excellent.' (CHRE 2010a)

Eight elements sit at the heart of right-touch regulation in practice:

1. Identify the problem before the solution
 2. Quantify the risks
 3. Get as close to the problem as possible
 4. Focus on the outcome
 5. Use regulation only when necessary
 6. Keep it simple
 7. Check for unintended consequences
 8. Review and respond to change
- (CHRE 2010a)

This approach is similar to what others have called 'smart' regulation. For example, the European Commission's Better Regulation Strategy seeks to promote the application of better regulation tools and principles at EU level (European Commission 2006). It builds on the Commission's 'smart regulation' agenda, which aims to deliver high quality regulation that respects the principles of subsidiarity and proportionality. Smart regulation is about delivering results in the least burdensome way (European Commission 2010).

A shift towards risk-based approaches to regulation is evident in the mission statements of a number of regulators – see, for example, the General Pharmaceutical Council and the Solicitors Regulation Authority ([Appendix A](#)). For legal services regulation, this shift reflects a stronger focus on consumer expectations and outcomes (for example, the Solicitors Regulation Authority has moved towards what it calls 'consumer-based' regulation).

The Regulatory Reform Committee (2009) has emphasised a need to avoid confusing risk-based regulation and so-called "light-touch" approaches. It states that risk-based 'right-touch' regulation is a valid approach provided there is: (a) diligence in understanding risk; (b) a willingness to accept some degree of failure; (c) an awareness that risk assessments should be subject to appropriate challenge; and (d) the willingness to be intrusive rather than light-touch when appropriate.

PROACTIVE REGULATION

Increasingly regulators are expected to take a more proactive approach to regulation. For example, the Nursing and Midwifery Council is developing a systematic 'heat map' approach to identifying where there may be a risk of poor nursing and midwifery practice that poses risk to public safety. It has also been using its powers to investigate concerns without first receiving a formal fitness to practise referral. As of December 2012 it had opened 266 such cases, which arise from evidence gathered from media reports, whistleblowers, other regulators, police, and coroners. This is in line with proposals by the Law Commission that all health professional regulators should consider any information which comes to their attention as an allegation and not just formal complaints.

Concern about professional regulation has also centred on failures by registrants to challenge or report poor practice by others. A number of regulators have responded to this by encouraging registrants to raise concerns about poor practice. The General Medical Council, for example, has set up a nationwide team of advisers to support medical directors on revalidation and on dealing with doctors about whom they have concerns. It has also set up a confidential helpline for doctors to raise concerns about patient safety, whether about individuals or organisations. Revalidation is also seen as an opportunity to embed a more reflective, more evidence-based, and less reactive approach to professional regulation.

APPLYING THE PRINCIPLES

The Professional Standards Authority sets standards of good regulation spanning five regulatory functions: standards and guidance; registration; fitness to practise; education; and governance and external relations. It uses the standards when undertaking annual performance review of the health professional regulators. For each standard, there are a number of minimum requirements that must be met. Professional regulators in other sectors could draw on these standards in considering how they demonstrate the principles of good regulatory practice.

The Legal Services Board (2011) considers that best regulatory practice for legal services regulation must consist of four constituent parts. In essence, these are:

1. Outcomes focused regulation
2. Risk Identification framework
3. Proportionate supervision
4. Appropriate enforcement strategy.

Underpinning the approach of the Legal Services Board is a determination to deliver regulation that is more flexible, consumer-focused and responsive.

2: Governance

Key messages:

- The governing bodies of the professional regulators examined for this report have (with two exceptions) councils that range in size from 7 to 14 members – the direction of travel is 8 to 12 members.
- All the governing bodies of health professional regulators have parity of lay and professional members. The regulators of legal services are required to have a lay majority. All board members are appointed. The international veterinary regulators examined here have only a minority of lay members.
- The regulators examined here have all separated regulation from representation, except for one veterinary regulator in Canada. The regulator of pharmacists in Northern Ireland has delegated its professional and leadership role to another body.
- Most of the UK regulators are London-based, however the General Medical Council has established offices in each of the four countries to enable it to respond effectively to devolution.

SIZE AND CONSTITUTION

Professional regulators in the UK are characterised by small governing boards and at least an equal balance of lay and registrant members. The governing bodies of the professional regulators examined here mostly comprise 12 or 14 members. The Health and Care Professions Council is the largest with 20 members, however legislation will be introduced in 2013 to reduce the size of its council (Department of Health 2012). Governing board members are appointed, including the chairperson (appointment of the chair will come into force for the General Medical Council and the General Dental Council during 2013). All the governing bodies hold council meetings in public and often include question and answers sessions from the public.

The four international veterinary regulators examined for this report have governing bodies of just seven or nine members; one has 18 members. For two of these boards, the members are appointed; for the other two, there is a combination of appointed and elected members. Lay members are a feature, but there is no parity with veterinary members.

In 2007, the Department of Health published the *White Paper Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*. This paved the way for a move from professional self-regulation, to arrangements where responsibility is shared by professionals and the public:

'In order to exercise their functions effectively and command the confidence of patients, the public and the professions, they need to be seen to be independent and impartial in their actions.' (Department of Health 2007a)

The White Paper proposed that the councils that regulate health professionals should have, as a minimum, parity of membership between lay and professional members, to address concerns about the domination of purely professional concerns. To dispel the perception that councils are overly sympathetic to the professionals they regulate, it proposed the independent appointment of council members. To enable councils to focus more effectively on strategy and the oversight of their executives, the White Paper heralded a move to smaller and more board-like structures.

The Command Paper, *Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers* (Department of Health 2011), credited these governance reforms with improving the health professional regulators' performance of their statutory duties and made clear the government's position on regulatory governance. It stated:

'By ending elected professional majorities on the health professions regulatory bodies' governing councils, this increased the independence of the regulators from those they regulate and sign-posted a commitment to ensuring that there is greater public, professional and parliamentary confidence in the regulators and reducing perceptions that they are either acting in the interests of the professions they regulate or acting overly punitively to counteract this view.'

In 2009, the Legal Services Board announced its package of measures on the composition of regulatory boards, including a requirement that boards have a lay majority (Legal Services Board 2009c). However, two of the eight regulators of legal services still have lawyer majorities (Legal Services Consumer Panel 2012a).

Shrinking the General Medical Council

When the Government consulted on plans to reform the General Medical Council in 2002 the aim was to reduce its Council to a maximum of 35, with a majority of elected (and a few appointed) medical members, and about 40 per cent lay members (Department of Health 2002a). For many this did not go far enough; some wanted the proportion of lay members increased and others were concerned that a Council of more than 25 members would be *'too large and unwieldy'* to operate efficiently (Department of Health 2002b).

A decade on, the Department of Health was again consulting on changes to the constitution of the General Medical Council (Department of Health 2012). It supported recommendations by CHRE that *'boards with a range of 8-12 members are associated with greater effectiveness'* and that the chair of a regulatory governing board *'should be independently recruited and appointed rather than elected from within the board membership'*. The consultation focused on the General Medical Council and the General Dental Council as these were the only health professions regulators to still have elected chairs and with the largest governing councils (with 24 members on each). The result was that the chair of both organisations must be appointed (by the Privy Council), and the composition of each is 6 registrant and 6 lay members.

In 2011 the Department of Health had asked CHRE for advice on the efficiency and effectiveness of health professional regulators. As part of this, CHRE considered the case for moving to smaller councils as a way of delivering more 'board like' and effective governance. It advised parity of membership between lay and professional members 'to ensure that purely professional concerns are not thought to dominate councils' work'. It suggested that smaller boards, in the range of 8 to 12 members, were associated with greater effectiveness:

'It appears that smaller sized groups are able to communicate more effectively and reach decisions more quickly than larger ones. In addition, they are less likely to suffer from fragmentation and clique-formation and more likely to develop a culture of inclusiveness than their larger counterparts. Finally, since smaller boards struggle to involve themselves in issues that should be delegated to the executive, a smaller size helps them to focus their efforts on core governance issues.' (CHRE 2011a)

Moving to smaller boards requires moving away from the concept of representativeness in membership, which CHRE argued was no longer a valid concept for a regulatory board:

'Small boards cannot 'represent' all relevant constituencies or stakeholders nor should they attempt to do so. Rather boards should demonstrate the knowledge, understanding and awareness to properly take into account relevant interests, such as those of different groups of professionals or the different health systems in the UK, but they should not attempt to 'represent' them.' (CHRE 2011a)

Others have found that different factors are equally or more important in determining a board's effectiveness. For example, Cornforth (2001) found how well boards perform five functions is most important in explaining overall effectiveness. These functions, in order of importance, are:

- Setting the organisation's mission and values
- Helping raise funds or other resources for the organisation
- Overseeing financial management
- Reviewing and deciding strategic direction, and
- Reviewing board performance.

Other factors that explain board effectiveness include: clarity over board roles and responsibilities; having board members with the right mix of skills, experience and time to do the job well; a shared vision between the board and the executive; and regular review by boards and the executive of how they are working together (Cornforth 2001). Nevertheless, CHRE points towards evidence of a trend towards smaller board sizes across a wide range of sectors, including FTSE private sector companies, public sector boards, voluntary and community sector boards, and school governing bodies.

The Law Commission has sought views on whether its proposed statute for health professional regulators should encourage Councils to become more board-like, including whether a statutory executive board should be established consisting of the chief executive and senior directors, and/or a unitary board structure that would mark a departure from a two-tier approach based on a Council and officials (Law Commission et al 2012). Those responding to the consultation were divided on this

issue (Law Commission et al 2013), however the Department of Health and the Scottish Government agreed that a Council's core purpose should be threefold:

1. To provide strategic direction
2. To provide a point of public accountability, and
3. To exercise scrutiny over the exercise of powers by officials of the organisation, in particular by providing a first point of appeal (for example, in relation to decisions not to accept an application for restoration to the register).

The Law Commission put forward three options for reform relating to the size of Councils and the proportion of lay and registrant members: first, specifying in the proposed statute a ceiling in terms of size and the proportion of lay/registrant members; second, requiring the government to specify in regulations the size and proportion of lay/registrant members; thirdly, giving regulators general powers to set the size and composition of their Councils and for the Government to intervene where necessary. Those responding to the consultation were again divided on this question, however most supported the third option (Law Commission et al 2013).

REGULATION AND REPRESENTATION

Only one of the four international veterinary regulators – the Alberta Veterinary Medical Association – has a professional leadership role in addition to its regulatory functions. It stood apart from the other veterinary regulators by referring to 'members' and its 'membership'.

CHRE has emphasised that regulatory processes must be seen to be independent of '*undue influence*' from any group with a particular interest (CHRE 2009d). It highlighted three principles important in promoting effective and independent regulation:

1. Council members should not be seen to represent any particular viewpoint or constituency – they should be appointed because of their knowledge, skills and judgement
2. Criteria should be set that define the knowledge and skills required of council members – one way of achieving this is to ensure that councils have expertise in areas such as education, fitness to practise, service-user experience and employing professionals
3. Fixed periods of office should be managed with staggered turnover of council members to ensure a degree of stability and continuity.

This echoes the Government's belief that, in order to sustain the confidence of the public and the profession, health professional regulators need to be independent of government, the professionals themselves, employers, educators and other interest groups (Department of Health 2007a). Given this, the position of both pharmaceutical regulators – the Royal Pharmaceutical Society of Great Britain and the Pharmaceutical Society of Northern Ireland – in regulating and representing the profession became subject to change.

General Pharmaceutical Council and Royal Pharmaceutical Society

The General Pharmaceutical Council came into existence in 2010 and became responsible for the regulation of pharmacists and pharmacy technicians, and the registration of pharmacy premises.

Lord Carter of Coles chaired the Working Party on professional regulation and leadership in pharmacy. He said it was *‘entirely appropriate that the regulation of the pharmacy profession falls in line with other healthcare professionals, by ensuring regulation is independent of professional leadership’*. However he also observed: *‘the complexity of establishing both a new regulator and an effective professional leadership body should not be underestimated’* (Department of Health 2007b).

The development of a Royal College – now called the Royal Pharmaceutical Society – happened in parallel to the creation of the General Pharmaceutical Council. It was established into a landscape of three existing membership organisations for pharmacists, yet real enthusiasm for the College was identified from within the profession.

Today, the General Pharmaceutical Council and Royal Pharmaceutical Society (RPS) are co-located within the same building, but there are separate entrances and RPS staff cannot access floors occupied by the General Pharmaceutical Council, and vice versa. They operate as two separate organisations, each with a distinct purpose. Further details about the work to separate pharmacy regulation from professional leadership are available at the footnoted weblink.⁴

Pharmacy Forum in North Ireland

The Act that enabled the regulatory functions of the Royal Pharmaceutical Society of Great Britain to transfer to the General Pharmaceutical Council, also allowed for the transfer of regulatory functions from the Pharmaceutical Society of Northern Ireland to the General Pharmaceutical Council in the future, subject to a decision by Northern Ireland Ministers.

In the meantime, since 2011, the professional and leadership roles of the Pharmaceutical Society of Northern Ireland have been delegated to the Pharmacy Forum. The Forum promotes the profession and facilitates continuing professional development and is the organisation for pharmacy professional leadership in Northern Ireland.

Legal professions

The pharmacists are not the only profession to have grappled with these issues. The separation of regulation from representation was a key plank of reform introduced under the Legal Services Act 2007. The Legal Services Board (LSB) was created to address a lack of trust in the regulatory framework and was required by the Act to make rules on regulatory independence to boost public confidence in legal services (Legal Services Board 2009a).

4

http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Managingyourorganisation/Workforce/Professionalstandards/pharmacyprofessionalregulation/DH_081562

The LSB proposed rules that would require the separation of regulatory work from any representative work within the eight approved regulators. It proposed that each regulator with representative functions should establish a separate regulatory arm with the power to control its own structure, processes, procedures and strategic direction (Legal Services Board 2009b).

The General Social Care Council (GSCC) was established in 2001 to regulate the social work profession and social work education in England. Little more than a decade later, in July 2012, the organisation was disbanded and the regulation of the social work profession was transferred to the Health and Care Professions Council. One of the GSCC's original mission statements was to champion social care workers. Reflecting on this it said:

'This caused confusion among the sector and the media as to our role in both holding the workforce to account and a body that represented its interest. This confusion arose because, unlike other professions, social workers did not have an effective professional body to act as the voice of the profession. However, in time, we learnt that we needed to be clear about our essential function.' (GSCC 2012)

3: Standards and guidance

Key messages:

- All professional regulators set standards of conduct, competence and ethics.
- Regulators with responsibility for more than one profession tend to have a single code that covers all regulated professionals, however they may produce supplementary guidance specific to each profession.
- The codes of the health professional regulators place a strong emphasis on making the care of the public the first concern, on respect and shared decision-making, on being honest and trustworthy, and on maintaining knowledge and skills.
- The codes for the two legal services regulators considered for this report include business-related standards. The General Optical Council stands out for having two codes of conduct – one for individual registrants and one for business registrants.
- A range of learning materials developed by the General Medical Council to help doctors apply standards guidance demonstrate innovative practice in this area.

CODES AND SUPPLEMENTARY GUIDANCE

All professional regulators carry responsibility for publishing and promoting standards of conduct and competence or proficiency, and ethical guidelines setting out the values and principles for good practice. These are often referred to as the ‘code’ or ‘code of practice’ for each profession. These are the standards that regulated professionals need to meet in order to join the register and maintain their registration. Codes are supplemented by additional guidance that addresses specific issues.

Where regulators have responsibility for regulating more than one profession, there tends to be a single code covering all the professions. For example, the Health and Care Professions Council’s *Standards of conduct, performance and ethics* covers all 16 professions it regulates.

Shared standards can be useful, particularly where professions tend to work in multidisciplinary teams. However, downsides can include a lack of specificity, which can undermine the application of the standards in practice. For example, when developing the Code of Practice for Social Care Workers, the General Social Care Council’s (GSCC) brief was to create a set of standards fit for both social workers and social care workers. The GSCC reflected that more specific standards for social workers may have been beneficial and, had it remained the regulator, it would have developed a set of standards, values and ethics specifically for social workers, who are trained to degree level and have significant legal responsibilities that are not expected of social care workers (GSCC 2012). The Health and Care Professions Council addresses this by supplementing its main code with standards of proficiency for each of its 16 regulated professions.

The codes of the health professional regulators examined as part of this report (see [Appendix A3](#)) place a strong emphasis on making the care of the public the first concern, on respect and shared decision-making, on being honest and trustworthy, and on maintaining knowledge and skills. The codes for the two legal services regulators both include business-related standards. For example, one of ten principles set by the Solicitors Regulation Authority is to run business effectively and in accordance with proper governance and sound financial and risk management principles. The General Optical Council stands out for having two codes of conduct – one for individual registrants and one for business registrants ('optical businesses' registered with the Council).

The standards for good regulation set by the Professional Standards Authority relating to codes and supplementary guidance are as follows:

1. Standards of competence and conduct reflect up-to-date practice and legislation.
 2. Additional guidance helps registrants apply the regulators' standards of competence and conduct to specialist or specific issues.
 3. In development and revision of guidance and standards, the regulator takes account of stakeholders' views and experiences, external events, developments in the four UK countries, European and international regulation and learning from other areas of the regulators' work.
 4. The standards and guidance are published in accessible formats.
- (Professional Standards Authority 2010)

NEW DEVELOPMENTS

Some regulators have introduced new ways of supporting professionals to embed standards in their daily practice. For example, the General Medical Council has developed a range of learning materials to help doctors understand and apply the guidance it sets. These include e-learning modules, interactive decision-making flow-charts and vignettes, and an interactive web section known as *Good Medical Practice in Action*. The General Medical Council has reported a 20 per cent increase in visits to the standards guidance pages of its website since the launch of *Good Medical Practice in Action*.

Other developments include the Law Commission's proposals for two types of guidance: tier one guidance, which must be complied with unless there is good reason not to; and tier two guidance, which must be taken into account and given due weight (Law Commission et al 2012). The regulators would be required to indicate in any guidance whether it is tier one or tier two. Responses to the Law Commission's consultation on this proposal were mixed and the Department of Health felt it was unhelpful to distinguish between mandatory and optional guidance.

4: Registration

Key messages:

- There is enormous variation in the size of registers, from around 2,000 to over 670,000.
- Registration requirements generally include providing evidence of health, good character and professional indemnity, in addition to the appropriate qualifications. Some regulators require proof of identity or a police check.
- The introduction of key performance indicators or targets has focused attention on improving customer service responsiveness of registration departments. Another trend is around the use of e-billing and online accounts to enable registrants to pay their fees swiftly and conveniently.
- Fees for registration vary widely – from £76 to £800 for health and care professions (and more than £1,000 for some barristers). A number of regulators have a lower fee rate for the first year of registration and one has established a lower income category. A number of regulators have reduced their registration fees.
- There is a growing emphasis on the need for professions to demonstrate continued fitness to remain on the register. The General Medical Council is the first regulator to implement a system of revalidation. The other health professional regulators have been developing their own systems, but they are unlikely to introduce revalidation for several years.

REGISTRATION

Holding and maintaining the register for the profession is a core regulatory function. There is enormous variation in the size of registers. The Nursing and Midwifery Council manages the largest register of healthcare professionals in the world, with 671,668 registered nurses and midwives. The next largest register in the UK is held by the Health and Care Professions Council, which has 308,000 registrants across 16 professions. In comparison, there are around 2,100 pharmacists registered with the Pharmaceutical Society of Northern Ireland. The international veterinary regulators held registers of 2,400-3,000.⁵

Registration requirements generally include providing evidence of health, good character and professional indemnity, in addition to the appropriate qualifications. Some regulators (the General Dental Council and the General Pharmaceutical Council) require proof of identity; the General Osteopathic Council requires a police check.

The Professional Standard Authority's standards of good regulation relating to registration are as follows:

1. Only those who meet the regulator's requirements are registered.

⁵ Register size was only available for three of the four case studies

2. The registration process, including the management of appeals, is fair, based on the regulators' standards, efficient, transparent, secure, and continuously improving.
 3. Through the regulators' registers, everyone can easily access information about registrants, except in relation to their health, including whether there are restrictions on their practice.
 4. Employers are aware of the importance of checking an individual's registration, and members of the public can find and check an individual's registration.
 5. Risk of harm to the public and of damage to public confidence in the profession related to non-registrants using a protected title or undertaking a protected act is managed in a proportionate and risk-based manner.
- (Professional Standards Authority 2010)

The Professional Standards Authority's predecessor, CHRE, recommended that regulators of the health professions should:

- Provide information about all current fitness to practise sanctions on the online register.
- Publish information about professionals who have been struck off on their online register for at least 5 years.
- Take a proportionate approach to making fitness to practise histories available against a register entry.
- Ensure that online registers have the following features:
 - Clear signposting from the regulator's homepage to the register search page
 - Search functionality that supports some flexibility, such as a 'sounds like' option
 - A comprehensive listing that reflects all current sanctions including suspensions and those who have been struck off
 - Links to information about previous fitness to practise sanctions
 - Ease of navigation to greater levels of detail where available, such as direct links to fitness to practise determinations
 - Provide an indication of location of practice to help to identify an individual professional
 - Provide a glossary to aid understanding of the terms used in registers
 - The absence of material that could compromise the credibility of the data, such as advertising. (CHRE 2010b)

Most regulators must satisfy themselves that an applicant is of good character before they can join the register. A standard definition and approach to good character has been proposed across the health professional regulators bodies, based on common criteria (CHRE 2008). Four key elements have been identified as pertaining to good character. These are whether an applicant has acted, or there is reason to believe they are liable in future to act:

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

The term 'good character' is not widely understood outside English-speaking countries and has no equivalent in Europe. So regulators need to give particular consideration to how they explain the concept to applicants from overseas.

Another requirement of registration is to take an applicant's health into account. CHRE (2009b) has made five recommendations to ensure that health is only considered as part of the requirement to be fit to practise. It recommended:

1. Removing all references to 'good health' as a requirement for registration and having a single requirement that an applicant's fitness to practise is not impaired.
2. A single fitness to practise committee to emphasise the focus on the safety and effectiveness of the registrant's practice and whether they meet their professional obligations; health is only considered when it is relevant in this context.
3. Regulatory bodies examine how best they can ascertain whether an applicant is capable of meeting their standards, including the proportionately of a full health reference from a medical practitioner as opposed to a self-declaration.
4. Regulatory bodies review how they provide information to registrants, applicants, students and others considering a career in the profession over the role of health in regulatory processes, including providing assurances that the only concern of the regulatory body is the person's capability to practise in line with competence and conduct standards, not the state of their health or any impairment they might have.
5. Regulatory bodies issue further guidance to education and training institutions and occupational health services, which explains their requirements for fitness to practise for those on or entering the register. This is important to end the different interpretations of regulatory bodies' requirements, which has led to discrimination against disabled people.

The statute proposed by the Law Commission (2012) would set out a number of requirements relating to registration. For example, the statute would specify which separate parts of the register or specialist lists must be established by the regulators. The Government would be given a regulation-making power to add, remove or alter parts of the register and specialist lists – and to introduce compulsory student registration. The regulators would be required to register applicants on a full, conditional or temporary basis, and have powers to introduce provisional registration. The statute would specify that in order to be registered on a full or temporary basis the applicant must be appropriately qualified, fit to practise, have adequate insurance or indemnity arrangements, and have paid a prescribed fee.

Other aspects of the proposed statute relating to registration include requiring the regulators to establish an appeals process for when registration applications are refused, for where registration has been fraudulently procured or incorrectly made, and in relation to restoration applications. There would be a requirement that all applications for restoration to the register where a registrant's entry has been erased must be referred to a Fitness to Practise Panel. The regulators would have broad powers to make rules concerning the content of the registers. However, there would be a requirement that all current fitness to practise sanctions must appear in the public register. Regulators would have discretion to include the details of undertakings, warnings and Interim Orders in the public register.

The introduction of key performance indicators or targets has focused attention on improving customer service responsiveness of registration departments. The General Medical Council and Health and Care Professions Council are good examples of this (see [Appendix A4](#)). Another trend is around the use of e-billing and online accounts to enable registrants to pay their fees swiftly and conveniently, as well as update registration details (such as change of address).

There is significant variation in annual registration fees (see table in [Appendix A4](#)). These range from £76 for a new graduate registering with the Health and Care Professions Council, to £800 for chiropractors (which represents a reduction of £200 since 2011), and more than £1,000 for some barristers.

A number of regulators have a lower fee rate for the first year of registration, and the General Optical Council has introduced a low income fee for registrants with a gross annual income of less than £12,000. Some regulators have reduced registration fees within the last year. The Nursing and Midwifery Council stands out for having increased its fees in February 2013.

The Professional Standards Authority conducted a cost-effectiveness and efficiency review of the health professional regulators for the first time in 2012. The report confirmed that scale – the size of the register – has an impact on efficiency. The tasks for each regulator, such as length of pre-registration education and training programmes, frequency and extent of harm linked to the profession, size of education provider sector, and type of allegations made about fitness to practise also explains some variation in costs (Professional Standards Authority 2012).

REVALIDATION

Regulatory registers have been criticised for failing to keep up with changes in the roles and responsibilities of professionals and for providing only a retrospective record of qualifications and competence. Most regulators already have a role in ensuring that, once registered, registrants remain up-to-date with evolving practices and continue to develop as professionals.

Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century (Department of Health 2007a), set out proposals to ensure that all the statutorily regulated health professions have arrangements in place for revalidation, which is defined as follows.

‘The purpose of revalidation is to ensure that health professionals remain up to date and continue to demonstrate that they continue to meet the requirements of their professional regulator. The professional standard against which each is judged is the contemporary standard required to be on the register, and not the standard at the point at which the individual may have first registered.’ (Department of Health 2008)

The General Medical Council is the first UK regulator to implement a system of revalidation. This follows the introduction of its concept of a licence to practice, which requires periodic renewal by revalidation. The other health professional regulators have been considering or developing their own systems for revalidation and a number have commissioned reviews of the different approaches to revalidation (the General Osteopathic Council, the Health and Care Professions Council, and the

Pharmaceutical Society for Northern Ireland have all commissioned and published research designed to support the development of revalidation).

A working group was set up in 2008 to take forward the recommendations for revalidation for the non-medical health professions. This identified twelve key principles to underpin approaches to revalidation by these regulators (Department of Health 2008), as set out in the table below.

Principle 1	Theme	Summary description
Principle 1	Consistency	Models should be consistent with the Better Regulation Executive's five principles of good regulation
Principle 2	Professional standards	The regulatory body for each profession should set out the contemporary professional standards, which registrants will have to meet in order to maintain registration
Principle 3	Remediation	Where revalidation processes highlight performance concerns there should be scope for remediation of the professional but measures to secure public safety must remain paramount
Principle 4	Patient and public involvement	A successful revalidation process must have the confidence of the public that it is appropriate, relevant and fit for purpose
Principle 5	Continuing professional development	The process by which individual registrants keep themselves up to date in order to maintain the highest standards of professional practice
Principle 6	Quality assurance	Quality assurance mechanisms must be built into revalidation processes
Principle 7	Equality	Equality and diversity considerations must be evident in the development of systems and processes for revalidation
Principle 8	Integration	Clinical governance frameworks yield information on professionals' performance and practice. Where appropriate, effective connections need to be made between them and the system of revalidation
Principle 9	UK-wide	Revalidation arrangements should be consistent in outcome across the UK
Principle 10	Demonstrating benefits	The structures and process of revalidation should be effective in confirming fitness to practise
Principle 11	Information	The nature of the information required by each regulatory body will be based on their risk profiling of their registrant groups
Principle 12	Incremental introduction	The introduction of revalidation should be incremental

The Department of Health asked regulators to submit their proposals for revalidation, in line with these principles, by January 2009, with a view to ensuring the process would encompass all health professionals within five years. However, a number of regulators are unlikely to introduce revalidation for several years and some, like the Health and Care Professions Council, are not yet convinced of its relevance or necessity for the professions they regulate.

Ultimately, any arrangements for revalidation need to be proportionate to the risk that the profession may pose. Other factors to consider include the impact of revalidation on multidisciplinary teams of professions (with team members contributing to each other's revalidation

processes through the use of team performance data), the impact of advanced practice, and the need for arrangements to work across all sectors including research and teaching.

Neither of the legal services regulators considered for this report have plans to introduce revalidation. There was no mention of revalidation in any of the materials reviewed relating to the four international veterinary regulators.

5: Education and training

Key messages:

- Quality assurance (QA) of education and training tends to revolve around self-assessment against set standards, external assessment or validation, and public reporting of the outcome (typically on regulators' websites).
- The emphasis of QA is shifting towards more outcome-focused, risk-based approaches – reflecting a more proportionate and risk-based approach to regulation. The more progressive regulators are combining this with a thematic approach to QA activity.
- The health professional regulators involve lay people (and sometimes students) in QA visiting teams. Some also seek views from the public as part of QA visits.
- Requirements in terms of CPD hours vary, as does the length of time over which CPD has to be carried out (ranging from yearly to five-yearly cycles). Some regulators make explicit requirements around spending CPD hours on learning with other professionals.
- A number of regulators have introduced online recording of CPD, making audit programmes easier to manage.
- Some regulators are currently reviewing their QA arrangements for education and training and many are reviewing their CPD requirements and processes.

SETTING EDUCATIONAL STANDARDS

A core function for professional regulators is to ensure that those who enter the profession have the required skills and knowledge to practice safely and effectively. This usually involves having systems in place to approve and quality assure educational programmes for students who wish to join the register and, for some regulators, also for programmes for those who are already on the register (for example, specialist training). All of the health professional regulators have powers to oversee the quality of pre-registration and post-registration education and training. The position is more complex for legal services regulators.

The Professional Standard Authority's standards of good regulation relating to education and training are as follows:

1. Standards for education and training are linked to standards for registrants. They prioritise patient and service user safety and patient and service user centred care. The process for reviewing or developing standards for education and training should incorporate the views and experiences of key stakeholders, external events and the learning from the quality assurance process.
2. Through the regulator's continuing professional development/revalidation systems, registrants maintain the standards required to stay fit to practise.

3. The process for quality assuring education programmes is proportionate and takes account of the views of patients, service users, students and trainees. It is also focused on ensuring the education providers can develop students and trainees so that they meet the regulator's standards for registration.
4. Action is taken if the quality assurance process identifies concerns about education and training establishments.
5. Information on approved programmes and the approval process is publicly available.
(Professional Standards Authority 2010)

The Law Commission's proposed statute would require health professional regulators to make rules relating to approved qualifications, the approval of education institutions, programmes, courses and/or environments, rights of appeals against decisions to refuse or withdraw approval, and a system of inspection of education institutions (Law Commission et al 2012). These rules would be supplemented by a duty on the regulators to establish and maintain a published list of approved institutions and courses, and publish information on any decisions regarding approvals.

QUALITY ASSURANCE (QA)

The broad structure of health regulators' approaches to quality assuring undergraduate education is the same; it follows a pattern of programme approval, monitoring and reapproval (CHRE 2009a). There are differences in the methods and frequency with which regulators quality assure.

The health professional regulators involve lay people in quality assurance visits to education providers and some also seek views from the public. For example, the General Chiropractic Council meets with patients and the public as part of its QA reviews, and the Nursing and Midwifery Council invites members of the public to become involved in the approval process of programmes through their nearest university. The General Medical Council includes students on its QA visiting teams (including undergraduates on visits to medical schools).

QA activity can create a burden for higher education and training providers that are subject to different QA processes. This has led to an emphasis on regulators to demonstrate that their processes are proportionate. Some regulators have found ways to discharge their QA responsibilities that dovetail with other QA bodies. For example, the General Osteopathic Council works closely with the Quality Assurance Agency for Higher Education (QAA), which manages QA reviews on behalf of the Council.

The emphasis on proportionality has also contributed to a growing shift towards more risk-based approaches (for example, in the Bar Standards Council and the Solicitors Regulation Authority). The General Medical Council has begun combining a more risk-based approach with a thematic approach to some of its QA activity. This enables it to share good practice across education and training providers in areas identified as requiring attention. Other examples of progressive practice by the General Medical Council include its regional visits, which seek to QA undergraduate education and postgraduate training at the same time.

The General Medical Council is currently undertaking a comprehensive review of its approach to quality assuring medical education and training, which will conclude towards the end of 2013. To inform this, it commissioned research to identify good practice in how education is quality assured by other regulators. The research revealed that the cyclical model to planning QA is most frequently reported (for example, a re-approval visit after a maximum of five years is typical), however there is a shift towards more proportionate targeting of QA, relying on a more risk-based, intelligence-led approach (Wright 2012). There is an increased emphasis in standard setting for outcomes, not just process. The importance of transparency in QA is a common theme, including reporting the outcomes of QA in the public domain and typically from regulators' websites.

CONTINUING PROFESSIONAL DEVELOPMENT (CPD)

CPD is a requirement for all professionals wishing to register with the health professional and legal services regulators. The requirements in terms of CPD hours vary, as does the length of time over which CPD has to be carried out (yearly, two-yearly, three-yearly or five-year cycles). Three of the four international veterinary regulators require registrants to complete 20 hours of CPD per year (over a two or three year cycle). The fourth regulator (Colorado) required 32 hours every two years.

Both the chiropractors and the osteopaths require half of CPD hours to be spent learning with others. This is thought to have a positive effect for those professionals who work alone and are often professionally isolated as a result (the majority of osteopaths, for example, are sole practitioners).

A number of regulators are moving towards online recording of CPD, which makes audit programmes easier to manage. For those that do not have online recording systems, registrants are normally expected to file an annual return and to keep a record folder which can be inspected upon request as part of an audit.

Several regulators expect to make changes to their CPD requirements over the next few years. For example, the Solicitors Regulation Authority, the General Chiropractic Council, the General Dental Council, and the General Osteopathic Council, are all reviewing or consulting on their CPD arrangements.

6: Handling complaints

Key messages:

- The numbers of complaints received by regulators varies enormously. For some regulators, the majority of complaints come from employers and the police; others are receiving year-on-year increases in complaints from the public.
- Some regulators have timeframes for responding to complaints about their services. There is no evidence of timeframes for responding to complaints about registrants.
- Regulators can only consider complaints that raise issues about fitness to practise – this generally includes competence or performance, as well as conduct, health and criminal convictions.
- Most regulators advise complainants to raise concerns locally first. The General Dental Council and the General Optical Council have responded to gaps in redress arrangements by setting up or contracting with complaints services.
- Some regulators are actively working to improve the way they explain their processes and outcomes to complainants.

RESPONDING TO COMPLAINTS

The numbers of complaints regulators receive varies enormously. There is also variation by source of complaint. For example, most complaints about nurses and midwives come from employers and the police; only about 23 per cent of referrals come from the public. For other regulators, like the General Medical Council, complaints from the public are increasing.

Some regulators articulate timeframes for responding to complaints about the organisation. For example, the General Medical Council aims to respond to concerns within ten working days; the Health and Care Professions Council commits to respond within 15 working days. The Nursing and Midwifery Council has strengthened its processes for complaints about its services, and aims to respond to complainants within 20 working days. Timeframes for responding to complaints about registrants are not in evidence.

Regulators can only consider complaints that raise issues about fitness to practise. Generally this includes personal and professional conduct, competence or performance, health and criminal convictions. Some regulators are able to signpost complainants to other organisations or processes, such as the NHS complaints procedure or the Legal Ombudsman. The General Medical Council streams complaints into one of two streams. Stream 2 complaints are referred to the organisation where the doctor was working to investigate and respond; the General Medical Council will only investigate if it is a complaint about a doctor's private practice or the doctor is a locum. Many regulators advise complainants to raise concerns locally first.

Complaints are normally considered by case examiners or screeners, before being passed to investigating committees, which will decide whether there is evidence that fitness to practice is impaired. The General Dental Council has commissioned the National Clinical Assessment Service (NCAS) to carry out a complaints review service. NCAS provides an independent opinion on whether the dentist complained about was performing to the standard expected, enabling the General Dental Council to decide whether disciplinary action may be needed. The General Pharmaceutical Council is unique in using its pharmacy inspectors to carry out investigations of complaints against individual pharmacy professionals, which feeds into the complaints and fitness to practise processes.

Some regulators are actively working to improve their interactions with complainants. For example, the General Medical Council is undertaking a pilot meeting scheme with complainants after a complaint has been received and also after an investigation or hearing process has concluded.

Regulators of legal services have been challenged with taking action to improve the quality of complaint handling by providers and to make full use of complaints intelligence to raise standards (Legal Services Consumer Panel 2012a). Most regulators of legal services have more to do in understanding the volume and nature of complaints, focusing on consumer experience of the process and using information about the effectiveness of complaints handling as part of wider monitoring, supervision and enforcement activities (Legal Services Board 2012b).

COMPLAINTS HANDLING SERVICES

Professional regulators are generally not complaints handling bodies and can only act when there is evidence that a registrant's fitness to practise is in question. However some have found it necessary to establish complaints handling arrangements.

The General Dental Council has responded to a gap in redress arrangements by setting up the Dental Complaints Service to consider complaints about private treatment. The Service is funded by the General Dental Council (at a cost of more than £500,000 a year), but it is independent and has its own staff. Response times are very good, with the majority of complaints being resolved in less than a week.

The General Optical Council has contracted with the Optical Consumer Complaints Service since 2007 to deal with consumer complaints. It deals primarily with matters of a contractual nature, such as poor service and practice, and conflicts between professional and commercial interests. In 2011, it received over 2,000 contacts and opened 820 cases.⁶

When the Law Commission asked whether health professional regulators should have powers to finance or establish a complaints service, opinion was divided although most disagreed that the regulators should have such powers (Law Commission et al 2013). For example, the Royal Pharmaceutical Society of Great Britain stated: *'Dealing with consumer complaints would cloud professional regulation and have the potential for the regulator to become embroiled in financial*

⁶ <http://www.opticalcomplaints.co.uk/2011%20Report%20Pages6-9.pdf>

redress rather than upholding public safety.’ The Department of Health took the view that a consumer complaints function *‘could detract from their core purpose’*.

However, several consultees felt the regulators should have such powers on the grounds that consumer complaints and fitness to practise issues can be intertwined. The Professional Standards Authority argued that *‘a funded but organisationally separate complaints service could provide a useful mechanism’* for regulators of registrants that *‘work outside a well-developed governance framework’*. The Scottish Government felt that the regulators should be able to fund a service that is run by another, independent organisation.

Comments by the General Optical Council may be of particular interest to the RCVS. It stated:

‘We believe that there is value for the regulator, registrants and for the public in having a mediation service in place where the sector is highly commercialised. For the regulator, it provides a clear avenue for directing complaints regarding poor products or services but not regarding fitness to practise. This helps minimise the number of minor complaints that regulators deal with and provides a way of helping satisfy complainants that their concern can be dealt with quickly and effectively. The work of the Optical Consumer Complaints Service can also be a useful contributor to our own work in setting standards and producing guidance for registrants on good practice.’

The General Dental Council supported the retention of its power to fund and manage the Dental Complaints Service on the grounds that *‘not only does it resolve complaints but learning is fed back into the Council’s other functions such as fitness to practise processes and setting standards’*.

7: Fitness to Practise

Key messages:

- The main statutory grounds for impairment of fitness to practise are generally: misconduct, deficient professional performance, criminal convictions (and cautions), and adverse health. The processes regulators have in place to investigate and hear cases vary quite significantly.
- The direction of travel for health professional regulators is for the following powers at investigation stage: warnings, interim orders, undertakings, voluntary erasure, and advice.
- A common set of sanctions has been proposed for adjudication by the health professional regulators: warnings, conditions of practice, suspension, striking off and fines.
- Many regulators are seeking to streamline their fitness to practise processes, making them swifter and more proportionate, for example, through making greater use of case examiners to reduce cases going before investigating committees, allowing for consensual panel determinations, and also voluntary removal from the register.
- The General Medical Council is driving forward more independent adjudication with the creation of its Medical Practitioners Tribunal Service. Independent adjudication arrangements already exist for solicitors and barristers.

DEMONSTRATING PROPORTIONALITY

Fitness to practise is the most high profile area of professional regulatory activity. It is also the costliest – on average, 62 per cent of expenditure for the health professional regulators in 2010-2011 went on fitness to practise (Professional Standards Authority 2012).

Many regulators are seeking to streamline their fitness to practise processes, making them swifter and more proportionate. This comes in response to criticism about the amount of time some regulators take to close fitness to practise cases, in the face of rising numbers of complaints and referrals. A number of regulators have introduced key performance indicators (KPIs) to drive performance. The General Medical Council's KPIs are the most comprehensive (see [Appendix A7](#)).

The Professional Standard Authority's standards of good regulation relating to fitness to practise are as follows:

1. Anybody can raise a concern, including the regulator, about the fitness to practise of a registrant.
2. Information about fitness to practise concerns is shared with employers/local arbitrators, and other regulators within relevant legal frameworks.
3. Where necessary, the regulator will determine if there is a case to answer and if so, whether the registrant's fitness to practise is impaired or, where appropriate, direct the person to another relevant organisation.

4. All fitness to practise complaints are reviewed on receipt and serious cases are prioritised and where appropriate referred to an interim orders panel.
 5. The fitness to practise process is transparent, fair, proportionate and focused on public protection.
 6. Fitness to practise cases are dealt with as quickly as possible taking into account the complexity and type of case and the conduct of both sides. Delays do not result in harm or potential harm to patients and service users. Where necessary the regulator protects the public by means of interim orders.
 7. All parties to a fitness to practise case are kept updated on the progress of their case and supported to participate effectively in the process.
 8. All fitness to practise decisions made at the initial and final stages of the process are well reasoned, consistent, protect the public and maintain confidence in the profession.
 9. All final fitness to practise decisions, apart from matters relating to the health of a professional, are published and communicated to relevant stakeholders.
 10. Information about fitness to practise cases is securely retained.
- (Professional Standards Authority 2012)

IMPAIRMENT

Regulators can generally consider cases of misconduct, poor performance or competence, physical or mental ill-health, and a criminal conviction or caution.

The Law Commission's consultation (2012) put forward three options for reform relating to impairment:

- First, the proposed statute could establish a single framework for determining impaired fitness to practise based on the four statutory grounds for impairment (misconduct, deficient professional performance, conviction and determinations by another regulator, and adverse health).
- Second, the statute could require regulators to determine at the investigation stage whether the allegations, if proved, might show that the practitioner has put a patient at risk of harm, brought the profession into disrepute, breached a fundamental tenet of the profession or acted (or is likely to act) dishonestly, and if so, whether there is a realistic prospect of proving the allegation. At the adjudication stage the regulators would then consider whether or not fitness to practise is impaired in such a way as to justify action.
- Finally, the statute could remove altogether the statutory grounds for a finding of impaired fitness to practise and instead require regulators to consider whether the facts alleged are proved and if so, whether they indicate that the practitioner is a risk to the public (and whether confidence in the profession has been or will be undermined). The evidence would not be limited to any predetermined categories. The regulator would then need to consider, on the basis of those facts, whether the practitioner's fitness to practise is impaired. A small majority of consultees supported this third option.

INVESTIGATION

The processes regulators have in place to investigate and hear cases vary quite significantly. For example, some health professional regulators have separate fitness to practise committees for health, conduct, and performance; other regulators combine conduct with performance; and for some regulators, a single fitness to practise committee will hear all types of cases.

As part of increasing efficiency and dealing with cases in a more proportionate way, some regulators are planning to introduce (the General Optical Council) or expand (the General Dental Council) the role of case examiners to reduce the number of cases going before an investigating committee. The General Medical Council already has a system where two case examiners, one medical and one non-medical, will review all the evidence and decide whether to conclude the case with no further action, issue a warning, agree undertakings to address a problem, or refer the case for a hearing. If they fail to agree, the case is considered by the Investigation Committee.

There is a move towards allowing consensual panel determinations, where a registrant admits the allegation against them and agrees a sanction with the fitness to practise committee without the need for a hearing. The Nursing and Midwifery Council has recently introduced this and it is already in use by the General Medical Council. Another move designed to demonstrate proportionality is voluntary removal from the register where, in certain situations, a registrant who admits that their fitness to practise is impaired and has no intention of practising again, can apply for voluntary removal.

In terms of investigation, the Law Commission has proposed that regulators should consider any information that comes to their attention as an allegation and not just formal complaints, and there should be no set format for allegations. A significant majority responded that the statute should set a consistent time limit across the regulators (and of those, a majority said it should be five years). All of the regulators would have the same powers to dispose of cases at the investigation stage:

- Warnings
- Interim orders
- Undertakings
- Voluntary erasure
- Advice.

All of the regulators would be given powers to introduce systems of mediation if they wish to (Law Commission et al 2012).

Since 2009 CHRE has audited the health professional regulators' handling of complaints that are not referred for a formal fitness to practise hearing. The frequency of audits varies according to the assessment of risks, with each regulator being audited at least once every three years. Its report of audits conducted between 2010 and 2011 found that, other than the Nursing and Midwifery Council and the General Dental Council, all the health professional regulators demonstrated a continuation of good practice or improvements on the previous year (CHRE 2011b). They had sound casework systems that generally achieved good standards of record keeping and decision making. Most of the

regulators explained why they had reached decisions to close cases and demonstrated good communication with the public. CHRE recommended that, unless already in place, regulators should introduce:

- Sufficiently demanding case-closure Key Performance Indicators (KPIs) or targets.
- Computerised case management and registration systems.
- Systems to give decision-makers relevant previous fitness to practise history.

ADJUDICATION

Some have questioned whether it is appropriate that professional regulators should act as ‘Judge, Jury and Prosecutor’ in fitness to practise cases. The previous government took forward legislation to create a new body, the Office of the Health Professions Adjudicator (OHPA). The idea was for an adjudication service that would be separate from the health regulators. It would adjudicate on fitness to practise matters for doctors, then the professions regulated by the General Optical Council and, in time, for the other health professions.

The new Government reassessed the policy in 2010 and reviewed whether there were other, more proportionate methods of delivering ‘more’ independent adjudication (Department of Health 2010a). It subsequently decided to repeal legislative provision relating to OHPA and instead enhance the independence of adjudication and modernise existing processes at the General Medical Council and, subsequently, for the other health regulators (Department of Health 2010b).

The Government’s defence of its position points to factors to consider in assessing adjudication arrangements. It argued that criticisms of the General Medical Council and its role in adjudication had to be considered in the light of the following changes:

- **Reformed governing body** – it cited the smaller, more strategic governing council, comprised equally of lay and registrant members who had been subject to an appointment process.
- **Human rights** – case law confirmed that the system of adjudication operated by the health regulators, which included the right of appeal to the high courts, did not, as some had argued, breach the right to a fair trial under the Human Rights Act 1998.
- **Evidence of public protection** – it stated that there was no evidence that current General Medical Council led adjudication arrangements were not ‘*properly protecting the public*’. Less than 1 per cent of cases determined by the General Medical Council had been assessed as ‘unduly lenient’ in 2009-10 by CHRE.
- **Appeals** – only a small proportion of adjudication decisions against doctors were appealed to the High Court (Department of Health 2010b).

Modernisation of the General Medical Council’s adjudication processes was still considered necessary. The Government believed that once the General Medical Council had a revised adjudication system in place, best practice could be shared with other regulators. So whilst the General Medical Council has felt the heat of public and parliamentary attention to its adjudication processes, it is also, or in time will be, used as an exemplar other regulators can learn from.

Following the Government's decision not to proceed with the establishment of OHPA, the General Medical Council has set up the Medical Practitioners Tribunal Service (MPTS) to adjudicate on doctors' fitness to practise. The MPTS is part of the General Medical Council, but operationally separate and accountable directly to Parliament. The General Medical Council wants the MPTS to be established in statute. An independent adjudication process also operates for solicitors, under The Solicitors Disciplinary Tribunal, and for barristers, under the Council of the Inns of Court.

The Law Commission sought views on whether its proposed statute should ensure the separation of investigation and adjudication. A majority agreed that this separation is necessary, mostly through the establishment of a separate adjudication body (Law Commission et al 2013).

SANCTIONS

The Law Commission has proposed parity in the range of sanctions available to the health professional regulators. All the regulators would be able to impose:

- erasure from the register
- suspension
- conditions of practice, and
- warnings.

They would also all have powers to agree undertakings and voluntary erasure. In addition, the Government would be given a regulation-making power to introduce systems of financial penalties and cost awards.

The single set of sanctions for all health professional regulators proposed by CHRE also includes fines (CHRE 2009c).

8: Engaging with stakeholders

Key messages:

- Professional regulators engage with a wide range of stakeholders, although the level and approach to engagement is variable.
- Engagement with registrants tends to be through electronic newsletters and regional events focused on consultations. More innovative approaches include engaging hospital ward staff during a night shift.
- A number of health professional regulators have established reference groups or panels with members of the public, and some carry out annual surveys of public perceptions.
- Regulators are increasingly using social media as a tool for engagement – examples include live Twitter feeds of council meetings and YouTube for information videos and interviews.
- The General Medical Council's employer and regional liaison services will be of interest to regulators seeking to increase their presence with registrants and employers at a local level.
- It has been proposed that health professional regulators should be given a duty to cooperate with employers, education and training providers, other regulators, and service providers.

APPROACHES TO ENGAGEMENT

Professional regulators engage with a wide range of stakeholders, including professional organisations, special interest groups, registrants and members of the public, although the approach to engagement is variable. The General Osteopathic Council is an example of a small regulator that appears to cover all areas of stakeholder engagement to an impressive degree for its size.

Engagement with registrants tends to be through electronic newsletters or letters and regional events, usually focusing on areas under consultation. The Nursing and Midwifery Council demonstrated an innovative approach by engaging ward staff during a night shift at a hospital and first thing in the morning, to reach an audience who would not normally be able to attend its events. Many of the regulators report working with relevant professional organisations on topical issues, and all are keen to attend regional and national events and conferences held by associated organisations.

Regulators are increasingly using social media, such as Facebook and Twitter, as a tool for engagement. The General Medical Council, for example, uses a wide range of social media and articulates what stakeholders can expect from its engagement using these channels. The Nursing and Midwifery Council used live tweeting of a Council meeting that considered a fee increase for registrants. Making use of social media is also an important element of the General Osteopathic Council's approach to engagement.

Regulators with a UK remit will need to demonstrate presence across the four countries. Most of the regulators are London-based, making this a challenge. Leading the way here is the General Medical Council, which has established offices in each of the four countries to enable it to respond effectively to devolution. It has also established an Employer Liaison Service to strengthen its working relationships with employers across the UK, and a Regional Liaison Service to work with groups representing doctors, patients, medical schools and students, to ensure its work is well understood and meets their needs (for further details see [Appendix A8](#)).

A number of regulators are involved with cross-regulatory groups on European issues, and all of the health professional regulators belong to the Alliance of UK Health Regulators on Europe (AURE). The Alliance facilitates cross-regulator collaboration on European proposals and consultations, particularly around issues relating to the recognition of qualifications and English language testing. The health professional regulators also belong to the Healthcare Professionals Crossing Borders Initiative, which is an informal partnership of regulators from across Europe looking at cross-border healthcare and free movement amongst the professions.

PUBLIC AND SERVICE USER ENGAGEMENT

Engagement with patients and the public tends to be through formal public consultations, although a number of regulators have established reference groups with members of the public – for example, the General Medical Council, the General Osteopathic Council, and the General Optical Council (see [Appendix A8](#)). Some of the regulators carry out annual surveys of the public to allow them to collect comparative information about public perceptions.

Many of the regulators belong to Professional Standard Authority's Learning Circle on Patient and Public Engagement, which is a forum for health and social care regulators to share ideas and promote good practice. Others are members of the joint regulators' patient and public involvement forum, which is comprised of a staff representative and a lay Council member from each of the health and social care regulators. Its outputs have included *A PPI Good Practice Handbook for UK Health Care Regulators*.

The Legal Services Consumer Panel was established under the Legal Services Act 2007 to provide independent advice to the Legal Services Board about the interests of consumers in England and Wales. The Panel's *Consumer Impact Report* uses a number of indicators to assess the legal services reforms from a consumer perspective. It has found levels of consumer engagement by the regulators of legal services to be 'very poor' (Legal Services Consumer Panel 2012a). The first *Consumer Impact Report* (2011) revealed: '*a stark imbalance of power between consumers and lawyers*', with black and minority ethnic and lower socio-economic groups worse off across many of the indicators. The Panel's second report highlighted disappointment in '*the almost complete absence of consumer engagement activity*' by the regulators of legal services. The report identified a wide range of actions needed by regulators, including developing a better understanding of the needs of vulnerable consumers and improving diversity at senior levels of the workforce (Legal Services Consumer Panel 2012a).

A DUTY TO COOPERATE

Under the Law Commission's proposals, the statute would include a permissive statement to the effect that each health professional regulator may carry out any of its statutory functions in partnership with another organisation (including another professional regulator). There would also be two concurrent duties to cooperate – a general duty and a specific duty. The general duty would require each regulator to make arrangements to promote cooperation with other relevant organisations or other persons, including those concerned with:

- The employment of registrants
- The education and training of registrants
- The regulation of other health or social care professionals
- The regulation of health or social care services, and
- The provision/supervision/management of health or social care services.

The specific duty to cooperate would apply when a regulator in question is:

- Considering registration applications and renewals
- Undertaking the approval of education and training
- Ensuring proper standards of practice and conduct, and
- Undertaking an investigation into a registrant's fitness to practise (Law Commission et al 2012).

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Appendices A1- A8: Regulatory profiles

Appendix A1: principles of better regulation

Appendix A2: governance

Appendix A3: standards and guidance

Appendix A4: registration

Appendix A5: education and training

Appendix A6: handling complaints

Appendix A7: fitness to practise

Appendix A8: engaging with stakeholders

Appendix A1: PRINCIPLES OF BETTER REGULATION

BAR STANDARDS BOARD (BSB)

- The BSB's mission is to promote and safeguard the highest standards of legal education and practice in the interests of clients, the public and the profession.
- Its vision is that:
 - the term 'BSB-regulated' will be an assurance of good, honest, independent advocacy and expert legal advice
 - the public and the profession will recognise and value that assurance
 - it will be recognised as a good, honest, independent and expert regulator.

GENERAL CHIROPRACTIC COUNCIL (GCC)

'Protecting patients, setting standards'

- The GCC's values are:
 - integrity – be honest and accountable
 - openness – in decision making and in willingness to engage and learn
 - fairness – deliver impartial, proportionate regulation
 - a commitment to continuous improvement.

GENERAL DENTAL COUNCIL (GDC)

'Protecting patients, regulating the dental team'

- The GDC aims to enhance patient safety, improve the quality of dental care and help ensure public confidence in dental regulation. Its aim is to regulate in a way that is proportionate, accountable, transparent, consistent, targeted, and responsive to changing demands, risks and priorities.

GENERAL MEDICAL COUNCIL (GMC)

‘Regulating doctors, ensuring good medical practice’

- The GMC is unequivocal regarding its role in protecting the public. It states: *‘We have strong and effective legal powers designed to maintain the standards the public have a right to expect of doctors. We are not here to protect the medical profession – their interests are protected by others. Our job is to protect patients.’*
- The GMC maintains that patients’ interests are best served by independent, accountable regulation. It states that the GMC must be independent of Government as the dominant provider of healthcare in the UK, independent of domination by any single group, and be publicly accountable for the discharge of its functions. It considers that independent, accountable regulation must:
 - put patient safety first
 - support good medical practice
 - promote fairness and equality and value diversity
 - respect the principles of good regulation: proportionality, accountability, consistency, transparency and targeting.
- The GMC’s work is underpinned by five core organisational values:
 - to protect the public
 - to treat everyone fairly
 - to be honest and strive to be open and transparent
 - to be committed to excellence in everything it does
 - to be a listening and learning organisation.

GENERAL OPTICAL COUNCIL (GOC)

‘Assuring the health and protection of those who use the services of optometrists and dispensing opticians’

- The GOC aims to protect the public by promoting high standards of education, performance and conduct amongst opticians. The GOC’s values are to be responsible, forward thinking and principled.

GENERAL OSTEOPATHIC COUNCIL (GOSC)

- The GOSC exists to regulate the profession, to promote public safety, to ensure that patients receive the highest standards of osteopathic care and to promote an understanding of osteopathic practice. It is committed to working with osteopaths and the public to ensure that the whole regulatory system is transparent and ‘fit for purpose’.

GENERAL PHARMACEUTICAL COUNCIL (GPhC)

‘Upholding standards and public trust in pharmacy’

- The GPhC aims to protect, promote and maintain the health, safety and wellbeing of members of the public by upholding standards and public trust in pharmacy.
- The GPhC considers itself to be a modern and responsive regulator that has public protection as its main objective. Pharmacy practice will change in the next ten years, as pharmacy professionals take on new services and more clinical roles. The GPhC intends to take a risk-based approach to regulation to ensure its resources are directed to the most appropriate areas, where they can have the maximum impact on outcomes.

HEALTH AND CARE PROFESSIONS COUNCIL (HCPC)

‘Regulating health, psychological and social work professionals’

- The HCPC seeks to demonstrate the following values:
 - transparency
 - collaboration
 - responsiveness
 - value for money
 - high quality service.

NURSING AND MIDWIFERY COUNCIL (NMC)

‘To safeguard the public by ensuring nurses and midwives consistently deliver high quality healthcare’

- The NMC’s values are to be:
 - accountable – acting in the best interests of people who use or need the services of nurses and midwives, taking responsibility for its actions and being open and transparent
 - fair – acting with integrity, trusted to use its powers responsibly, consistent in the way it deals with people and showing consideration and understanding
 - professional – known for its expertise and work to high standards, looking for innovative solutions and learning from mistakes
 - progressive – providing strategic direction and leading the way in modern healthcare regulation, building and maintaining networks and working in partnership with others
 - inclusive – respecting and valuing the contributions of others, celebrating diversity and providing equality of opportunity, and engaging and listening to stakeholders.

‘Protecting, registering, regulating’

- The PSNI is both the regulator and the professional body for the pharmacists in Northern Ireland. Its primary purpose is to ensure practising pharmacists in Northern Ireland are fit to practise, keep their skills and knowledge up to date and deliver high quality safe care to patients.

‘Smarter regulation, better outcomes’

- The SRA’s vision is to be the leading regulator of legal services, recognised for the outcomes it achieves. It seeks to act in the public interest and promote and protect the interests of consumers of legal services by:
 - making fair, impartial and transparent decisions and focusing on achieving the right outcomes
 - enabling the provision of good quality, ethical and safe legal services and helping consumers to make informed choices
 - committing to the principles of better regulation and being proportionate and transparent in how it regulates
 - making the identification, analysis and management of risk integral to its regulatory approach and decision-making.
- The SRA has moved towards consumer-based regulation, introducing a new organisational structure in 2011, designed around three regulatory areas: authorisation, supervision and enforcement. This new structure is underpinned by:
 - intelligent authorisation processes, to ensure it only authorises firms and individuals who are fit to provide legal services
 - enhanced supervision to enable it to identify and prevent risks sooner, working with those it regulates to manage risks down
 - firm, proportionate, transparent enforcement to deal with those who do not comply with the regulatory principles, and to act as a deterrent
 - robust risk criteria enabling it to focus resources on serious risk.

Appendix A2: GOVERNANCE

BAR STANDARDS BOARD (BSB)

- The BSB regulates barristers called to the Bar in England and Wales. The BSB is responsible for:
 - setting the education and training requirements for becoming a barrister
 - setting continuing training requirements to ensure that barristers' skills are maintained throughout their careers
 - setting standards of conduct for barristers
 - monitoring the service provided by barristers to assure quality
 - handling complaints against barristers and taking disciplinary or other action where appropriate.
- The governing body of the BSB is its Board. This is made up of 15 people, a combination of lay (eight) and barristers (seven). All of the Board members are appointed. At the end of 2011, several retirements took the Board to a lay majority, which had been both an aim of the BSB and a requirement of the Legal Services Board's internal governance rules. The Board meets approximately ten times a year in public, except for one private meeting regarding the budget.
- The Board is supported by eight regulatory committees: Education and Training; Equality and Diversity; Governance, Risk and Audit; Planning, Resources and Performance; Professional Conduct; Qualifications; Quality Assurance; and Standards.
- The BSB has approximately 60 staff based in a London office.

GENERAL CHIROPRACTIC COUNCIL (GCC)

- The GCC regulates chiropractors in the UK. It was established by the Chiropractors Act 1994. Its statutory duty is to develop and regulate the profession of chiropractic, thereby protecting patients and the public. Its statutory functions are:
 - to set the standards of chiropractic education, conduct and practice
 - to recognise chiropractic degree programmes that achieve its standards
 - to maintain the Register of individuals who meet its requirements in respect of character, health, competence and continuing professional development
 - to investigate and determine all complaints against registrants.
- The GCC has a Council of 14: seven lay people and seven chiropractors, appointed by the Appointments Commission. It normally meets six times a year. It has a code of conduct for members.
- The GCC has four statutory committees: Education, Investigating, Health, and Professional Conduct.
- The GCC has 12 members of staff based in one office in London.

- In 2010 the GCC put together a Governance Working Group to investigate concerns raised by four chiropractic professional associations. These addressed disclosure policies, fitness to practise processes, drafting of allegations, registration fees and improving relations with professional associations.

GENERAL DENTAL COUNCIL (GDC)

- The GDC regulates dentists and dental professionals in the UK. Dental professionals cover dental nurses, dental technicians, clinical dental technicians, dental hygienists, dental therapists and orthodontic therapists.
- The GDC's role is to protect the public by regulating dental professionals. It does this through:
 - registering qualified dental professionals
 - setting and enforcing standards of dental practice and conduct
 - protecting the public from illegal practice
 - assuring the quality of dental education
 - ensuring professionals keep their knowledge and skills up to date
 - investigating and acting upon complaints received about fitness to practise
 - helping patients and the profession to resolve complaints about private dentistry, through the Dental Complaints Service.
- The Council of the GDC was restructured in 2009. It currently has 24 appointed members. In October 2013, the Council will reduce its size to 12 members (11 Council members and a Chair); six dentists / dental care professionals and six lay members. All members, including the Chair, will be appointed. At least one member will live or work mainly in England, Scotland, Wales and Northern Ireland. Council meets approximately seven times a year and meetings are held in public (although any items considered private will be considered in a closed session).
- The Council is supported by six statutory committees:
 - Investigating Committee
 - Interim Orders Committee
 - Professional Conduct Committee
 - Health Committee
 - Professional Performance Committee
 - Registration Appeals Committee.

There is also an independent Appointments Committee that oversees the appointments to the statutory committees.

- There are four standing committees, comprised of Council members, which look at policies and procedures. These include Audit Committee, Policy Advisory Committee and Remuneration Committee. There are also a number of working groups and boards set up from time to time, for example, to look at revalidation.

- The GDC has around 175 staff, led by the Chief Executive and Registrar, and the executive management function. The staff are based in an office in London. The GDC is about to take occupation of a second office in London to house its new legal team. There is also a Director for Scotland who is based in Scotland.
- The GDC has asked the Department of Health to consider a further constitutional change to allow for meetings to be held by audio or visual conference, rather than face to face. This is to allow for swift responses, when required, and to reduce venue, travel and subsistence costs of meetings.

GENERAL MEDICAL COUNCIL (GMC)

- The statutory purpose of the GMC is to protect, promote and maintain the health and safety of the public by *‘ensuring proper standards in the practice of medicine’*.
- Under the Medical Act 1983 the GMC has four main functions:
 - keeping up-to-date registers of qualified doctors
 - fostering good medical practice
 - promoting high standards of medical education and training
 - dealing firmly and fairly with doctors whose fitness to practise is in doubt.
- The GMC was established under the Medical Act of 1858. Since then, new legislation has been introduced to further define its powers and responsibilities.
- The GMC’s governing body, the Council, has 12 members of which six are doctors and six are lay members, all appointed following an independent appointments process.
- The Council meets about ten times a year. Council meetings are open to the public. In addition, Council members attend committee meetings, including Audit and Risk Committee and Remuneration Committee. All Council members are required to confirm their commitment to the Members’ Code of Conduct⁷. Council members’ expenses are detailed on the GMC website.
- One of the GMC’s strategic aims is to use resources efficiently and effectively. It has saved £30 million since 2003 through initiatives to increase its economy, efficiency and effectiveness. During 2011 alone it delivered efficiency gains of £8.7 million (approximately 9 per cent of its budget for the year), which enabled it to reduce the annual retention fee paid by doctors in April 2012.
- The GMC employs 654 staff (2011 figures). It has offices in Northern Ireland, Scotland and Wales, to enable it to respond effectively to devolution and ensure that regulation remains appropriate in all four countries. Its five offices are based in London, Manchester, Edinburgh, Cardiff and Belfast.

⁷ www.gmc-uk.org/about/register_code_of_conduct.asp

GENERAL OPTICAL COUNCIL (GOC)

- The GOC regulates optical professions in the UK. It is governed by the Opticians Act 1989. Its core functions are to:
 - set standards for optical education and training, performance and conduct
 - approve qualifications leading to registration
 - maintain a register of individuals who are qualified and fit to practise, train or carry on business as optometrists and dispensing opticians
 - investigate and act where registrants' fitness to practise, training or carry on business is impaired.
- The GOC has a wide range of rules and regulations available on its website (http://www.optical.org/en/about_us/legislation/rules_and_regulations.cfm) covering registration, fitness to practise, continuing education and training.
- The GOC is governed by the Council, which is made up of 12 members (equal numbers of lay and professional members) appointed by the Privy Council. The Council normally meets in public about four times a year. Council members sit on the Audit and Remuneration Committees.
- The remaining committees (Companies, Education, Investigation, Registration and Standards) do not comprise any of the Council members. They contain a mixture of lay and professional members.
- The GOC has one office based in London with approximately 40 staff.

GENERAL OSTEOPATHIC COUNCIL (GOSC)

- The GOSC regulates osteopaths in the UK. It is governed by The Osteopaths Act 1993. The GOSC:
 - keeps the Register of all those permitted to practise osteopathy in the UK
 - works with the public and osteopathic profession to promote patient safety by registering qualified professionals and sets, maintains and develops standards of osteopathic practice and conduct
 - help patients with any concerns or complaints about an osteopath and has the power to remove from the Register any osteopath who is unfit to practise
 - assures the quality of osteopathic education and ensures that osteopaths undertake continuing professional development.
- In 2009, the GOSC introduced a new governance structure. It is governed by a Council of 14 members: seven lay and seven osteopaths, and appointed by the Appointments Commission.
- The Council has four statutory committees: Education, Investigating, Health, and Professional Conduct. These work in much the same way as those of the GCC.

- In 2011/12, the GOsC had 23.4 full time equivalent members of staff based in one office in London.

GENERAL PHARMACEUTICAL COUNCIL (GPhC)

- The GPhC is the independent regulator for pharmacists, pharmacy technicians and pharmacy premises in Great Britain. It came into existence on 27 September 2010, its function having previously been undertaken by the Royal Pharmaceutical Society of Great Britain (RPSGB) (now the professional body for the profession).
- The RPSGB was formerly the regulatory and professional body for pharmacists and pharmacy technicians. The transfer of its regulatory powers to the GPhC followed the White Paper, *Trust, Assurance and Safety* (2007), which was concerned that regulators are able to demonstrate independence. The RPSGB's responsibilities towards pharmacists for professional leadership were seen to be potentially in conflict with its role as an independent regulator.
- The Health Act 1999, as amended by the Health and Social Care Act 2008, was the primary legislation which enabled the GPhC to be established via the Pharmacy Order 2010. The Act enabled all the regulatory functions of the Royal Pharmaceutical Society of Great Britain to be transferred to the GPhC. The Act also allowed for the transfer of regulatory functions from the Pharmaceutical Society of Northern Ireland to the GPhC in the future, subject to a decision by Northern Ireland Ministers.
- The Pharmacy Order 2010 established the GPhC as an independent statutory regulator. In addition, the GPhC has powers and responsibilities for the registration of pharmacy premises and for enforcing certain provisions under the Medicines Act 1968 and the Poisons Act 1972.
- The GPhC's principal functions include:
 - approving qualifications for pharmacists and pharmacy technicians and accrediting education and training providers
 - maintaining a register of pharmacists, pharmacy technicians and pharmacy premises
 - setting standards for conduct, ethics, proficiency, education and training, and continuing professional development (CPD)
 - establishing and promoting standards for the safe and effective practice of pharmacy at registered pharmacies
 - establishing fitness to practise requirements, monitoring pharmacy professionals' fitness to practise and dealing fairly and proportionately with complaints and concerns.
- The GPhC has a governing council of 14 members made up of seven pharmacy professionals and seven lay members. At least one member has to live or work in each of England, Scotland and Wales. The members are appointed by the Privy Council.
- The governing council sets the strategic direction and objectives for the organisation. It monitors the organisation's performance and holds the executive to account, as well as ensuring probity and safeguarding the organisation's assets.

- The GPhC has three statutory committees – Investigating Committee, Fitness to Practise Committee, and Appeals Committee – and three non-statutory committees (Audit and Risk, Remuneration and Appointments).
- The GPhC has approximately 134 full-time staff based in one office in London, and 247 associates including fitness to practise panel members and other staff working around the country (such as inspectors).

HEALTH AND CARE PROFESSIONS COUNCIL (HCPC)

- The Council develops and monitors strategy and policy. It is comprised of 20 members (ten registrant and ten lay). All members are appointed. It is supported by four statutory and four non-statutory committees. There are around seven or eight meetings of Council each year; these are held in public.
- A particular feature of the HCPC is its quality management system, which is registered with BSI to ISO 9001:2008. By establishing a Quality System and undertaking self-assessment against standards that represent best practice benchmarks, the HCPC seeks to ensure that it adheres to best practice in all its activities. For further details, see www.hpc-uk.org/aboutus/aimsandvision/quality/.
- The HCPC describes people who work as agents of the HCPC as ‘partners’. They cover a variety of different roles and include CPD assessors, legal assessors, fitness to practise panel members, registration assessors and visitors.
- In 2012, the HCPC had 158 staff based at its offices in London.

NURSING AND MIDWIFERY COUNCIL (NMC)

- The NMC regulates nurses and midwives across the UK. The governing council is comprised of 14 lay and registrant members (half are registrant members) appointed by the Privy Council, including one member from each of the four UK countries.
- The NMC Council will be reconstituted on 1 May 2013 and reduce in size to 12 members.
- The Council meets in public 10 times a year, usually at the NMC’s offices in London, but sometimes in other parts of the UK. Any member of the public can observe a Council meeting (although it is necessary to request a place in advance). There is a question and answer session during the meeting at which observers are able to ask questions or make comments.
- The Council is supported by seven committees.

- There is a code of conduct for Council members.
- As part of work to strengthen the NMC's governance, it has been actively considering the size of Council. It has looked at the competencies and skill sets required to provide effective strategic oversight. It has strengthened governance by:
 - improving the information available to Council on which to reach decisions and scrutinise performance, including a balanced scorecard of performance measures relating to delivery of its regulatory functions and complaints
 - improved transparency and accountability by ensuring that Council considers and decides issues in public and by reinstating public questions at Council meetings.

PHARMACEUTICAL SOCIETY OF NORTHERN IRELAND (PSNI)

- The PSNI regulates pharmacists in Northern Ireland (NI). It is responsible for:
 - setting and promoting standards for pharmacists' admission to the register and for remaining on the register
 - maintaining a publicly accessible register of pharmacists, and pharmacy premises, in Northern Ireland
 - handling concerns about the Fitness to Practise of registrants, acting as a complaints portal and taking action to protect the public
 - ensuring high standards of education and training for pharmacists in Northern Ireland.
- The PSNI was established by the Pharmacy and Poisons Act (Northern Ireland) 1925 and conferred with additional powers and responsibilities by the Pharmacy (Northern Ireland) Order 1976 and the Pharmacy (NI) Order 1976 Amendment Order (NI) 2012. The latter modernised the structure of the organisation and allowed for a Council to be appointed as the governing body, which took effect in October 2012.
- The Council is comprised of 14 members, seven lay and seven pharmacists. All members are appointed by the Department of Health, Social Services and Public Safety (DHSSPS) for a period of two to four years. Council meetings all take place in public.
- Three statutory committees report into the Council: Resources, Audit and Risk, and Regulatory Compliance. The latter has the following sub-committees: Education, Standards and Guidance, Registration, and Fitness to Practise.
- The professional and leadership roles of the PSNI have been delegated to the Pharmacy Forum, as part of the White Paper, *Trust, Assurance and Safety* (2007). The Pharmacy Forum promotes the profession and facilitates continuing professional development. It started in December 2011 and is the organisation for pharmacy professional leadership in Northern Ireland.

SOLICITORS REGULATION AUTHORITY (SRA)

- The SRA is the regulator for solicitors in England and Wales. It regulates a wide range of other legal professionals, including registered European lawyers (REs) and registered foreign lawyers (RFLs) practising in England and Wales, and law firms authorised by the SRA.
- The SRA is set in the Solicitors Act 1974 and the Administration of Justice Act 1975, as amended by the Legal Services Act 2007.
- The SRA defines its aims as follows:
 - setting the standards for qualifying as a solicitor and the rules of professional conduct
 - monitoring the performance of organisations that provide legal training
 - providing authoritative guidance and rules to solicitors on ethical issues, laws and regulations that affect solicitors' work
 - administering the roll (register) of solicitors and setting requirements for solicitors' continuing professional development
 - providing information to the public about solicitors, their work and the standards the public is entitled to expect
 - monitoring firms to make sure they are complying with the rules and, when necessary, closing down solicitors' firms so as to protect clients and the wider public, and returning papers and monies to their owners
 - monitoring solicitors and investigating concerns about their standards of practice and compliance with the rules
 - referring solicitors to the independent Solicitors Disciplinary Tribunal where necessary
 - running a compensation fund to help people who have lost money as a result of a solicitor's dishonesty or failure.
- The SRA is overseen by a board of 15 members: seven solicitors (one of whom is chair) and eight lay people. The board was reconstituted in 2010 and must have a lay majority. Appointments last for three years. Board meetings are open to the public.
- The board is supported by committees and subgroups, including the Regulatory Risk Committee, Education and Training Committee, Finance and Resources Committee, Standards Committee, Communications Group, and Equality and Diversity Group.
- The SRA has a risk-based approach to regulation and is driving forward its work on outcomes-focused regulation (OFR). It details this in its annual report for 2011: *OFR and beyond: The SRA's vision for regulating legal services in the 21st century incorporating the Annual Report for 2011*.
- The SRA has recently merged two of its offices in the Midlands into one central office in Birmingham (now its headquarters). The SRA also has an office in London.

Appendix A3: STANDARDS AND GUIDANCE

BAR STANDARDS BOARD (BSB)

- The BSB has published the eighth edition of *The Code of Conduct* (2004) to provide the requirements for practice, and the rules and standards of conduct, applicable to barristers. For example:
 - in relation to self-employed barristers, to provide common and enforceable rules and standards which require them:
 - to be completely independent in conduct and in professional standing as sole practitioners
 - to act only as consultants instructed by solicitors and other approved persons (save where instructions can be properly dispensed with)
 - to acknowledge a public obligation based on the paramount need for access to justice to act for any client in cases within their field of practice
 - to make appropriate provision for:
 - barrister managers, employees and owners of Authorised Bodies and
 - employed barristers taking into account the fact that such barristers are employed to provide legal services to or on behalf of their employer.
- The BSB has an area on its website that brings together resources, including what it defines as essential practising information and guidance (<https://www.barstandardsboard.org.uk/regulatory-requirements/for-barristers/>).

GENERAL CHIROPRACTIC COUNCIL (GCC)

- The GCC has the *Code of Practice and Standard of Proficiency* (2010) for chiropractors. The principles are to:
 - respect patients' dignity, individuality and privacy
 - respect patients' rights to be involved in decisions about their treatment and healthcare
 - justify public trust and confidence by being honest and trustworthy
 - provide a good standard of practice and care
 - protect patients and colleagues from risk of harm
 - cooperate with colleagues from their own and other professions.
- The GCC also publishes other advice, information and guidance notes for its registrants and trainees (http://www.gcc-uk.org/page.cfm?page_id=437).

GENERAL DENTAL COUNCIL (GDC)

- The GDC's *Standards for dental professionals* (2009) applies to dentists and dental professionals. The main principles are to:
 - put patients' interests first and act to protect them
 - respect patients' dignity and choices

- protect the confidentiality of patients' information
 - co-operate with other members of the dental team and other healthcare colleagues in the interests of patients
 - maintain their professional knowledge and competence
 - be trustworthy.
- Further guidance documents including consent, confidentiality, team working, complaints handling, raising concerns, management responsibility and ethical advertising are available. See <http://www.gdc-uk.org/Dentalprofessionals/Standards/Pages/default.aspx>.

GENERAL MEDICAL COUNCIL (GMC)

- The GMC's *Good Medical Practice* (2006) sets out the high level principles of good practice expected of all doctors. The underpinning principles are to:
- make the care of patients the first concern
 - protect and promote the health of patients and the public
 - provide a good standard of practice and care by keeping professional knowledge and skills up to date, recognising and working within the limits of competence, and working with colleagues in ways that best serve patients' interests
 - treat patients as individuals and respect their dignity
 - work in partnership with patients, including giving patients the information they want or need in a way they can understand and supporting patients in caring for themselves to improve and maintain their health
 - be honest and open and act with integrity.
- A new edition of *Good Medical Practice* will be published in March 2013 (and come into effect in April 2013).
- The GMC has developed a range of learning materials to help doctors understand and apply the guidance in their daily practice. These include e-learning modules, interactive decision-making flow-charts and vignettes, and an interactive web section known as *Good Medical Practice in Action*. The GMC has reported a 20 per cent increase in visits to the standards guidance pages of its website since the launch of *Good Medical Practice in Action*.
- Explanatory guidance provides more detail on a range of topics. New guidance has been issued in six areas, including assisting suicide, leadership and management, and raising concerns about patient safety. Nine pieces of explanatory guidance will be published alongside the new edition of GMP in March 2013. These include use of social media and acting as a witness in legal proceedings. A full list of ethical guidance is available at http://www.gmc-uk.org/guidance/ethical_guidance.asp.

GENERAL OPTICAL COUNCIL (GOC)

- The GOC introduced new codes of conduct in 2010: one for individual registrants and another for business registrants ('optical businesses' registered with the GOC).
- The *Code of Conduct* (2010) for individual registrants includes the following principles of good practice:
 - making the care of the patient the first and continuing concern
 - being honest and trustworthy, and treating patients with respect
 - listening to patients and respecting their views
 - maintaining adequate patients' records
 - respecting the rights of patients to be fully involved in decisions about their care
 - keeping professional knowledge and skills up to date; recognising, and acting within, the limits of professional competence
 - ensuring that financial and commercial practices do not compromise patient safety
 - respecting and protecting confidential information
 - making sure that personal beliefs do not prejudice patient care
 - protecting patients where a colleague may not be fit to practise
 - never abusing professional position and ensuring conduct does not damage public confidence in the profession.
- The *Code of Conduct for business registrants* (2010) provides that they must take reasonable and proportionate steps to:
 - Avoid contributing to or causing a breach of the *Code of Conduct for Individual Registrants* by any individual registrant employed or otherwise engaged by it to provide optical services
 - ensure that individual registrants are always able freely to exercise their professional judgement in the best interests of patients
 - provide a system for the proper maintenance of patient records
 - respect and protect confidential information in accordance with current legislation
 - ensure that advertising or publicity complies with appropriate advertising codes of practice
 - provide mechanisms to enable concerns about risks to patients to be raised
 - protect patients if an individual/business registrant or other health professional may not be fit to practise
 - ensure that financial and commercial practices do not compromise patient safety.
- The GOC does not provide its own professional supporting guidance, but it does review guidance by other relevant bodies. These are available on its website (http://www.optical.org/en/Standards/Professional_guidance.cfm).

GENERAL OSTEOPATHIC COUNCIL (GOSC)

- The standards required of osteopaths to ensure quality care for patients and to protect them from harm are set out in the *Osteopathic Practice Standards* (2012). These comprise both the code of practice and standard of proficiency for osteopaths, concentrating on four main themes:

- communication and patient partnership
 - knowledge, skills and performance
 - safety and quality in practice
 - professionalism.
- The standards were only recently introduced (September 2012) and were consulted on before implementation.
 - The GOsC has a publications page that details its publications including its magazine, public information leaflets and annual reports (<http://www.osteopathy.org.uk/resources/publications/>).

GENERAL PHARMACEUTICAL COUNCIL (GPHC)

- *Standards for conduct, ethics and performance* (2012) set out the behaviours, attitudes and values expected of pharmacy professionals and explain the standards that all pharmacy professionals must comply with.
- The standards apply to pharmacists and pharmacy technicians. The seven underlying principles are as follows:
 - to make patients the first concern
 - to use professional judgement in the interests of patients and the public
 - to show respect for others
 - to encourage patients and the public to participate in decisions about their care
 - to develop professional knowledge and competence
 - to be honest and trustworthy
 - to take responsibility for working practices.
- The GPhC has also produced *Standards for registered pharmacies* (2012).
- The code is supported by guidance documents on areas such as obtaining patient consent, patient confidentiality, raising concerns and maintaining clear sexual boundaries (<http://www.pharmacyregulation.org/standards/guidance>).

HEALTH AND CARE PROFESSIONS COUNCIL (HCPC)

- The *Standards of conduct, performance and ethics* (2012) require registrants across the 16 health and social care professions it regulates to:
 - act in the best interests of service users
 - respect the confidentiality of service users
 - keep high standards of personal conduct
 - provide (to the HCPC and any other relevant regulators) any important information about their conduct and competence
 - keep professional knowledge and skills up to date

- act within the limits of their knowledge, skills and experience and, if necessary, refer the matter to another practitioner
 - communicate properly and effectively with service users and other practitioners
 - effectively supervise tasks that they have asked other people to carry out
 - get informed consent to provide care or services (so far as possible)
 - keep accurate records
 - deal fairly and safely with the risks of infection
 - limit their work or stop practising if their performance or judgement is affected by their health
 - behave with honesty and integrity and make sure that their behaviour does not damage the public's confidence in them or their profession
 - make sure that any advertising is accurate.
- The HCPC also publishes standards of proficiency for each regulated profession, which are standards to make sure the professions work safely and effectively – see <http://www.hpc-uk.org/aboutregistration/standards/standardsofproficiency/>.

NURSING AND MIDWIFERY COUNCIL (NMC)

- *The code: standards of conduct, performance and ethics for nurses and midwives* (2008) is the professional code for nurses and midwives. It has four underlying principles:
- make the care of people your first concern, treating them as individuals and respecting their dignity
 - work with others to protect and promote the health and wellbeing of those in your care, their families and carers, and the wider community
 - Provide a high standard of practice and care at all times
 - be open and honest, act with integrity and uphold the reputation of your profession.
- The standards address the following areas:
- nursing and midwifery education, leading up to qualification as a nurse or midwife
 - nursing and midwifery education, throughout a nurse or midwife's career
 - administration, dispensing and storage of medicines
 - supervision of midwives
 - registration of nurses and midwives who trained outside of the UK
 - nurses and midwives with a qualification to prescribe medicines.
- In addition to the code, the NMC sets a range of other standards and guidance covering various areas of their practice, for example medicines management, record keeping and the care of older people. See <http://www.nmc-uk.org/Publications/Standards/>.

PHARMACEUTICAL SOCIETY OF NORTHERN IRELAND (PSNI)

- The PSNI has produced the *Code of Ethics* (2009), which has eight mandatory principles and obligations that explain the required standards of professional behaviour required of a pharmacist. These are:

- make the safety and welfare of your patients your prime concern
 - respect and protect confidential information
 - show respect for others
 - exercise professional judgement in the interests of patients and the public
 - encourage patients (and/or their carers as appropriate) to participate in decisions about their care
 - maintain and develop professional knowledge and competence
 - act with honesty and integrity
 - provide a high standard of practice and care at all times.
- The code is supported by a range of guidance documents, including on raising concerns, advertising and internet pharmacy services (<http://www.psn.org.uk/about/code-of-ethics-and-standards/>).
- The PSNI has also published *Standards for registered pharmacy premises (community)* (2010). The standards are designed to be used as a self-audit tool and for use by pharmacy inspectors, and include checklists. Standards are broken down by essential and desirable requirements.

SOLICITORS REGULATION AUTHORITY (SRA)

- The SRA has a *Code of Conduct* (2011) which forms part of the SRA Handbook (<http://www.sra.org.uk/handbook/>). Authorised firms and individuals providing legal services must adhere to ten principles:
- uphold the rule of law and the proper administration of justice
 - act with integrity
 - not allow their independence to be compromised
 - act in the best interests of each client
 - provide a proper standard of service to their clients
 - behave in a way that maintains public trust in legal services
 - comply with legal and regulatory obligations and deal with regulators and ombudsmen in an open, timely and co-operative manner
 - run business or carry out their role in the business effectively and in accordance with proper governance and sound financial and risk management principles
 - run business or carry out their role in the business in a way that encourages equality of opportunity and respect for diversity
 - protect client money and assets.

Appendix A4: REGISTRATION

Regulator	Registrants	Annual fee
BSB	15,000 barristers	Ranging from £136 to £1,511 (depending on length of service, employment status or whether a QC)
GCC	2,658 chiropractors	£800
GDC	38,609 dentists 62,208 dental professionals	£576 (plus £72 for each specialist area) £120
GMC	252,469 doctors	£185 (first full registration with a licence to practise) £390 (full registration with a licence to practise, including specialist and GP) £90 (provisional registration with licence to practise)
GOC	25,000 optometrists, dispensing opticians, students opticians and optical businesses	£260 (£160 for low income category), individual registrants and bodies corporate £30 (specialty registers) £20 (students)
GOsC	4,400 osteopaths	£375 (year one), £500 (year two), £675 (year three)
GPhC	45,345 pharmacists 20,766 pharmacy technicians 13,850 pharmacy premises	£240 £108 £221
HCPC	308,000 registrants, across 16 professions	£76 (new UK graduates) £152 (renewal fee for two years)
NMC	671,668 nurses and midwives	£100 (increased in February 2013 from £76)
PSNI	2,101 pharmacists	£372
PSNI	548 pharmacy premises	£155
SRA	120,000 solicitors	£122-£344 (fees vary according to when paid in year)

BAR STANDARDS BOARD (BSB)

- A new registration process has recently been introduced to deal with new practising certificate rules (authorisation to practise). The registration process requires barristers to:
 - verify their contact details, practising status and entitlement to exercise reserved legal activities
 - confirm they have completed CPD
 - declare that they have indemnity insurance
 - paid their practising certificate fee
 - sign a declaration of truth, which is designed to ensure understanding of the process and new system.
- During 2011/12, the BSB introduced an online registration system.
- The BSB has a complex fees structure, which involves a fee for the practising certificate (that can only be applied in relation to particular activities) and a fee for members' services. Fees differ for employed and self-employed barristers, and number of years since called to the bar. Fees are reduced for those on 'relatively low income'.

Revalidation

- No information identified on the BSB's website or in its latest annual report.

GENERAL CHIROPRACTIC COUNCIL (GCC)

- The GCC application for registration requires a character reference, medical report, identification evidence, professional indemnity insurance and certificates of good standing from other regulators. Annual renewal can be completed online.
- Those applying for registration with a foreign qualification not recognised by the GCC are expected to complete and pass tests of competence.
- The GCC reduced its registration fees by £200 in 2011 following complaints from professional associations. Its fees are amongst the highest of the medical regulators, which may reflect that almost all chiropractors operate in private practice.

Revalidation

- The GCC is continuing work to develop a scheme for revalidation that will:
 - assure the public of chiropractors' continuing fitness to practise
 - enhance patient safety and the quality of care that patients receive
 - help chiropractors demonstrate that they are up to date and fit to practise.
- It is currently consulting on its proposals for revalidation.

GENERAL DENTAL COUNCIL (GDC)

- The GDC has two separate registers with different sets of fees – one for dentists and one for dental professionals.
- To register, applicants are required to provide the following information:
 - proof of identity
 - certified copy of qualification certificate
 - a character reference
 - health certification
 - self-declaration and payment.

They may also be required to undergo an individual assessment of their knowledge and skills or an examination.

Revalidation

- The GDC is working to introduce revalidation for dentists and has carried out a public consultation in 2010. It subsequently published *Revalidation: Post-consultation statement on revalidation for dentists* (2011), which outlined the need for further research to ensure that revalidation is in line with the Government's recommendations for proportionality. The GDC intends to engage in further public consultation as its model develops.
- The GDC is undertaking further work to decide its approach to revalidation of other dental care professionals.

GENERAL MEDICAL COUNCIL (GMC)

- Doctors must be registered with a licence to practise with the GMC to practise medicine in the UK. The online register is called the List of Registered Medical Practitioners. The List shows if a doctor is on the Specialist and/or GP Register.
- The information required to register with the GMC depends, amongst other things, on whether it is the first application for registration, an application from an international medical graduate, or from a doctor with EC rights. For more information see <http://www.gmc-uk.org/doctors/applications.asp>.

Licensing

- The GMC introduced licensing in 2009 as the first step towards the introduction of revalidation. Licences require periodic renewal by revalidation, which means doctors must demonstrate to the GMC that they are practising in accordance with the generic standards of practice set by the GMC.
- Doctors on the GMC's Register of Medical Practitioners can be:
 - registered with a licence to practise or
 - registered without a licence to practise.
- Doctors registered *with* a licence to practise are able to legally practise medicine in the UK and to legally undertake any of the activities restricted by law to doctors holding a licence, such as writing prescriptions or signing death certificates. They are subject to the requirements of revalidation, are required to follow the GMC's guidance contained in Good Medical Practice and are subject to fitness to practise actions.
- Doctors registered *without* a licence to practise are not legally able to practise medicine in the UK, or to write prescriptions, sign death certificates or undertake any of the activities restricted by law to doctors holding a licence. They are not required to participate in revalidation, however they are required to follow the GMC's guidance and are subject to fitness to practise actions.

Revalidation

- Revalidation started on 3 December 2012. It is the process by which licensed doctors are required to demonstrate on a regular basis (usually every five years) that they are up to date and fit to practise. It aims to give extra confidence to patients that their doctor is being regularly checked by their employer and the GMC. The majority of licensed doctors in the UK are expected to revalidate for the first time by March 2016.
- Patient feedback is one of the six types of supporting information that a doctor must collect about their practice for revalidation. Doctors are required to review this feedback with their appraiser. The GMC has developed a patient questionnaire for doctors and their organisations to use. Doctors are not required to use this questionnaire, but they must follow the guidance that the GMC has published, to ensure that meaningful and accurate feedback is sought from patients. Doctors are also expected to bring a review of any complaints or compliments they have received from patients to each annual appraisal.

Performance against target

- Registration performance against targets in 2011:
 - respond to 95 per cent of applications within five working days – 100 per cent
 - answer 90 per cent of calls within 15 seconds – 91 per cent
 - see 95 per cent of doctors visiting reception within ten minutes of their arrival – 97 per cent
 - answer 95 per cent of emails and letters (enquiries) within five working days – 98 per cent
 - answer 95 per cent of emails and letters (updates) within five working days – 97 per cent
 - respond to 95 per cent of complaints within ten working days – 97 per cent.

Change and reform

- The GMC has a range of initiatives underway in this area, for example:
 - It has proposed limiting the length of time for which doctors can hold provisional registration to three years
 - it has been reviewing its test for doctors from outside Europe who want to register in the UK
 - it has introduced e-billing to enable registrants to receive their bill for fees in a quick and convenient way, and to manage their account details online. Registrants can also download and print a Certificate of proof of entry on the Register and choose to receive reminders by SMS text message. A paperless Direct Debit service allows doctors to set up a Direct Debit through GMC Online and over the telephone.

GENERAL OPTICAL COUNCIL (GOC)

- The GOC maintains registers for optometrists, dispensing opticians, student opticians and optical businesses. It also has a specialty register.
- Applicants for registration have to provide the following:
 - a health declaration

- details of any criminal convictions, cautions or investigations, or disciplinary proceedings which have been taken against them or are currently pending
 - proof of professional indemnity insurance (full registrants only).
- The GOC has produced a useful leaflet for members of the public entitled *Check your optician is registered* (undated).
 - The GOC aims to process most registration forms within three working days. It has an online registration system called 'MyGOC', although this cannot be used by optical businesses. This has enabled a higher number of registrants to renew by the deadline than previous years. The GOC is currently reviewing its policies and legislation around student registration and optical businesses, to see if any changes can be made to improve patient safety.
 - The GOC recently reduced its registration fees (which are the same for individual registrants and bodies corporate) by £10. It has also introduced a low income fee for registrants whose gross annual income is less than £12,000.

Revalidation

- In 2010, the GOC consulted on its revalidation scheme, including whether a licence to practise should be included within it. The profession considers itself as low risk. There was no other information about revalidation on the GOC's website since the 2010 consultations.

GENERAL OSTEOPATHIC COUNCIL (GOSC)

- Registration requirements are as follows:
 - proof of qualification
 - registration fee
 - character reference
 - health reference
 - Disclosure and Barring Service or other police check
 - passport-sized photograph if an identity card is required
 - proof of adequate professional indemnity insurance for a minimum cover of £2.5 million.
- As with the GCC, overseas osteopaths must take a test of competence if they do not hold a recognised qualification.
- Renewal is required each year, at which point the GOSC checks that osteopaths have current professional indemnity insurance and have met mandatory CPD requirements. The fees system increases from years one to three, and is then maintained at this level.
- The GOSC has introduced a voluntary identity card system for osteopaths.

Revalidation

- The GOsC is being advised on revalidation by three working groups: Revalidation Standards and Assessment Working Group, Revalidation Public and Patient Involvement Group, and Research Working Group. It has produced a useful poster summarising the development of its model (www.osteopathy.org.uk/uploads/revalidation_poster.pdf).
- Revalidation was piloted with 263 osteopaths between October 2011 and September 2012. It was funded by a Department of Health grant. In February 2013, the GOsC published an independent evaluation of the pilot. It also commissioned an independent review of the work undertaken by other regulators to outline, costs, benefits, financial and regulatory risks (for details, see www.osteopathy.org.uk/uploads/work_done_by_other%20regulators_kpmg.pdf)

GENERAL PHARMACEUTICAL COUNCIL (GPhC)

- The GPhC maintains registers for the registration of pharmacists, pharmacy technicians and pharmacy premises. Registration must be renewed annually.
- The GPhC has produced guidance on *Criteria for registration as a pharmacist* (2012), which includes education, training and experience requirements, as well as health, character and identity checks. In order for a trainee pharmacist to enter the register, they must pass the GPhC's registration exam. Pharmacy technicians are not required to take the same exam.
- The GPhC ensures that registrants (pharmacists and pharmacy technicians) complete a fitness to practise declaration during their annual renewal process and regularly undertake continuing professional development activities.
- The GPhC has the power to prosecute when illegal practice occurs. Pharmacy technicians have only been required to register since 1 July 2011 and the GPhC is therefore monitoring the impact of the introduction of the new requirements for compulsory registration and how employees and employers respond to it.
- The GPhC introduced a 10 per cent reduction in renewal fees in October 2012.

Revalidation

- The GPhC has scoped the development of a programme of revalidation. It has met with stakeholders, reviewed evidence and looked at the challenges experienced by other health professions. It intends to develop different approaches for revalidation depending on areas of pharmacy practice. The GPhC does not expect to introduce revalidation until 2014/15.

- The HCPC regulates 16 health, psychological and social work professions.
- The HCPC's Registration Department has adopted a range of service standards, including:
 - processing UK applications and readmission forms within ten working days and undertaking an initial assessment of international and EEA applications within 16 weeks
 - processing CPD audits within three months
 - processing renewal forms on paper within 10 working days – within five minutes when using the online renewal system
 - responding to complaints within 18 working days
 - responding to emails within 48 hours and answering 80 per cent of calls within 30 seconds.
- In response to queries from employers and managers, the HCPC has developed a simple way to check the register. Up to 100 registration records can be searched for at any one time.
- Before an applicant can join the Register, the HCPC undertakes the following checks:
 - character – a character reference and details of any convictions or cautions
 - health – a health declaration
 - standards of conduct, performance and ethics – applicants are asked to sign a declaration to confirm that they have read and will keep to the standards once they are registered
 - standards of proficiency for the relevant profession – as above.
- Registrants renew their registration every two years. This involves paying a renewal fee and signing a professional declaration confirming that they have continued to practise since the last registration, or, if they have not practised, that they have met the HCPC's return to practice requirements. They are also confirming that they continue to meet the HCPC's standards of proficiency, there have been no changes to their health or good character, and that they continue to meet the HCPC's standards for CPD.
- Fees can be paid by direct debit, cheque, postal order or bankers draft. Each registrant can have their own online account by which to change address or contact details and change payment methods.

Revalidation

- The HCPC maintains that it already has robust systems in place to ensure the continuing fitness to practise of registrants, including its registration renewals process, continuing professional development standards and fitness to practise processes. It is undertaking a series of projects to understand whether additional measures are needed.
- In 2008, the HCPC concluded that revalidation for the professions regulated by the HCPC was not necessary. However, a number of further pieces of work were identified as important to build the evidence base further. It is undertaking this work in three phases:

- **Phase One (current):** The first phase is focusing on whether additional measures are needed to ensure the continuing fitness to practise of registrants. The HCPC is undertaking nine projects that look at the current level of risk posed to the public by registrants, the systems already in place to identify any gaps where fitness to practise concerns may not be picked up, and the feasibility and cost of different revalidation approaches.
 - **Phases Two and Three:** If the HCPC decides that a system of revalidation is needed, phase two would develop its approach and phase three would involve operational implementation.
- In September 2011, the HCPC published a study into approaches to revalidation amongst UK health regulators (see www.hpc-uk.org)

NURSING AND MIDWIFERY COUNCIL (NMC)

- The NMC manages the largest register of healthcare professionals in the world.
- The information a nurse or midwife needs to provide in order to join the register varies according to whether they are a UK graduate, trained in the European Union or an EEA member state, or trained elsewhere in the world.
- To remain on the register, nurses and midwives must renew their registration every three years (periodic renewal). This requires that they:
 - keep their registration up to date – they must declare on a notification of practice form that they have met ‘Prep’ standards in the previous three years
 - pay an annual retention fee at the end of the first and second year of the registration period (this can be done online, by direct debit, by post or over the telephone)
 - satisfy the Registrar of their good health and character.
- Employers and the public can find out about a nurse or midwife’s registration by using the NMC’s online register. The Registrations Directorate is working to provide a secure, fully automated online service, and a variety of services are already available to use online. These include paying fees, setting up direct debits, changing address, and new EU and overseas applications.
- The NMC announced plans in February 2013 to review its overseas registration policy and procedure, with a view to introducing a clearer, better understood and more robust registration process for overseas applicants.

Revalidation

- The NMC has committed itself to implementing an effective system of revalidation for nurses and midwives, although it does not anticipate having the system in place before the end of 2015.
- In laying the groundwork for revalidation, the NMC has undertaken a programme of stakeholder engagement with around 1,700 stakeholders across the UK. It has also undertaken research to

help in the development of a risk-based model of revalidation. This has included analysis of key issues such as:

- how to evaluate risk, and what the key factors are in this
- the value of CPD
- the value of current Prep standards
- what other regulators have done
- methods of obtaining third party feedback
- the value of supervision and appraisal.

PHARMACEUTICAL SOCIETY OF NORTHERN IRELAND (PSNI)

- The PSNI holds registers for pharmacists and pharmacy premises. The 2012 Pharmacy Order made CPD a mandatory part of registration. The PSNI operates a paper-based application and renewal system. The registers are available online.
- In order to register, pharmacists must:
 - complete a Master of Pharmacy Degree (MPharm), at an accredited UK university
 - complete one year's pre-registration training
 - complete the PSNI's registration exam
 - complete online training with regard to first aid, law and ethics, controlled drugs, patient medication review and records, improving medicines safety, the responsible pharmacist and minor ailments
 - meet the fitness to practise requirements for registration as a pharmacist. This involves completion of appraisal and Performance Standards Assessment Summary (with log of evidence) completed at specified intervals signed off by a tutor, together with a declaration form signed by a tutor confirming completion of pre-registration training and demonstration of competence.
- Once registered, they must maintain CPD and adhere to the *Code of Ethics* and Professional Standards. Pharmacists are required to make self-declarations regarding their fitness to practise, criminal convictions, health or conduct issues.
- Registration for new pharmacy premises involves completion of a one page form indicating the name of the body corporate or superintendent pharmacist, and detailing the internal layout of the pharmacy describing where medicines are to be sold, supplied, prepared, dispensed and stored. The form makes no reference to the *Standards for registered pharmacy premises* (2010).
- The annual retention form for pharmacy premises includes:
 - whether the pharmacy has a website and whether it supplies medicines over the internet
 - confirmation that the pharmacy record is maintained daily and displays appropriate information
 - requests for information on the services provided by the pharmacy (e.g. repeat dispensing, smoking cessation)
 - requests for information on pharmacy workforce data

- confirmation that employer checks have been completed (e.g. CPD compliance for employed registered pharmacists)
- additional information relating to, for example, whether the pharmacy has a dedicated area for private consultations.

Revalidation

- In 2011, the PSNI published research by the University of Manchester to provide evidence-based guidance to support the development of risk-based revalidation. In November 2012, the PSNI established a Revalidation Task Group to provide leadership on the future direction of a revalidation model for pharmacists in Northern Ireland.

SOLICITORS REGULATION AUTHORITY (SRA)

- The SRA maintains a 'roll' of solicitors. It does not hold a register or roll of firms but firms need to be recognised by the SRA to be able to provide legal services.
- Registration requirements vary according to whether the applicant seeks a practising certificate or registration as a registered European lawyer (REL) or registered foreign lawyer (RFL), for example. Requirements for firms depend on its business structure, for example, whether it is an ABS licensed body (see below), limited liability partnership (LLP), company, or sole practitioner.
- The SRA has developed 'mySRA' through which registrants can access their own online account for paying renewal fees, updating practising details and making a broad range of applications.
- In January 2013 the SRA completed its first year of authorising and regulating alternative business structures (ABS), which it credits with enabling innovation in the legal services market. The SRA was approved as an ABS licensing authority by the Legal Services Board (LSB) in December 2011 and started accepting applications on 3 January 2012. (ASB are a new type of law firm structure allowing non-lawyers and external investors to share management and control of law firms. This means that new types of law firm can be created, and businesses that could not previously offer reserved legal services will now be able to invest in law firms, and offer legal services in new, flexible ways.)
- The SRA has a complex fees structure for registered firms. The fees for individuals vary depending on the point at which the fee is paid during the year (ranging from £122 to £344). See <http://www.sra.org.uk/solicitors/pc-registration-renewal/fees/fee-policy-2012-2013.page> for further information.

Revalidation

- The SRA consulted solicitors about revalidation in 2008. At that time, over half of respondents felt that revalidation should not be introduced.

Appendix A5: EDUCATION AND TRAINING

BAR STANDARDS BOARD (BSB)

- The BSB oversees and administers all aspects of education. Its Education and Training Committee sets the standards of education and training necessary to practise as a barrister, together with the further training requirements that barristers must comply with throughout their careers.
- A Legal Education and Training Review, a joint initiative between legal regulators, is currently underway. This will be an evidence-based review of education and training requirements.
- The BSB undertakes annual monitoring visits to each bar professional training course provider (BPTC), of which there are approximately 11 institutions. It uses a risk-based approach, with a 'lighter touch' where the course provider is trusted. It also administers the BPTC application system and annual revisions of various handbooks including BPTC and Pupillage.

CPD

- In the first three years of practice, barristers are required to undertake 45 hours of CPD to include advocacy and ethics training. Thereafter, barristers are required to undertake 12 hours of CPD per year. The Education and Training Committee sets the standards relating to CPD.
- In 2011/12, a BSB working group began a review of CPD review, which will feed into Legal Education and Training Review. Work is expected to be complete in late 2013, with any changes to the CPD system taking place in 2014/15.

GENERAL CHIROPRACTIC COUNCIL (GCC)

- The GCC's Education Committee, comprised of registrant and lay members, advises Council on matters relating to education and training, including standards. Its members make up the inspection panel when visiting institutions.
- Quality assurance of educational institutions includes a rolling programme of visits to ensure that new programmes meet the requisite standards. New programmes must get formal approval from the Privy Council for the degree to be recognised for the purposes of the Chiropractors Act 1994.
- Three institutions are currently recognised. They undergo annual monitoring, which includes visiting panels meeting with patients and the public.

CPD

- Chiropractors are required to complete 30 hours of CPD per year, reporting this online or using a paper-based system. Fifteen hours of learning must take place with others.
- CPD must either improve the care chiropractors give their patients or develop the chiropractic profession. A review of CPD for chiropractors is currently underway.

GENERAL DENTAL COUNCIL (GDC)

- The GDC quality assures all courses (programmes) leading to registration as a dental professional through submissions, annual monitoring (through questionnaires) and inspections. The *Quality Assurance Process* (2012) document contains full details.
- The GDC does not quality assure individual educational and training providers, although it can investigate complaints about them and withdraw approval (sufficiency) of a training programme.
- The GDC's *Standards for Education* (2012) require that providers can only pass students who meet a set of learning outcomes. These are set out in *Preparing for Practice* (2012), which contains separate outcomes for dentists and each of the different categories of dental care professionals.
- Inspections are carried out by teams of four to five, comprising registrants and lay people. Inspections of new programmes take place within the first year of completion for a set of students. Once registered, programmes are normally inspected every five years.
- The GDC has a different legal relationship with dentistry programmes to dental care professional programmes. In cases where approval of a dentistry programme is withheld, the GDC must petition the Privy Council to remove the provider from the list of dental authorities. This action is not necessary where the GDC withholds approval of a dental care professional programme.
- The GDC is currently developing its quality assurance processes and is giving consideration to a risk-based approach to inspections.

CPD

- CPD was made compulsory for dentists in 2002 and for dental care professionals in 2008. There are separate CPD requirements for dentists and dental care professionals, which include recommended topics for CPD.
- *Continuing professional development for dentists* (2012) requires a dentist to do 250 hours of CPD over a five year period, 75 hours of which has to be 'verifiable CPD'.

- *Continuing professional development for dental care professionals* (2012) requires a dental care professional to do 150 hours of CPD over a five year period, 50 hours of which has to be 'verifiable CPD'.
- The GDC carries out an audit at the end of each five year cycle and the registrant may be required to submit their full CPD record, including documentary proof of verifiable CPD.
- CPD requirements are currently under review.

GENERAL MEDICAL COUNCIL (GMC)

- On 1 April 2010, the GMC assumed statutory responsibility for regulating all stages of medical education and training. It discharges its legal function in two main ways: first, by setting standards and requirements for education and training; and, second, checking that these are met through quality assurance activity.
- The GMC is currently undertaking a comprehensive review of its approach to quality assuring medical education and training (this will conclude towards the end of 2013; to find out more see www.gmc-uk.org/education/10932.asp). To inform its review, the GMC commissioned research to identify good practice in how the provision of education is quality assured by other regulatory bodies (see report by Colin Wright Associates 2012, available at www.gmc-uk.org).

Quality Improvement Framework

- The GMC introduced a new Quality Improvement Framework during 2011, to provide a more coordinated approach to quality assurance. Under the new Framework, the GMC has begun conducting integrated regional visits to deaneries and medical schools.
- The GMC also publishes reports on notable practice and learning points, as well as case studies to support medical schools in implementing standards that they find challenging.
- The GMC also established a Quality Scrutiny Group to bring a consistent view across the quality assurance of all stages of education and training, helping to provide scrutiny and identify priorities and themes. The Group considers annual returns from medical schools and deaneries, as well as the results of the survey of junior doctors – the national training survey – which the GMC conducts annually.
- The GMC has evaluated the case for mandatory or voluntary registration of medical students, and has decided to revisit the issue in 2015. In the meantime, it is implementing a programme of enhanced engagement with medical students, including making provisional registration more straightforward.
- The GMC is currently reviewing the challenges that disabled medical students and trainee doctors face at all stages of education and training and any implications for the regulatory framework. For further details, go to <http://www.gmc-uk.org/education/12680.asp>

- The GMC has sought views on new arrangements for the recognition and approval of trainers. By July 2013 local systems will be in place and all trainers in four specified roles will be fully recognised by July 2016.
- The GMC's Education Strategy for 2011-2013 provides further details of its priorities (see http://www.gmc-uk.org/Education_strategy.pdf_39254208.pdf).

CPD

- The GMC published new guidance on Continuing Professional Development (CPD) in 2012, following a two-year review and consultation. Details of how the guidance was developed can be found at: http://www.gmc-uk.org/education/continuing_professional_development/reports.asp
- The guidance is built upon the following principles of continuing professional development:
 - responsibility for personal learning
 - reflection
 - scope of practice
 - individual and team learning
 - identification of needs
 - outcomes.
- The guidance describes how doctors should plan, carry out and evaluate their CPD activities. It places importance on taking account of the needs of patients and of the healthcare team when doctors consider their own learning needs. Doctors are expected to reflect on the Good Medical Practice domains when evaluating their CPD needs. The guidance addresses the relationship between CPD and revalidation, as well as the use of appraisal, job planning and personal development plans in managing CPD. The responsibilities of others, such as employers and Colleges, in supporting doctors' CPD, are also addressed.

GENERAL OPTICAL COUNCIL (GOC)

- The GOC sets the criteria for, and assesses the quality and content of education provided for students. It also accredits qualifications which allow entry to the register. Nine universities currently offer optometry degrees and six institutions provide training courses for dispensing optometrists.
- The GOC uses an independent Visitor Panel to undertake regular quality assurance visits to the training institutions. The Panel comprises a mix of optometrists, dispensing opticians, those with specialty qualifications, ophthalmologists and lay members from educational backgrounds.
- During 2010-11, the GOC carried out 15 quality assurance visits to accredited training courses (including an optometry programme in Europe).

Continuing education and training (CET)

- CET is the GOC's equivalent of CPD, which is mandatory for registrants who can use the online system 'MyGOC' to maintain a record of their CET.
- Following a consultation in 2010, the GOC introduced a new CET system in January 2013. CET works on a three year cycle with a minimum requirement of 36 points. Changes include:
 - an expectation that registrants manage their CET across the three year cycle achieving at least six points per year
 - no automatic shortfall period
 - restrictions on the maximum number of points per cycle that can be gained via text-based distance learning (e.g. journals)
 - CET must be gained in each of the GOC's core competency units.
- Optometrists and contact lens opticians have to complete at least one peer review session each cycle, where they meet with colleagues to consider their own and others' decision making and record keeping on cases.
- Further information on the GOC's CET scheme is available in *Enhanced CET Scheme: Principles and Requirements v2.1* (2012).

GENERAL OSTEOPATHIC COUNCIL (GOSC)

- The GOSC works with ten higher education providers and a total of 19 'recognised qualifications'. The Education Committee considers how a course meets the standards. Initial approval needs to be made by the Privy Council.
- All courses are reviewed periodically. The GOSC works closely with the Quality Assurance Agency for Higher Education (QAA), which manages the quality assurance reviews on its behalf. The QAA inspects documentary evidence and conducts visits to the institution.
- The GOSC works closely with the Osteopathic Educational Institutions (OElS) to maintain high standards in osteopathic education. As part of this work the GOSC has:
 - monitored all recognised courses to ensure standards are maintained
 - scoped out the requirements for a review of the pre-registration curriculum
 - produced draft guidance for OElS on managing student fitness to practise
 - held a best practice seminar and regular meetings with OElS
 - commissioned research on graduate preparedness for practice
 - commissioned research on managing health and disability in osteopathic education.

CPD

- CPD is a mandatory required for continued registration. Osteopaths are required to complete 30 hours of CPD per year, 15 hours of which must involve learning with others. CPD can include

lectures, seminars, courses, practical sessions, individual study or other activities that can advance an osteopath's professional development, as well as postgraduate courses.

- Osteopaths are required to complete an annual summary form and to keep a record folder that can be submitted to the GOsC upon request as part of its audit arrangements.
- The GOsC has recently produced a discussion document on its CPD scheme (http://www.osteopathy.org.uk/uploads/cpd_discussion_document_public.pdf), and anticipates making new proposals for CPD in 2013/14, once its revalidation scheme has been considered further.

GENERAL PHARMACEUTICAL COUNCIL (GPhC)

- The GPhC's role in education and training is to:
 - set standards for the education and training of pharmacists and pharmacy technicians
 - accredit courses and approve qualifications for pharmacists and pharmacy technicians, including MPharm degree courses
 - assure the quality of pre-registration training
 - set and run the registration assessment for trainees seeking to become pharmacists
 - accredit courses for pharmacy support staff, including dispensing assistants and medicines counter assistants.
- There are 24 fully accredited pharmacy schools in Great Britain. Accreditation involves submission of a self-assessment document supported by documentary evidence, followed by an accreditation event attended by an accreditation team. The accreditation event may involve some or all of the following: site visit; meetings with academic, research, teaching and practice staff; meetings with senior management; meeting with students; viewing of teaching facilities. The GPhC only awards full accreditation status once a provider has been through the full process, which will normally take seven years. Until that point, provisional accreditation is awarded.
- Once a programme is accredited, it requires full accreditation every six years, with an interim site visit every three years. The accreditation methodology is set out in *The accreditation of MPharm degrees in Great Britain* (2011).
- Accreditation or recognition is undertaken by a dedicated panel, which includes lay members. The size and composition of the team will depend on the type of course being accredited.

CPD

- Registrants are required to document a minimum of nine examples of learning and development. At least three of the nine entries have to start with reflections on what the pharmacy professional needs to learn and why.

- The GPhC operates a 'call and review' process (a statutory process), which means that registrants are required by law to keep a copy of their CPD and to submit this on request. Most registrants expect their CPD records to be called every five years. The GPhC aims to 'call and review' approximately 10,000 cases over a six month period.

HEALTH AND CARE PROFESSIONS COUNCIL (HCPC)

- The HCPC sets the standards of education and training that an education programme must meet in order to be approved. The standards ensure that anyone who completes an approved programme meets the standards of proficiency for their profession and can apply for registration.
- The Education Department conducts approval visits to education providers to ensure their programmes meet the standards. Visiting teams consist of registered members of the profession and members of the public. Approval visit reports can be found on the HCPC website.
- Annual monitoring is a retrospective, documentary process to determine whether a programme continues to meet the standards of education and training. Annual monitoring involves two types of monitoring submissions: an audit or a declaration, depending on which of two groups the education provider is assigned to each year.
- If any changes are made that significantly impact on the provision of the programme, the HCPC will consider these via its major change process.
- The HCPC has guidance for education providers when preparing for an approval visit, completing annual monitoring submissions, or making significant changes to programmes.
- The HCPC produces *Education Update* to communicate with education stakeholders at three key points during the year.
- In addition to approving and monitoring approved programmes, the HCPC listens to concerns about an education or training programme. Its website contains the Education Provider Complaint Form for people who wish to make a complaint. The complaint may be reviewed by HCPC Partners (members of the profession who are independent from the case). On the basis of all the information gathered, a recommendation will be made to the Education and Training Committee. The Committee will decide whether any action is needed, such as undertaking a directed visit to the programme. It should take about six months to reach a final decision.
- During 2013-14 the HCPC will be conducting a comprehensive review of its education activities. In preparation for this, it is surveying education providers on the ways they engage with the HCPC as part of its approval and monitoring processes.

CPD

- The HCPC's standards for CPD require registrants to:

- maintain a continuous, up-to-date and accurate record of their CPD activities
 - demonstrate that their CPD is a mixture of learning activities relevant to current or future practice
 - seek to ensure that their CPD has contributed to the quality of their practice and service delivery
 - seek to ensure that their CPD benefits the service user
 - upon request, submit a written profile explaining how they have met CPD standards
- The HCPC provides a series of online resources for registrants to use when choosing CPD activities and writing a CPD profile (if selected for audit), including advice on how to meet the standards and an online presentation about the audit process.

NURSING AND MIDWIFERY COUNCIL (NMC)

- The NMC sets standards, guidance and requirements for nursing programmes of education across the UK. The NMC introduced new outcome-focused standards for pre-registration nursing education (SPNE) in September 2011.
- Following a review of its QA arrangements, the NMC decided to transfer the provision of QA from external to internal provision in 2012.
- It has a number of professional and QA forums, which is used to consider key components of the education standards and how implementation is managed and delivered.
- It is a requirement of its standards for pre-registration nursing education that service users contribute to programme design and delivery. Members of the public are invited to become involved in the approval process of nursing and midwifery programmes by contacting the health sciences faculty at their nearest university.

Prep

- As part of periodic renewal, nurses and midwives must declare on a notification of practice form that they have met the Prep standards in the previous three years. These are: 450 hours of registered practice and 35 hours of learning activity (Continuing Professional Development).
- It conducted an audit of its Prep arrangements in March 2012. A random stratified sample of 100 registrants was audited. This found that the Prep standards do not provide adequate assurance of registrants' continuing fitness to practise. This finding is informing the NMC's approach to revalidation.

PHARMACEUTICAL SOCIETY OF NORTHERN IRELAND (PSNI)

- The PSNI works alongside the GPhC in accrediting university pharmacy degrees.

CPD

- As of June 2013, CPD will become a statutory requirement. A new CPD framework consultation was launched in September 2012.
- The PSNI has an online CPD system. Registrants are required to undertake 30 hours of CPD per year. It describes CPD as a four stage cycle is comprised of:
 - reflection (identification of learning needs)
 - planning (what activities will be undertaken to meet the learning needs and when?)
 - action (documenting what was learned)
 - evaluation (deciding if learning needs were met and how this has been used in professional practice).
- In 2011 the PSNI assessed CPD portfolios of 199 registrants. Where registrants do not meet the standards they are entered into a reassessment process where the registrant can submit further information. Of the 23 that did not initially meet standards, ten did not pass reassessment and non-compliance notices were placed on their files.

SOLICITORS REGULATION AUTHORITY (SRA)

- The SRA sets qualifications standards and monitors performance. It also provides guidance to those interested in a career as a solicitor, including training contracts. The SRA is not responsible for the validation of Qualifying Law Degrees (QLDs) and law conversion courses – this responsibility falls with the Joint Academic Stage Board (JASB).
- The SRA carried out a work-based learning pilot looking at different ways of assessing competence in qualifying as a solicitor at the training contract stage. It has also been working with the Bar Standards Board (BSB) and ILEX Professional Standards (IPS) as part of the Legal Education and Training Review (LETR), which is being undertaken by The UK Centre for Legal Education (UKCLE).
- The SRA set up a Risk Centre in 2010 to ensure that monitoring and investigative activity was better targeted, through more effective use of intelligence and risk criteria. Distinctions are made between thematic risk – an issue that potentially could affect groups of firms or sectors of the legal services market, and risk inherent in an individual firm.
- The SRA has developed a risk-based approach to monitoring organisations – what it calls a supervisory approach, based on the level of risk posed by the firm. It has two approaches to supervise firms: desk-based supervision (immediate engagement with firms to discuss issues and

request information) and visit-based supervision (visits to address one-off events and thematic risks).

CPD

- The SRA has had a compulsory scheme of CPD since 1985. Those who work 32 hours per week or more must undertake a minimum of 16 hours CPD per year. They must record their activities and share it with the SRA on request.
- The SRA has commissioned research to examine how well CPD is operating within the profession and build on good practice, which will feed into the Legal Education and Training Review.

Appendix A6: HANDLING COMPLAINTS

BAR STANDARDS BOARD (BSB)

- Complainants are directed to the Legal Ombudsman if they have a complaint about a barrister acting for them. If the barrister is not acting for them, they can complain to the BSB about a barrister's behaviour (professional misconduct). Examples include misleading the court, failing to keep information confidential, acting dishonestly or in a way that damages the profession's reputation, discriminating because of race, sex, disability, religion or belief, sexual orientation, gender reassignment, age or marital/civil partnership status.
- The BSB has produced a leaflet entitled *How to complain about a barrister* (undated), which sets out how to make a complaint and the steps that the BSB will follow. Where the BSB's assessment team identifies a possible breach of the *Code of Conduct*, the case is handed to the Investigation and Hearings Team to investigate. During the second quarter of 2012/13 the BSB was working on 446 complaints. Of these, 142 complaints were closed without action and 19 were referred for disciplinary action.
- The BSB received 128 complaints about barristers in 2012. The most common allegations were 'discreditable/dishonest conduct' and 'misleading the court'.
- During 2011/12 an Independent Observer (a lay person) was appointed to provide independent assurance to the Board that the systems for complaints and the disciplinary process are operating in accordance with its procedures.

GENERAL CHIROPRACTIC COUNCIL (GCC)

- The GCC has an information leaflet for patients on how to complain about a chiropractor.
- The GCC will consider complaints and concerns about:
 - personal conduct
 - professional conduct
 - competence
 - health
 - criminal conviction.
- It cannot deal with complaints about companies or clinics, compensation or refunds of fees.
- The GCC investigates every complaint it receives, initially gathering information and obtaining a statement of evidence, giving the chiropractor the opportunity to respond to the complaint. The information is then forwarded to its Investigating Committee, which may seek further information before reaching its decision.

- In 2011, the GCC received 21 complaints. In previous years, the GCC received over 700 complaints in relation to claims made by chiropractors on websites, of which 583 were referred to the Professional Conduct Committee. This prompted the GCC to issue new guidance on this area.
- There is a separate process for complaints about the GCC.

GENERAL DENTAL COUNCIL (GDC)

- The GDC gives clear guidance to patients about how to complain, the three main ways being:
 - a practice's in-house complaints procedure
 - the NHS complaints procedure (if the treatment was provided on the NHS)
 - the Dental Complaints Service (if the treatment was private).
- In 2012, the GDC received 163 complaints.
- The GDC also gives advice about how to raise a concern about a dental professional. This advice, *How to report a dental professional to us* (2008), gives examples of the types of concerns that might be reported, including:
 - sexual assault or abuse
 - being under the influence of drink or drugs
 - fraud
 - seriously poor treatment
 - failure to get a patient's consent (permission) for treatment
 - not having professional indemnity insurance
 - cross-infection issues (for example, dirty equipment).
- The GDC also has an Illegal Practice (IP) team where members of the public can complain if they have concerns that a member of the public or DCP is practising illegally. In the *Council Performance Report Q3 2012*, 313 complaints were received.
- The GDC cannot provide compensation. The different stages of the investigation process are as follows:
 - First stage: a caseworker analyses the information and decides whether the GDC can deal with the case
 - Second stage: the Investigating Committee (IC) looks at the information gathered and decides whether to issue any advice/warnings, refer the matter to one of the three practice committees, or close the case
 - Third stage: a public hearing by one of the three practice committees. The complainant may be called as a witness at this stage. The GDC has produced a leaflet for witnesses entitled *Witness: Information for conduct case witnesses* (2010).
- Due to a backlog of cases, the GDC has commissioned the National Clinical Assessment Service (NCAS) to carry out a complaints review service. NCAS provides an independent opinion on whether the dentist complained about was performing to the standard expected.

Complaints about the GDC's service

- Complainants are invited to contact the GDC if they are not happy with the service that has been provided to them.

Dental Complaints Service (DCS)

- The DCS is a free service funded by the GDC to help resolve complaints about private treatment. It is reviewed by the GDC on an annual basis. The DCS is a non-statutory service with its own website. It has nine permanent staff members.
- The GDC's annual report for 2011 indicated that the DCS had received 1,708 complaints. The average time for resolution was 8 days. Of the complaints, 418 were referred to fitness to practise and 213 referred to the NHS. The running costs were £546,000.
- The latest annual review of the service (May 2011 - April 2012) showed the following:
 - 1,887 complaints had been received across the year
 - two thirds were resolved in less than a week
 - an average resolution time of 7.5 days.

GENERAL MEDICAL COUNCIL (GMC)

- The GMC emphasises that it values comments and complaints. It distinguishes four types of complaint.
- **Making a complaint about a GMC decision** (e.g. a decision not to investigate a complaint about a doctor, or not to refer a doctor to a public hearing following an investigation, or a data protection request) – the individual has the right of appeal. The GMC will not treat concerns as a complaint if they relate to an appealable decision.
- **Making a complaint about the services the GMC provides** – the GMC has a three stage complaints procedure and its aim is that this:
 - is easily accessible and well publicised
 - is simple and easy to understand
 - allows it to act quickly, with clear timescales for action – the GMC aims to answer any concerns within 10 working days
 - keeps complainants informed of progress
 - is fair, objective and free from discrimination
 - maintains complainant's and staff's confidentiality
 - treats everyone politely and with dignity
 - answers all the points and issues and provides appropriate redress.

Complaints can be made by email or letter. The website is BrowseAloud enabled and information about the complaints procedure is available on request in Braille, on audio cassette tape, on disk, in large print and in other languages

- **General feedback and comments about GMC services** – can be sent to the GMC’s Customer Service Manager, who will aim to reply within ten working days.
- **Making a complaint about a doctor.** The GMC is careful to articulate its role in relation to complaints. On its website, the GMC sets out what it cannot do, which is:
 - deal with concerns or complaints about anyone who is not a registered doctor
 - normally give the person who raised concerns a detailed explanation of what happened to them (this can only come from the doctor or health provider)
 - order a doctor to provide the treatment the person wants
 - pay compensation
 - fine a doctor
 - order the doctor to provide access to the person’s records
 - make a doctor apologise.
- The website has an interactive guide to help signpost which organisation to complain to. It gives contact details for support organisations across the UK, and explains the GMC process once it receives a complaint. If the complainant feels their complaint should go to the GMC they are asked to complete an online complaint form (or a paper version and submit it by post, www.gmc-uk.org/Complaint_form.pdf 3799687.pdf). The form begins by asking questions to determine whether the complaint is one the GMC would deal with. Complaints information is available in a number of languages and there are specific versions for Scotland, Northern Ireland and Wales.
- The GMC is mainly limited to taking action on serious concerns which call into question a doctor's fitness to practise and suitability to retain unrestricted registration. Most of the complaints it receives do not fall into that category. Where this is the case, the GMC refers the complaint to the doctor’s employer or contracting body (after seeking the complainant’s consent). It asks the employer/contracting body to confirm receipt and to seek reassurance that there are no fitness to practise issues that the GMC should be made aware of.
- All complaints are assessed and categorised as Stream 1 (complaints where it is immediately clear that the GMC needs to investigate) or Stream 2 (complaints which could justify action by the GMC only if they are part of a wider pattern of concern about a doctor – these are referred to the organisation where the doctor was working at the time the incident took place). The GMC will not normally investigate Stream 2 complaints that have already been considered locally and have not identified any concerns about the doctor's fitness to practise. It will continue to investigate Stream 2 cases where the concerns relate to a doctor's private practice or where the doctor is a locum.
- The GMC will not normally investigate complaints about matters that took place more than five years previously, unless it is in the public interest to do so.

- The GMC received 8,781 concerns about doctors' fitness to practise in 2011. This compared with 7,153 in 2010 – a year-on-year increase of 23 per cent. It follows a 24 per cent increase in 2010. The greatest increase was in complaints from patients.

Confidential helpline

- The GMC launched a confidential helpline at the end of 2012, staffed by specially trained advisors, for doctors who have concerns about patient safety, whether about individual doctors or organisations. There is also an online decision aid to help doctors report patient safety concerns.

Pilot 'meeting with patients' scheme

- In September 2012 the GMC launched a new Patient Information Service to improve the way it communicates with people who have made a complaint about a doctor. As part of this, the GMC is piloting two different meetings:
 - Meeting people after they make a complaint about a doctor – it will provide an opportunity to ask any questions about what happens when the GMC investigates a complaint and how the outcome is decided. It also enables the GMC to clarify particular aspects of the complaint. The GMC may also refer people to services to provide emotional support during the investigation.
 - Meeting people to explain the outcome – a patient information officer will offer to meet with the person who made the complaint after a decision has been made either at the end of an investigation or a panel hearing. They will explain next steps and the reasons for this and provide details of organisations that can offer further help.
- The pilot will last until the GMC has run 100 meetings and is limited to people living in Greater London and the North West region. It will then be independently evaluated before a decision is taken to extend the service across the UK. The service will not be offered where a complaint is closed because it is not relevant to a doctor's fitness to practise.

GENERAL OPTICAL COUNCIL (GOC)

- The GOC has a useful document entitled *What to expect from your optician* (undated), together with leaflets about how to complain and what standards are expected. It makes it clear that factors it can look at when investigating a complaint are:
 - poor professional performance
 - physical or mental problems which are affecting their work
 - inappropriate behaviour
 - being under the influence of alcohol or drugs at work
 - fraud or dishonesty
 - criminal conviction or caution
 - finding by another regulatory body.

- The GOC cannot:
 - arrange refunds or compensation
 - provide legal advice
 - provide a detailed explanation of what happened during a visit to an optical practice
 - make a GOC registrant apologise
 - order a GOC registrant to permit a patient access to their optical records
 - take action in response to false or misleading advertising.
- The GOC received 148 complaints during 2010-2011.
- The GOC investigates all complaints (which can take between three to nine months), which includes obtaining witness statements, records and other relevant documents, and giving the registrant a chance to make written representations. All complaints are then considered by the Investigation Committee.
- The GOC also investigates complaints about illegal practice and any complaints about its own service.
- The General Optical Council (GOC) has contracted with the Optical Consumer Complaints Service since 2007 to deal with consumer complaints. It deals primarily with matters of a contractual nature, such as poor service and practice, and conflicts between professional and commercial interests. In 2011, it received over 2,000 contacts and opened 820 cases.⁸

GENERAL OSTEOPATHIC COUNCIL (GOSC)

- The GOsC encourages patients to speak to the osteopath (or to use the practice's complaint procedure) before contacting the Council to see if the complaint can be resolved. Its *Making a complaint* factsheet (http://www.osteopathy.org.uk/uploads/making_a_complaint_leaflet.pdf) emphasises that complaints to the GOsC should relate to the osteopath's fitness to practise. It outlines its legal power where it is alleged that an osteopath:
 - has been guilty of unacceptable conduct
 - has been guilty of professional incompetence
 - has been convicted of a criminal offence
 - is unable to practise properly as an osteopath because of his/her physical or mental condition.
- In 2011/12, the GOsC received 20 complaints about registrants (nine from members of the public, six from fellow professionals and five raised by the Registrar). Complaints are initially considered by a screener (a registrant member of the Investigating Committee). The screener will consider whether the GOsC has powers to investigate the complaint and, if so, will refer the complaint to the Investigating Committee.

⁸ <http://www.opticalcomplaints.co.uk/2011%20Report%20Pages6-9.pdf>

- The GOsC also makes it clear about how to complain about a member of its staff or Council (see <http://www.osteopathy.org.uk/about/the-organisation/complaints-against-members/>). The GOsC has a complaints manager and commits to fully investigating all complaints.

GENERAL PHARMACEUTICAL COUNCIL (GPhC)

- The GPhC considers concerns/complaints about pharmacy professionals and registered pharmacies. It produces guidance on raising concerns about a pharmacist or pharmacy technician (<http://www.pharmacyregulation.org/raising-concerns/raising-concerns-about-pharmacy-professional/expectations>).
- The GPhC sets out the following examples of fitness to practice issues:
 - errors in dispensing medication
 - sexual misconduct
 - pharmacy professionals working under the influence of alcohol or drugs
 - fraud
 - theft
 - dishonesty.
- The GPhC will not investigate claims for compensation, customer service issues and contract issues.
- In 2011/12, the GPhC received 777 complaints relating to fitness to practise. Of these, 254 were closed at the first stage.
- The General Pharmaceutical Council uses its pharmacy inspectors to carry out investigations of complaints against individual pharmacy professionals. This involves visiting the pharmacy professional, carrying out interviews and taking witness statements from those involved. This investigation feeds into the complaints and fitness to practise processes.

Complaints about the GPhC's service

- In 2011/12, the GPhC received 292 complaints about its service, almost 50 per cent of which were in relation to its registration services. It has since initiated a review of its registration process and has made amendments to it.

HEALTH AND CARE PROFESSIONS COUNCIL (HCPC)

The HCPC distinguishes between four different types of complaint:

1. Raising a concern about a professional registered with the HCPC

- Anyone can contact the HCPC about a concern and there are no time limits. The HCPC will first assess whether the concerns are about fitness to practise. If it is something it can deal with, the case will be passed to a case manager in the Fitness to Practise Department, who will decide

whether it meets the 'standard of acceptance'. The standard of acceptance is that all the information must be in writing (by letter, email, or using a form on the website; where necessary statements can be taken over the phone and sent to the complainant to check and sign), identify the registrant, and set out the nature of the concerns in sufficient detail that the registrant is able to respond to them.

- When a case meets the standard of acceptance, the HCPC then takes responsibility for the case. This means that it will take the matter forward under its fitness to practise procedures. Where a case does not meet the standard of acceptance, the case is closed. In 2011–12, 340 cases were closed in this way – an increase of 36 per cent on the previous year.
- In 2011–12, most complaints (31 per cent) about registrants came from employers; the previous year, for the first time, members of the public were the largest group.
- Two research reports commissioned by the HCPC may be of interest to the RCVS:
 - *Scoping report on existing research on complaints mechanisms* (2009) available at www.hpc-uk.org/assets/documents/10002AACScopingreportonexistingresearchoncomplaintsmechanisms.pdf
 - *Expectations of the Fitness to Practise Complaints Process* (2010) available at www.hpc-uk.org/assets/documents/10003E52ExpectationsoftheFitnessToPractiseComplaintsProcess.pdf

2. Raising a concern about a social worker student in England

- In 2012 the HCPC agreed a new scheme to deal with concerns about social work students in England. It follows the HCPC's decision that social work students in England should not be registered by the HCPC. It believes that the most effective means of assuring the fitness to practise of social work students in England is through the standards of education and training (SETs) and the approval of education and training programmes. These standards will ensure that education providers have processes in place to deal effectively with concerns about the conduct of students.

3. Making a complaint about a HCPC decision

- Anyone dissatisfied with the outcome of a fitness to practise investigation or with concerns about the way in which the HCPC investigated or dealt with a fitness to practise concern, should contact the Director of Fitness to Practise at the HCPC.

4. Making a complaint about the service the HCPC provides

- Complaints and feedback about the HCPC should be sent by letter, email, or made over the telephone, to the Director of Operations. The HCPC aims to acknowledge receipt of feedback within three working days and to respond to complaints within 15 working days or, if further investigation is needed, to provide details of progress within 15 days.

Whistleblowing and raising concerns in the workplace

- The HCPC provides guidance to registrants on how raise and escalate concerns in the workplace.

NURSING AND MIDWIFERY COUNCIL (NMC)

Dealing with concerns and allegations about a nurse or midwife

- The NMC tends to refer to concerns, allegations and referrals, instead of complaints. It encourages the raising of concerns locally first, in recognition that employers can sometimes solve issues quickly and fairly without the need for involvement from the NMC. If the employer decides to refer the case to the NMC, they will be able to provide information from their investigation, which makes the process much quicker. Employers and the police refer most cases of alleged impairment to the NMC. In 2010-2011, just 23 per cent of referrals came from the public.
- Concerns must be set out in writing or using an online form (which includes a consent form to enable the NMC to share the referral with the nurse or midwife). The NMC provides on its website a list of organisations that can provide advice and support throughout the complaints process.
- The NMC aims to complete the initial assessment of a referral within 16 weeks; investigate the case within 12 months; and reach a decision and decide on actions within six months. A booklet for organisations that work with or represent patients provides further guidance (see www.nmc-uk.org/Documents/NMC-Publications/NMC-Complaints-against-nurses-and-midwives.pdf).

Making a complaint about the NMC

- The NMC introduced a new corporate complaints process in April 2012. It has a dedicated complaints manager within the Office of the Chair and Chief Executive to demonstrate a commitment at the highest level to responding appropriately to complaints. The complaints manager is responsible for following up the outcomes of complaints, ensuring that any learning is taken on board, and that any changes to policy or process are implemented as necessary. Regular reports are discussed by Council in open session. Having a complaints manager has provided a single contact point for complaints and meant that information is centrally logged and that the organisation is able to respond quickly where complaints indicate a problem.
- The NMC encourages complainants to first complain to a member of the team that deals directly with the area of concern. If the complainant is unhappy with the initial response to their complaint or would like a formal response, they can write to the complaints manager. Complaints can be made in writing or by email.
- The NMC aims to provide a response to complaints about its services within 20 working days.

PHARMACEUTICAL SOCIETY OF NORTHERN IRELAND (PSNI)

- The PSNI can deal with the following complaints:
 - complaints about the professional service provided by a pharmacist/pharmacy at all levels of healthcare (e.g. a dispensing error, wrong labelling, or out of date medicine supplied)
 - complaints about the conduct of a pharmacist e.g. unprofessional behaviour
 - complaints against owners of pharmacies including companies.
- It cannot deal with:
 - claims for compensation
 - complaints regarding other health professionals
 - employment issues (e.g. hours of work, contracts)
 - non-medical products (e.g. faulty hairsprays etc.)
 - contractual issues (e.g. hours of opening, charges for private prescriptions).
- In February 2013, the PSNI released new regulatory guidance on *Raising Concerns*.
- In 2011/12, the PSNI received 36 new complaints about registered pharmacists. Complaints are initially reviewed by the Registrar who can close cases relating to no or minor harm, or minor conduct issues (under established criteria). Where a complaint relates to recurrent, major or moderate harm, convictions or cautions, these cases are referred to the Scrutiny Committee.
- Of the 24 cases dealt with during 2011/12, the registrar closed 12, referred ten to the Scrutiny Committee and two were heard by the Fitness to Practise Committee. Eleven cases were closed in under ten weeks, seven further cases closed in less than a year, and six cases had been open for more than a year.
- The Scrutiny Committee consists of four members: two lay and two pharmacists. It met on eight occasions during 2011/12 and reviewed ten cases.

SOLICITORS REGULATION AUTHORITY (SRA)

- As part of its standards charter, the SRA will take complaints seriously and use feedback to improve its services.
- Consumers are advised to complain to the solicitor or firm first. Where the firm is not able to resolve the complaint to the consumer's satisfaction, they will need to approach the Legal Ombudsman. The Legal Ombudsman deals with all aspects of poor service.
- The SRA can deal with complaints about a solicitor or firm that has breached the principles of conduct. It does not have the power to award compensation for poor service, or to reduce or refund legal fees (although it can address non-payment of professional fees in certain circumstances where there is a County Court judgment in respect of the fee).

- The SRA also explains to the public how they can complain about the SRA. There is a two stage process, the first stage is to resolve the complaint by telephone or carry out a detailed review of the case. The second stage involves referral to the Complaint Team, which aims to respond within 20 days.

Appendix A7: FITNESS TO PRACTISE

Fitness to practise is a complicated area. The profiles provided here do not seek to describe in any detail the processes that regulators have in place. Instead, the focus is mainly on the types of allegations that fitness to practise committees can examine and the sanctions at their disposal.

BAR STANDARDS BOARD (BSB)

- The Professional Conduct Committee has the power to refer complaints to disciplinary action, decide to take no further action or dismiss a case due to lack of evidence.
- Where the BSB decides it should take action against a barrister, the Council of the Inns of Court establishes an independent disciplinary tribunal to hear a case. The panel comprises of lay people, barristers and, in some cases, judges. If charges against the barrister are approved, the disciplinary tribunal can issue a reprimand, a fine, a requirement to undertake professional development, a suspension or disbarment. If found guilty of professional misconduct, the result is published on the BSB's register and remains there for two years.
- In the second quarter of 2012/13, 19 new referrals to disciplinary action were made. Only 55 per cent of complaints were referred for disciplinary action within the target of six months.
- Where a barrister's fitness to practise is in question as a result of their health, information is initially heard by the Complaints Committee, which then refers the case to a Medical Panel. A preliminary hearing is held which may lead to a full hearing. A medical adviser is appointed to advise the panel.

GENERAL CHIROPRACTIC COUNCIL (GCC)

- The Investigating Committee considers all complaints against chiropractors received by the GCC. It has the power to order the Registrar to suspend registration. If it decides there is a case to answer it refers the matter to either the Health Committee or the Professional Conduct Committee.
- The Health Committee has the power to impose a 'Conditions of Practice' order or suspend the chiropractor's registration for a specified period. Hearings can be held in public or private as decided by the committee.
- The Professional Conduct Committee considers allegations of personal or professional misconduct or incompetence, referred to it by the Investigating Committee or the Health Committee. It can:
 - admonish the chiropractor
 - impose a 'Conditions of Practice' order
 - suspend the chiropractor's registration
 - order the Registrar to remove ('strike off') the chiropractor from the register.

- In 2011, all eight cases requiring a Professional Conduct Committee hearing were listed within the target of nine months of referral.
- The GCC is currently reviewing its fitness to practise procedures and seeking amendments to the legislation. These include introducing two Case Examiners to replace the Investigating Committee and amending the 'case to answer' test to the 'realistic prospect' test. It also intends to introduce new case management provisions for the Professional Conduct Committee which would allow it to:
 - cancel cases prior to a hearing where there is no realistic prospect of proving the case
 - allow procedural points to be resolved at case review meetings prior to the hearing
 - change from the criminal standard of proof to the civil rules of evidence
 - define who may be treated as vulnerable witnesses.

GENERAL DENTAL COUNCIL (GDC)

- The Investigating Committee has powers to:
 - close the case and take no further action
 - adjourn the case for further information
 - issue a letter of advice to the registrant
 - issue a warning letter to the registrant (it can direct that it is published on the GDC website)
 - refer the case to one of the three practice committees (professional conduct, professional performance, and health) for a full inquiry
- The IC may also commission an assessment from the National Clinical Assessment Service (NCAS), an independent and impartial agency, to assess the professional performance of a dentist.
- The Interim Orders Committee holds hearings in public and may:
 - impose a suspension (up to 18 months with six monthly reviews)
 - impose conditions (up to 18 months with six monthly reviews)
 - decide that no order is necessary.
- The three practice committees adopt the civil standard of proof in consideration of impairment of fitness to practise. Hearings are usually held in public.
- Where impairment is found, the Professional Conduct Committee (PCC) may:
 - issue a reprimand
 - impose conditions (for up to 36 months)
 - suspend the registrant (for up to 12 months)
 - erase the registrant from the Register.
- The Health Committee has the same set of sanctions available, except for erasure in cases where fitness to practise is impaired solely on the ground of adverse physical or mental health.

- The Professional Performance Committee (PrPC) considers allegations that a dental professional's performance is deficient. In cases where an NCAS assessment of the dentist was commissioned, the PrPC will consider the assessment report as part of a range of evidence in establishing whether or not a registrant's fitness to practise is impaired by reason of performance, and to determine what action needs to be taken. The PrPC has the same set of sanctions available as the PCC.

KPIs

- The GDC's *Council Performance Report Q3 2012* provides a summary of the GDC's performance in this area. For example, 83 per cent of cases completed the investigation stage within 6 months (target is 90 per cent) and 37 per cent of cases went from the Investigating Committee to hearing stage within the target of 9 months.

Improvements to process

- The GDC has experienced a high volume of cases over recent years and this has led to significant delays and a backlog of cases. In response to this, a major programme of change has been put into operation. The GDC's 'Fitness to Practise reforms' page (<http://www.gdc-uk.org/Governanceandcorporate/Pages/Fitness-to-practise-reforms.aspx>) provide further detail of the changes, which include:
 - scrutiny and amendment of casework procedures
 - more committee meetings and hearings scheduled
 - a new casework database system
 - a triage process
 - a clinical review service provided by the National Clinical Assessment Service to give an early view on the significance of clinical matters outlined in a complaint
 - a system of internal quality assurance and audit of cases.
- The GDC is considering introducing a new role for case examiners, who would be able to make some of the decisions that are currently made by the Investigating Committee (in the way that GMC case examiners do).

GENERAL MEDICAL COUNCIL (GMC)

- The GMC received 8,781 concerns about doctors' fitness to practise in 2011 – an increase of 23 per cent on the previous year. Research commissioned by the GMC to investigate the upward trend in fitness to practise concerns, suggested that factors driving the increase included changing attitudes on the part of doctors and the public towards raising concerns, and improved clinical governance.
- The GMC can take action if the doctor's fitness to practise is impaired by:
 - misconduct
 - poor performance

- a criminal conviction or caution in the UK (or elsewhere for an offence which would be a criminal offence if committed in the UK)
 - physical or mental ill-health
 - a determination (decision) by a regulatory body either in the UK or overseas.
- If it believes that a doctor's fitness to practise may be impaired it can:
- agree undertakings with the doctor
 - place conditions on their registration
 - suspend their registration
 - remove them from the medical register.
- If it believes their fitness to practise is not impaired but there has been a significant departure from the principles set out in *Good Medical Practice*, it can issue a warning to the doctor.
- How the GMC conducts its investigation depends on the nature of the concerns. It may involve getting further documentary evidence from, for example, an employer or the complainant, or an assessment of the doctor's performance or health. At any stage in the investigation the doctor can be referred to the Medical Practitioners Tribunal Service (see below) for an interim orders panel hearing.
- At the end of the investigation, two senior GMC staff known as case examiners, one medical and one non-medical, will review all the evidence collected and decide whether to:
- conclude the case with no further action
 - issue a warning
 - agree undertakings to address a problem, or
 - refer the case to the MPTS for a hearing.
- If they fail to agree, the case is considered by the Investigation Committee, a statutory committee of the GMC. The Investigation Committee will also consider a case when case examiners believe a warning is appropriate, but the doctor has disputed the facts, or requested a hearing of the Investigation Committee. The hearing will take place in public.
- Except for cases concerning a doctor's health, the GMC informs both the doctor and the complainant of the case examiner's decision and their reasons. Where the case concerns a doctor's health it will inform the doctor and the complainant of the case examiner's decision but their reasons will only be given to the doctor.

Medical Practitioners Tribunal Service (MPTS) hearings

- The MPTS makes decisions about doctors' fitness to practise. It is part of the GMC, but operationally separate and accountable directly to Parliament. MPTS panels consist of specially trained people, both lay and medical, who decide whether the doctor's fitness to practise is impaired and, if so, what sanction may be needed. Hearings are held at the MPTS hearing centre in Manchester (they are heard in public, except for health cases).

- At the end of a hearing, the panel may decide:
 - to take no action or issue a warning (if no impairment is found)
 - place conditions
 - suspend
 - remove the doctor's name from the medical register (so that they cannot work as a doctor in the UK for at least five years, and possibly for life).
- The MPTS panel may take into account any written undertakings made by the doctor, which may include restrictions on a doctor's practice or a commitment to practise under medical supervision or to undergo retraining.

Changes underway

- During 2012, the GMC consulted on proposals to change the rules which govern how the GMC investigates concerns and how cases are heard by fitness to practise panels.⁹ The aim is to make the pre-hearing and hearing procedure shorter and to make the rules simpler and more flexible. The proposals include:
 - improving witness scheduling
 - removing the need to read out the written allegations at the start of a hearing
 - routinely using written statements as evidence-in-chief
 - clarifying the process for use of video-link and telephone-link evidence at hearings
 - allowing case managers to make a broader range of decisions relating to preliminary issues
 - enabling panel chairs to be involved in pre-hearing case management.
- It is the first part of a larger piece of work to establish the Medical Practitioners Tribunal Service (MPTS) in statute to adjudicate concerns about doctors' fitness to practise. This follows the Government's decision not to proceed with the establishment of the Office of the Health Professions Adjudicator (OHPA).
- In 2011, the GMC consulted on proposals to change the way it deals with cases at the end of an investigation.¹⁰ The aim is to introduce a more proportionate approach that, where possible, supports the rehabilitation of doctors. As a result it agreed to:
 - make it easier to strike off doctors who are convicted of the most serious crimes
 - suspend doctors who refuse to co-operate with its investigation
 - meet with doctors at the end of an investigation into a complaint about their fitness to practise to explain the action it considers necessary to protect the public and maintain public confidence
 - allow doctors to accept the measure considered appropriate without a hearing if there is no significant dispute about the facts.
- Other reforms the GMC has sought to introduce have focused upon modernising the way hearings are run, speeding up the adjudication process and reducing the stress for all those

⁹ http://www.gmc-uk.org/The_future_of_adjudication_rules.pdf_48726068.pdf

¹⁰ http://www.gmc-uk.org/FTP_reforms_consultation_paper.pdf_38085201.pdf

involved. Proposals have included the use of legally qualified chairs, greater use of written evidence and more effective management of cases as they are prepared for hearings.

KPIs

- During 2011, the GMC was able to meet six of its seven service level targets for the timely handling of fitness to practise activity. This reflected more efficient case management through enhanced management controls and a new training regime for staff.
- Fitness to practise performance against targets in 2011:
 - To conclude 90 per cent of fitness to practise cases within 15 months (96 per cent)
 - To conclude or refer 90 per cent of cases at the investigation stage within six months (87 per cent)
 - To conclude or refer 95 per cent of cases at the investigation stage within 12 months (95 per cent)
 - To commence 90 per cent of panel hearings within nine months of referral (93 per cent)
 - To commence 100 per cent of Interim Orders Panel hearings within three weeks of referral (100 per cent)
 - To review 100 per cent of doctors with conditions or undertakings attached to their registration before being returned to unrestricted registration (100 per cent)
 - To commence 100 per cent of Investigation Committee hearings within two months of referral (100 per cent)

GENERAL OPTICAL COUNCIL (GOC)

- The GOC's Investigation Committee can decide to:
 - take no further action (and at the same time provide advice)
 - issue a warning
 - invite the registrant to attend a voluntary performance review
 - direct the registrant to undergo a performance assessment at their workplace
 - refer the allegation to the Fitness to Practise Committee, which will usually hold a public hearing to decide what action to take
 - issue interim orders to suspend or place conditions on registration.
- The Fitness to Practise Committee can consider:
 - whether a registered optometrist's or a registered dispensing optician's fitness to practise is impaired
 - a business registrant's fitness to carry on business as an optometrist or a dispensing optician (or both) is impaired
 - a student registrant's fitness to undertake training as an optometrist or a dispensing optician is impaired.
- Following a consultation in 2011, the GOC will be changing its fitness to practise rules with the aim of speeding up investigation of complaints. This will include the introduction of case examiners to consider complaints in lieu of the Investigation Committee.

GENERAL OSTEOPATHIC COUNCIL (GOSC)

- The GOSC can investigate the following types of allegation:
 - serious unacceptable conduct
 - professional incompetence
 - matters relating to ill health
 - criminal convictions.
- The following sanctions are available to the Professional Conduct Committee:
 - admonishment
 - conditions
 - suspension
 - removal from the register.

KPIs

- In 2011/12, the GOSC:
 - screened 20 cases in an average of 7 days (its target was 3 weeks)
 - considered its 18 cases at Investigating Committee within an average of 4 months (the target)
 - heard its 10 cases at Professional Conduct Committee within an average of 15.5 months (target was 13 months).

GENERAL PHARMACEUTICAL COUNCIL (GPhC)

- If a pharmacy professional's fitness to practise is found to be impaired the GPhC can:
 - issue a warning
 - impose conditions
 - suspend from practising
 - remove from the register.

The Inspectorate

- The GPhC is unique among healthcare professional regulators because it has its own Inspectorate. The inspectors (who are required to be registered pharmacists or pharmacy technicians) have two main roles:
 - inspecting registered pharmacy premises in order to monitor and secure compliance with relevant legal requirements and professional standards
 - investigating complaints and allegations involving registered pharmacists or pharmacy technicians.
- The cost for inspection in 2011-12 was £1.89 million. The GPhC currently has 26 home-based inspectors.

- The investigation may include speaking to the complainant, any witnesses and the pharmacy professional(s), and visiting the pharmacy premises. They may need to take witness statements from patients and the public, and interview pharmacy professionals or employees, and evidence may be seized.

Sanctions

- The Investigating Committee has the following powers:
 - warning
 - advice to the person concerned
 - advice to any other person or body involved in its investigation
 - dismiss the case
 - in relation to a health allegation, to require the person concerned to undergo a medical examination
 - agree undertakings
 - refer the matter to the Fitness to Practise Committee
 - initiate criminal proceedings.
- The Fitness to Practise Committee can impose the following sanctions where it finds impairment of fitness to practise:
 - warning
 - advice
 - conditions
 - suspension from the register (not exceeding 12 months)
 - removal from the register

KPIs

- The GPhC has sought to deal with cases more proportionately. It has reduced the fitness to practise caseload by 30 per cent and reduced the length of time for a fitness to practise hearing from three days to two. It GPhC aims to conclude cases within 15 months (it did not meet this target in 2011/12).

HEALTH AND CARE PROFESSIONS COUNCIL (HCPC)

- The HCPC can consider concerns about fitness to practise if the evidence shows that they:
 - were dishonest, committed fraud or abused someone's trust
 - exploited a vulnerable person
 - failed to respect service users' rights to make choices about their own care
 - have health problems which they have not dealt with, and which may affect the safety of service users
 - hid mistakes or tried to block the HCPC investigation
 - had an improper relationship with a service user
 - carried out reckless or deliberately harmful acts

- seriously or persistently failed to meet standards
 - were involved in sexual misconduct or indecency (including child pornography)
 - have a substance abuse or misuse problem
 - have been violent or displayed threatening behaviour or
 - carried out other, equally serious, activities which affect public confidence in the profession.
- The HCPC can also consider concerns about whether an entry to the HCPC Register has been made fraudulently or incorrectly.
- Where the HCPC takes on a case under its fitness to practise procedures it will carry out an investigation. It will then give the registrant an opportunity to respond to the information it has gathered. Details of the case will then be passed to the Investigating Committee to decide whether there is a 'case to answer'. Each panel is made up of at least three people, including someone from the relevant profession and a 'lay' person. The meeting is held in private.
- If it decides that there is a case to answer, the case will be heard by one of three committees: Conduct and Competence Committee, Health Committee, or another panel of the Investigating Committee.
- The HCPC has a specific person witnesses can contact in the Fitness to Practise Department for support and advice. It also provides a brochure called for anyone asked to be a witness (www.hpc-uk.org/assets/documents/10002D1CInformationforwitnesses.pdf).
- Panels have the power to:
- take no further action or order mediation (a process where an independent person helps the registrant and others involved agree a solution to any issues)
 - caution the registrant (place a warning on their registration details for between one to five years)
 - make conditions of practice that the registrant must work under
 - suspend the registrant from practising
 - strike their name from the Register.

NURSING AND MIDWIFERY COUNCIL (NMC)

- The NMC has experienced a 52 per cent increase in referrals over the past two years. It has allocated additional funds to fitness to practise, which has necessitated making fundamental changes to how the organisation operates, including reassessing a wide range of existing activities.
- In February 2013, the NMC reported improvements in its fitness to practise performance:
- average case investigation is 10 months, compared to more than 22 months two years ago
 - 22 substantive hearings take place each day, compared to 8 two years ago
 - Interim Orders are imposed on average within 26 days of referral, compared to 58 days two years ago.

- Ways in which the NMC has sought to strengthen its fitness to practise processes include:
 - introducing routine medical examinations for registrants with cautions or convictions for drink or drug-related offences
 - establishing internal quality assurance for key decision points (such as screening) in the fitness to practise processes
 - improving witness care and support
 - identifying and prioritising serious cases
 - engaging more closely with employers (referring approximately five cases per week back to employers)
 - improving case management: meeting key performance indicators (KPIs) of completing investigations within 12 months and adjudication of cases within six months
 - improving customer service by introducing a new “customer service” pledge for all participants in fitness to practise proceedings and implementing a 48 hour KPI for acknowledging all correspondence and a five day KPI for sending out decision letters – these are attributed with helping to improve the culture of customer care within fitness to practise.
 - introducing voluntary removal, whereby nurses and midwives who admit that their fitness to practise is impaired and who do not intend to continue practising can apply to be permanently removed from the register
 - introducing consensual panel determination (already in use by the GMC).

- The NMC can investigate allegations that include:
 - misconduct
 - lack of competence
 - bad character
 - serious ill health.

- Where a nurse or midwife’s fitness to practise is impaired, the following sanctions are available:
 - caution
 - conditions of practice (for between one to three years)
 - suspension (for up to a year in the first instance)
 - striking-off (after five years, the nurse or midwife can apply to rejoin the Register).

- The NMC has sought to strengthen its communications with and support offered to witnesses. As part of this, it has published three booklets for witnesses, giving information on what to expect from investigations, hearings, and after a hearing (for further details see www.nmc-uk.org/Publications/Information-for-the-public/).

- The NMC routinely seeks feedback from nurses and midwives who have been subject to the fitness to practise process. The feedback form can be found at www.nmc-uk.org/Hearings/Fitness-to-practise-feedback-form/.

KPIs

- 12 months for investigation; 6 months for adjudication; and 28 days for Interim Order from receipt of referral. The NMC routinely seeks feedback from nurses and midwives who have been subject to the fitness to practise process. The feedback form can be found at www.nmc-uk.org/Hearings/Fitness-to-practise-feedback-form/.

Proactive regulation

- The NMC has been keen to demonstrate a proactive approach to regulation and use its powers to investigate concerns without first receiving a formal fitness to practise referral – these are known as article 22(6) cases. As of 1 December 2012 it had opened 266 such cases. This followed detailed assessment of evidence gathered as a result of information contained in media reports or information received from whistleblowers, other healthcare and systems regulators, police, and coroners. The scale of investigatory activity has resulted in a significant increase in direct communications with heads of midwifery, nurse directors and chief executives in the NHS and the independent sector.
- The NMC will be developing a systematic ‘heat map’ approach to identifying where there may be a risk of poor nursing and midwifery practice that poses a risk to public safety. A Head of Critical Standards Intervention (CSI) has been appointed and will proactively identify where the code or standards need enhancing or gaps need to be addressed.

PHARMACEUTICAL SOCIETY OF NORTHERN IRELAND (PSNI)

- The PSNI does not carry out its own investigations into fitness to practise. It works closely with the Department of Health, Social Services and Public Safety (DHSSPS) pharmacy inspectorate in the Medicines Regulatory Group. Inspectors from the DHSSPS can gather information, conduct investigations, inspect premises and take statements on behalf of the PSNI. The Pharmacy Network Group (PNG) was created in order for the PSNI, the Health and Social Care Board and the DHSSPS to safely share information effectively and facilitate communication.
- The PSNI’s Statutory Committee (Fitness to Practise Committee) hears cases referred by the Scrutiny Committee. It consists of 12 members (six lay and six pharmacists) and is chaired by a lay member. Three cases were dealt with in 2011/12.
- The Statutory Committee can issue interim orders at any point. It can give warnings, offer advice, impose conditions, suspend registration or strike a registrant from the register.

SOLICITORS REGULATION AUTHORITY (SRA)

- The SRA has criteria to determine the focus of an investigation. It can:
 - issue a warning about future conduct
 - impose a disciplinary sanction, such as a fine
 - control how a firm or individual practices

- refer a firm or individual's conduct to the Solicitors Disciplinary Tribunal
 - revoke recognition of a firm or refuse to renew recognition of a firm
 - order a non-solicitor manager or employee to obtain its approval before being employed by, becoming a manager of, or investing in a firm
 - close a firm with immediate effect.
- An independent adjudication process operates for solicitors. The Solicitors Disciplinary Tribunal (a separate organisation) has wider powers than the SRA and can order removal of a solicitor from the roll of solicitors.
 - The SRA's enforcement powers are focused on firms. A firm (or individual) can avoid formal proceedings where it has demonstrated openness to guidance, supervision and monitoring and works with the SRA constructively to take prompt remedial action.
 - Enforcement action can include controlling the way firms work, preventing them from providing certain legal services, or even closing firms down if the breaches have been severe. Compliance with a firm's regulatory obligations is the primary responsibility of a firm, but the SRA may decide to investigate an individual if, for example, there is evidence of personal culpability.

Appendix A8: ENGAGING WITH STAKEHOLDERS

BAR STANDARDS BOARD (BSB)

- The BSB's latest annual report refers to several public consultations over the last few years and several joint initiatives with other legal regulators/organisations, including the Solicitors Regulation Authority. Other than this, engagement activity would appear to be limited.

GENERAL CHIROPRACTIC COUNCIL (GCC)

- The GCC routinely involves stakeholders in its work, for example, through its Communications Advisory Group and project specific stakeholder consultation events. It belongs to the Professional Standard Authority's Learning Circle on Patient and Public Engagement. It also works with the Alliance of UK Health Regulators on Europe (AURE).

GENERAL DENTAL COUNCIL (GDC)

- The GDC's *Stakeholder Engagement* report (2012) listed numerous organisations that the GDC engages with, including regulatory, parliamentary, educational and defence organisations, as well as registrants.
- The GDC is embarking on a new *Communications and Engagement Strategy* to increase engagement with the public and other external stakeholders.
- It carries out an annual patient survey. The last of these was published in June 2011, the objectives of which were to:
 - capture public and patient awareness and perceptions of the GDC.
 - provide the GDC with a snapshot of how patients and the public view particular policy initiatives that are being developed by the GDC.
 - test public views and levels of understanding of core issues that are currently prevalent within the dentistry profession, including regulation.
 - benchmark the GDC's reputation against comparator organisations.
- The GDC produces a monthly *Gazette* for dental professionals and a separate monthly newsletter for non-registrant stakeholders.

GENERAL MEDICAL COUNCIL (GMC)

- The GMC is clear that it relies on the support and co-operation of others in the health sector to discharge its regulatory functions. Working in partnership with key partners to develop more effective relationships to achieve an integrated approach to medical regulation is a core strategic objective for the GMC (see the GMC's corporate strategy for 2010-2013 http://www.gmc-uk.org/Corporate_Strategy_2010_13.pdf 29731738.pdf). In particular, it seeks to strengthen links between local workplace regulation and national professional regulation.

Employer Liaison Service (ELS)

- The ELS seeks to create closer working relationships between the GMC and employers across the UK. There are 15 Employer Liaison Advisers (ELAs). To find out more, see <http://www.gmc-uk.org/concerns/11956.asp>.

Regional Liaison Service

- The GMC's Regional Liaison Service (RLS) works with key partners across England to ensure that the GMC's work is understood and meets their needs. There are eight Regional Liaison Advisers across England. They facilitate the involvement of stakeholders in consultations and in discussing changes that could affect them. They also promote GMC standards for doctors and are supporting the implementation of revalidation by ensuring doctors and patients understand what it will mean for them. The Advisers work primarily with groups representing patients, groups representing doctors, medical schools and students.

UK, European and international

- The GMC demonstrates its presence in the four countries through a range of activities. For example, it has held conferences and road shows in Wales and Scotland. It publishes a range of guidance documents in Welsh. It conducts an annual national survey of trainees and another of trainers.
- One of its strategic aims is to help shape the local, UK, European and international regulatory environment through effective engagement with decision makers, other regulators and key interest groups – 35 per cent of new applications to register with the GMC come from European Economic Area and International Medical Graduates. Since 2005, healthcare professional regulators from 24 EU member states have participated in the European-wide Healthcare Professionals Crossing Borders initiative.

GMC Reference Community

- The GMC's Reference Community is one of a number of ways in which it works with members of the public and doctors, and complements other engagement and formal consultation activity.
- The Reference Community consists of 27 members of the public (public members) and 27 doctors (professional members). It acts as a 'sounding board' that enables the GMC to access the individual views of its public and professional members on a range of issues.
- Much of the Reference Community's work is undertaken virtually with either all or a subsection of members being emailed briefings about the development of a new policy or process, along with questions concerning key issues that the GMC wants to seek their individual views about.

- Sometimes the GMC invites a small group of Reference Community members to come together for a one-off face to face discussion about an issue. This allows it to access opinion resulting from a deliberative process. From time to time, a Reference Community member may be appointed to a GMC Board or working group for a period of around 12 months.
- The membership can vary and there are not always an equal number of public and professional members. Reference Community members were appointed in 2009 through an open process as individuals and not as representatives of an organisation. They live and work across the four countries of the UK and come from a range of backgrounds.

GMC Black and Minority Ethnic Doctors Forum

- The GMC's Black and Minority Ethnic Doctors Forum serves as a sounding board to help the GMC to understand the issues that affect its members and shape the development of the GMC's plans and activities. The Forum provides feedback on the GMC's consultations and advice on the issues that impact on black and minority ethnic doctors and international medical graduates as a result of the GMC's activities (e.g. its fitness to practise procedures). It also cascades key messages and information about GMC developments and raises issues with the GMC on behalf of the members of the networks and individual doctors represented on the Forum.

GMC and social media

- The GMC uses social media sites to raise awareness of its work, promote good medical practice, engage with doctors, patients and members of the public, and to seek views on its work. These include: Twitter, Facebook, Google+, LinkedIn, YouTube (for information videos and interviews), Audioboo (for podcasts), Slideshare (for archive presentations), Pinterest (for infographics and visuals from GMC projects), Scribd and Issue (for publications), Flickr (for photos from GMC events). The GMC articulates what to expect from engagement across social medical channels (for example, it explains that it may not be able to respond to certain comments for legal reasons).

GENERAL OPTICAL COUNCIL (GOC)

- The GOC engages with registrants through exhibitions, consultation events, a regular eBulletin newsletter, and its annual registrants' survey. The survey asks about the online retention system, customer service and communications (885 registrants responded in 2010-11).
- In 2010-11, the GOC launched its new Stakeholder Reference Groups: one made up of professionals and the other of patients and members of the public. It issues a Stakeholder Update three to four times a year. It is also a member of the Learning Circle on Patient and Public Engagement.

GENERAL OSTEOPATHIC COUNCIL (GOSC)

- The GOSC has established a Patient and Public Partnership Group. Members of this group provide a patient and public perspective to the work of the GOSC and assist in developing communications materials. It operates as a 'virtual' group, mainly by email and post.
- The GOSC has an ongoing patient survey on its website. It also holds regular consultations and events.
- The GOSC uses a range of social media to communicate, including Facebook and Twitter. Its aim is to:
 - provide information to anyone with an interest in osteopathic care and its work
 - provide bite-sized pieces of information accessible to people on the move
 - communicate with people who might not usually visit its website
 - keep stakeholders up to date with new developments
 - enable followers to contribute to its work through consultations and feedback.
- Engagement with registrants is through regional meetings, the GOSC's bimonthly magazine, *The Osteopath*, a dedicated registrant website, monthly e-bulletins, and a fitness to practise e-bulletin produced three times a year.
- The GOSC coordinates the work of the Forum for Osteopathic Regulation in Europe (FORE), to facilitate the regulation of osteopathy across Europe. It has agreed in principle to the establishment of a pan-European set of standards for osteopathy, working with the European Federation of Osteopaths (EFO) and the Committee for Standardisation in Europe (CEN), an EU-recognised standards body.

GENERAL PHARMACEUTICAL COUNCIL (GPHC)

- The GPhC has a consultation toolkit, which it has distributed to more than 30 organisations that work with or represent members of the public. It also operates under the *Patient and Public Involvement Good Practice Handbook for UK Health Care Regulators* (2010).
- It has sought to improve how it communicates with its registrants by:
 - setting up an in-house customer contact centre, which deals with more than 1,000 queries a week
 - redesigning its communications tools and activities to raise awareness of the need to renew registration
 - revamping its website to make it easier to use
 - using social media to raise awareness of its work
 - setting up online reference groups in England, Scotland and Wales, which have over 3,000 subscribers.

- The GPhC produces a bulletin (*Regula+e*) to communicate with registrants, including updating them about pharmacy regulation and sharing learning from fitness to practise cases.

HEALTH AND CARE PROFESSIONS COUNCIL (HCPC)

- The HCPC engages with stakeholders in a number of different ways, including consultation activity and a bi-monthly e-newsletter.

Professional Liaison Groups (PLGs)

- A number of PLGs provide advice to the Council or committees on strategic issues. PLGs are project-based and set up for a defined timescale. Each PLG will always have a rationale, terms of reference, a plan of activities, a timetable and a budget. The membership varies according to the task, but may include educational or employer representatives, patient or user representatives, lay members and experts. For example, the Continuing Professional Development PLG drafted further information on CPD and the CPD audit process for use by registrants, CPD assessors and employers.

Patient and public involvement

- Representatives of patients and the public are often involved in the PLGs mentioned above. In addition the HCPC is committed to undertaking research with members of the public, for example to inform the development of public information campaigns and the website, as well as into attitudes and knowledge about the HCPC. Research into the expectations and views of complainants was carried out in 2009.

NURSING AND MIDWIFERY COUNCIL (NMC)

- In October 2012, the NMC launched a public newsletter. People who sign up to the newsletter receive news and updates on, amongst other things, the outcomes of fitness to practise cases, events, live chats and consultations. The NMC also began holding a regular Patient Forum with events attended by a range of patient groups, patient advocates and health charities.
- The NMC is developing an Engagement strategy, which it hopes will define more clearly how views and feedback from stakeholders are used to inform its work. As a first step it is systematically capturing and disseminating internally the outcomes and actions from the range of engagements involving staff.
- The NMC held an innovative 'NMC night shift' event at Central Manchester University Hospitals, engaging with around 180 ward level staff on tours of the wards from 20:00 to 23:00 one evening, and through an exhibition stand in a public area the following morning from 06:30 to 08:30, was able to reach an audience who would not normally have an opportunity to attend its events.

- The NMC is seeking more engagement with nurses and midwives, employers and educators through its regular e-newsletters and through social media. For example, it hosted a panel discussion as part of Social Media Week in September 2012 on how healthcare regulators can better engage with patients and the public. NMC directors have been interviewed on Twitter, and there was live tweeting of the Council meeting which considered a proposed fee increase, enabling registrants and others to stay in close touch with the discussions.

Europe and beyond

- The NMC describes itself as having close partnerships with colleagues and decision makers in Europe, to enable it to influence EU legislation in the interests of patients and the public. It is the only European nursing and midwifery regulator to have introduced a sustainable system of compensation measures to comply with the professional qualifications directive (Directive 2005/36/EC). The EU Commission has welcomed its approach as best practice.
- The NMC has met with counterparts from the Republic of Ireland, New Zealand, Singapore, South Africa, Canada and the United States for discussions on international registration, professional leadership, continuing professional development and revalidation.

PHARMACEUTICAL SOCIETY OF NORTHERN IRELAND (PSNI)

- The PSNI produces regular newsletters, and letters for registrants, and premises owners/superintendents. It carries out public consultations from time to time (for example, its consultation on the CPD framework, which includes a webcast).
- The PSNI belongs to the Pharmaceutical Group of the European Union (PGEU) as a way of keeping in touch with European issues that affect pharmacy in Northern Ireland. There are plans to introduce a blueprint for European community pharmacy. A recent EU directive has meant that it will now be mandatory for pharmacists to recognise prescriptions coming from other EU countries.

SOLICITORS REGULATION AUTHORITY (SRA)

- The SRA produces numerous guidance documents for trainees, solicitors and members of the public. It has a Professional Ethics helpline number.
- The SRA has a developed consumer affairs function to provide support and information for all those who use legal services.
- It regularly undertakes public consultations on its documents or reviews, and has developed standards for consultation (<http://www.sra.org.uk/sra/consultations/consultation-approach.page>).

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Appendix B: International regulation of veterinary surgeons

The New Zealand model of professional veterinary regulation is similar to the UK, in that there is a single regulatory body. Approaches to veterinary regulation in Australia, Canada and the United States follow a distinct model, whereby each state or province has its own regulatory organisation. Veterinarians (a term commonly used internationally) must be registered with each regulatory body in a particular state or province to practise in that geographic area. Australia is working towards national recognition of registration across its provinces, with two of its eight regulatory boards already working in this way. The case studies that follow provide an example of a regulatory organisation in each of Australia, Canada and the United States. The regulatory board in Colorado, the United States case study, is part of a wider state department of regulators. It is a small organisation and it was not possible to identify an annual report or details about the number of registrants, complaints or fitness to practise cases.

In addition to state and province based regulators, there are also national organisations that promote professional standards and areas such as animal welfare (for example, the American Veterinary Medical Association and the Canadian Veterinary Medical Association). The United States also has an American Association of Veterinary State Boards, which regulators across the states are encouraged to join. The New Zealand regulator is examining international standards of accreditation for veterinary qualification programmes and already recognises several programmes through Australia, Europe and the United States.

The governing bodies of the four case studies considered here tend to be very small – two have seven members, one has nine, and the fourth has 18 members. For two governing boards, the members are all appointed; for the other two, some members are appointed and some elected. Lay members are a feature of governing bodies, but there is no parity with veterinarian members. The Canadian case study (ABVMA) is the only one to have a professional leadership role in addition to regulatory functions, and stands apart from the other case studies by referring to ‘members’ and its ‘membership’.

Safeguarding animal health and welfare, and also the health and work-life balance of veterinarians, are key areas of focus. For example, the New Zealand regulator has been working with the New Zealand Veterinary Association (NZVA) on health promotion and work/life balance strategies. It is also developing guidance for veterinarians on the links between the abuse of animals and child abuse, and other forms of domestic violence, and has surveyed veterinarians on this issue. The Canadian case study, the ABVMA, has made animal welfare leadership as one its key strategic priorities. In 2012 it published a range of guidance relating to animal welfare, and in April 2013 it is launching an arms-length charitable foundation to provide veterinary care to Alberta residents in financial need. The ABVMA is also keen to improve the work-life balance and health of veterinarians. It has two ‘member wellness programmes’ including counselling and a residential treatment programme for those with an addiction.

CASE STUDY (AUSTRALIA) – VETERINARY PRACTITIONERS REGISTRATION BOARD OF VICTORIA (VPRBV)

- Each state and territory in Australia has a registration board and a veterinarian needs to be registered in each state they wish to work in. Registration boards are governed by state legislation. They can also investigate complaints against veterinarians, and impose disciplinary measures.
- The Australian Veterinary Association (AVA) has developed a model for national recognition of veterinary registration in association with the Australasian Veterinary Boards Council and the Animal Health Committee. Australia is in the process of setting up national recognition of veterinary registration, which will mean that a veterinarian's home state registration will be recognised by all other Australian jurisdictions. Victoria and New South Wales have already enacted this legislation.

Governance

- The VPRBV is one example of a state registration board. It is governed by the Veterinary Practice Act 1997 and the Veterinary Practice Regulations 2008. It is responsible for:
 - registering of veterinary practitioners in Victoria
 - acting proactively to help ensure that appropriate standards are maintained
 - ensuring veterinary practitioners maintain continuous professional development
 - handling complaints about the professional conduct of veterinary practitioners.
- The Board comprises of nine members, nominated and appointed by government, and includes two lay (community) members. The Board normally meets monthly and holds one joint meeting with the AVA. The Board is supported by committees of three to four members; the VPRBV president is an ex-officio member of each committee.

Standards and guidance

- The VPRBV has produced guidance on what to expect from a veterinarian (http://www.vetboard.vic.gov.au/docs/what_can_i_expect.pdf), as well as about standards of veterinary practice and facilities (<http://www.vetboard.vic.gov.au/guidelines.php>). These guidelines include certification of drugs, euthanasia of animals and continuing professional development.

Maintaining the register and CPD

- In 2012, there were 2,431 veterinarians on the register. Application for registration includes submitting a letter of good standing. As part of the annual renewal process in Victoria, veterinarians are asked to report on CPD. The guidelines recommend 60 hours per three year period. The renewal process is available online. The annual renewal fee for 2012 was \$435.

Education and training

- The Board has recently considered accreditation visit reports undertaken by the RCVS and the American Veterinary Medical Association. As a result of this, the bachelor of veterinary medicine awarded by the RCVS was accredited for three years (from August 2011). Other degrees have also been recognised.

Complaints handling and fitness to practise

- In 2012, 232 complaints were received by the VPRBV. Of the 49 written complaints received, one resulted in a fitness to practise investigation, ten in informal hearings, 22 in no further action, one was withdrawn and 19 remain under investigation.
- Initial investigations into complaints are carried out by two Board members who cannot then be involved in an informal hearing. Most informal hearings relate to allegations of inadequate care. In these circumstances, there is usually a finding of unprofessional conduct, but not of a serious nature. Where the unprofessional conduct is of a serious nature, a formal hearing is held to hear evidence. Powers available to hearings panels are counselling, caution, reprimand, written undertakings, further education or training, the imposition of conditions, limitations or restrictions on registration and imposing fines and costs. In serious cases, they have the power to suspend or cancel registration.

Engaging with stakeholders

- Every two to three years the Board hosts a series of 'roadshows' or seminars. The seminars for 2012 focused on complaints and included a presentation and an opportunity to meet Board members. There was also a webinar.
- The Board produces newsletters approximately three times a year. It also carries out a survey of registrants every two years. The Board welcomes feedback via its website.
- In 2012, the VPRBV held a joint meeting with the Victorian Division of the AVA. It also worked with the Australasian Veterinary Boards Council (AVBC). Board members participate in standing committees of the AVBC.
- The VPRBV has also worked with the Office of Racing Integrity Commission and with universities offering veterinary courses.

CASE STUDY (NEW ZEALAND) – VETERINARY COUNCIL OF NEW ZEALAND (VCNZ)

- The VCNZ regulates veterinarians in New Zealand. It aims to protect the public interest by ensuring that veterinarians are competent and fit to practise.
- The VCNZ has the following responsibilities:

- setting minimum standards for practising as a veterinarian
- setting and monitoring standards for veterinary performance
- promoting and encouraging high standards of professional education and conduct.

Governance

- The VCNZ is governed by the Veterinarians Act 2005. There are seven members of Council who meet four times a year:
 - three members elected by veterinarians
 - two lay members appointed by the Minister for Agriculture
 - one veterinarian appointed by the Minister for Agriculture
 - the Academic Programme Director of the Faculty of Veterinary Science at Massey University.
- The VCNZ has one office based in Wellington.
- The Council is supported by the following committees: Registration, Complaints Assessment, Judicial, Professional Standards, Health, Preliminary Assessment, Finance and Risk. The legislation does not prevent members of committees from also serving on Council, but the VCNZ has recently been debating this issue and recognises perceptions of a conflict of interest.
- The Council is seeking to update the Veterinarians Act 2005 and a Statutes Amendment Bill. It is looking to remove the word 'minimum' in relation to practising standards and extend its powers in the complaints process to suspend registration pending competency assessment or disciplinary proceedings.

Codes of practice

- The VCNZ has a professional code of conduct, described as minimum standards of behaviour, which is structured around seven principles of professional behaviour:
 - protecting animal welfare and alleviating animal suffering
 - practising in a way that promotes effective communication, trust, meets confidentiality and consent requirements and recognises clients' right to choose
 - interacting with colleagues honestly and with respect and in a way that fosters good relationships and communication
 - acting in a manner that promotes the public's trust and confidence in the profession
 - striving to provide a high standard of veterinary practice
 - exercising sound professional judgement when authorising, dispensing, recommending, selling and using veterinary medicines
 - practising in accordance with relevant legislation and other applicable standards.
- The VCNZ has produced detailed explanatory notes on each of these areas. It has also produced competency standards and performance indicators (www.vetcouncil.org.nz).

Maintaining the register

- The VCNZ has approximately 2,400 veterinarians on its register. Veterinarians are required to apply for an annual practising certificate.
- The Registration Committee makes recommendations to Council on applications for registration in New Zealand. It oversees the administration of specialist registration in New Zealand and also the administration of the examination for overseas veterinary graduates (11 candidates sat the examination in 2011, two of which passed).
- The Council has increased its annual practising fee for the third year in a row to ensure a minimum level of reserves. The current fee is \$440.

Education and training

- The Registration Committee monitors accreditation of international veterinary degree courses.
- In 2011, the Council approved the accreditation recommendations of AVBC, RCVS and AVMA on the veterinary science degree courses at a number of universities, including two in the UK (Nottingham and London). Any students graduating after the accreditation date will be eligible to apply for registration in New Zealand without further examination.
- The Council is a member of the International Accreditors Working Group (IAWG) which is working towards international accreditation.

CPD

- The code of practice requires veterinarians to keep their skills and knowledge up to date by taking part in relevant CPD activities that maintain and develop their competence and performance. As of 2014, veterinarians will be required to declare (and if asked to do so, demonstrate) involvement in CPD over the previous three years.
- Veterinarians are required to complete 60 CPD points over three years (15 points must relate to the first and second categories outlined below).
- Veterinarians are encouraged to relate CPD activities to their specific areas of work. CPD is divided into three main areas of activity:
 - continuing veterinary education (e.g. conferences, workshops, studying towards a qualification)
 - collegial activity (e.g. in-house training, peer discussion and review, supervision and mentoring)
 - self-directed learning (e.g. reading and research, publications, learning diaries).
- The CVNZ website and annual report makes no mention of revalidation.

Complaints handling

- In 2011, 34 complaints were received. At the end of the year, 25 complaints remained open.
- The Complaints Assessment Committee (CAC) investigates complaints against veterinarians and considers what action, if any, should be taken. It is made up of three people, one of which is a public member. The actions available are: taking no further action, providing advice to the veterinarian and/or complainant, recommending medical or competence assessment for the veterinarian, facilitating mediation between the parties, or laying charges of professional misconduct against a veterinarian.
- Complaint categories for 2011 included:
 - inappropriate behaviour
 - unsatisfactory treatment
 - unprofessional/unethical behaviour
 - fees charged.
- In late 2010 the VCNZ introduced a new 'concerns' notification policy to deal with cases where someone wants to bring concerns about a veterinarian's actions to Council attention but does not necessarily wish to make a formal complaint. These are dealt with by Preliminary Assessment Committee (PAC) which:
 - considers issues raised about a veterinarian's conduct, performance or health in circumstances where the notifier does not wish to make a formal complaint
 - where indicated makes appropriate referrals to the Council or its Health Committee
 - where indicated makes inquiries and refers matters to a CAC under Section 39 of the Veterinarians Act 2005.
- In 2011, the PAC considered 17 such concerns, seven raised by members of the public and ten by veterinarians. Three of these were referred to the CAC.

Fitness to practise

- A Judicial Committee is formed to hear any charge of professional misconduct against a veterinarian brought by the CAC.
- A Judicial Committee consists of three to five members, including an experienced solicitor/barrister, a layperson, a member of the Council and a veterinarian with relevant experience (i.e. relevant to the animal/species/area of the complaint).
- Most hearings are held in public and a pre-hearing conference is often held. The Judicial Committee uses the standard of the 'balance of probabilities' to make its decision. The decisions of the committee include:
 - suspension or cancellation of registration or of the practising certificate
 - censure
 - placing conditions of practice upon a person

- fine
 - refund of professional fee to complainant
 - costs and expenses of hearing and investigation.
- Appeals can be made to the District Court, or in some cases, the High Court.
 - The Health Committee is responsible for administering medical assessments, monitoring the health of veterinarians and making recommendations to the Council regarding veterinarians and veterinary health in general. The Health Committee has two members and a medical adviser.
 - In 2011, 65 veterinarians declared a physical or mental health condition that had the potential to affect their fitness to practise. Practising certificates were issued in all but one case, although many were only issued after a GP had confirmed the individual's fitness to practise. Two cases were referred to the Health Committee from the Complaints Assessment Committee.

Engaging with stakeholders

- The VCNZ commits to set standards in consultation with the public and the veterinary profession.
- The Council held regular meetings with key stakeholder organisations and individuals during 2011, including with the New Zealand Veterinary Association (NZVA) on health promotion and work/life balance strategies.

Other issues

- The Council will be developing guidance for veterinarians on the links between the abuse of animals and child abuse, and other forms of domestic violence. This will be incorporated into the 2012 work plan of the Professional Standards Committee. Veterinarians were invited to complete a short online survey on their experiences.

CASE STUDY (CANADA) - ALBERTA VETERINARY MEDICAL ASSOCIATION (ABVMA)

'Serving society by regulating, enhancing and providing leadership in the practice of the profession of veterinary medicine'

- The ABVMA is the professional regulatory organisation governing the practice of veterinary medicine in Alberta, Canada, under the authority of the Veterinary Profession Act. As a self-governing profession, the ABVMA is required to perform its regulatory and professional functions in accordance with the law and in a manner responsible to the public of Alberta through the government of Alberta Employment and Immigration.
- The ABVMA is responsible for:
 - reviewing the academic, personal and ethical qualifications of all veterinarians applying for a license to practise in Alberta

- requiring that veterinarians continually upgrade their skills by attending a minimum number of continuing education sessions each year
- inspecting all veterinary clinics to ensure they meet or exceed ABVMA standards
- providing a process for the resolution of complaints about the conduct or skills of Alberta veterinarians.

Governance

- The ABVMA operates under the Veterinary Profession Act (Revised Statutes of Alberta 2000) and Bylaws (2012).
- The ABVMA is governed by a Council consisting of approximate 18 members: 12 member-elected veterinarians and animal health technologists, as well as six government-appointed public representatives of organisations such as the Canadian Veterinary Medical Association, the Canadian Food Inspection Agency and various universities. The current Council includes two public members.
- The Council is supported by statutory and non-statutory committees, advisory groups, delegates and representatives, and regional veterinary clubs. The statutory committees consist of:
 - Discipline - Hearing Tribunal and Complaint Review Committee
 - Practice Inspection and Practice Standards Committee
 - Practice Review Board
 - Registration Committee.
- The committees appear to have very few public members (lay people). The ABVMA is looking to increase representation of animal health technologists on its committees.

Codes of practice

- The ABVMA did not appear to have any standards of practice for an individual veterinarian or animal health technologist on its website. A Practice Inspection and Practice Standards Committee appears to relate only to inspection of practices.

Maintaining the register

- As at 31 October 2012, the ABVMA had 3,037 'members' (1,604 veterinarians and 1,433 animal health technologists). 'Membership' is approved by the Registration Committee, which does not contain any public members.
- New 'members' are required to attend a registration day (two are held each year). This appeared to be a helpful introduction, and included an overview of the ABVMA's work, a review of the discipline process, case studies and group discussion.
- The registration process (obtaining a licence) includes requirements for an individual to provide evidence of identity, good 'moral' character, citizenship, ability to communicate in English and a

certificate of qualification. Applicants may be required to attend an interview with the Registration Committee and/or to take additional examinations, including a language assessment. Individuals can be registered temporarily or on a short-term basis.

- The ABVMA has a complex fees structure but appears to charge in the region of \$1,100 for membership. Annual renewal is required. CPD is a mandatory requirement of renewal.

Education and training

- The Practice Inspection Practice Standards Committee is responsible for auditing veterinary facilities on a three year cycle. In its 2012 annual report the ABVMA had inspected 152 practices. Veterinary facilities are required to complete a self-audited quality assurance guide.
- Practices are audited for:
 - proper professional, business and workplace standards
 - facility standards including animal housing and care
 - specific equipment requirements (including x-ray and surgery equipment)
 - maintenance of proper medical records
 - safe drug storage and disposal
 - biosecurity standards
 - proper biomedical waste handling
 - orderly and sanitary premises
 - a medical reference library
 - adequate staffing.
- In 2012, an area of focus for the auditors was the processing of a prescription from start to finish. Non-compliance was usually dealt with in the form of a letter requesting compliance within 30 days.
- Practices that are not functioning properly are referred to the Practice Review Board. Two practices were referred in 2012.

CPD

- Each registered veterinarian is required to accumulate a minimum of 20 credit hours of continuing education per year, and must have completed not less than 40 hours within the 24 month period prior to renewal of their registration.

Handling complaints and fitness to practise

- In 2012, the ABVMA received 23 formal written complaints, of which 21 were investigated.
- Complainants are encouraged to discuss the complaint with their veterinarian as a first step. A Complaints Director (who sits on the Council) will contact complainants and offer assistance in resolving the complaint with their veterinarian.

- Where it is not possible to resolve the complaint in this way, the complaint is referred to the Complaint Review Committee, which may carry out an investigation and peer-review. This committee consists of six veterinarians, two public members and two animal health technologists.
- Complaints can be redirected to an alternative complaints resolution process at any time, with the agreement of the complainant and the veterinarian.
- The Complaint Review Committee can dismiss a complaint or refer the case to a Hearing Tribunal. In 2012, the committee reviewed 17 cases. Of these, seven were referred for a hearing.
- The Hearing Tribunal will take forward an investigation of a registered veterinarian where requested to do so by the Practice Review Board. The Hearing Tribunal consists of at least three members appointed by the Council, and 25 per cent of the Tribunal panel must be public members. The Tribunal has the powers to:
 - caution
 - reprimand
 - place conditions on registration (including supervision and restriction of areas of practice)
 - direct counselling or a treatment programme
 - suspension
 - removal
 - direction to waive, repay or reduce fees, pay hearing costs or fines (up to \$10,000 for each finding of unprofessional conduct).

Engaging stakeholders

- One of the ABVMA's strategic priorities is to improve its communication with members, the public and stakeholders. Approaches to improving communication have included:
 - a Council 'road-trip' visiting 15 veterinary practices
 - a regional meeting with 'members'
 - increased use of social media to educate the public on animal health and welfare
 - weekly e-news
 - electronic surveys
 - attending meetings of other veterinary organisations
 - ongoing communication with veterinary colleges (the Deans of the colleges are ex-officio members of Council). One Council meeting is held at each college annually.

Other priorities

- The ABVMA considers animal welfare leadership as one its strategic priorities. In 2012 it published the following guidance:
 - *A Good Death – ABVMA guidelines on euthanasia of compromised livestock*
 - *My tail and I – tail docking for dogs*

- *Best Management Practices for Animal Shelter and Rescue in the Province of Alberta.*
- The ABVMA recognises the companionship that animals provide but that not everyone can afford veterinary care. It has therefore established an arms-length charitable foundation to provide veterinary care to Alberta residents in financial need, which will launch in April 2013.
- The ABVMA is keen to improve the work-life balance and wellness of its members, with research showing that veterinarians could be at higher risk of burnout, compassion fatigue and suicide. It has two member wellness programmes including counselling and a residential treatment programme for members with an addiction. The annual report for 2012 highlights the increasing risks of stress and addiction in veterinarians. The ABVMA has monitoring programmes, such as drug logs and triplicate forms, to identify veterinarians with addictions and protect the public.

CASE STUDY (COLORADO, UNITED STATES) – STATE BOARD OF VETERINARY MEDICINE (SBVM)

- The SBVM regulates and licenses veterinarians in the State of Colorado, United States. The SBVM operates under the State Board of Veterinary Medicine Practice Act. It is part of the Department of Regulatory Agencies (DORA) within the Division of Professions and Occupations (which is responsible for licensing and enforcing more than 50 professions, occupations and businesses in the State of Colorado).
- The SBVM did not appear to have produced an annual report and did not have its own website (information about the organisation was on the DORA website).
- The SBVM's mission is to safeguard the health, safety, and welfare of the people and animals of Colorado by establishing and enforcing professional standards, and developing and maintaining rules and policies to ensure that only qualified persons are licensed to provide veterinary care, and that violators of the laws and rules regulating veterinary medicine are sanctioned as appropriate.
- The SBVM is responsible for:
 - licensing veterinarians
 - investigating complaints about the licensed and unlicensed practice of veterinary medicine
 - disciplining those who violate the law and/or the Board's Rules
 - making, amending, and adopting reasonable rules and regulations governing the conduct of veterinarians.

Governance

- This SBVM's governing Board is made up of seven members: five veterinarians and two public members, appointed by the state governor.

Codes of practice

- The SBVM's rules and regulations establish a code of ethical conduct. Violations of the code may result in disciplinary action. The code includes prioritising the needs of the patient, parameters of care (relating to ability and competence), advertisement of 24 hour care, providing essential services in emergency situations (including relief of suffering and end of life), medical record keeping and maintaining a sanitary environment to treat patients.
- The SBVM has produced guidelines regarding prescription medications, costs of treatment, informed consent, vaccinations and medical records.

Maintaining the register

- There was no information as to the number of veterinarians licensed in Colorado. The SBVM is responsible for maintaining a register of veterinarians who are issued with a license to practise.

Education and training

- The SBVM has the power to inspect premises. The SBVM has developed criteria for continuing education approval requests, relating to approval of a course or programme.

CPD

- Veterinarians are required to complete 32 hours of CPD every two years. There was no reference to revalidation.

Handling complaints and fitness to practise

- The SBVM cannot:
 - require any individual or business to refund money
 - provide civil types of remedies such as filing lawsuits for damages
 - provide legal advice.
- Complaints are considered by the SBVM to determine whether there has been a violation of a rule or regulation. The complaint can be resolved by the SBVM or referred to the Office of Investigations.
- If a rule or regulation has been violated, the SBVM can:
 - issue a Letter of Admonition (a public reprimand)
 - refer it to the Office of Expedited Settlement
 - put the individual on probation
 - require the individual to participate in continuing education
 - issue a fine
 - suspend a license
 - revoke a license

- adjourn the case while further information is gathered or to wait the outcome of criminal or civil litigation
 - refer it directly to the Attorney General, who acts as the board's lawyer, for legal action
 - require other disciplinary actions.
- An administrative law judge is appointed for hearings.

Engaging stakeholders

- There was no information on how the SBVM engages with stakeholders.

FURTHER GUIDANCE

Alberta Veterinary Medical Association (2012). *Annual report*.

Colorado revised statutes (2011). *Title 12 Professions and Occupations, Article 64 Veterinarians*.

State of Colorado, Department of Regulatory Agencies (2012). *Division of Registrations, State Board of Veterinary Medicine, 4 CCR 727 – 1, RULES AND REGULATIONS*.

Veterinary Council of New Zealand (2011). *Annual Report for the year ended 31 December 2011*.

Veterinary Council of New Zealand (2011). *Code of Professional Conduct for Veterinarians*.

Veterinary Council of New Zealand (undated). *Continuing Professional Development. Information for Veterinarians*.

Veterinary Practitioners Registration Board of Victoria (2012). *Annual report 2011-2012*.

The Professional Standards Authority has produced papers on systems of regulation in different countries, including doctors in France and Greece, nurses in the USA, and pharmacists in Canada. For further details, see <http://www.chre.org.uk/>