House of Commons

Health Committee

Professional Standards Authority for Health and Social Care

Oral Evidence

9 July 2013

Baroness Pitkeathley, Harry Cayton and Rosalyn Hayles

Ordered by The House of Commons
to be printed 9 July 2013

HC 528-i
Published on 28 August 2013
by authority of the House of Commons
London: The Stationery Office Limited
£6.00

Oral evidence

Taken before the Health Committee

on Tuesday 9 July 2013

Members present:

Mr Stephen Dorrell (Chair)

Andrew George	Mr Virendra Sharma
Barbara Keeley	David Tredinnick
Grahame M. Morris	Valerie Vaz
Andrew Percy	Dr Sarah Wollaston

Examination of Witnesses

Witnesses: **Baroness Pitkeathley OBE**, Chair, **Harry Cayton OBE**, Chief Executive, and **Rosalyn Hayles**, Director of Scrutiny and Quality, Professional Standards Authority for Health and Social Care, gave evidence.

Q1 Chair: Good afternoon. Could I welcome you first of all to the Committee and ask you briefly to introduce yourselves, with the positions and roles that you fulfil within the PSA?

Baroness Pitkeathley: Thank you very much, Chair. My name is Jill Pitkeathley. I am the chair of the Professional Standards Authority. On my right is Harry Cayton, the chief executive. On my left is Rosalyn Hayles, the director of scrutiny and quality. Can I say a few introductory words about what the Professional Standards Authority does?

Chair: That would be okay.

Baroness Pitkeathley: Thank you very much. We are very pleased to have the opportunity to appear before you this afternoon. The Professional Standards Authority for Health and Social Care was launched last year. We were formerly known as the Council for Healthcare Regulatory Excellence, so you can imagine that we were very pleased to have a change of name. The CHRE was established in 2003 as a response to the Kennedy report of that time to improve professional regulation and make sure that it worked in the interests of patients and the public.

We carry out a range of activities that promote the health, safety and well-being of patients, service users and the public in the regulation of health and social care professionals. We are concerned with the professional regulators, such as the General Medical Council and the Nursing and Midwifery Council, not the systems regulators like the CQC and Monitor. We have duties and powers in relation to the oversight of nine statutory bodies that regulate the health and care professions across the United Kingdom. We also provide advice to, and undertake commissions on behalf of, the Government. With our new name we did acquire new responsibilities last year. For example, we acquired the oversight of social workers in England through the Health and Care Professions Council. We took on the accreditation of voluntary registers of non-statutory health and social care professionals and we now advise the Privy Council on the appointments process to the regulators' councils.

Our oversight of the nine regulators may be what is of most interest to this Committee. In our annual performance reviews—which you have seen, I am sure—we examine the regulators on guidance and standards, education and training, registration and fitness to practise. We also audit the initial stages of fitness-to-practise cases and review the outcomes of final fitness-to-practise cases. We can appeal them to court if we think they have been too lenient and do not sufficiently protect the public. We have a board of eight: seven non-executives and one executive—our chief executive, who is also the accounting officer. The chair is appointed by the Privy Council, the members from Scotland, Wales and Northern Ireland by the appropriate authorities, and others by the Secretary of State for Health. We have 36 staff and a budget of about £3 million, and we operate according to the principles of right-touch regulation. I should say that is emphatically not light-touch regulation.

Q2 Chair: We shall want to return to that.

Baroness Pitkeathley: I hope you will. This is a concept that we have developed and which has evoked a good deal of interest both in the United Kingdom and internationally. In essence, the right-touch way of doing things looks at using regulation appropriately and understanding its limits as well as its uses.

Finally, we are not a regulator ourselves, nor do we manage the statutory and voluntary registers. We are organisational auditors, really. We aim for oversight, insight and improvement in the regulators of the professionals who deliver health and social care and we believe we make an effective contribution to that improvement.

Q3 Chair: Thank you very much for that introduction, which sets the scene very well. We would like, if we may, to focus what can be a reasonably brief session essentially around two themes: first, how you set about doing your job as a regulator of regulators, or an overseer of regulators, and, secondly, substantively, what you have found this year in some of the regulatory bodies that you look at. I think you have answered the first question we were going to ask, which is, "What is new in the PSA?" You have set out where the additional functions are. We have one specific question about how you do your job. Do you have 360° assessment? In other words, how do you ensure that you take account of other people's views of what you do?

Baroness Pitkeathley: Yes, indeed, we do do that. I will ask our chief executive to tell you more.
Harry Cayton: Thank you. We take third-party evidence, in a number of different ways. First, during the year we get a number of members of the public—patients and service users—who approach us directly because they have been dissatisfied with their experience of one or other of the regulators and the way that regulator has handled their complaints. We monitor all those public responses that we get. We make sure that we deal with those and even though we may not be able to take any action on them individually because of the limitations of our powers, we always take account of them in the performance review. When we do the performance review, we also put out a call for evidence from third parties. That often includes unions, professional associations, NHS bodies and others, again, who have had experience of the regulator. It would be fair to say—and I am going to defer to Ros because organising the performance review falls within her responsibility—that we recognise that that third-party evidence is not impartial, that it comes from those who have a particular interest or who have had a particularly bad experience, but it is still very relevant to us and, because of our strong commitment to acting on behalf of the public, we think we should take that firmly into account.
Rosalyn Hayles: Every year, when we do receive third-party feedback—that is taken into account in the performance review—we will ask the regulators to comment on it. Your question was also about how we take account of other people's views of what we do ourselves. Of course, as a public body, we consult on how we do our business, so we will take account of the public's views in that process as well.

Q4 Chair: How do you do that?
Rosalyn Hayles: We hold a public consultation if we are going to introduce a new process or change a process.

Q5 Chair: Do you have a formal process on a regular basis, providing an opportunity for people to express their views about the effectiveness of the PSA as an organisation?
Harry Cayton: Yes. We have a patient and public involvement network, which we have slowly built. I have to say that although, as some members of the Committee know, I have a bit of a background in involvement with the public, when I went to what was then the CHRE, I found this was the most difficult area to get the public interested in, because, of course, we are not even a regulator—we are the next tier beyond—but we have built it up. We have over 160 people now who are in contact with us on a regular basis, so we can consult them by e-mail. We also hold workshops and face-to-face discussions, and we invite them to take part in a number of our planning and other opportunities, and the board always meets in public.
Baroness Pitkeathley: It is always in public, yes.

Q6 Dr Wollaston: I want to come on to the issue of levers. You are regulators; what levers do you have over the organisations that you regulate to follow up and make sure that they are complying with your guidance?
Baroness Pitkeathley: That is a very interesting question. We have levers. The performance review is how we do that. Of course that varies in how it is done, and in what the history of that is, but we also have learning points. I will ask Ros to talk about that.
Rosalyn Hayles: Yes. We try to identify good practice and learning points for the regulators and to disseminate that across the sector to help them improve their own practice. That is particularly relevant for the fitness-to-practise cases, but we do identify good practice in other areas as well. We hold seminars and encourage the regulators to share learning between themselves about how to do things well.

Q7 Dr Wollaston: What if they don't take you up on those suggestions? Identifying learning points is a great idea, but if you come back and look at them again and none of those has been taken up, what can you do to make sure that they comply?
Rosalyn Hayles: Under our legislation, they have a duty to co-operate with us, but the approach that we have always taken is one of working with them to achieve the improvements that we want them to achieve.
Harry Cayton: By and large, it would be true to say that we have common cause, in that I do not believe that any of the regulators are not committed to protecting the public. They may not always do it as well as we, you or even they would want to do it, but I do not think there is a difference of approach. We have persuasion. We have the wonderful power of transparent reporting. We do say, "They should have done it last year. They have not done it." I can give you a concrete example. Several years ago, we started looking at the position of registrants who had drink-driving convictions. We took the view that a drink-driving conviction or a drugs conviction might not be a one-off; it might be a symptom of an underlying problem rather than a single event. In fact, the GMC initially and then the NMC started doing health assessments of any registrant who had a drink-driving conviction and found that that was indeed the case, and that there was a pattern. Since that time, all the regulators except one have adopted that as a policy.

Q8 Chair: Which is the one?
Harry Cayton: The one is the Health and Care Professions Council, but although we do not agree with them, they took evidence and had a paper before their council to consider whether or not they should adopt that policy.

Q9 Dr Wollaston: That is an important point. If they disagree with you, you will allow them to disagree and carry on—
Harry Cayton: We have no option, of course. They are independent bodies. We have said in our performance review this year that we are disappointed that they have taken that position still. We do have a power in our legislation, which is not enacted, to

instruct the regulators to change their rules. That particular power—I think, if my memory serves me, it is 27(2) in the original legislation—has never been put into effect.

Q10 Dr Wollaston: Would it be helpful to you—and the point of these hearings is to help—to see that enacted?
Harry Cayton: Yes. There are two parts of the legislation that have never been brought into full effect. One is the power to instruct the regulators and the other is a power to investigate complaints.
Baroness Pitkeathley: Neither of those has been brought in since the 2002 Act—I think that was the legislation. The other lever, just to add to your question, is about the boards, of course, of the regulators, because we expect and ask that the performance reviews are considered by the boards, so it is not just the staff who are looking at them but the boards and councils of the regulators, and they have the responsibility to see that those improvements are made.

Q11 Dr Wollaston: Thank you. Can I follow up on a point that you made in your opening remarks about the face of the PSA that the public see, which is where you can take cases to court where you feel a regulator has been too lenient? There have only been, as I understand it, three cases in the last year.
Baroness Pitkeathley: Yes.

Q12 Dr Wollaston: That is a very small number of cases. Why is it so small?
Rosalyn Hayles: It is so small because the legal threshold for us to appeal a case to court is quite high. There is a lot of case law about it. It is important also to remember that when Parliament introduced section 29 of the Act, which allows us to do that, the Department of Health made it clear that it was only envisaged it would be used in extreme circumstances. The intention was never that there would be a lot of CRHP—as it was then—appeals to court. It was only intended to be exceptional.

Q13 Dr Wollaston: Yet if you say as an organisation you are there to represent the public, there is no doubt that patients and the public are unhappy about the decisions that are being made. Again, do you think it would be helpful, as a body, if that threshold was lowered?
Harry Cayton: Yes. We have discussed this with the Law Commissions as part of their review and we have discussed it with colleagues at the General Medical Council in relation to their own proposals for a power of appeal in due course.
There are a number of areas. There are quite a number of cases—not a large number—and it is important to say that we believe the vast majority of cases are properly dealt with and that one of the reasons why the number is very small is that the regulators have improved their performance. It was much larger five or six years ago. Nevertheless, there are cases that we would have wished to appeal that we have felt unable to.

Q14 Dr Wollaston: Could you give an example of the kind of case?
Harry Cayton: A well-known example, which I give particularly because it is in the public domain, was the case of Dr Barton who, it was alleged and indeed found by the General Medical Council, had acted perhaps cavalierly in relation to the care of older people at Gosport hospital. A number of people died as a result of large doses of morphine being given. She was found impaired but the GMC panel gave her, I think, 14 separate conditions on her practice. The GMC itself said in public that it thought that was an unfortunate decision. We reviewed the case twice internally. We took advice from two counsels, which is unusual for us. Everyone said that the case was unappealable because the detail of the restrictions on Dr Barton's practice were so precisely chosen that there was no way she could repeat any of the errors that she had made in the past. I think the public felt that that was an unacceptable outcome. The second part of our appeal process, as my chair has said, is that it has to be in the public interest for us to appeal and Dr Barton announced her retirement the day before our panel met. She was not practising as a doctor, and if she did practise she has these conditions, so there could not be a public interest in a very expensive case.

Q15 Dr Wollaston: Of course, the whole issue of voluntary erasure I think is something the public do feel concerned about.
Harry Cayton: Exactly. We have raised separately—Ros might talk about this in slightly more detail—the issue of registrants who come off the register while we are in the process of reviewing their case.
Rosalyn Hayles: Yes. We have had two or three cases where we have wished to appeal a particular decision but in the intervening period between the regulator's fitness-to-practise panel decision that we want to appeal and our appeal the registrant has come off the register and that effectively means jurisdiction is lost.

Q16 Dr Wollaston: Do you think we should end voluntary erasure in those circumstances? Do you think the public interest is better served by a point being made about the safety of patients?
Rosalyn Hayles: I can see that there are benefits to having voluntary erasure powers. They have to be used very carefully by the regulators, and when you have someone who is already in a fitness-to-practise panel process, the decision making around that is quite complex. I am not sure it is in the public interest to remove the power to voluntarily erase somebody entirely. You could end up with even more backlogs and delays in the system if you were not to permit that at all.

Q17 Barbara Keeley: Sarah has asked all the things I wanted to ask, really, but you said you had talked to the Law Commission about this, in terms of making changes. Would you be able to tell us what its advice was?
Harry Cayton: As you know, the Law Commissioners are considering regulatory reform. We are waiting for them to publish their draft Bill in February next year,

but we have found them extremely good to talk to about reforms. They, I think, understand the issues well, and we have certainly put to them a number of changes, including those we have just mentioned. We have put to them the issue of the threshold. We have put to them the issue of people coming off the statutory register while processes are still continuing, and they have sounded sympathetic, but I cannot say at this stage—I do not know any more than they do, perhaps, at the moment—exactly what they will decide.

Baroness Pitkeathley: This is in the context of the wider issues about regulation that the Law Commissions is looking at in the future.

Q18 Andrew George: This may not necessarily be following the same line. I want to come back to some of the broader-brush questions. If you were abolished tomorrow, what would patients notice most?

Baroness Pitkeathley: As I think my colleague has said, our contact with patients is relatively limited, but I think it would be the issue of regulators working together across some common framework; they are doing that more and more, in terms of the co-operation that they have. It would also be in terms of having standards to which we expect all the regulators to adhere each year, and certainly the audits of cases that we have been looking at, and which my colleague has been talking about; that is what I think the public would notice. This is already a very difficult field for the public to find their way around, because all the regulators are operating according to different bits of legislation, and have different ways of doing things, and I think the public would find it more difficult if we were not there.

Q19 Andrew George: Could it be done in a different way, and how many layers of regulators and inspectors do you think it is appropriate to have?

Baroness Pitkeathley: In a sense, there is only one layer for each regulator, depending on which profession you are looking at, and then ourselves. That does not feel like very many layers.

Q20 Andrew George: But the Law Commission is engaged with you.

Baroness Pitkeathley: The Law Commissions are looking at reforming, yes.

Harry Cayton: But I think the intention of the Law Commission reforms would be to simplify, rather than complicate. It is worth remembering that, as Baroness Pitkeathley said, we were established—partly through the Kennedy Report, but that was reinforced by Dame Janet Smith's inquiry into Shipman—in order to hold the regulators to account for their commitment to public protection, as opposed to professional interests. If you wanted to compare the UK internationally, you would find that we are recognised, as a country, as leaders in the shift of regulation away from professional interests to public and patient interests. I would think that this organisation has played a part—there are many other things that have played a part, but it has played a part, as has your Committee—in that change of approach.

Baroness Pitkeathley: One example of that might be the composition of the councils or boards of the regulators, which have changed out of all recognition in recent years in terms of their size and particularly in terms of their membership. They have much more representation of lay people.

Chair: That is why, as you know, this Committee has got into the habit of calling two professional regulators—and we want to come on to talk about the possibility of a third—and, indeed, why we have this session this afternoon.

Q21 Valerie Vaz: I want to go back to the comments on Dr Barton. Had you explored—for example, where there is an imminent retirement just before a hearing—whether you could look at the possibility of, say, a caution on a register, where you say, "We are very concerned about this person"? I am wondering about it because this voluntary erasure may be not permanent, and they may come back in a different guise, but at least the whole world would know if you registered a caution against them.

Rosalyn Hayles: Our right is to appeal the case to the court, but we do allow for mediation with the parties, even if we have made an appeal, so, yes, there could be scope for us agreeing to some form of lesser sanction in those circumstances. We have never come across them, but yes, we could do that.

Q22 Valerie Vaz: Is that something you would have to discuss with the Law Commission?

Harry Cayton: We are certainly very keen on the public acknowledgment of any conditions, restraints or findings against a registrant. We did a paper a few years ago on what is available to the public on the register, and we recommended a range of improvements. I have to say that all the regulators have taken that up, and there is far more information available for the public now on the registers than there was, and we are constantly urging not only the public but employers to use the registers that the regulators have to check on individuals and confirm that they are who they say they are, have the qualifications they say they have, and do not have any fitness-to-practise conditions against them.

Q23 Valerie Vaz: On the threshold, are you operating on "a balance of probabilities" or "beyond reasonable doubt"? You said it is a very high threshold.

Rosalyn Hayles: Yes. The test that we have to apply is whether the decision that the panel have made is so unreasonable that no reasonable panel could make it.

Q24 Valerie Vaz: The Wednesbury judgment.

Rosalyn Hayles: Yes. It is akin to a judicial review threshold, so it is very high. The regulators themselves all now operate their fitness-to-practise panel hearings on the "balance of probabilities".

Q25 Valerie Vaz: Finally on this particular topic, you basically say that you are disappointed with the regulators. Could you have a one, two or three-tier system—a red, green and amber light—rather than "disappointed"? I am always writing things like "I am

concerned" and "I am disappointed," but it does not seem to have a ringing effect, does it?
Harry Cayton: I said we were disappointed in one particular context. I say to my colleagues every year when we produce the performance review that "Most regulators doing quite well" does not make much of a headline, but if that is what we think is the truth, that is an important thing for us to say. We are certainly not, as an oversight body, seeking to create a fuss where a fuss is not necessary, but you can see—and no doubt you will come on to it—that when we have done special investigations we have been very clear about what we have found and about the failures that we have found, and that those investigations have resulted in people resigning from their posts and significant change happening. Although quite often the language we use is relatively mild, the impact is not necessarily so.

Q26 Dr Wollaston: I want to clarify one point. Are regulators obliged to inform you if they are undertaking fitness-to-practise hearings, so that you know in advance?
Rosalyn Hayles: We have to be informed of every final fitness-to-practise decision that they make.

Q27 Dr Wollaston: That is of the decision, but not in advance.
Rosalyn Hayles: No.

Q28 Dr Wollaston: You hear about them afterwards. Do they also notify you if they think there are concerns?
Rosalyn Hayles: We strongly encourage the regulators to do that, and a number of them do. I cannot answer on whether they always do it, but yes, we do get notifications.

Q29 Dr Wollaston: Are there some that are not doing it at all?
Rosalyn Hayles: There are some that we have not had any contact from, but they have far fewer cases generally so that is not necessarily a surprise.

Q30 Dr Wollaston: So you don't know whether it is because they are concerned.
Baroness Pitkeathley: There is a tremendous variation in the numbers of registrants, and therefore the number of cases.
Harry Cayton: My general impression would be, in the six years I have been in the role, that the openness of the regulators with us and their actively informing us of issues in advance has increased significantly. It is much more likely that the registrar or the chair of a regulator will contact us and say, "We think you should be aware of this. We are not happy about this," or even, "We have reported ourselves to the Information Commissioner and you should know about it." The dialogue has become, over the years, much more constructive.

Q31 David Tredinnick: Running on from that, do you think that you have a role in influencing the wider field of regulatory policy? You have already explained to us that there has been, I would say, a seismic shift in the people that you oversee becoming more patient-friendly, so is there, logically, another stage out there?
Baroness Pitkeathley: We have had some influence in the wider field of regulatory interest, as it were, and perhaps we would refer specifically to our concept of right-touch regulation here, which is something that we have developed and which has elicited a great deal of interest among regulators, not necessarily in the health field but outside the health field, and indeed outside this country

Q32 David Tredinnick: So that is your right-touch regulation idea, is it?
Baroness Pitkeathley: Yes.
Harry Cayton: One of the things that we were required to do initially was to say what good regulation looked like. When I arrived, and with a new board, we thought we had better set about that task. It was quite a helpful time to be trying to do it, because it was the time when banking regulation was under considerable scrutiny. It seemed to me that there were a number of things that regulation, as established, was failing to do. One of them was that regulators were regulating for the mistakes of the past, rather than the possible mistakes of the future. Health care in particular, especially some of the health care professions such as dentistry, medicine or pharmacy, is moving extremely rapidly in scientific terms, so you need regulators who are agile, who are able to respond to change in the professions that they are regulating. You need to develop a more risk-based approach to regulation. We are very good at describing risks, but not at measuring them. We need to get better at measuring risk. You need to focus regulation on the things it does and, of course, regulation is expensive, cumbersome and tends to be after the event, rather than before. We need also to get regulation that is alert to the existing tools that you can use to improve quality and safety.
One of my phrases, which I am not ashamed to repeat, is that the regulator is never in the room when something goes wrong. The people who are in the room are those who are involved in something going wrong, so we developed these principles of right-touch regulation. The first law of right-touch regulation is, "Only use the regulatory force necessary to achieve the desired effect." Too much force is a waste of effort and too little is not enough. That is why it is not "light touch". Having said that, in answer to your question, you can have a continuum of regulatory force, with high force at one end, such as the GMC, including revalidation, lower force in the middle, such as our new assured voluntary registers scheme, and perhaps even less force if you had, for certain groups of people working in health care, employer-led codes of conduct written into contracts of employment and supported by national standards and training. So you could create a regulatory framework that was based on the risk of particular occupations.

Q33 David Tredinnick: It seems to me that you are talking about two different things. You are talking about the degree of oversight that you have, whereas you go from light to heavy, and your "right" is

somewhere in the middle that is proportionate to the task in hand. Do you then seek to influence or change the regulatory practices of those you oversee? Do you look at their articles of association and say, "I do not like the look of that?"

Harry Cayton: Yes, we do, in so far as that is within our power, and we certainly talk to them about how to apply right-touch principles to decisions. For instance, we are quite sympathetic to those regulators who are looking at mediation and agreement for lesser allegations, as it were, at an earlier stage in the process, because if the outcome is to protect the public in a cost-effective way, then that must be what the desirable consequence of regulation is. Most of them will need to change their rules or regulations in order to achieve that more proportionate response. I might ask Ros if she has anything to add to that.

Rosalyn Hayles: I do not think I do in particular. I wonder if you want to talk about some of the international work as well, in terms of influence.

Harry Cayton: Yes. It is certainly true that "right-touch" has attracted a lot of international interest. Most interesting to us was an approach from the regulator of the construction industry in California, who wanted to know how they could apply our principles to their work, because they felt it was heavy touch and inappropriate. We are currently advising the Government of Hong Kong on reforms of regulation there. We have done work in Canada, Australia and New Zealand. We had a telephone conference this morning with the new regulator of health professions in Qatar. So there is interest in this model.

Chair: I think Valerie Vaz's next question is rather closer to home and relates to Staffordshire.

Q34 Valerie Vaz: Our senior Clerk helpfully pointed out this right-touch regulation in volume II, page 12. I must admit that when I first read it, I thought it was "light touch." I am not sure if there is a right touch and a left touch. You have a list there, but I am wondering how you apply this right-touch regulation to big issues like Mid Staffordshire, and whether you have done any right-touch regulation there, or whether you are going to do any.

Harry Cayton: That is a good and helpful question. The first proposition is, "Identify the problem before the solution." I am sure you will accept that one of the tendencies of Government in particular is to describe the solution before they have fully described the problem. We think it is really important to get that the right way round. What Robert Francis did in his first report was describe the problem extraordinarily clearly and well.

Q35 Valerie Vaz: The public described the problem; no one listened, and they probably had the solution. That is why we had to have someone independent doing the solution.

Harry Cayton: I would apply this by saying that the need to use the tools you already have before you invent new ones is a really important part of the approach.

Q36 Valerie Vaz: I am sorry, but can I push you on this? What have you done in relation to Mid Staffordshire, because it has obviously been around for a fair while now?

Harry Cayton: We have been working with the regulators for over two years on issues to do with sharing information between them, and being more active in their response to concerns. It certainly was the practice of some of the regulators in the past only to act when they received a complaint and not to act on the basis of intelligence. We had a meeting just last week with all the regulators to discuss specifically the implementation of Francis's recommendations on joint working. As to the issue of how you regulate teams, and how you regulate where issues are systemic, we have worked with CQC on these issues. I would like us—and I am sure they would like us—to do more work, because we need to mesh the systems regulators and the professional regulators much more closely together in their style of working and sharing of information.

Baroness Pitkeathley: That relates very much to the issue for the public, who find it extremely difficult to understand the difference between a professional regulator and a systems regulator. In Mid Staffordshire, as we saw very clearly, people were working without cross-information and without sharing things. That is one of the things we are encouraging the regulators to do.

Q37 Valerie Vaz: What specifically are you doing in terms of the GMC and the NMC in relation to the doctors and the nurses who are involved in Mid Staffordshire?

Harry Cayton: We are just auditing all their decisions at the moment, and we have paid particular attention to Mid Staffordshire cases.

Rosalyn Hayles: We have just finished our on-site audit of some of the General Medical Council's cases, and we highlighted, as a particular target area for us to look at, the Mid Staffordshire cases. We will be auditing a sample of the Nursing and Midwifery Council's cases later in the summer and we will do the same thing. We will be publicly reporting on what we find. If we feel that recommendations have to be made, then we will be making them.

Q38 Valerie Vaz: When are you going to report?

Rosalyn Hayles: It will be the early autumn, I would say, by the time we have collated our audit findings, drafted a report and finalised it.

Q39 Valerie Vaz: Is there room for whistleblowers in that? When you are doing your investigation, are you identifying the whistleblowers?

Harry Cayton: As we said earlier, we do take third-party information extremely seriously. We do not discount any of it and we record all of it. We have to make a judgment about it, but we bring it into our thinking.

Valerie Vaz: Thank you.

Q40 Barbara Keeley: I want to take you back on the point you made about the CQC. There may be aspects of your work that are relevant to bodies; you have

touched on the CQC, and there is obviously Monitor. Can you tell us what connections you have with them? We have just been in a situation of looking at the CQC, which was trying to examine its own role and getting into a bit of a mess—oddly enough, as we found when we questioned it, by using an outside organisation, Grant Thornton. It would be worth knowing what connections you have with them, what scope you would have in a situation like that, as a systems regulator, and what capacity you have if there was a question of, "Would you be able to do a report on that specific issue?" Is that something that would be helpful for you to develop?

Harry Cayton: Our relationship with the CQC has been an effective and professional one, I would say, for many years, but because there is no formal relationship between us, it has depended on individuals and professionals working together as appropriate. I worked with the previous chief executive, and I work with David Behan now. Both he and I would like to formalise more that relationship across the regulators. The Parliamentary and Health Service Ombudsman has also engaged in those discussions, and there is a process at the moment for setting up a forum of the chief executives. However, the real meat of good co-operation lies at the level of case managers and staff teams. It does not matter how many memorandums of agreement are signed by chief executives; the real issue is, is the person who is looking at a Mid Staffordshire case at CQC thinking, "I must inform the NMC about that," and is the NMC capable of acting on that information? That is what I do not think we have had in the past. So we had a workshop for all our regulators in 2011 to look at how you could introduce better case management across the regulators, and we are continuing to discuss with them how you can use what you might call soft intelligence to build a harder picture of where you need to intervene. That is what Robert Francis is getting at. Of course, there is a balance in that between not intervening when you are just operating on insubstantial gossip and always intervening when there is substance to it. That is quite a tricky thing to achieve.

In terms of your other question, I have to say that, yes, we could, had we been asked, have done the inquiry for the CQC. We were not invited to tender for that, but there is nothing within our legislation to stop us doing that. We did it for the General Teaching Council, for instance, a couple of years ago and the General Social Care Council when both those were technically outside our remit. We have checked the legal framework and we are free, if invited, to do work for others.

Q41 Barbara Keeley: We certainly questioned here why an outside, and financially based, organisation like Grant Thornton was brought in. I am quite surprised, and it is very interesting, that you were not invited to tender. Your understanding of the professionals involved and the structure of casework is important. It does seem that there was a serious point there: between caseworkers working at an area level and decisions being made about referring something between the ombudsman and the CQC, the baton was dropped. That is something that should be being looked at; is it being addressed?

Harry Cayton: It is being addressed. I would not want to claim for a minute that we have solutions to that as yet, but there is a will to address it and certainly no indication to us that the regulators are not engaged in trying to address that. They are serious about the recommendations that Francis has made to them.

Baroness Pitkeathley: In terms of our relationships with the CQC, we have run a series of seminars and workshops and a symposium. We have always found the CQC very willing to be an active participant in those.

Q42 Barbara Keeley: There is a question about why it did not ask you to tender for this work. I think that might have been better.

Baroness Pitkeathley: That is perhaps not a question for us.

Barbara Keeley: Not at all. Thank you.

Q43 David Tredinnick: This is a technical question. You have all these different bodies with all their different governances and all the rest of it, but have you tried to come up with a computer program so that you can key in information and get some kind of comparison, something that is not so hugely labour intensive?

Valerie Vaz: An algorithm.

David Tredinnick: I am grateful to my colleague here.

Harry Cayton: It would be lovely to have an algorithm.

Baroness Pitkeathley: It would.

Harry Cayton: Ros, do you want to talk about the difficulty of comparing unlike with unlike?

Rosalyn Hayles: It is difficult. They all have different legislative frameworks and processes. Inside our organisation, we have just had to develop some expertise, so that we feel we can make useful and meaningful comparisons, but no, we do not have an IT solution for that.

Harry Cayton: There is also a huge difference in size. When it comes to chiropractors, there is something over 2,000; with nurses, there are 670,000-plus.

Baroness Pitkeathley: Some of them have large commercial interests.

Q44 David Tredinnick: What about the construction industry of California? That is even larger.

Baroness Pitkeathley: We are not doing that.

Harry Cayton: One of the benefits of the Law Commissions' reform, if the Government support it, would be finding a framework in which all the regulators operated effectively under the same set of rules, with greater consistency, and that would also enable savings to be made and economies of scale to be generated, because it would be easier for them to co-operate with each other.

Q45 Chair: Can I ask one final question on process? Then perhaps we can get on to what you found when you went into these regulators. You say at 2.18 of volume I that the 2012 Act states that a levy will be put in place to change the funding basis of the PSA.

Have you any indication of when that is going to come into effect and what its effect will be?

Harry Cayton: Yes. The intention is that, through fee regulations, we will become self-funded by putting a levy on the regulators. My original proposition is a bit like what happens at the National Audit Office, which is funded by those organisations which it audits. They have to pay the cost of the National Audit Office. The Department of Health and the Treasury are currently in discussion about the fee regulations, and there is some difficulty between them.

Q46 Chair: You said your budget was £3 million. How long are they going to be in consultation about this £3 million?

Harry Cayton: We put our proposals forward in 2010 as to how it would work.

Q47 Chair: So it is three and a half years so far.

Harry Cayton: Yes, it is three and a half years so far. They have assured us that we will continue to be funded at least until April 2015.

Baroness Pitkeathley: That is under the current system.

Harry Cayton: So we are not holding our breath. However, the voluntary registers scheme is already moving towards being self-funding, and any consultancy and international advice we give is already entirely self-funding.

Q48 Chair: Okay. With that, perhaps we can move on to look at some of the substance. First of all, looking at general themes coming out of what you have found, one of the issues coming out of the performance review is that seven of the nine regulators for which you have responsibility are still establishing robust systems to assure themselves of the continuing fitness to practise of registrants, the two presumably that are outside that being the GMC and the General Optical Council. That leaves us with seven where there is no public assurance about continuing fitness to practise. That is not remotely satisfactory, is it?

Rosalyn Hayles: All the regulators have been working on revalidation or continuing fitness to practise for a number of years. It is fair to say the GMC and the GOC are much further ahead than the rest of the group. The GMC was, of course, strongly encouraged to move ahead and implement its proposals. The others are working on them, and we expect them to learn from the experiences of the two that are further ahead. I know that this Committee has raised concerns in the past, with both the NMC and the GMC, about the time frame for implementing revalidation. My understanding is that, following the Committee's comments last year, the NMC is intending to review its current Prep standard,[1] so that it has an improved process in place prior to the introduction of a full-blown continuing fitness-to-practise scheme.

Q49 Chair: We will come on to talk about the NMC specifically, but one of the issues there is that it needs to sort out what it is currently doing before it moves on to the next item on the agenda. I understand that, but one of the opportunities for the PSA, it seems to me, is to set out where all nine bodies need to be headed, and to create a greater sense of urgency about the need to move beyond once-in-a-lifetime registration.

Harry Cayton: I completely agree with that, Chairman. We did publish a paper earlier this year on a right-touch approach to continuing fitness to practise. It is important that we understand that, for instance, assuring the continuing fitness to practise of self-employed professionals, such as osteopaths, is quite different from those who are employed full time in the health service, which is different from those who work in retail. So it is necessary for the regulators to develop different approaches according to the professional group. In that sense, the osteopaths have made a great deal of progress in developing ideas around peer review and peer assessment. Individual osteopaths are finding another osteopath who will help provide some assurance. I agree with you: in terms of defining the task, and defining the simple question that a patient has the right to ask at any given moment—"Is the health professional in front of me up to date and still fit to practise?"—that is quite a hard question to answer, but each regulator needs a tailored approach to its own professional group to ensure that.

Q50 Chair: Is that part of your regular annual dialogue with them?

Harry Cayton: Yes, and it will become more so, now that the GMC has established revalidation. There is a sense now—all the regulators are working on this—that they will need to act on it. It is quite legitimate for this Committee to both ask us to report on progress on that and also to ask the regulators how they are progressing.

Q51 Chair: I think I can speak for my colleagues: we would encourage you to regard it as a theme to be followed through consistently. It would be hard to understand what the counter-argument would be.

I have a further question on that. Do you have a view of what the attitude of the Department of Health is to this theme of progressive introduction of the principle of revalidation, beyond medicine?

Harry Cayton: Yes. As I am sure the Committee is aware, in the White Paper, "Enabling Excellence", they did rather row back from universal revalidation. I personally do not disagree with that as such. I prefer "assuring continuing fitness to practise" as a concept. I have to confess that I am, I think, the only person who has sat on both the medical revalidation working group and the non-medical revalidation working group, in about 2004, and it is a complicated issue. It is not a one-size-fits-all solution, in my view. It would be wrong to take the Department's rowing back from universal revalidation as a suggestion that it did not think that this matters. It is right that we should think that it does matter.

Chair: Thank you.

Q52 Dr Wollaston: The Pharmaceutical Society of Northern Ireland ran a survey to gauge attitudes about where, when and how registrants should raise

[1] Prep is an abbreviation of Post registration education and practice.

concerns about colleagues' fitness to practise and, rather shockingly, 38% of those who replied felt that it was not necessary for professionals to raise concerns about others. Are you actively encouraging regulators to follow this up and make sure it is made very clear to their members that they absolutely have to raise concerns about failing colleagues?

Rosalyn Hayles: I think we will be, but obviously, in the light of the Francis report, that is an issue that has come very much to the fore for all of the regulators, so I would anticipate that that is a specific question that we will ask them in this year's performance review: to demonstrate how they are doing that.

Harry Cayton: I agree with you that that survey response was shocking. One might say it reflects a relatively insular professional group. It is one of the problems of small professions and small regulators that everybody knows everybody in certain communities and in certain professions.

Q53 Dr Wollaston: Do you think it is just this small group? I would say that is a fairly widespread attitude.

Chair: Would that not have been a fair reflection of the view in Mid Staffordshire?

Harry Cayton: I do not think it is the view that the GMC would say doctors generally held.

Q54 Dr Wollaston: It is a good marker for failing hospitals, isn't it, where that is the attitude?

Harry Cayton: No, absolutely, I agree.

Q55 Dr Wollaston: One wonders whether that is a survey that should be carried out across professions.

Harry Cayton: It would be interesting if you could do it to ensure that you got an honest answer. I think the proof of whether professionals believe in reporting the performance of colleagues is how often they do it. That is a much better measure than what they say they think they would do. We have done a little bit of work ourselves looking at some of the evidence around whistleblowing, and one of the interesting things is that there are, it appears, some gender differences, for instance, in the issues that individual professionals take into account when deciding whether or not to whistleblow. There is some suggestion that men are more inclined to take their career prospects into account and women are more inclined to take their relationships into account. Both obviously take both into account, but there is an interesting issue for all of us who are interested in whistleblowing as one of the tools of quality as to how we encourage whistleblowing in ways that people feel comfortable about. I have talked to colleagues in the office about this. Everybody knows it is quite hard to stand up to a colleague and say, "You are not doing your job properly."

Q56 Chair: Isn't it important to get this concept of raising concerns beyond the concept of whistleblowing?

Harry Cayton: Yes.

Baroness Pitkeathley: Absolutely.

Q57 Chair: Describing it as whistleblowing is one thing. It is actually part of the professional dialogue in any healthy culture, is it not?

Harry Cayton: I take that point, absolutely. Robert Francis himself says that whistleblowing is not a solution, but a symptom of the problem.

Chair: Let me bring Grahame in. I pinched his question, but he did express an interest in question 12.

Q58 Grahame M. Morris: This is on the same point about good practice and spreading it from one regulator to another. How would you disseminate good practice? Would you say that a particular regulator is doing something very well and bring that to the attention of another?

Baroness Pitkeathley: We do that.

Rosalyn Hayles: Yes. We try to do that in a lot of our work. In the performance review reports, we will highlight where we think one regulator has done something particularly well or something innovative. We also try to disseminate good practice from our review of their fitness-to-practise decisions. We issue bulletins where we explain where we think someone has got something wrong. We also hold regular seminars where we try and get the regulators together and we invite people who have done one particular thing well to explain to the others how they have done it, and share it at an operational level, rather than just at a theoretical level in a report.

Q59 Grahame M. Morris: I am sorry that I missed the earlier exchange. Mr Cayton mentioned that it is difficult to encourage whistleblowing as the norm, but arising out of the Mid Staffordshire report and so on, is there not an obligation on all of us to actively encourage individuals and regulators to reinforce the message that this is not just a nice thing, but something that there is a professional obligation to do? Is that a fair assessment?

Baroness Pitkeathley: Their own contact with patients and the public would also reinforce that, it seems to me.

Grahame M. Morris: The report refers to the Pharmaceutical Society of Northern Ireland and a survey that it carried out—

Chair: I am sorry, Grahame, we have covered that.

Grahame M. Morris: Okay.

Q60 David Tredinnick: Before we get on to the question I want to ask, whistleblowing has achieved an almost iconic status now. Have you come across any occasions where there was malicious whistleblowing, where it has been used against an individual incorrectly? Are you concerned that, in this new culture, a degree of hysteria and witch hunt can be attached to this new term, whistleblowing?

Harry Cayton: If I was to adopt the Chair's phrase—that is, "raising concerns"—there is an interesting distinction. Raising concerns should be a normal part of professional practice and, of course, it should be done at such an early point in a problem becoming noticeable that there is no need to call it whistleblowing because it should be part of an organisation's internal good processes. You are correct if you are to say that on occasions individuals may

have a mixed set of motivations for raising an issue, but that does not mean the issue is not worth raising. We are not necessarily engaged in judging the motivation of the individual. What we are trying to do is gauge the seriousness of the allegation and whether it has a basis in truth.

Q61 David Tredinnick: This is the last question on this. Have you come across any single individual whose motivation was clearly malicious?
Harry Cayton: No. We get people who are very angry, upset and concerned. We see people who have been through the NHS complaints process and have been damaged by it, and who have been made angry, concerned and upset by the way their concerns and complaints have been dealt with. That is not their fault; that is our fault for having a complaints system that does not work.

Q62 David Tredinnick: That is very helpful. Moving on, what is your view of the Health and Care Professions Council taking on the care professions?
Baroness Pitkeathley: Taking on social workers in England?
David Tredinnick: Taking on the responsibility of the General Social Care Council. Not everyone was in favour of it. What is your view?
Baroness Pitkeathley: No, not everyone was in favour, but that was the decision taken, and we were involved in implementing that. Indeed, our view is that that transition has gone very smoothly. There is no indication that anything has gone wrong with it, and I think both the Health and Care Professions Council and the General Social Care Council are to be congratulated on the way in which they handled that transfer. Of course, we did have the social work oversight group, which my colleague here chaired, which I have to say was not necessarily an easy process, but it did manage what could have been a very difficult and combative transition relatively well. At the moment, we do not have any indication that there is any problem with that.

Q63 David Tredinnick: In this House occasionally we have consolidating Bills when we bring things together. There is quite a long list of bodies that are being regulated here. Do you think that this merger, which is what it is, has lessons for other regulators, and do you think that it is time to consolidate some of this diaspora of different organisations?
Baroness Pitkeathley: We can refer back to what my colleague said about the plans of the Law Commissions and the possibility of legislation in the relatively near future, which we understand is in the pipeline.
Harry Cayton: Yes. If we had greater similarity of legislation, then mergers would be easier to effect. The findings of our cost-effectiveness review demonstrated that small regulators struggle to be both effective and cost-effective. That is not to say they cannot be both, but they struggle, if they are going to be effective, to be cost-effective, and if they are going to be cost-effective, to be effective. There are significant economies of scale, so a smaller number of larger regulators would certainly be a possibility.

Q64 David Tredinnick: Last on this point, the HCPC—the Health and Care Professions Council—only regulates in England at the moment, not Scotland.
Rosalyn Hayles: It only regulates social workers in England.

Q65 David Tredinnick: Yes. Do you think that is satisfactory?
Baroness Pitkeathley: That is a matter for the devolved Administrations. There is still the Scottish Social Services Council, so it is not for us to comment on that.

Q66 Valerie Vaz: Can I pick up the point about the Law Commission and the legislation? Is this something different from what the regulators want? I understand seven out of nine of them want changes in their primary legislation. Is that right? Could you expand a little bit on that and on what other legislation is going to be brought forward by the Law Commission?
Rosalyn Hayles: The Law Commissioners have been undertaking a review of the entire health care profession sector, and the idea is that they will produce an Act that will mean that the regulators will not need to have a section 60 order every time they change their legislation in future. It will enable them to be more flexible in adapting to circumstances. What we have been encouraging the Law Commissioners to look at in this whole piece of work is harmonising across the sector where it is appropriate to do so. The obvious example would be in the area of fitness to practise, so that if a patient makes a complaint about a physiotherapist, a doctor or a nurse, they can have a realistic expectation that it might be dealt with in the same way. We have been encouraging them to look at aligning and harmonising, where it is appropriate to do so, while allowing the regulators flexibility to change their arrangements where they need to.

Q67 Valerie Vaz: Are they in discussions with the Department of Health?
Rosalyn Hayles: The Law Commissioners?
Valerie Vaz: Yes.
Rosalyn Hayles: I would imagine that they are, yes.

Q68 Valerie Vaz: Do you know when they are going to report?
Rosalyn Hayles: They are due to publish the legislation next year.
Harry Cayton: It will be February 2014.
Baroness Pitkeathley: We understand that there is an intention to legislate in this Parliament, but, of course, that is not for us.
Valerie Vaz: Thank you.

Q69 Barbara Keeley: You have carried out two special reviews over the last year: the operation of the Nursing and Midwifery Council and looking into the allegations about the fitness-to-practise functions of the General Dental Council by its outgoing chief executive. Can you tell us how you conduct those special reviews? For instance, are they always

in-house? Are they at a Minister's instigation, or do you have criteria where you can decide to investigate?
Rosalyn Hayles: Yes, I can answer that. We have our own risk assessment process that we can use to initiate a review, but there is also a provision under the legislation for the Secretary of State to ask us to investigate a specific matter. As to the General Dental Council investigation that you referred to, we were asked to do that by the Secretary of State. Our approach would very much depend on the matter we are being asked to investigate. We would draw up a specific plan and scope out the review. We have a code of conduct that anyone doing the investigation signs up to. We would usually aim to conduct them in-house, but we have called on external resources and we did that for the NMC strategic review. So it was led by CHRE staff, but we did call on external resources for that.

Q70 Barbara Keeley: Okay. On the evidence of the performance review report, the Nursing and Midwifery Council has the most problems of all the regulators for which you have responsibility. Your strategic review talked of "high-level recommendations for improvement in the delivery of the NMC's regulatory functions," and you said that you were expecting to see a "demonstrable improvement within two years." We are nine months on. Could you tell us if you think progress so far is satisfactory, and is there evidence at this point, nine months on, that it will be able to deliver that improvement across two years?
Rosalyn Hayles: There is definitely evidence of improvement, and I hope that comes across in the performance review report, but I have to say that there are still some standards that are not being met where progress is slow, and I am sure it is slower than the NMC would want, and it is slower than we would want.

Q71 Barbara Keeley: Can you say what they are?
Rosalyn Hayles: The most important area is fitness to practise. In some ways it is not surprising that progress is slow. They have a huge caseload and it takes a lot of time to turn that sort of function around. I do not mean to avoid the question, but I don't think I am in a position to comment on whether at the end of the two years they will be where they and we would hope they would be. They have had a new council introduced recently. They have had a new chief executive permanently appointed. They have a lot of change going on at the moment. That is a question you would have to ask them.
Barbara Keeley: Okay.

Q72 Andrew George: The performance review notes of the NMC have stated that public protection is the litmus test—it needs to be central to the approach which they are taking—against which all of their work must be measured. What was central to their approach before? It seems to me rather odd that you need to tell them that public protection should be central to their core objectives. What was it before, and why did you feel you needed to point it out to them?
Harry Cayton: What we said in the strategic review was that they had not been solely and fully focused on public protection. If you ask what it was before, my view is that they were too interested, as it were, in promoting nursing and midwifery as occupations, as roles and as important parts of health care—and indeed they are, but that is not, in our view, the role of a statutory regulator. There was, for instance, quite a large body of people employed by the NMC at that time—no longer—in communications and parliamentary liaison and so on. There were a very large number of people employed as professional advisers to the NMC, and the new chair and chief executive have undoubtedly refocused the organisation on regulatory function, setting standards, having a safe and effective register, assuring standards of education and dealing with fitness to practise. As Ros has said, the size of the challenge after many years of lack of clear direction has been considerable for the current management team and the new council.
Baroness Pitkeathley: There is also the size of the register; it is much the largest of all the regulators.

Q73 Andrew George: It concerns me if you have to tell a regulatory body that it should be concerned with public protection. You have also gone on to say that you are concerned that the NMC has not yet been able to identify measures to assess whether it is meeting its objective or not—whether the litmus test that you describe has been passed. What are you doing to help it create, if you like, measures by which it can assess their success in meeting their objectives?
Rosalyn Hayles: One of the difficulties it has had as an organisation for a number of years is a lack of management data, which has always made it quite difficult for it to measure and monitor the success of what it is doing. We do not set key performance indicators or metrics for any of the regulators, but we encourage them to do that for themselves. I hope that we have made it quite clear in this year's performance review report that we expect them to be setting realistic expectations for themselves that they can measure, so that they can see how much progress they are making.
Harry Cayton: My own view, if I may say so, is that looking overall at the NMC—and I have been looking at it and working with it now for quite a number of years—it can now do everything it needs to do well, but it cannot do it well all the time and every time. Quality assurance has become the key thing that it needs to do. I know that it has recently appointed people to help it work on quality assurance, but it is exactly the point that you are making. If you do not have good internal measurement of performance, you cannot quality assure performance. I understand and believe that that is certainly a task that it is committed to, but it is not something it has yet absolutely achieved. I hope and believe it will do so. But as we have said and as you have noted, it takes longer than any of us would wish.

Q74 Andrew George: This is my final question. To what extent is it important that the measures that you put in place reflect their role with regard to the professional and clinical standards of the registrants,

and to what extent is it their role, particularly in that sector, to be monitoring and measuring that they are working in the environment of the right staffing complement?

Harry Cayton: It is absolutely true that patient safety and good quality care partly derive from the right mix and number of people with the right skills, but that varies massively from place to place and from circumstance to circumstance, and even within an individual ward or setting during the day, as patients with different complexities of needs come in and out. I have never taken the view—and certainly it would not be along right-touch regulation principles—that we should define from the centre a staffing ratio as a regulatory outcome; rather, we try to define from the centre that the outcome should be safe care by the appropriate skill mix and number of staff, and organisations should demonstrate that they have ways of ensuring that that is the case. It clearly was not the case, for instance, in Mid Staffordshire, but since we saw that regulation pretty much failed in Mid Staffordshire, I do not think that more regulation would have solved the Mid Staffordshire problem.

Q75 Andrew George: No, but the point I am trying to make is that if public protection is the ultimate litmus test, then you can have the most brilliant, high-quality, clinically proficient professionals working in the service, but if they are not working at the right complement, where is your management data to be able to assess whether it is professional competence that has failed? Therefore, the NMC is perhaps focusing on that when in fact the system is failing to get the right staffing complement to ensure that the public are protected. Do you see what I am getting at?

Harry Cayton: Yes, but I think—and I would defer to the chair if she wants to come in—the point you are making goes back to our earlier answer that collaboration between systems regulators and professional regulators and a focus on the responsibility of the boards of trusts and the senior management of trusts to meet that outcome that you are looking for is essential. There is no doubt that regulators should be asking the question: how can you demonstrate that you have the right skill mix and the right number and complement of people, and that you have sufficient resource to move people around? That is what I believe good chief executives and trusts would do. There are good chief executives and trusts, and we need to remember that as well.

Q76 Andrew George: Should the NMC have an eye to that as well, or is that beyond its brief, do you think?

Harry Cayton: It is more a CQC brief, to be frank, but what we would not want is the NMC to be taking the same position as the RCN and seeing itself as somehow representing the nursing profession.

Q77 Andrew George: That is where you think it went wrong before.

Harry Cayton: That is not its role.

Q78 Chair: The NMC role in this surely is when an individual nurse sees care falling below standards, whether it is because of staffing or any other issue. It is the responsibility of the registrant to raise concerns.

Harry Cayton: Yes, and it is the responsibility of the regulator to act as well.

Q79 Chair: Okay. Can I take us to the General Dental Council? You would normally think, would you not, that the chief executive resigning is a reasonable smoke-signal that something is not quite right there?

Rosalyn Hayles: It was the former chair of the GDC who resigned. When she resigned she raised various concerns about the governance of the organisation and also about its handling of two matters that had been raised about her. She raised those directly with the Secretary of State, and we were asked to investigate the allegations, which we did. We have a 250-page report. I think I can summarise it fairly briefly by saying that we conducted a lot of interviews and reviewed a lot of evidence but, at the end of the day, we were asked to answer two questions by the Secretary of State about whether the GDC had been or was failing to fulfil its statutory functions and about whether any of its council members should be reported to the Appointments Commission or the Privy Council. Our answer to both those questions was no. We did identify that there had been problems at the General Dental Council. We identified some concerns, particularly about the early stages of its fitness-to-practise process, but we were content that those had not meant that at any point it was failing to deliver its statutory functions and we were also content that the problems that we had identified had already been, or were in the process of being, addressed.

Q80 Chair: So you give it an unqualified clean bill of health.

Rosalyn Hayles: We found things that we would have liked to have seen done differently, and we found that there were ongoing issues, which we highlighted for them to rectify, but we had no concerns that it was failing as a regulator.

Q81 Chair: Could you summarise those ongoing issues?

Baroness Pitkeathley: It was a clean bill of health in terms of what we were asked to investigate.

Q82 Chair: Put yourself in the position of the patient who looks to the PSA to investigate the GDC. I ask, clearly, because one of the options open to this Committee in the context of what we are doing with the GMC and the NMC is to invite the GDC to come and give evidence to us. What questions do you think we might ask them on behalf of patients?

Harry Cayton: I think the issues within the GDC were issues of governance rather than of direct regulatory performance. As we know, governance, when it goes wrong, can be enormously damaging to organisations.

There was undoubtedly a breakdown in professional relationships between the chair, Dr Lockyer, the interim chief executive and then the new chief executive who came in. There were weaknesses in the GDC's systems for managing internal complaints and disagreements, but we really—we wrote a very boringly detailed report—dug into everything we could. I used to say to Ros when she was working on it, "We have turned over all the stones and the pebbles under the stones; let's see if there is anything in the sand under the pebbles under the stones." People kept urging us to dig deeper and find more, and the deeper we dug, the less we found. I believe there were some very unhappy relationships and some very poor governance practices, but I seriously believe there was no evidence that we could find that the public were not being protected, even during that period when the council was distracted.

Q83 Chair: Taking Baroness Pitkeathley's point about ongoing concerns, could you summarise to the Committee what those are?
Rosalyn Hayles: Yes. We found some poor practice in the handling of its investigation of fitness-to-practise matters, but the poor practices we found were already being remedied and are still being remedied. We audited last year and are auditing this year, so we will have another opportunity to establish for ourselves that those have all been fixed, but we do not have any serious concerns about those still ongoing now.
Chair: Okay, thank you. We are on to David and voluntary registers.

Q84 David Tredinnick: I want to talk about the powers conferred on you by the Health and Social Care Act in respect of voluntary registers. I see that seven organisations have applied for accreditation of their voluntary registers, of which five have so far been successful. What has happened to the other two, please?
Baroness Pitkeathley: More than that have applied in fact.
Harry Cayton: There are now, I think, six further applications in the pipeline. The application process takes a little time, and we have a mechanism that we have introduced to pause any application if we are not satisfied that they are going to get through to give them more time either to provide us with additional evidence or to amend their policies and procedures to meet our standard. One of the reasons we do that is that these are relatively small organisations. They must pay us a fee for registration, and it would be very unhelpful and destructive to take their money and then just turn their application down without seeing if we can assist them to get through. The situation at the moment is that there are two applications that are paused while we ask the applicants for better and further particulars and to amend some of their processes. There are, I think, three others—
Baroness Pitkeathley: Four others.
Harry Cayton: Four others that are just starting going through the process of assurance.

Q85 David Tredinnick: I think we heard earlier that the voluntary registers are about to break even. Is that right?
Harry Cayton: Yes. The original business model, as I should call it, was that we would need 20 assured voluntary registers on the scheme for the scheme to become sustainable and self-funding. The Department of Health has given us a subvention, which of course decreases year on year as the income increases. My original ambition was that it should be self-funding within three years. We are ahead in the sense that we expected to accredit five in the first year and we have accredited five in the first six months, but of course it will depend on a continuing flow of organisations wanting to be, and seeing the benefit of being, accredited.

Q86 David Tredinnick: The voluntary register has been more successful than you might have expected.
Harry Cayton: Yes.
Baroness Pitkeathley: Yes.

Q87 David Tredinnick: Actually, you have about 70 organisations who are queuing up to get registered.
Harry Cayton: We have 70 organisations who have expressed interest. Not all of them are queuing. Some of them are a little apprehensive. Many of them think it is too expensive.

Q88 David Tredinnick: It is £12,000 to join the club, isn't it, and then £9,000 per annum?
Harry Cayton: Yes.

Q89 David Tredinnick: Should there not be some form of sliding scale here? Why should the larger organisations have the benefit of a not very large fee while the tiny ones find this almost ruinous?
Baroness Pitkeathley: We are aware of the problems for smaller organisations, and one of the things we are looking at is them getting together, forming consortiums to make an application.
Harry Cayton: We have one application already from two organisations that deal with sporting injuries and massage, who have joined together to make a single application, so of course the cost is halved for them. We would like to encourage more. I think we are less enthusiastic about a sliding scale because that would mean organisations subsidising others. The cost to us of doing the work of analysing, visiting and reviewing is the same whatever the size of the organisation.

Q90 David Tredinnick: Are you actually going out and seeking? Are you writing to organisations saying, "Would you like to consider joining?"
Harry Cayton: Yes, in a sense, we did. We designed the scheme through a series of participative workshops with a whole range of organisations, and with members of the public and patients actively taking part in designing the rules and the standards. What was interesting was that the organisations themselves pushed us towards higher standards. They said, "If you set the standard too low, there will not

be a value to us of being accredited," so we have set quite robust standards, and I think it is quite challenging for some of the organisations. They think initially they will get through it quite easily, but then they find that they don't. If it really got to a serious size, the chance then would be that we could afford to bring the individual costs down. We should have economies of scale, just as anybody else would.

Q91 David Tredinnick: I put it to you that that is probably what will happen. I wonder whether you have looked at the House of Lords Science and Technology Committee report of 2000, which drew up three categories of therapies, those that it was recommended should receive statutory regulation—herbal medicine and acupuncture—and then there was a second category, and then a third category with, from memory, reiki and shiatsu and things like that in it. I am wondering if you have looked at that, and whether you are hoping to cover that whole group in the House of Lord Science and Technology report of 2000?

Harry Cayton: We did look at the Science and Technology Committee report early on. We have to work within the framework we have been given, but the legislation around this is fairly flexible, and we have had discussions, for instance, with the Chinese medicine practitioners recently and with a number of other bodies representing what you might call complementary practice. But, again, every organisation will have to meet our standards and those standards are not negotiable in terms of either the size of the organisation or the therapy that it represents.

Q92 David Tredinnick: Fine. On that point, there was a debate this morning in Westminster Hall—actually, it was in my name—on herbal medicine, at which the Under-Secretary said there was going to be a further working group, which he has asked me to join. Have you looked at the possibility of regulating herbal medicine? The original recommendations of that report, of subsequent inquiries and of Professor Pitillo and others was that there should be regulation through the Health Professions Council, as it was then. Do you have a view on this?

Harry Cayton: We have taken the view that, primarily, who is or is not regulated remains a matter for the Government and not for us. However, again, because the Government indicated that statutory regulation was not their preferred way, I do believe that the assured voluntary registers scheme would be an appropriate approach if that is something that people who practise herbal medicine want to do. It is a voluntary scheme; they need to want to do it. It is not a statutory scheme. It is important that we recognise that the AVR scheme is not regulation; it is consumer protection. It is a different level of intervention.

Q93 David Tredinnick: Okay. If you were to go down that route, the oversight that you would provide would have to conform to the traditional herbal medicines directive and the other European legislation to make sure that we have practitioners who meet the required standard. There is a form of words that I cannot exactly remember, but have you looked at it to see whether your style of regulation or oversight would enable us to interface the herbal practitioners with the European legislation as it stands?

Harry Cayton: We have not looked at that specifically because we have been waiting for the Government to announce their decision on herbal practitioners.

David Tredinnick: Okay. There will be a working party starting in September to see if they can get this sorted out.

Chair: I have one eye on the monitor and the Minister is on his feet, which suggests we are going to be interrupted by a Division bell fairly soon.

Q94 Barbara Keeley: I have almost the opposite point about organisations that may not be happy with voluntary registration. I was lobbied by a constituent who is a clinical physiologist and there was an event here, and I am sure other people might have been lobbied. They say that they have concerns about voluntary registration, because they do not think the assurance process you have in that voluntary registration scheme improves patient safety. They cited examples where clinical physiologists could be working with obstetrics patients, and they think there is a need in terms of patient safety. They quoted to me that Health Ministers have said in the past that those professions for which a patient safety case can be made will be considered for statutory regulation. They feel that the position they are in at the moment will mean they are a bit caught, because if they cannot be moved on to statutory regulation, they think that people will de-register because it is not worth it. Do you see what I mean? It is understandable, in terms of the points that have just been made, but if there are bodies who believe they should be regulated statutorily, this may not be enough for them. You may say it is just for Ministers.

Harry Cayton: Yes. We have been in touch with them over a number of years; they have written to the chair and I have met with them. I have a great deal of sympathy for their case, in fact. Nevertheless, they need to think—as indeed some other groups who wanted to be statutorily regulated are already thinking—about whether the AVR scheme is an alternative that at least gives a measure of recognition and assurance. It may be, in their view, less than statutory regulation, but it may be better than nothing.

Baroness Pitkeathley: In terms of the risk to the public, it may provide more public protection than they currently have.

Harry Cayton: I absolutely accept their point.

Q95 Grahame M. Morris: Whose decision is it? Is it the Minister's?

Harry Cayton: No. It is their decision whether or not to apply to us, but it is the Minister's decision whether or not they should be statutorily regulated. There are a number of groups who are seeking, or have been seeking, statutory regulation. But there are others such as the counsellors and psychotherapists who have said they much prefer the AVR scheme.

Baroness Pitkeathley: Yes, they have chosen it.
Harry Cayton: It allows a greater flexibility and sensitivity to particular clinical issues that they have.

Q96 Barbara Keeley: If they and maybe other groups have that concern, is there any way to help with groups where there is a patient safety issue? Clearly, if a clinical physiologist is working with an obstetrics patient, that is a bit more sensitive than some of the other things that are listed under the voluntary registration scheme. Is there anything more that can be done to help with that? There is an obvious concern, which most of us would share, as to how unfit practitioners can be kept away from patients. We would all want to do that.
Harry Cayton: I slightly hesitate to move into areas such as this, but I will.
Chair: The hesitation is noted.
Harry Cayton: We did suggest to the Department of Health prior to the 2008 legislation, I believe, that perhaps we should be given a role in advising the Department on which professions should or should not be statutorily regulated. That was not agreed, so that is not a position that we take, but to go back to my original point, right-touch regulation has to be properly risk based. We do not have a properly risk-based system for deciding who should and should not be subject to statutory regulation.

Q97 Chair: Can I ask another question about the AVR system? Does it enter into your considerations that there is an implied endorsement of efficacy in this process, and how do you protect yourselves on that issue?
Baroness Pitkeathley: We are very clear that we do not take a position on the efficacy of the treatment, but on the standards by which it is delivered.
Harry Cayton: It is a genuine concern and one that we have thought about hard. Our position is that these are all legal and proper therapies that are wanted by members of the public, used by them, and quite often used in parallel in the health service, and that it is not our business to judge the efficacy of an intervention. We say it is very simple: we will say to a member of the public, "If you use someone on an accredited voluntary register, you can know that they have committed to standards of personal behaviour, standards of technical competence in that therapy, and standards of business practice. They will not rob, harm or abuse you." That is all we are offering, but that is quite a big offer in terms of consumer protection.

Q98 Valerie Vaz: I have a final question about the budget and the number of staff you have. Obviously your work is expanding, so do you think you have enough of both?
Baroness Pitkeathley: Far be it from us to make a comment on that. We are always willing, and indeed eager, to take on commissions, but those commissions need to be separately funded, of course, because, as I have said, we have a very small staff. They are very competent, but it is a very small staff.
Harry Cayton: I prefer to work on a small expert core staff and to bring in additional resource, because we often need that additional resource, as Ros has explained, for a performance review or a special review on a temporary basis. It is better and more cost-effective to work that way.

Q99 Valerie Vaz: Where do you get your additional resource from?
Harry Cayton: The AVR scheme, as I have said, is self-funding. We are funded, of course, by Scotland, Wales and Northern Ireland under the Barnett formula as well and the external commissions that we receive are fully costed. For instance—and this is in the public domain because they have published it—the dentists in Ontario for whom we have recently conducted a review have paid us $45,000 for doing that work and that covered our time, transport and accommodation and so on.
Valerie Vaz: Thank you.
Chair: "Fully costed" is an old accounting phrase. Thank you very much for that and thank you for the evidence you have given, which will be useful background for us when we meet with the regulators in the autumn. Thank you very much.

Written evidence from the Professional Standards Authority for Health and Social Care

1. Introduction

1.1 The Professional Standards Authority for Health and Social Care oversees the work of nine health and care professional regulators across the UK:

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

1.2 The Authority is an independent body, accountable to the UK Parliament.

1.3 The Authority was established, as the Council for the Regulation of Healthcare Professionals, by the National Health Service Reform and Health Care Professions Act 2002, following a recommendation of the Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984–95.

1.4 Parliament amended our legislation in 2008 and 2012, expanding our oversight and scrutiny of the professional regulators. Our functions include:

- Annually reviewing the performance of the regulatory bodies to identify areas where regulators are doing well and where they can improve.
- Auditing the initial stages of the regulators' fitness to practise procedures, to assess whether the regulators' decision-making processes are effective; and to assess whether the decisions they make protect the public.
- Examining final decisions made by the regulators' fitness to practise panels about whether health professionals in the UK, and social workers in England, are fit to practise. We may refer decisions to court where we believe they are unduly lenient and do not protect the public.

Alongside these scrutiny roles, we also advise the Secretary of State for Health and health ministers in Northern Ireland, Scotland and Wales on matters relating to the regulation of health professionals in the UK and social workers in England.

1.5 In addition to our responsibilities across statutory regulation, in December 2012 the Authority was given the power to set standards for organisations that hold voluntary registers for people in unregulated health and care occupations and accredit those that meet the standards. To date we have accredited five organisations:

- British Acupuncture Council.
- British Association for Counselling & Psychotherapy.
- National Counselling Society.
- National Hypnotherapy Society.
- Play Therapy UK.

1.6 Throughout all our work we promote the health and well-being of patients, service users and the public in the regulation of health and social care professionals. To do this, we listen to people's views and concerns and commission research on people's experiences and expectations, and consider these when developing our work.

1.7 We promote good practice in regulation through policy papers, seminars and special reviews. We use the concept of "right-touch regulation", the minimum regulatory force required to achieve the desired result, as a framework to guide our scrutiny and policy work.

1.8 Our *Annual Report and Accounts and Performance Review 2012–13* were laid in the four UK Parliaments and assemblies on 27 June 2013.

2. Annual Performance Review 2012–13

2.1 The Performance Review is our annual check on how effective the regulators have been in protecting the public and promoting confidence in health professionals in the UK, social workers in England and in the regulators themselves. The report provides Parliament and the public with our opinion of how each regulatory body has met its statutory responsibility to protect the public.

2.2 We review the regulators' performance against 24 Standards of Good Regulation (listed in Annex 2 of the Performance Review report). These standards are grouped under four headings and are outcome focused, describing what the public expect the regulators to do. They do not describe how the regulators should achieve these outcomes.

2.3 The 2012–13 performance review took place between September 2012 and May 2013. It draws primarily on evidence of performance during the 2012–13 financial year.

2.4 We have found that, while most of the regulators are performing well against most of the Standards of Good Regulation, some improvements in performance are needed in relation to certain standards, most of which relate to the regulators' fitness to practise functions. In particular we have identified that:

- Seven regulators (the NMC, GDC, GCC, PSNI, GPhC, GOsC and HCPC) are at different stages of development for establishing robust systems to assure themselves of the continuing fitness to practise of registrants. The PSNI and the NMC do not yet meet the related standard (2nd Standard of Good Regulation for education and training) because they do not have any system in place, either by means of revalidation or continuing professional development (CPD), to assure themselves of the fitness to practise of registrants, and these two regulators are not likely to have a system in place before 2016. We acknowledge that the PSNI and NMC have justifiable reasons for the timescales within which they are aiming to achieve this work.

— Three regulators (the NMC, GDC and GCC) were not able to demonstrate that fitness to practise cases were being dealt with as quickly as possible (taking into account the complexity and type of case, and conduct on both sides), and therefore have not met the 6th Standard of Good Regulation for fitness to practise.

— Two regulators (the NMC and the GCC) were not able to demonstrate that parties were consistently being kept up to date on the progress of their cases and supported to participate effectively in the fitness to practise process. These two regulators have therefore not met the 7th Standard of Good Regulation for fitness to practise.

— One regulator (the NMC) was not able to demonstrate that information about fitness to practise cases was being securely retained and its confidentiality protected, and therefore has not met the 10th Standard of Good Regulation for fitness to practise. We were not able to identify whether the GPhC has met this standard as we are waiting for a ruling from the Information Commissioner's Office about a data security breach.

2.5 The report also highlights the good practice we identified in the course of reviewing performance:

— Stakeholder engagement by the GDC and the GMC.

— Maximising use of online resources by the GMC and the GOC.

— Induction of professionals trained overseas by the GMC.

— Examining challenges for students with disabilities by the GMC.

— Supporting witnesses and registrants through the fitness to practise process by the GMC and the HCPC.

2.6 We make a number of recommendations for individual regulators within the report, and we have identified areas of work that we intend to follow up on in next year's review.

2.7 We are refreshing our approach to Performance Review to make it more efficient and effective. We will consult on proposed changes later in 2013.

3. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

3.1 The final report of the Mid Staffordshire NHS Foundation Trust public inquiry was published in February 2013. This report made a number of recommendations (indirectly and directly) for implementation by the regulators overseen by the Authority. The report also recommended that the Authority works with the regulators we oversee to devise procedures for dealing consistently and in the public interest, with cases that arise from the same event (or series of events) but involve professionals regulated by different regulatory bodies. We are beginning work with the regulators on this recommendation and will report on this in next year's performance review.

3.2 This year, our annual schedule of audits of the cases closed by the regulators at the initial stages of the fitness to practise process (without referral for a final fitness to practise hearing) will include the GMC and the NMC. In these audits we will consider a sample of the cases that involved registrants employed at Mid Staffordshire NHS Foundation Trust. We will pay particular attention to the outcomes of final fitness to practise panel hearings concerning employees of the Mid Staffordshire NHS Foundation Trust.

4. Improving Professional Regulation

4.1 We welcome the Government's recognition, in response to the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, that the regulators we oversee are hampered from performing as effectively as they could in some areas by an outdated legislative framework.

4.2 Through our scrutiny of the regulators we see the impact that working with out-dated legislative frameworks has on the delivery of effective, consistent, targeted and proportionate regulation. It has become evident that for some regulators, their legislation does not allow them to protect the public as effectively and efficiently as possible.

4.3 In 2012, at the request of the Department of Health, we reviewed proposals from seven regulators for changes to primary legislation through Section 60 orders[2] that would remedy these issues. We identified a number of changes that in our view improved public protection and closed potentially serious loopholes in current arrangements.

4.4 At the same time, the current legislative framework for the regulation of health professionals in the UK and social work professionals in England was being reviewed by the Law Commissions across the UK. This is an important project that represents a significant opportunity to modernise the legislation that delivers public protection.

[2] A Section 60 order allows Parliament to make changes to the regulators' legislation without the need for an Act of Parliament. They can take up to two years to be approved.

4.5 Earlier this year, the Department stated it would not proceed at this time with the recommendations we put forward for inclusion in Section 60 orders as it was "seeking an early legislative opportunity to bring forward the draft legislation being constructed by the Law Commission." We agree that the Law Commissions' legislative proposals are, if they can be implemented quickly, the best opportunity for reform. We welcome the Government's commitment to implementing the Law Commissions' review and overhauling 150 years of complex legislation.

July 2013

Printed in the United Kingdom by The Stationery Office Limited
08/2013 032351 19585

ISBN 978-0-215-06154-6