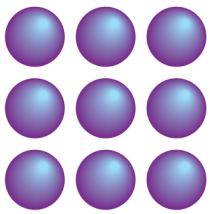
Modern and efficient fitness to practise adjudication

CHRE's advice for Secretary of State

August 2011



council for healthcare regulatory excellence

About CHRE

The Council for Healthcare Regulatory Excellence promotes the health and well-being of patients and the public in the regulation of health professionals. We scrutinise and oversee the work of the nine regulatory bodies[1] that set standards for training and conduct of health professionals.

We share good practice and knowledge with the regulatory bodies, conduct research and introduce new ideas about regulation to the sector. We advise the four UK government health departments on issues relating to the regulation of health professionals. We are an independent body accountable to the UK Parliament.

Our aims

CHRE aims to promote the health, safety and well-being of patients and other members of the public and to be a strong, independent voice for patients in the regulation of health professionals throughout the UK.

Our values and principles

Our values and principles act as a framework for our decision making. They are at the heart of who we are and how we would like to be seen by our stakeholders.

Our values are:

- Patient and public centred
- Independent
- Fair
- Transparent
- Proportionate
- Outcome focused

Our principles are:

- Proportionality
- Accountability
- Consistency
- Targeting
- Transparency
- Agility

Right-touch regulation

Right-touch regulation is based on a careful assessment of risk, which is targeted and proportionate, which provides a framework in which professionalism can flourish and organisational excellence can be achieved.

1 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 Professions Council (HPC), Nursing and Midwifery Council (NMC), Pharmaceutical Society of Northern Ireland (PSNI)

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1. Executive summary

1.1 Right-touch regulation describes the approach we adopt in the work we do. It means always asking what risk we are trying to regulate, being proportionate and targeted in regulating that risk or finding ways other than regulation to promote good practice and high-quality healthcare. Of all the statutory functions of the health professional regulators, none of them has more of a direct impact on mitigating risk and contributing to high quality healthcare than their fitness to practise functions. CHRE was asked by the Secretary of State to provide advice on modernising and improving the efficiency of fitness to practise adjudication. Therefore using a right-touch approach to set out our vision for a modern and efficient fitness to practise adjudication function presents both a challenge and a unique opportunity.

1.2 We began this work by understanding what had been done so far, in particular by working closely with the Office of the Health Professions Adjudicator (OHPA). The work has also been informed by our considerable experience of scrutinising decisions made by the regulators' fitness to practise panels, and our wider policy work in the area. We sought the views of key stakeholders and the public on the issues raised by their experience of adjudication, and were keen to hear suggestions on how it could be improved. Finally, we listened to the experiences of those people who have been through the fitness to practise process, to really understand what it is like to raise a concern with a regulator, to go through the investigation process and to appear as a witness at a hearing.

1.3 Using the right-touch approach, we must understand the problem we are trying to address. OHPA was set up on the principle that public and professional confidence in regulation would benefit from separating the adjudication and investigation of cases, beginning with the GMC. This development arose from a recommendation of the Fifth Report of the Shipman Inquiry in 2004.[2] In late 2010 the Government announced it would not proceed with establishing OHPA, opting instead to pursue greater separation and independence for adjudication within the GMC. At the same time, we were asked to identify what could be learnt from OHPA's work for fitness to practise adjudication.

1.4 It would be inaccurate to suggest that fitness to practise adjudication remains the same in 2011, as it was in 2004. However, while investigation and adjudication of cases is held within the same organisation, the problem of public confidence identified by the Shipman Report remains. Furthermore, this report shows that other issues are present in adjudication today. The process can deliver poor outcomes; this is evident by the continued rise in learning points that we issue to regulators. There remains a strong sense of inconsistency in the outcomes between, and inconsistencies within, regulators. This was a major theme in the responses we received to our Call for Information. Good practice in adjudication and the investigation preceding it is not consistently demonstrated. People who raise a concern to a professional regulator find the process stressful and daunting, to the point that it may deter people from raising a concern again in the future. Finally, there remains confusion, not just amongst the public but also stakeholder organisations, about the purpose of the fitness to practise process.

[2] The Shipman Inquiry. 2004. *Fifth Report - Safeguarding Patients: Lessons from the Past - Proposals for the Future.* Available at: http://www.shipman-inquiry.org.uk/fifthreport.asp [accessed July 2011]

1.5 Our response to the problems identified above has to meet a key principle of right-touch regulation: to use regulation only where necessary. We have identified a range of solutions and recommendations based on the work that OHPA had completed and other evidence we have heard during this work. Some are the responsibility of the regulators alone, and some require the input of other stakeholders. Some are relatively 'quick wins' but others require deeper change. Some of our recommendations require legislative change, and we are conscious of the implications of recommending this. Uniting all of our recommendations is the aim of achieving our vision for a modern and efficient adjudication system:

> ***CHRE's vision of a modern and efficient system of adjudication is one that delivers high-quality decisions which fulfil the three-fold purpose of fitness to practise while demonstrating the principles of right-touch regulation.***
>
> A *modern system* is one which uses up to date practices and approaches; an *efficient system* is one that optimises the resources available to it to achieve the intended purpose. For fitness to practise, case-law identifies a threefold *purpose*:
>
> - Protection of the public
> - Declaring and upholding professional standards
> - Maintaining public confidence in the profession and the regulatory process.
>
> *High-quality decisions* mean those that are robust, based on thorough examination of the evidence and taken in line with established good regulatory practice and legal frameworks. The principles of right-touch regulation mean that adjudication systems must be proportionate, consistent, targeted, transparent, accountable and agile. We provide more detail on what this means in our conclusions.

1.6 With a shared commitment to this vision and these outcomes we would maximise the regulators' chances of delivering high-quality decisions and reducing the frequency of poor quality adjudication outcomes. In practice it would mean training and appraising all those involved in the process more effectively, allowing a more flexible approach to adjudication, and adopting greater use of active case management techniques. In addition, there are some particular pieces of work that we ask the regulators to work on, these are:

- Exploring mechanisms to enable **better support and advice** options for people to raise a concern to a regulator
- Exploring the possibility of **sharing adjudication services** across the regulators, to achieve the independence and value for money that people expect
- Achieving **greater consistency** across health professional regulation in the investigation and adjudication of fitness to practise decisions
- Establishing a clear and consistent **statement on the purpose of fitness to practise** in health professional regulation, to improve understanding of what the process is intended for, and can realistically deliver.

1.7 We therefore make the following recommendations:

- **Regulators** must:
  - Review their current performance in adjudication against our vision for a modern system and take steps to learn from good practice identified in CHRE Performance Reviews, and provide evidence of progress in future Performance Reviews
  - Work with panellists to act on CHRE learning points to continue to improve decision making in adjudication
- **Regulators should work together** to improve the operational efficiency of adjudication by:
  - Getting more value from the time, people and resources invested in adjudication, for example, through joint training of panellists, better use of pre-hearing case management, and shared use of hearing rooms
  - Providing greater support to witnesses throughout investigation and adjudication to allow them to participate fully in the process
- **CHRE will facilitate** a wider programme of work, in partnership with regulators and other interested parties, dedicated to improving adjudication in the future. This programme will include:
  - Developing and agreeing a common statement on the purpose of fitness to practise
  - Working to deliver greater consistency across regulation, through shared adjudication services, harmonised sanctions, shared indicative sanctions guidance for panellists in relation to common issues, exploring the options for a joint pool of panellists and clarifying the accountability and roles of panellists in the interests of greater separation and continuous improvement.

1.8 We also recommend that the Law Commission simplification review of health professional regulation includes exploration of other ideas that OHPA proposed that received some support in our engagement exercise. This includes, for example, limiting the use of oral hearings, considering wider use of 'consensual disposal', and how costs powers can be used in adjudication.

1.9 The work that OHPA completed before the decision not to proceed with its establishment has offered an opportunity to review the current approach to adjudication in the light of the expectations, experience and knowledge of a wide range of interested parties. Through this work we consider we have described a practical vision for adjudication that is consistent with existing good regulatory and legal practice. Ultimately adjudication in health professional regulation is about making good decisions in the public interest and by embedding this fundamental principle within our vision for the future, we hope to have identified the direction and development of the reforms the regulators will undergo in the next few years.

2. Introduction

2.1 In summer 2010, against a backdrop of reviews of arm's-length bodies across Government and concerns about value for money and economic efficiency, plans for the launch of the Office of the Health Professions Adjudicator (OPHA) were put on hold and the Department of Health consulted on options to increase the independence of adjudication of fitness to practise cases in health professional regulation. After this consultation, in November 2010, the Coalition Government announced its intention not to proceed with establishing OHPA.

2.2 Following that decision, CHRE was asked by the Secretary of State to provide advice on modernising and improving the efficiency of fitness to practise adjudication. This is a statutory request under section 26A of the NHS and Healthcare Professions Act 2002 (as amended). The intention was to capture what OHPA had learnt during the course of its preparatory work and use this alongside our own experience and the views of interested parties to improve adjudication of fitness to practise across the nine UK health professional regulators. We were asked to set out a vision of what a modern, cost effective and efficient fitness to practise adjudication system would look like for health professional regulators.

2.3 Fitness to practise adjudication is an area of health professional regulation that has been the subject of much discussion, policy development and legislative change over recent years. The Fifth Report of the Shipman Inquiry published in 2004 recommended greater separation between investigation and adjudication.[3] This would enhance public confidence, it was argued, by taking away the adjudication element from the regulator so they are not acting as both the 'prosecutor' and the adjudicator. The responsibility for adjudication, including hearing the case in front of an independent panel, would fall to another organisation. In response to this in 2007 the Government announced its intention to establish OHPA. The Health and Social Care Act 2008 made provision for this. In the first instance, OHPA would be asked to adjudicate in GMC cases. In 2007, the GOC had expressed their desire to move to adjudication by OHPA and the Health and Social Care Act 2008 also allowed for this.[4] In time, many believed that the intention was that fitness to practise hearings from all nine health professional regulators would be heard by OHPA. In our special report in 2008 we recommended this should be accelerated for the NMC.[5] This would have delivered separate investigation and adjudication of cases across health professional regulation in line with Dame Janet Smith's 2004 recommendation.

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3 The Shipman Inquiry. 2004. *Fifth Report - Safeguarding Patients: Lessons from the Past - Proposals for the Future.* Available at: http://www.shipman-inquiry.org.uk/fifthreport.asp [accessed July 2011]

4 GOC. 2007. GOC supports early move to Independent Adjudication. Available at: http://www.optical.org/en/news_publications/news_item.cfm?id=32D93066-0246-4198-B29E76F1F34033D4 [accessed July 2011]

5 CHRE. 2008. *Special report to the Minister of State for Health Services on the Nursing and Midwifery Council.* Available at: https://www.chre.org.uk/_img/pics/library/080611_NMC_Final_Report_1.pdf [accessed 8 June 2011]

Our approach

2.4 We have been fortunate to learn from the development work that OHPA had undertaken in preparation for assuming the role of independent adjudicator. Our task is to articulate a strategic vision for this aspect of regulators' work, and to identify some practical reforms and developments that would help regulators to achieve this vision in practice. A number of factors have influenced our approach. Firstly, case law, which has established a three-fold purpose in fitness to practise:

- Protection of the public
- Declaring and upholding professional standards
- Maintaining the reputation of the profession and public confidence in the profession.[6]

Here, the reputation of the profession does not refer to an individual's personal reputation, but rather the collective reputation of the profession. These principles have underpinned our approach, the research and analysis we have conducted and our final recommendations.

2.5 Our approach has also been informed by a need to consider how adjudication can be modern and efficient. A modern system is one that uses up to date practices and approaches. An efficient system is one that makes best use of the resources available to it to achieve the intended outcomes. In this report we consider adjudication both as a process and an outcome, and the interplay between these two are important for our conclusions. A more modern process should not be pursued at the expense of the quality of the outcome, which is public protection. The urgency of any need to improve efficiency should not override the importance of other duties and obligations, including enhancing public confidence. So, we have considered the quality of adjudication outcomes alongside the options for modernising and improving the efficiency of adjudication process.

2.6 Our recommendations are guided by our assessment of the opportunities that are available to regulators and to others to make changes. We have looked to build on opportunities that already exist. And finally, as CHRE, we are committed to the application of right-touch regulation in our work, that is, the minimum regulatory force necessary to achieve the desired result.[7]

The report

2.7 In Chapter 3 we discuss adjudication today and the changes that have recently been proposed. We report in Chapter 4 on the work that OHPA had completed in developing its approach to adjudication. Following this we report on the results of our engagement exercise that built on the work completed by OHPA. We have sought the views of a wide range of stakeholders with an interest in this area of the regulators' work to understand their views on where improvements to the process of adjudication could be achieved. We identified a number of questions about the scope to improve adjudication, both in terms of modernising its

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6 The Shipman Inquiry. 2004. *Fifth Report - Safeguarding Patients: Lessons from the Past - Proposals for the Future.* paragraph 25.352. Available at: http://www.shipman-inquiry.org.uk/fifthreport.asp [accessed July 2011]

7 CHRE. 2010. *Right-touch regulation*. Available at http://www.chre.org.uk/_img/pics/library/100809_RTR_FINAL.pdf [accessed 21 February 2011]

processes and making the system more efficient. Chapter 5 describes in greater detail the methods and results from our engagement exercise.

2.8 In Chapter 6 we discuss the results of a research exercise that sought the views of those people who have been directly involved in fitness to practise processes as witnesses. We follow this in Chapter 7 with a summary of CHRE's experience and what this tells us about opportunities to improve adjudication. Our performance review standards clearly identify the outcomes we expect regulators to achieve through their fitness to practise work. Alongside these standards, we have built up a picture of good practice in the management and administration of fitness to practise cases through our scrutiny of final decisions taken by panels. We describe our views and experiences of this work in detail in this chapter.

2.9 The final chapter discusses the implications of our research and analysis for fitness to practise adjudication. We describe our vision for adjudication drawing on our own experience and the information we have gathered during the project. Based on this we then identify a range of recommendations and opportunities for regulators, and others involved in this process, to make improvements to the current system in line with our vision.

Acknowledgements

2.10 We are grateful for the support and input we received from OHPA, in particular Wendy Harris, Policy Director, during the course of this project. We would also like to thank all those who responded to our call for information (see Appendix 1 for full details), and those in the regulatory bodies who shared their experience and perspectives. Finally, we would like to thank all those individuals who were willing to be interviewed about their experience of fitness to practise processes.

3. Fitness to practise adjudication

3.1 There is no single agreed definition of fitness to practise. The Health Professions Council describes it as follows:

> 'If a health professional is fit to practise it means that they have the skills, knowledge and character to practise their profession safely and effectively; and their behaviour contributes to public protection and enhances confidence in their profession.'[8]

3.2 The fundamental purpose of fitness to practise procedures, as described in the Fifth Report of the Shipman Inquiry, is to promote and safeguard the *public interest,* which includes individual patient protection, alongside the maintenance of public confidence in the profession, and declaring and upholding proper standards of conduct.[9] This description reflects the three-fold purpose of fitness to practise proceedings identified in the relevant case-law.[10] The purpose of fitness to practise is not to punish the health professional. However, the sanctions imposed by fitness to practise panels may have a punitive effect.

3.3 In her report, Dame Janet Smith identified some 'basic principles that should be applied' in the regulators' work in fitness to practise, including:

- Everything a regulator does must (subject to confidentiality) be capable of scrutiny, ie it must be transparent
- The work of the regulator must be thorough, careful and of high quality, meaning that every aspect of the fitness to practise procedures must be properly resourced, with each process being undertaken by persons who are suitably qualified and properly trained to carry it out
- In the interests of fairness and of the proper maintenance of standards, procedures must be followed and decisions made in a consistent, transparent manner.[11]

3.4 The need for fairness in the process is also reflected in the requirement that regulators' fitness to practise proceedings must comply with the Human Rights Act 1998. Under the Act it is unlawful for a 'public authority' to act in a way that is incompatible with a European Convention right. The health professional regulators' fitness to practise panels are 'tribunals' and therefore 'public authorities' for the purposes of the Act and it would be unlawful for them to act in a way that is incompatible with the European Convention.

3.5 Although regulators to some extent rely on third parties (including patients, health professionals, employers and others) raising concerns about their registrants' fitness to practise, the fitness to practise process is not a 'complaints process' as such, and its purpose is not to provide redress to the person who raised the

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8 Health Professions Council. *Fitness to Practise: What does it mean?* Available at: http://www.hpc-uk.org/assets/documents/10002FD8FTP_What_does_it_mean.pdf [accessed July 2011]

9 The Shipman Inquiry. 2004. *Fifth Report - Safeguarding Patients: Lessons from the Past - Proposals for the Future.* paragraph 25.352. Available at: http://www.shipman-inquiry.org.uk/fifthreport.asp [accessed July 2011]

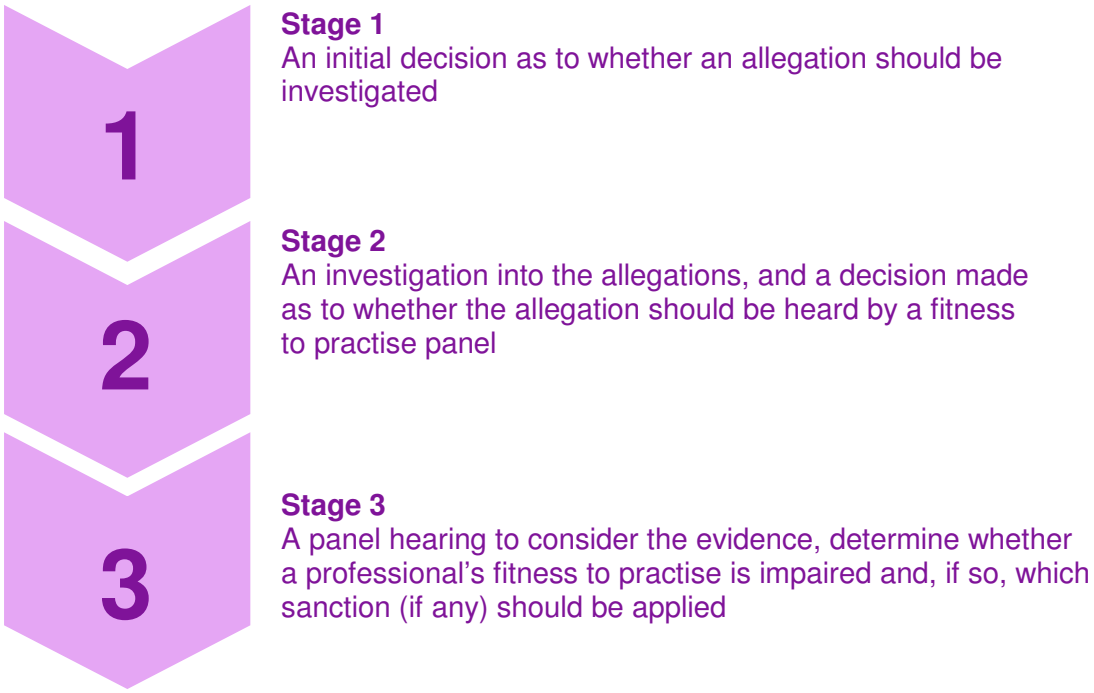
10 *Garfoot v General Medical Council* [2002] UKPC 35

11 The Shipman Inquiry. 2004. *Fifth Report - Safeguarding Patients: Lessons from the Past - Proposals for the Future.* paragraph 25.352. Available at: http://www.shipman-inquiry.org.uk/fifthreport.asp [accessed July 2011]

concern. Its focus is on protecting the public by ensuring that health professionals are fit to continue practising (or restricting their practice if not). However there are certain principles that govern good practice in handling complaints which we would expect fitness to practise processes to adopt, such as timeliness and a strong emphasis on good customer service.[12]

3.6 If a concern is raised with a regulator about a professional who is registered with them, the regulator will follow the three stages of the fitness to practise process outlined in Figure 1 below. This report focuses on the adjudication stage of the process (Stage 3 below). However, it is important to recognise that the quality of the work done by the regulator at the earlier stages of the fitness to practise process can have an important bearing on the outcome of the adjudication stage.

Figure 1:



If the circumstances of a particular case indicate an immediate threat to public protection, regulators can take action to impose an 'interim order' on a registrant at any point in the process.

3.7 At stage 3, the fitness to practise panel is responsible for inquiring into the allegations, and deciding whether the health professional's fitness to practise is impaired. A fitness to practise panel is made up of at least three people, comprising both professionals and non-professionals, with the support of a legal assessor. Panellists and assessors are appointed by the regulator[13] but operate 'independently' of it. In practice, individual panellists may sit on panels for more than one regulator. One member of the panel chairs the discussions. Chairs may be legally qualified but this is not a common requirement across all regulatory bodies.

[12] Parliamentary and Health Service Ombudsman. 2009. *Principles of Good Complaint Handling.* Available at: http://www.ombudsman.org.uk/improving-public-service/ombudsmansprinciples/principles-of-good-complaint-handling-full [accessed July 2011]

[13] Some regulators use independent assessors as part of panellist recruitment

Recent developments in adjudication

3.8 In 2004, the Shipman Inquiry Report concluded that it was necessary to separate adjudication from investigation to enhance public confidence in the process. This step would take the adjudication element away from the regulator and the responsibility for adjudication, including hearing the case in front of an independent panel, would fall to another organisation. This organisation would be responsible for recruiting and training the panellists who would hear the allegations and the registrant's case before adjudicating on the case. The Government responded to the Inquiry's recommendation by legislating for the establishment of an independent adjudicator (OHPA) within the Health and Social Care Act 2008.

3.9 With the change in Government policy in late 2010 relating to the implementation of the plans for independent adjudication through OHPA, the focus turned instead to identifying the potential for modernising fitness to practise adjudication across all the health professional regulators without the formal independence of the investigation and adjudication functions that would have been achieved by the handover of the GMC's responsibility for adjudication to OHPA.

3.10 The Command Paper, *Enabling Excellence*[14] published in February 2011, expanded upon this change in approach and a shift in emphasis. It signalled the Government's intention to reduce the overall costs associated with health professional regulation, of which the investigation and adjudication of concerns about registered health professionals forms a sizable portion. For example, *Enabling Excellence* notes that 54 per cent of the NMC's total expenditure in 2009/2010 (£19.7m out of a total of £36.7m) related to its fitness to practise work.

3.11 As part of an ongoing intention to reflect good practice some of the regulators have recently consulted on changes to their fitness to practise rules and processes. The consultations have ranged from altering how the process is managed, to wholesale reforms in the way fitness to practise cases are dealt with. For example:

- The Department of Health, Social Services and Public Safety in Northern Ireland, recently consulted on proposed changes to the legislation governing the PSNI. This included matters relating to its fitness to practise procedures.[15] The specific proposals include reconstituting the Statutory Committee which will allow it to consider health cases, and extending the range of sanctions to include advice, warnings, suspension, conditions on practise and removal from the register and bring the PSNI in line with good practice in other regulators. Other changes proposed include the power to obtain information from other sources, the disclosure of information when it is in the public interest and the ability for the Registrar to refer cases directly to the Statutory Committee

[14] Department of Health (2011). *Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers*. Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124374.pdf [accessed July 2011]

[15] Department of Health, Social Services and Public Safety. 2011. Confidence in Care Programme - Consultation on the Pharmacy (Northern Ireland) Order 1976 (Amendment) Order (Northern Ireland) 2011. Available at: http://www.dhsspsni.gov.uk/showconsultations?txtid=47933 [accessed July 2011] You can see CHRE's full response to the consultation at: http://www.chre.org.uk/satellite/406/ [accessed July 2011]

- The GOC recently consulted on proposed amendments to its legislative framework to permit the Registrar to refer a complaint relating to a criminal conviction directly to the Fitness to Practise Committee and to enable consolidation of the hearing process where there are various allegations of impairment. The proposals aim to reflect good practice and the relevant case law[16]
- The GMC recently consulted on an alternative to holding a public hearing in the majority of fitness to practise cases.[17] Its proposals would mean a greater degree of discussion with doctors to encourage them to accept the sanctions proposed by the GMC, without the case being heard by a fitness to practise panel. The GMC has also recently announced its intention to establish the Medical Practitioners Tribunal Service (MPTS)[18] to deliver its adjudication function within a framework which means that it will be 'operationally separate' from the rest of the GMC.

3.12 These developments are in addition to a range of requests from regulators to the Government for changes to their legislative frameworks arising from the 2007 White Paper, *Trust, Assurance and Safety*. The regulators highlighted a number of improvements and developments they wished to implement relating to fitness to practise in general and adjudication in particular, which could only be achieved by using powers in section 60 of the Health Act 1999 to change their procedural rules. More details of these requests can be found in advice we provided to the Department of Health in 2009.[19]

3.13 The changes that the regulators want to introduce vary, reflecting their individual circumstances and the different combinations and configurations of legislation and rules that govern how they currently deliver their fitness to practise functions. In part this reflects their different backgrounds and development over time, and the differing opportunities that have been available to some of them to update their legislative frameworks.

3.14 One consequence of this is a significant degree of inconsistency across the regulatory bodies. This was evident in work we completed in 2008 on sanctions. The nine regulators currently have different sanctions that they are able to impose (as set out in their legislative frameworks) and also use a variety of different terms to describe essentially identical sanctions. We investigated the demand for and the opportunities available for harmonising the sanctions used by all regulators.[20]

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16 General Optical Council. 2011. *Amendments to the Fitness to Practise Rules: Consultation*. Available at: http://www.optical.org/goc/filemanager/root/site_assets/consultation_documents/ftp_rules/ftp_rules_consultation.pdf
You can see CHRE's full response to the consultation at: http://www.chre.org.uk/satellite/397/ [accessed July 2011]

17 General Medical Council. 2011. *Reform of the fitness to practise procedures at the GMC - changes to the way we deal with cases at the end of an investigation*. Available at: https://gmc.e-consultation.net/econsult/consultation_Dtl.aspx?consult_Id=161&status=3
You can see CHRE's response to the consultation at: http://www.chre.org.uk/satellite/391/ [accessed July 2011]

18 General Medical Council. 2011. *New tribunal service for doctors gets the go-ahead.* Available at: http://www.gmc-uk.org/news/10151.asp [accessed July 2011]

19 CHRE. 2009. *Section 60 prioritisation exercise*. Available at: http://www.chre.org.uk/satellite/409/ [accessed July 2011]

20 CHRE. 2009. *Harmonising fitness to practise sanctions: common terms*. Available at: http://www.chre.org.uk/_img/pics/library/0911_Sanctions_terminology_paper_Final.pdf [accessed June 2011]

The public consultation carried out during that project highlighted the strong desire to see greater harmonisation and consistency across the regulatory sector and we were able to identify a range of options that if available across the regulators would provide a proportionate and targeted set of sanctions, while also improving the consistency across the sector.

3.15 In the Command Paper, *Enabling Excellence*, the Government announced their intention to ask the Law Commission to conduct a simplification review of health professional legislation that should help to address these areas of difference. This report on adjudication and the work that the Law Commission has been asked to do offer useful opportunities for a reconsideration of whether all of the inconsistencies that arise from the different legislative framework applying to each of the regulators (not only in relation to sanction, but also in relation to their fitness to practise function more generally) remain justifiable – or whether action should now be taken to deliver greater harmonisation where possible across the sector.

Summary

3.16 The fitness to practise process is the aspect of the health professional regulators' work that members of the public are most likely to be aware of or come into contact with. Undoubtedly this is in part because fitness to practise hearings are generally held in public and their outcome is accessible and frequently publicised by local and national media. It also reflects the fact that individual members of the public may be the source of concerns about a particular professional's fitness to practise, and/or may be called to give evidence at regulators' fitness to practise hearings. Given the high profile of this area of the regulators' work, it is essential to maintaining public trust in the health professions and in their regulation that the fitness to practise function of each regulator not only works effectively to deliver the right outcomes, but that it is also seen to do so.

3.17 At present, considerable variety exists across the various health professional regulators' fitness to practise processes and outcomes. This in part reflects differences in their legislation, rules and internal processes. Our harmonising sanctions work underlined the strong public desire for and the value inherent in greater consistency being achieved across the nine regulators. In our ongoing work in reviewing the regulators' annual performance, scrutinising each final fitness to practise panel decision, and auditing the decisions made at the investigation stage of each regulator's fitness to practise process, we assess and report on the outcomes that each regulator's fitness to practise process delivers, and, where appropriate, comment on factors that may have contributed to poor outcomes as well as highlighting good practice. We expect the individual regulators to take account of our recommendations – which should contribute to greater consistency across the sector.

4. Building on OHPA's work

4.1 In this chapter we describe the work that OHPA had completed in preparation for adjudicating on cases from the GMC from April 2011. This includes the approach that OHPA intended to take from 'day one', and the longer-term policy ambitions OHPA had for the process of fitness to practise adjudication in both GMC and GOC cases and, it was hoped in due course in cases referred by other health professional regulators. We have used these ideas as the basis for an engagement exercise that canvassed the views of a wide range of stakeholders for their thoughts on potential improvements to the adjudication process, including the merits of the different proposals that OHPA had developed. The results of this exercise are described in Chapter 5.

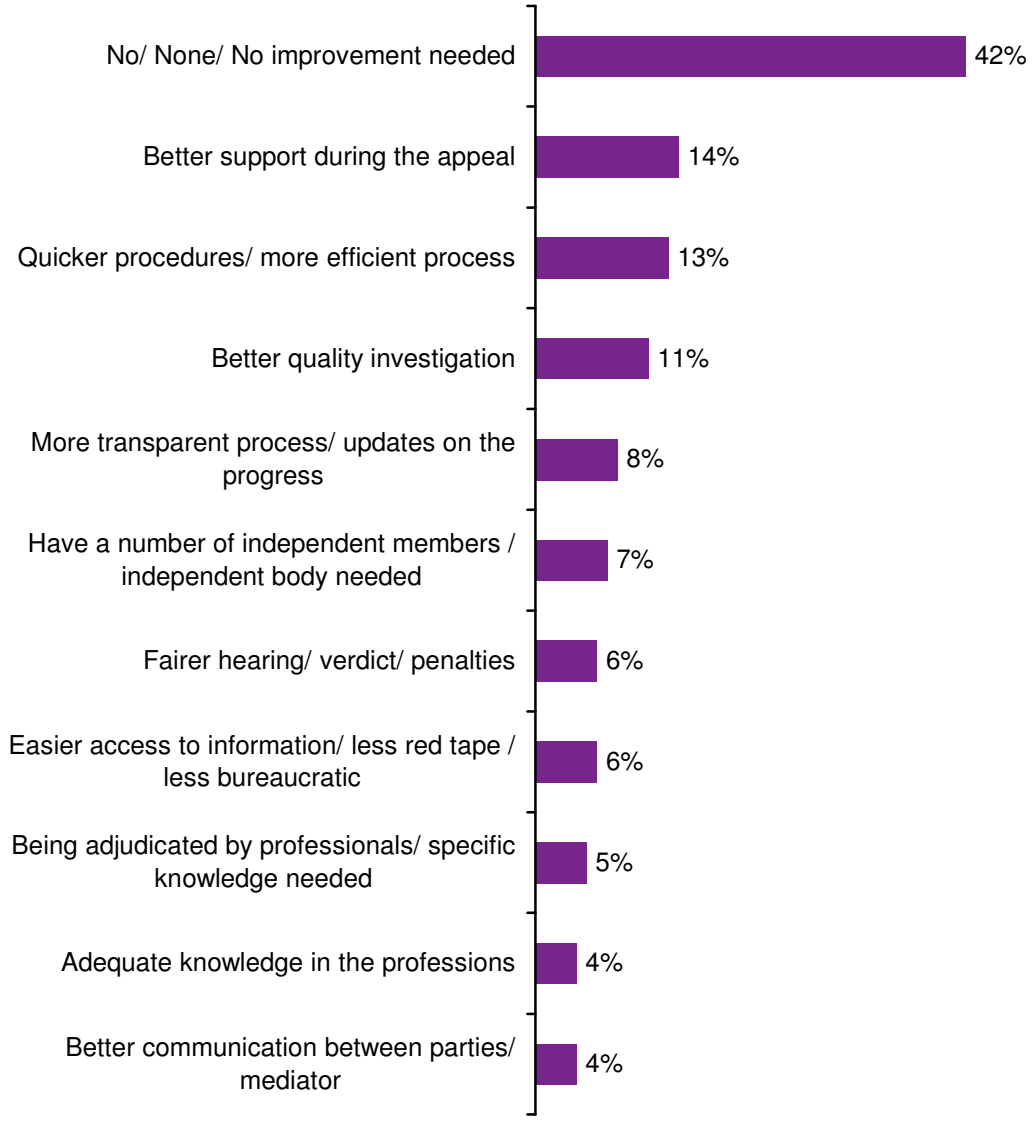
OHPA's early research and policy development

4.2 The Government's policy intention in establishing OHPA was to enhance public confidence in regulation by achieving the separation of investigation and adjudication of fitness to practise cases, as recommended by the Shipman Inquiry. OHPA was to be funded by fees paid by the referring regulator. As OHPA scoped its intended approach to adjudication, it considered the process it would adopt as an independent organisation. It considered the existing approaches used by regulators, and by other adjudicative bodies such as tribunals. It also considered the views and experiences of frontline professional and regulators in health and in other sectors, and reflected on current thinking in regulatory policy.

OHPA benchmarking research

4.3 OHPA commissioned a survey of over 1000 frontline health professionals in 2010. The aim of this research was to measure their perceptions of the current fitness to practise adjudication processes and assess what potential improvements could be made. Those with no personal experience of the adjudication process were more likely to believe that the current process needed no improvement (42 per cent), compared to others with some personal experience (27 per cent). Across the full sample, nearly 6 out of 10 identified areas for improvement, particularly for better support (although the nature of this support was not specified), and a quicker, more efficient process. Further results can be seen Figure 2.

Figure 2: Improvements that could be made to fitness to practice adjudication



A wider perspective

4.4 Recent reviews and reforms to reduce regulatory burden that led to changes to the style and format of adjudication of other professionals within the UK were also considered by OHPA,[21] and helped to define the outline criteria to shape its style and format of adjudication. The regulatory practices across the health professions are well advanced when compared both with non-health professional regulation and health professional regulation at an international level. Evidence from other sectors had demonstrated the benefits of consolidation and rationalisation and OHPA felt there was an opportunity to for a similar approach in health professional regulation. For example, the HM Courts and Tribunals Service had, through provisions made in the Courts and Enforcement Act 2007, unified a range of different tribunals. Two key benefits from this development were enhancing the effectiveness of smaller, specialist tribunals and efficiency gains of at least £150m in the first four years.

[21] Harris, W. 2011. *Early considerations for the establishment of OHPA – the style and format of adjudication*. Available at: www.ohpa.org.uk [accessed June 2011]

OHPA's vision for adjudication – day one rules and policy ambitions

4.5 OHPA sought to draw upon existing good practice within health professional adjudication and modernise it, introducing procedural efficiencies through consolidating or rationalising rules and policies in a similar manner to the changes introduced by the unification of administration of the tribunal system.

4.6 OHPA expected to receive cases for adjudication from the GMC from 1 April 2011. The OHPA Board made an early decision to develop its modernised format and operational procedures in two phases. Firstly they intended adopting the existing GMC Fitness to Practise rules, with adaptations to introduce some early efficiencies.[22] These adaptations would have focused on the following areas:

- Allowing the substitution of panel members where a panel becomes inquorate, in order to maintain the continuity of the hearing, by re-starting at the last decision supported by reasons, and that this would be with the consent of both parties
- Greater use of pre-hearing case management and empowering the OHPA case manager to make directions to the registrant and the regulator in order to make the hearing run more smoothly
- Saving time in the hearing by removing the requirement to read out the allegations at the start of a hearing
- Avoiding unnecessary delay through more flexible ways of working. These include:
  - The ability for a panel to decide the outcome based on only the papers, in the confirmed absence of the parties
  - The panel to be able to deliver their decision orally to the parties at the end of the hearing, with the written copy served by OHPA as soon as reasonably practicable after the hearing.

4.7 Secondly, OHPA proposed policy ambitions which reflected its thinking on adjudication, for introduction some 12-18 months later.[23] This approach was taken to ease the transfer of existing cases from the GMC. It also afforded opportunity for OHPA to formulate and formally consult upon broader changes to deliver an equitable, timelier and cheaper adjudicatory process, applicable for all health and social care professions (some of which would have required legislative/rule changes). OHPA recognised that the interrelated nature of some of the ambitions would have required further investigation, piloting and assessment to determine whether or not they should be implemented.

[22] OHPA. 2011. Health professions final fitness to practise adjudication – extract from OHPA day one rules; the adoption and adaptation of GMC rules. Available at: www.ohpa.org.uk [accessed July 2011]

[23] OHPA. 2010 (updated 2011). *Health professions final fitness to practise adjudication* – Available at: http://ohpa.org.uk/wp-content/uploads/2011/01/Ambitions-policy-discussion-paper1.pdf [accessed July 2011]

OHPA's vision for adjudication: policy ambitions

1. The appointment of a Tribunal President or Senior Chair to take an active role in ensuring consistency in decision making and acting as a leader for panellists
2. More effective, consistent training and appraisal systems for panellists
3. The employment of legally qualified chairs for tribunals
4. Active pre-hearing case management with clear directions given to parties
5. Oral hearings only where necessary to resolve matters that are disputed
6. A two-stage, rather than a three-stage decision process
7. Limiting the number of allegations only to those required for a determination
8. Use of 'impact statements' so that the adjudication panel recognises the impact the alleged conduct has had on a complainant (if the complainant is a patient)
9. Awarding costs in certain circumstances
10. Use of 'cost capping' to limit the costs that a successful party can recover
11. More efficient use of hearing rooms, and holding evening and weekend hearings to make best use of panellists availability
12. Locally-focused panellist recruitment and empanelment.

Summary

4.8 In terms of modern and efficient adjudication, OHPA's work provides a useful starting point to examine potential areas of improvement for the processes that may be used by the health professional regulators. They were developed with the input from key stakeholders but other views had not been sought at the point the Government took the decision not to proceed with OHPA. In particular, the views and experiences of patients and the public who had experienced the regulators' fitness to practise processes had not been formally considered in the same way as the experiences of registrants and regulators. We will address this in Chapter 6.

4.9 We are also mindful of the fact that OHPA's proposals were intended to be implemented by a single organisation with responsibility for adjudication. Independent adjudication, and how this enhances public confidence, would have been implicit and integral to the process OHPA intended to adopt. We report in the next chapter that the demand for separation of investigation and adjudication remains strong among stakeholders. As we build on OHPA's work to develop our vision this need for greater separation, and the significance this has for public confidence, must not be overlooked.

5. Gathering views on options to improve adjudication

5.1 We were asked to take account of the views of patient and public representative groups, regulatory bodies and healthcare practitioners and their employers on improving adjudication. We undertook two different exercises to gauge the views of these different groups:

- A call for information, aimed at all interested parties, to seek views on how fitness to practise adjudication could be improved, how the fitness to practise processes of the nine regulators could be harmonised or streamlined, and people's views on the policy ambitions presented by OHPA[24]
- Letters to the regulators inviting them to offer their views on how to modernise and improve the efficiency and effectiveness of adjudication, and their thoughts on the OHPA ambitions.

This chapter summarises the responses we received. Further details on the feedback around OHPA's ambitions can be found in Appendix 1.

Views on areas for improvement

5.2 In terms of the views we heard from the *Call for Information*, there was overall support for the following principles and ambitions:

- Panels with greater independence
  Many respondents stated that genuinely independent panels would help to reinforce confidence in fitness to practise. This could, for instance, be in the form of a common pool of panellists for all of the regulators, independently recruited, trained and appointed to cases.
- A more streamlined process
  There was overwhelming support for a more streamlined process, which it was thought would help to reduce the overall time it takes to conclude a case. Many respondents expressed concern about the length of time between the original investigation and bringing a case to a hearing. We heard that the process can be slowed, for instance by delays in the disclosure of documents, poorly set out allegations, having to wait for panel members to arrive, or because witnesses cannot accommodate slippages in the timetable around their other commitments.

5.3 There was also some support, although not widespread, for the following suggestions:

- Better case management
  Case management refers to procedures which take place prior to a hearing, which parties take part in, to facilitate the timely and effective running of a hearing. It can enable effective communication between parties prior to the hearing and help to seek agreements in relation to several key issues. The feedback we received from some respondents was that this approach, together with clear timelines for each step of the pre-hearing process, can

[24] CHRE. 2011. *Fitness to practise adjudication: A call for information.* Available at: http://www.chre.org.uk/_img/pics/library/pdf_1298541408.pdf [accessed July 2011]

help to reduce the overall length of a case, and help to ensure the process runs smoothly.

- Transparent, straightforward procedures
  Responses from groups representing patients and the public in particular, emphasised the importance of having transparent processes clearly outlined for people participating in fitness to practise hearings. We heard from a group that represents people with multiple or complex health needs that correspondence should be in Plain English, with the use of interpreters and/or sign language at hearings.
- Uniform set of rules, shared processes
  A number of respondents thought there was merit in exploring the idea of an overarching set of rules applicable to all regulated professions. The example of the HPC, which registers a wide range of professions, was cited by some as to how this could work. Some respondents recognised that there may be a need for some profession specific rules, but these could be considered on a case by case basis. The advantage of this would be that people would expect the same of the fitness to practise process, no matter what regulated professional they complained against.

5.4 In our call for information we sought views about any alternative mechanisms for resolving fitness to practise concerns. We used the example of alternative dispute resolution services, which could involve a meeting between the complainant and the health professional to offer an opportunity for an explanation and an apology. Although there was some support in principle for this idea, particularly if it led to earlier resolution of the issue, many respondents considered that this was not within the scope of the regulator and may not be an approach consistent with putting the public interest first. Other respondents commented that, once the adjudication stage has been reached, the opportunity for any 'dispute resolution' has already passed.

5.5 We also sought views on where the regulators might be able to harmonise their procedures. Some respondents did not feel able to comment on this, given their experience was only with one of the health professional regulators. Others felt that, aside from inconsistencies between regulators, the more pressing concern was inconsistencies in the processes and outcomes within the same regulator. However, the most common response was the need to improve the consistency of adjudication decisions between regulators, particularly when on the face of different individuals are being treated differently in respect of the same issue.

5.6 The most commonly cited suggestions to harmonise processes – or bring under the auspices of a centrally coordinated function between the nine regulators – were:

- The shared appointment, training and appraisal of panel members
- Introducing a common pool of panellists available to sit on any of the regulators' fitness to practise panels
- The production of a unified and consolidated set of procedural rules.

5.7 Other suggestions included creating a single regulator to replace the current system of nine; introducing the same standard operating procedures across the regulators; and giving a commitment that the regulators should also meet the

same service standards for what people should expect from the fitness to practise process.

Views on OHPA's ambitions

5.8 At the time that the Government took the decision not to progress with the establishment of OHPA, OHPA's policy ambitions for the delivery of a modern and efficient adjudication process were still in development. As such, the ambitions had not been widely shared or publicised, and were without the benefit of external scrutiny and consideration.

5.9 We used the opportunity of the Call for Information to share the OHPA policy ambitions and seek views on them. We also wrote to each of the nine health professions regulators to request their views on OHPA's policy ambitions, and whether there would be the potential to apply the ambitions within their current procedural frameworks.

5.10 A common view held across the various groups of respondents was that OHPA's intended approach to initially adopt and adapt the GMC procedural framework whilst giving broader, in-depth consideration to its policy ambitions, was a sensible approach. Across the ambitions, there was widespread support for the proposal to introduce more effective and consistent training and appraisal systems for panellists. There was some support for the introduction of a tribunal president role, using legally qualified chairs and active case management, better use of hearing rooms and local panel recruitment, and limiting oral hearings, and using cost powers. The proposals to use a two stage process, introduce victim impact statements and use cost capping measures did not receive any clear support. A detailed breakdown of the views expressed by regulators and other interested parties can be found in Appendix 1.

Summary

5.11 As an independent adjudicator, OHPA's intention was to establish a modern and efficient system. Their preparatory work built on research into issues within health professional regulation and existing good practice in related sectors. Our call for information and responses from the regulators provides an opportunity to assess stakeholder views on these 'day one' and longer-term ambitions for adjudication. The results indicate broad support for some specific ideas – most notably training and appraisal for panellists and better use of facilities and technology. However, other ideas received less widespread support, and suggest a need for further investigation to fully understand the benefits and interdependencies. These included use of impact statements, moving to a two-stage adjudication process and cost capping. The responses we received provide an insight into the characteristics that people with interest in adjudication are looking for from the system, be they registrants, patients, public, panellists, regulators or legal experts. They highlight a continuing expectation of independence, timeliness, consistency and harmonisation in adjudication. In our view they also show how public confidence in adjudication could be enhanced, which was the original impetus for establishing OHPA. We will reflect on these findings in Chapter 8.

6. Learning from the experience of those going through the process

6.1 As we noted earlier, OHPA's early work did not include seeking the views from patients and the public. We received responses to our call for information from representative organisations and individuals, but we also wanted to understand more about the experience of those who had participated in the regulators' fitness to practise process. We hoped this would help us to identify particular areas where improvements could be made.

Background

6.2 We commissioned an independent research organisation so that we could understand people's experience of going through the fitness to practise process. We particularly wanted to focus on the experience of members of the public who raised the initial concern with the regulator. The research explored the adjudication stage, however it was important that due consideration was given to all stages of the process, given the impact that experiences and decisions earlier in the process can have on outcomes of adjudication. The research therefore included exploration of experiences of: raising a fitness to practise concern, the investigation stage, the pre-hearing preparation stage, experiences on the day of the hearing, communication throughout the process, how the adjudication outcome was communicated, as well as overall satisfaction.

Research method and sample

6.3 Twenty-five one-to-one in-depth interviews were undertaken (1 hour duration, 12 face-to-face and 13 by telephone) with people who had participated in a fitness to practise process with either the GMC, NMC, GDC or GPhC.[25] We heard primarily from patients who raised their concern with the regulator, and participated through to the end of the process. Representation was also achieved from people who raised a concern but did not attend a hearing, registrants and other witnesses. A breakdown of participants is included below.

Table 1: Breakdown of respondents

Country	*Role*
England - 15	Patient - 14
Wales - 5	Witness - 3
Scotland - 5	Lay person/Committee member - 4
	Registrant - 4

6.4 The sample was not designed to be representative of every concern raised or to highlight differences between regulators. The nature of the research means that the findings are not statistically significant. The aim, instead, was to get a fuller understanding of the views of those with first hand experience of the process.

[25] Throughout this analysis when we use the term witness we refer to people who took part in the process. It includes registrants and people who provided testimony for the registrant.

Key findings

Navigating the system

6.5 Most complainants reported that they did not know where to go to raise a fitness to practise concern. They said that finding the regulator currently relies on good signposting from other health organisations, and there appeared to be a clear lack of understanding of the different regulatory bodies and what their functions are (with the exception of the GMC). One respondent said:

I had to do quite a lot of surfing on the net and quite a few phone calls. I wouldn't say it's very easy to find out…Having more guidance on what to do and how you go about the process would be a lot easier.

It was clear that complainants generally lack an in-depth understanding of the range of fitness to practise hearing outcomes.

6.6 We know that the regulators already publish information and guidance that helps to explain their role and the fitness to practise process, as well as guidance targeted specifically at those raising concerns and/or appearing as witnesses at hearings. Regulators also hold meetings and events with patients and the public. We have done some work to improve complainants' understanding of how to raise fitness to practise concerns, and a copy of our complaints guidance can be found on our website.[26] Despite this work, it is clear that there is still widespread confusion about the different channels for complaining (e.g. the differences between the NHS complaints, legal and regulatory processes) and the links between them. For example, two witnesses (one of whom was a complainant) were unaware that the NHS organisation involved had referred their complaints to the regulator. One respondent said:

I had no idea that I was entering this fitness to practise thing. I thought I was just making a complaint. I thought it was still within the hospital. No one told me that.

Starting the process

6.7 Having found out who to raise a fitness to practise concern with, complainants then often experienced difficulties with completing the detailed paperwork involved, and referred to the regulators' insistence that everything had to be communicated in writing rather than over the telephone as a problem.

You want to talk to someone when you're emotional and frustrated and ill. The last thing you want to do is put things in writing, at least not straight away.

6.8 The density and volume of documentation involved was clearly daunting for some complainants, with many suggesting that additional support, either from the regulator or another body, would be invaluable. Most felt that a more personalised approach to giving information from the regulator would be preferable to receiving largely generic advice and information.

The investigation stage

6.9 A lack of regular communication by regulators during the initial investigation stage of the fitness to practise process was identified as problematic - with witnesses

[26] CHRE. 2011. *Complaints guidance*. Available at: http://www.chre.org.uk/policyandresearch/325/ [accessed July 2011]

reporting that they had needed to 'chase' regulators for progress. One respondent said:

You'd have weeks of silence. I kept having to ring up to try and find out what was happening

6.10 In contrast to this, respondents reported that regulators typically communicated with them much more effectively during the hearing phase of the investigation. Regulators who communicated proactively during the hearing phase were very positively rated. We think it is significant that the most satisfied complainant was the one who had been provided by the regulator with a named contact, who was accessible by phone and email. Complainants were clearly surprised by the apparent lack of an obvious 'customer service' ethos within the regulators, and typically felt that they were only taken seriously if they received regular communication from the regulator.

The hearing stage

6.11 Witnesses reported feeling underprepared for giving evidence at the fitness to practise. One said:

I was only prepared because my friend's wife is a solicitor and she prepared me. She took the time to get me ready…

6.12 In future, respondents felt that witnesses should be given more information in order to prepare more fully for the hearing. One said:

I would have wanted them to tell me how the hearing is going to be … the sort of people going to be at the hearing, how many doctors are going to be at the hearing, what sort of questions they're going to ask me, can I refuse to answer any of the questions.

6.13 There were several examples of witnesses finding it difficult to cope with the process. For example, one complainant decided not to attend the fitness to practise hearing because her family and friends advised her that it would most likely be overly traumatic. Another attendee had to leave the room because the details of the case were too upsetting. Another witness said that their health deteriorated during the time of the case, as a consequence of stress. Typical comments about the process were *'You've got to be very strong'* and *'I found it all quite daunting'.*

6.14 Generally, the lack of 'aftercare' offered by regulators was noted as disappointing. There were reports of little contact, if any, from regulators following the hearing or conclusion of the case. In one case, a witness only found out in the press that a regulator's decision had been overturned by the High Court because of an appeal by the health professional. Another respondent said:

There was no, 'I'm very sorry to hear this.' They didn't offer us any counselling. They just seemed very cold.

6.15 It seems that some witnesses and complainants might be reassured (and therefore more likely to co-operate with the process) if they received a greater degree of personalised contact from the regulators before the hearing to answer their queries about what will happen. While it would clearly be inappropriate to discuss the questions the witness may be asked at the hearing, the other queries highlighted in the research are ones that could be addressed by appropriately trained staff within the regulators as part of the pre-hearing preparations. Similarly,

communicating the outcome of the hearing promptly and sympathetically to witnesses might help to maintain their confidence in the regulatory process going forwards.

Summary

6.16 Overall, the research findings indicate that raising a fitness to practise concern with a regulator is often experienced negatively, particularly because of the length of time that the process takes, as well as the stress involved and lack of support for witnesses. These mirror the main findings of OHPA's benchmarking survey with registrants (see page 16). There was a perceived lack of empathy for witnesses on the part of regulators and for some, this was a particular problem during the fitness to practise hearing. Pursuing a concern from the initial investigation right through a fitness to practise hearing was generally seen as daunting and stressful. Witnesses explained that strong resolve and tenacity is needed to persist with a case, which can be time-consuming, as well as intimidating. Two people we spoke to gave up during the process, one because of stress and another due to frustration over the timescales involved. Others questioned whether the process was worthwhile. The overall length of time taken to complete the process, as well as the specific challenges attached to the various stages of the process, were seen as factors which generated significant levels of stress. One person said:

It's not healthy…every time you open a letter it makes your blood boil. Even if they eventually decide it was misconduct, it was so long ago, it defeats the object of what I was initially trying to make a point of.

6.17 It is clear that there is currently a mismatch between people's expectations at the beginning of the process and their experience of it in reality. We know that the regulators already make considerable efforts to explain the nature of the process and to manage complainants' and witnesses' expectations, but it is clear that those efforts are not always achieving the desired outcome. In particular, there seems to be little understanding by complainants that the fitness to practise process is similar to an inquiry (in which their role is that of a witness) rather than a court case or a complaints process (in which the complainant would be the party making the claim against the health professional).

6.18 We consider that the findings from this work demonstrate that the regulators should review the arrangements that they currently have in place to support witnesses, in order to maximise the effectiveness of their contribution (as well as to maintain their confidence in the regulatory process) at all stages of the fitness to practise process. In doing so, the regulators may find it helpful to take into account any relevant formal/informal feedback they have themselves received from witnesses/complainants about the fitness to practise process. We will take the lead on a piece of work, in collaboration with all of the regulators, to clearly communicate the purpose of fitness to practise procedures. It may be that one outcome of this work will lead to any reference to 'complainant' or 'complaints process' being replaced by 'witness' and 'raising a concern' respectively.

7. What our experience tells us about adjudication

7.1 As CHRE we have considerable experience of the fitness to practise adjudication process through our oversight and scrutiny of the regulatory bodies. Our position allows us to offer two different perspectives on the regulators' performance in this area:

- Our annual performance reviews allow us to highlight good practice among the regulators in meeting our standards of good regulation around adjudication
- Our role in scrutinising all final fitness to practise decisions allows us to highlight areas for improvement through our learning points.

7.2 In addition, our audits of the cases that are closed at the 'initial stages' of the regulators' fitness to practise processes highlight issues in the regulators' handling of the investigation stage of the fitness to practise process that may ultimately impact upon outcomes at the adjudication stage. We discuss these perspectives below. Then, based on our experience, we offer some thoughts on what influences the delivery of high-quality adjudication decisions.

Reviewing the regulators' performance

7.3 In our annual performance reviews of the regulators, we assess their performance against our standards of good regulation.[27] These outline the outcomes we expect regulators to deliver across their functions. There are five standards that refer to their management of adjudication:

- The fitness to practise process is transparent, fair, proportionate and focused on public protection
- Fitness to practise cases are dealt with as quickly as possible taking into account the complexity and type of case and the conduct of both sides. Delays do not result in harm or potential harm to patients. Where necessary the regulator protects the public by means of interim orders
- All parties to a fitness to practise case are kept updated on the progress of their case and supported to participate effectively in the process
- All fitness to practise decisions made at the initial and final stages of the process are well reasoned, consistent, protect the public and maintain confidence in the profession
- All final fitness to practise decisions, apart from matters relating to the health of a professional, are published and communicated to relevant stakeholders.[28]

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[27] CHRE. 2011. *Performance review report: changing regulation in changing times 2010/11*. Available at: http://www.chre.org.uk/satellite/402 [accessed July 2011]

[28] CHRE. 2010. *The Performance Review Standards: Standards of Good Regulation.* Available at: https://www.chre.org.uk/_img/pics/library/100601_The_Performance_Review_Standards_1.pdf [accessed June 2011]

7.4 These are high-level, outcome focused standards for adjudication. The regulators, as we have already noted, vary in their approach to investigating and hearing cases and the processes they have in place to reach these outcomes. However, there are common characteristics we have highlighted in our performance reviews and audit reports that we consider represent good practice and lead to good quality adjudication outcomes. These are summarised below:

- Getting the best from panels and panellists
  - Recruiting against competencies, providing training, regular appraisal and feedback
  - Providing clear and comprehensive indicative sanctions guidance to help in decision making
- Getting the best from staff
  - Training, appraisal and performance management
  - Providing guidance on operations and decision-making
  - Bespoke training on investigation skills
  - Manageable caseloads
- Widening understanding of the process with external stakeholders
  - Information for patients and the public about fitness to practise process and nature of concerns investigated
  - Guidance for employers on thresholds for referral
  - Working with groups representing registrants and patient advocates
- Effectively administering and hearing cases
  - Service standards for case progression to encourage timely adjudication and avoid delays
  - Using IT to improve administration and record keeping of cases, and to provide accurate management information
  - Dedicated accommodation for hearings
- Communicating clearly with all parties about case progress and decision making
  - Training staff in good communication skills
  - Corresponding with all parties at regular intervals and after panel decisions
  - Disclosing decisions to third parties, including overseas regulators
- Good stakeholder relationships
  - Working with employers to build relationships and deliver faster resolution of complaints
  - Working with primary care organisations at a local level
  - Increasing focus on customer service

- Supporting witnesses through the process
  - Virtual hearing room and patient information websites
  - Vulnerable witness support scheme
  - Witness guidance and information packs
- Learning from experience for continuous improvement
  - Customer satisfaction survey of those who go through the process
  - Mystery shopping
  - Learning from complaints
  - Quality assurance audits of decisions
  - Sharing learning points from individual cases.

Reviewing final fitness to practise decisions

7.5 We review the final decisions made by regulators' fitness to practise panels. Figure 3 below describes the review process and the number of cases involved at each stage. Our role gives us a unique opportunity to identify those issues in adjudication that currently have a detrimental impact on the public interest. This role is described in section 29 of the National Health Service Reform and Health Care Professions Act 2002 (as amended by the Health and Social Care Act 2008). Section 29 allows us to refer a decision to court where two tests are met:

1. We consider that the decision was unduly lenient, and
2. It is desirable for the protection of members of the public for CHRE to do so.

7.6 In this context, undue leniency in a decision can relate to the sanction imposed, to the decision about whether or not the professional committed misconduct, and / or to the decision their fitness to practise is impaired *provided that* the sanction imposed is also unduly lenient. Under-prosecution by a regulator can amount to a serious irregularity in the regulator's fitness to practise proceedings, and therefore result in a successful appeal by CHRE against the panel's decision.[29]

7.7 After our review of a case, we may provide feedback to the regulators. The learning points are often specific to the circumstances of the individual case. Often learning points concern an apparent failure by panels to give due consideration in their decision-making to one or more of the three purposes of fitness to practise proceedings highlighted in the Introduction.[30] Other learning points have focused on the quality of a regulator's investigation and preparation for hearings, or to the consistency or transparency of the panels' reasons for their decisions. When there are learning points of general application we share these more widely across the

[29] CHRE successfully appealed the GMC panel's decision in the case of Dr Mahesh Rajeshwar on the basis that there had been under-prosecution by the GMC. The Council for the Regulation of Healthcare Professionals v the General Medical Council and Dr Mahesh Rajeshwar: [2005] EWHC 2973 (Admin)

[30] The High Court has recently reiterated the importance of all three elements of the public interest in the CHRE appeal of an NMC's Conduct and Competence Committee decision, in the *Grant* case. The High Court stated in *Grant* that: 'The Committee should … have asked themselves not only whether the Registrant continued to present a risk to members of the public, but whether the need to uphold proper professional standards and public confidence in the Registrant and in the profession would be undermined if a finding of impairment of fitness to practise were not made in the circumstances of this case.'

Figure 3: Process for reviewing final fitness to practise decisions

Step 1
We carry out an initial review of all final fitness to practise decisions

2192 **decisions were reviewed in 2010/2011. We reviewed 1835 cases in 2009/2010**

Step 2
Recommendations are reviewed by a senior manager, who authorises:

1. Further review of the case
2. No further action, or
3. The drafting of 'learning points' to be fed back to the regulator.

264 **cases were subject to further review in 2010/2011**

Step 3
If a case is subject to a further review, a case meeting may be held to consider whether the threshold for appeal has been met

8 **case meetings were held in 2010/11, 3 of which were referred to court**

Step 4
Decisions taken at case meetings are communicated to the regulator, recorded, and made available on our website (once any appeal has been heard). If the decision is taken that an appeal is not appropriate, learning points are sent to the regulator

425 **cases resulted in a learning point being fed back to the regulators in 2010/2011. This was approximately 19 per cent of cases**

health professional regulators, through bulletins and training sessions for fitness to practise panel members.[31]

The quality of final fitness to practise decisions: getting a 'good' outcome

7.8 The quality of the decision-making by the panel, reflected in the quality of the determination, is crucial in influencing whether or not the adjudication outcome can be judged to have met the three purposes of fitness to practise proceedings highlighted in Chapter 2. A 'good' outcome from a fitness to practise hearing means that the 'right' decision has been made about whether the particular professional's fitness to practise is impaired, and if so, which sanction should be imposed.

7.9 However, a fitness to practise decision has to do more than achieve the 'right' outcome about the individual practitioner. In order to achieve the three-fold purpose of fitness to practise proceedings, it has to achieve the 'right' result for professional standards and public protection, which includes deterring other professionals from similar conduct, and for the maintenance of public confidence in the profession and in the regulatory process. In practice, this means that a 'good' fitness to practise decision will explain:

- The facts that the regulator alleges took place
- Which of those facts have been found proved and why
- Whether the facts that have been found proved amount to one (or more) of the statutory grounds on which a registrant's fitness to practise may be impaired (and if so which one(s) and why)
- Whether the registrant's fitness to practise is *currently* impaired, and if so, the reasons why (including assessing the registrant's insight, any remediation that has taken place, and any risk of future repetition)
- Whether a sanction should be imposed, and if so, which one and why.

7.10 In contrast, a highly undesirable outcome from a fitness to practise hearing for a regulator is a poorly-reasoned decision that is appealed, either by the registrant or CHRE, and ultimately overturned by the Court. Losing an appeal to the Court is a highly undesirable outcome for a number of reasons:

- The decision may have failed to protect the public, in which case a dangerous practitioner could carry on practising until the appeal is decided and may harm others
- The decision may have failed to uphold public confidence in regulation or that regulator
- The poor handling of the case may lead to reputational damage for the regulator, for example, amongst its registrants as well as the public, if the appeal succeeds
- An appeal will inevitably mean a significant delay to the outcome of the case

[31] CHRE. 2009. *Protecting the public: learning from fitness to practise.* Available at: https://www.chre.org.uk/_img/pics/library/Protecting_the_Public_-_Learning_from_Fitness_to_Practise.pdf [accessed July 2011]

- There is a possibility that any fitness to practise panel that is asked to look at a case that has been remitted following a successful court appeal may be reluctant to re-impose a serious sanction if the original sanction was overturned on appeal. In theory at least, this could result in an overly lenient sanction ultimately being imposed.

7.11 There are also significant financial implications associated with an adjudication outcome that is appealed. The costs of having a decision appealed far outweigh the costs of getting the decision 'right first time' - even if getting it right first time lengthens the original hearing. If the appeal is successful, the regulator may have to bear:

- Its own costs in presenting the case to the fitness to practise panel at the original hearing
- Its own costs of the appeal hearing
- The costs of a second fitness to practise panel hearing in the event that the court decides to remit the matter back to the regulator's panel to reconsider
- Possibly a proportion of the registrant's costs of the entire process (or CHRE's costs on a CHRE appeal).

This could result in a total cost to the regulator that is several times higher than the cost of getting the decision 'right first time'. This approach was supported by a recent report from the Administrative Justice and Tribunals Council.[32]

7.12 A poorly-reasoned decision can result solely from failings by the fitness to practise panel in its decision-making. However in our experience other factors that are also under the regulators' control, either singly or together, often contribute to a poor quality decision, most significantly:

- The quality of the regulator's investigation and presentation of the case, including under-prosecution
- Failure to follow the regulator's own process and/or good practice either in relation to the hearing procedure or in relation to the structure of the panel's decision-making.

Appendix 2 discusses these issues in greater detail.

Improving determinations: our learning points

7.13 In our 2009 Learning Points Bulletin[33] we discussed how to panels should draft their determinations. We described how determinations should explain the panel's consideration of the sanctions, starting with the lowest possible sanction and moving upwards. The determination should note that the panel has considered the sanction below and immediately above the sanction imposed and the reasons for not imposing those sanctions. Reasons should be given in sufficient detail so that interested parties can understand why a sanction has been imposed. The explanation should include:

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[32] Administrative Justice and Tribunals Council. 2011. *Right First Time.* Available at: http://www.justice.gov.uk/ajtc/docs/AJTC_Right_first_time_web(7).pdf [accessed July 2011]

[33] CHRE. 2009. *Protecting the public: learning from fitness to practise.* Available at: https://www.chre.org.uk/_img/pics/library/Protecting_the_Public_-_Learning_from_Fitness_to_Practise.pdf [accessed July 2011]

- Why the sanction imposed is the most appropriate one and how it protects the public
- Why other sanctions would not be suitable
- Why the period imposed for the caution, conditions of practice or suspension order has been chosen
- Reference to the relevant Indicative Sanctions Guidance (ISG)
- Where the panel's decision does not appear to accord with the ISG, an explanation for this, based on the specific circumstances of the case.

7.14 We regularly highlight learning points arising from our review of individual final fitness to practise determinations with the relevant regulators. We have recently highlighted concerns about determinations:

- Lacking clear, comprehensive and consistent explanation of :
  - The background to the case/previous findings (including compliance with conditions previously imposed)
  - Relevant professional standards and/or case-law
  - Any mitigating circumstances
- Lacking clear, comprehensive and consistent explanation of the panel's reasons for:
  - Deciding to find a disputed factual allegation proved/not proved (including where the panel prefers one witness's evidence to another's)
  - Deciding that a serious breach is not considered to be fundamentally incompatible with continued registration
  - Concluding that a failing is capable of being remediated, and that it has been remediated
  - Finding current impairment
  - Imposing a particular sanction (including clear application of the regulator's ISG and appropriate specification of any future requirements)
- Failing to separate out the panel's findings in relation to the factual allegations, impairment of fitness to practise, and sanction.

7.15 In addition, we have highlighted a number of concerns about the quality of the regulators' investigation and pre-hearing preparations which can contribute to poor-quality outcomes.

7.16 Although the number of cases referred to court under our section 29 powers has fallen over the years, the number of learning points we highlight has not shown a similar decrease. Our ongoing identification of learning points about the quality of determinations indicates to us that there is still room for considerable improvement in the quality of some regulators' panels' decision-making. If adjudication is to achieve the purpose of fitness to practise (protecting the public, upholding professional standards, and maintaining public confidence in and the reputation of the profession) and if it is to be seen as modern and efficient, it is essential that all the regulators take all necessary steps to minimise the number of poor-quality outcomes from the process. Successfully addressing these issues and supporting high-quality decision making is at the heart of our vision for a modern adjudication

system. Any reforms that are proposed to achieve efficiencies must support the delivery of these aims.

Summary

7.17 In fitness to practise hearings, getting the process right is critical to achieving the right outcome. Our experience has allowed us to look at adjudication from two angles – good practice and learning points. When analysed alongside the case law around good fitness to practise, three key areas emerge that regulators need to focus on to ensure that they minimise the number of poor quality adjudication outcomes:

- Ensuring that their staff/external solicitors investigate and present cases thoroughly, including presenting all relevant allegations, and calling appropriate evidence to support them
- Ensuring that the process before and during the hearing follows the regulator's fitness to practise rules and is 'fair' (within the meaning of Article 6 of the European Convention on Human Rights)
- Ensuring that their panellists deliver well-reasoned, well-structured, and clear decisions at the end of the process.[34]

7.18 In our experience, high-quality determinations tend to be delivered by regulators that have robust systems in place for:

- Recruitment of staff, panellists and advisers against competencies, and regular training and appraisal (including training about relevant case-law)
- Comprehensive guidance, including detailed ISG, for both fitness to practise staff and panellists
- Thorough quality assurance of decisions taken throughout the investigation and fitness to practise process (including of decisions taken by and process compliance by staff as well as by panellists)
- Effective systems for learning from quality assurance, from feedback highlighted by CHRE and from developments in case-law.

7.19 We also think that complaints that the regulators receive about the fitness to practise process can be a valuable source of information about administrative issues that may be contributing to poor adjudication outcomes. For example, an administrative failure to notify a registrant about a hearing in accordance with the rules can result in their non-attendance and the hearing having to be adjourned (or if the hearing proceeds, the panel's decision being overturned on appeal). Similarly, failing to communicate effectively with a witness can lead to their non-attendance at the hearing, which may have a negative impact on the evidence available to the panel and therefore on the quality of the adjudication outcome. It is therefore essential that regulators have systems in place to communicate effectively with complainants and witnesses during the investigation and hearing process, and also that they have system in place to identify from complaints/other feedback they receive from participants in the fitness to practise process areas for potential improvement.

[34] Glynn J, Gomez D. 2005. *Fitness to practise: health care regulatory law, principle and process*. London: Sweet & Maxwell

8. Discussion and recommendations

8.1 In this final chapter of the report, we bring together what we have learnt from OHPA, heard from regulators and other interested stakeholders, the experience of those who have gone through the process, and our own assessment and analysis of adjudication to present our vision of a modern and efficient system. We also make recommendations on how progress towards this vision could be achieved.

Learning from OHPA

8.2 The work that OHPA had done that led to its ambitions paper, and the day one rules, offered a view of how a single adjudicator could improve delivery of an adjudication function, not only by virtue of its being independent from the GMC, but also by achieving efficiencies. The challenge for us in providing our advice is to identify the learning from OHPA that is relevant to adjudication across the nine health professional regulators and to take advantage of the opportunities that are available to recommend reform.

8.3 To us it is clear that some of the ambitions offer greater potential long-term and short-term benefits than others. OHPA's plan to introduce the role of a tribunal president, providing leadership to the panellists, has the potential to improve adjudication if it prompts better decision making, improves the competency of panellists, and encourages learning from experience and sharing of good practice. It could also help to demonstrate greater independence of the panellists from the regulator.

8.4 Similarly a more collaborative and cooperative approach to training for panellists across different regulators would be attractive in terms of the efficiencies it could offer, and the opportunity to share good practice. There are limits to this, however as the regulators currently operate to different frameworks and have different sanctions. Some degree of regulator-specific training would still be necessary. Taking this further we consider that there are both obvious benefits to and willingness amongst the regulators for exploring the potential for sharing some panellists on a formal basis, which might provide a means to save on some training costs as well as promoting consistency across the sector. This would demand further discussions to identify who was responsible for recruitment and appraisal in this scenario.

8.5 Sharing the use of hearing rooms could also potentially achieve efficiencies overall if it meant less delay in hearings being scheduled (we appreciate that some regulators already rent out their hearing rooms to others) although we would have concerns that holding hearings at weekends and evenings may not lead to better decisions, or greater efficiencies, due to the practical difficulties and costs associated with working outside normal business hours. Cooperation and collaboration of this nature is not something that relies on changing legislation, and in our view if the regulators are committed to achieving efficiencies, these are measures that they can implement relatively quickly.

8.6 In the report of the Shipman Inquiry[35] Dame Janet Smith suggested the use of full-time panellists used jointly across all health professional regulators, and the use of full-time legally qualified chairs (i.e. removing the need for legal assessors). She also suggested that legally qualified chairs could undertake pre-hearing case management work. It seems to us from the work carried out by OHPA and the feedback we have received that there is potential for exploring better use of pre-hearing case management provisions in order to achieve more effective administration of hearings. This would allow time in hearings to be focused and used more effectively. If regulators were to adopt more active pre-hearing case management then the use of legally qualified chairs could be helpful, as suggested by the Shipman Inquiry Report. The ultimate effectiveness of case management procedures is likely to depend to some extent on having enforcement measures in place (for example, allowing panel chairs to impose costs orders for culpable non-compliance). We think that this is an area that could usefully be explored further by the Law Commission in their simplification review.

8.7 The potential offered by other ambitions developed by OHPA is more difficult to assess. Respondents were divided on some of the proposals, and we do not consider that the possible efficiency gains offered by, moving to a two-stage process, limiting the number of allegations, or only holding oral hearings 'when necessary' are sufficient to outweigh concerns about the impact such proposals might have on the quality of the adjudication outcomes and in particular on public confidence in the regulatory process. Limiting allegations could, for example, increase the chance of 'under-prosecution' and correspondingly impact on the quality of adjudication. OHPA's proposal to introduce impact statements was related to their proposal to reduce the number of oral hearings and to limit the number of allegations as a way to appease complainants. It may be a useful step to take in these circumstances, but given the lack of widespread support for limiting allegations and hearings, we have not examined this proposal further.

8.8 Increasing emphasis on the cost of adjudication inevitably raises the question of whether awards of costs should be made - either in every case or only in certain circumstances (e.g. in the event of non-compliance with case management directions). OHPA also proposed the idea of cost-capping, to limit the amount of costs any party to the proceedings could expect to recover if a costs regime were introduced. As referred to above, in order to make the proposed wider use of pre-hearing case management effective, it may be necessary to consider how cost awards can be used to encourage both parties to comply with the process. In our view, the questions raised by these issues, and the range of approaches currently being used by the regulatory bodies, suggests that this area needs further exploration and given the legislative change that would be necessary, it would be appropriate for the Law Commission's review to consider these questions further.

8.9 Ultimately, a vision for modern and efficient fitness to practise adjudication must balance the requirements for delivery of good quality adjudication outcomes against the drive to achieve costs and procedural efficiencies. It is only where such efficiencies can be achieved without a negative impact on protecting the public, upholding professional standards, and maintaining the reputation of the professions and public trust in the regulatory process that they should be pursued.

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[35] The Shipman Inquiry. 2004. *Fifth Report - Safeguarding Patients: Lessons from the Past - Proposals for the Future.* paragraph 27.207-208. Available at: http://www.shipman-inquiry.org.uk/fifthreport.asp [accessed July 2011]

8.10 The ambitions that OHPA was planning to discuss with stakeholders reflected different aspects of the process of adjudication where, in OHPA's view, improvements could be delivered to achieve efficiencies and to modernise the process, and these are relevant to our vision. However, beyond this list of proposals, other issues remain. It is clear that the fundamental question of how to achieve greater separation between adjudication and investigation in order to enhance public confidence needs to be resolved. The experiences and views of patients and the public must be addressed. Finally, our own perspective on health professional regulation and adjudication offers a unique insight that our vision must reflect.

Our vision

8.11 Generally, a modern system is one that uses up to date practices and approaches and an efficient system is one that optimises the resources available to it to achieve the intended outcomes. Given this, based on what we know about adjudication and what we have heard during the course of this project, our vision is summarised in the panel below:

CHRE's vision of a modern and efficient system of adjudication is one that delivers high-quality decisions which fulfil the three-fold purpose of fitness to practise while demonstrating the principles of right-touch regulation.

High-quality decisions mean those that are robust, based on thorough examination of the evidence and taken in line with established good regulatory practice and legal frameworks.

Fulfilling the purpose of fitness to practise means decisions are taken that protect the public, uphold professional standards and maintain public confidence in the profession and the regulatory process.

Demonstrating the principles of right-touch regulation means adjudication systems should be:

- *Proportionate:* Using different procedures in adjudication where this allows an high-quality decision to be made by a more effective route, especially in cases where interim orders are necessary, and with a range of sanctions appropriate to the individual finding of impairment
- *Consistent:* Within regulators, through the use of indicative sanctions guidance and a single panel to hear all fitness to practise cases, and across regulators through the use of harmonised sanction set, with greater consistency in misconduct issues common across regulated professions
- *Targeted:* Focusing on the purpose of fitness to practise, taking action quickly through interim orders when individual cases demand
- *Transparent*: Being open with the public about the process in general, and allowing people to understand how and why individual decisions were made

- *Accountable:* Regulators and panels report and explain their decisions publically, fulfilling their roles in investigation and adjudication satisfactorily
- *Agile:* Means a system that responds to feedback and experience and uses this to improve administration, develop skills, knowledge and experience of the staff and panellists, improving the timeliness of case progression, and amending process and procedure when necessary.

Delivering the vision

8.12 With a shared commitment to this vision and these outcomes we would maximise the regulators' chances of delivering high-quality decisions and reducing the number of poor quality adjudication outcomes. In practice it would mean doing the following:

- Training and appraising all those involved in the process – receiving concerns, investigating and adjudicating – to maximise the likelihood of high-quality decisions that meet the three-fold purpose of fitness to practise
- Allowing a more flexible approach to adjudication would mean regulators to target resources more effectively on the costly and intensive aspects of adjudication, including hearings
- Adopting greater use of active case management techniques, allowing regulators to take a different approach to some cases where appropriate, robustly and rapidly applying a sanction while being transparent and accountable about the decisions made.

8.13 In addition to these changes, we have identified a number of particular pieces of work across the regulators that are essential to improving adjudication.

Better support for witnesses

8.14 A modern and efficient system would provide greater support to those who raise concerns about fitness to practise, to maximise the opportunity of achieving high-quality outcomes. Our performance review report has highlighted the progress that some regulators have made in this area, but further progress is needed. Poor communication with potential witnesses can also have a negative impact on the outcome of the adjudication process. If a witness does not understand the fitness to practise process properly, they may be less willing to participate, and the quality of the evidence available to the fitness to practise panel may be negatively affected as a result. For example, greater support could

- Help and guide people through the investigation and adjudication process
- Support witnesses before, during and after the hearing
- Give people different options for giving evidence at a hearing, for example by video link
- Signpost support and advocacy services
- Process cases in a timely fashion to minimise the detrimental impact on people.

Separating adjudication and investigation – sharing services

8.15 It is clear is that the desire to see greater independence in the adjudication process remains strong among stakeholders. It remains to be seen what the impact on public confidence will be of continuing to hold hearings under the auspices of a regulator. However, it may be that making changes elsewhere in the process will help to mitigate the risk of undermining confidence through this change in policy direction. We have suggested to the Department of Health and the GMC that the GMC could develop its planned Tribunal system in a way so that it could be used by other health professional regulators.[36] We considered that 'this would be an alternative way to realise the benefits of increased independence, consistency and economies of scale that the original reforms were seeking.' Building on an idea previously suggested to establish 'a central list of vetted and approved panellists for all adjudication panels',[37] this could also be extended to sharing legal assessors, training and accommodation. The example of the Tribunals Service described in Chapter 4 shows that bringing adjudication together across a wider range of disciplines than the health professional regulators is not only possible, but beneficial in terms of saving costs and enhancing their effectiveness.

Greater consistency across health professional regulation

8.16 The desire for independence in adjudication is matched by an expectation of greater consistency. Looking across the sector as a whole there is a concern at inconsistency of the regulators' fitness to practise outcomes as well as their processes for investigation and adjudication. Our own experience scrutinising fitness to practise decisions raises concerns about the quality of some of the decisions being taken by some regulators' panels. Alongside this there are issues with the timely processing and administration of cases, coupled with an increasing case load for many regulators at a time when there is pressure to stabilise or reduce the burden and costs of regulation.

8.17 The expectation of greater consistency is also longstanding and the responses received to our call for information for this project mirror those CHRE received during its consultation on harmonising the sanctions set available to the regulators in 2008. In that work we highlighted the need to provide a flexible range of sanctions that would enable proportionate and targeted sanctions to be applied in individual cases where fitness to practise was impaired. Similarly on this occasion, responses sought to balance the desire for greater consistency in this area while respecting the individuality of particular cases and different professions.

8.18 Other areas that may benefit from increasing consistency include indicative sanctions guidance. In the report of the Shipman Inquiry[38], Dame Janet Smith suggested that CHRE might facilitate the setting of consistent indicative sanctions

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[36] CHRE. 2010. *Response to the Department of Health consultation on fitness to practise adjudication.* Available at: http://www.chre.org.uk/satellite/324/ [accessed July 2011]

[37] Department of Health. 2007. *Trust, Assurance and Safety: The Regulation of Health Professionals in the 21st Century*. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_065946 [accessed July 2011]

[38] The Shipman Inquiry. 2004. *Fifth Report - Safeguarding Patients: Lessons from the Past - Proposals for the Future.* paragraph 27.230. Available at: http://www.shipman-inquiry.org.uk/fifthreport.asp [accessed July 2011]

guidance across the health professional regulators as many of the issues (eg, dishonesty, indecency, breach of confidentiality and failure to obtain proper informed consent) are likely to arise across the sector and this is something we are willing to explore in partnership with the regulators.

A statement of purpose

8.19 It is often remarked that patients and the public fail to understand what they can 'get out of fitness to practise' if they are looking for redress. This is also clear from some of the contacts we currently have with dissatisfied complainants.

8.20 Regulators' fitness to practise processes have a different purpose to complaints-handling/mediation processes. Therefore the role of the individual who raises a concern is likely to be limited to that of a witness rather than a formal 'complainant' with rights to expect their views to be taken into account or to receive an apology or redress. We have recently amended the guidance on our website[39] to explain the distinction. We are also aware that the information that regulators provide for complainants sets out the purpose of fitness to practise proceedings and identifies the different potential outcomes of the process. However, evidence gathered during our call for information indicates that misunderstandings about the fitness to practise process are more widespread. Responses we received from organisations representing the views and interests of health professionals failed to demonstrate they completely understood the purpose and the process. Taken together these findings suggest to us that there would be considerable benefit in establishing a clear, consistent statement about the role and remit of fitness to practise in health professional regulation.

Conclusions

8.21 Based on our research and analysis we draw the following conclusions:

- **There is considerable scope for change:** the feedback we received about OHPA's policy ambitions, alongside the ideas for improvement and harmonisation that were discussed by respondents to our call for information, and the interviewees who described their experiences all suggest that there is scope to improve the effectiveness and the efficiency of the fitness to practise process
- **There is a desire and willingness to change:** among the regulators we heard from it is evident that there is a will to deliver changes in adjudication. This is partly driven by the financial costs of adjudication, but also because of the pressures caused by increasing case-loads
- **There are opportunities to change:** it has also became evident from the responses and our analysis is that there is perhaps an unprecedented series of opportunities now and over the next few years to make changes that would lead to a more modern and efficient system of fitness to practise adjudication. In particular the opportunities offered by the Law Commission's simplification review allow us to consider how greater harmonisation and consistency could be achieved.

[39] CHRE. 2011. *Complaints guidance*. Available at: http://www.chre.org.uk/policyandresearch/325/ [accessed July 2011]

8.22 Given these conclusions our recommendations take advantage of the emerging or likely future opportunities. In doing this we are clear that this may not mean complete standardisation or consistency across all nine regulators; rather it will allow for greater consistency both within and between regulators than is seen currently, which in time and with appropriate evaluation and collaboration could be the precursor to more integration and harmonisation.

Our recommendations:

8.23 Regulators must:

- Review their current performance in adjudication against our vision for a modern system and take steps to learn from good practice identified in CHRE Performance Reviews, and provide evidence of progress in future Performance Reviews
- Work with panellists to act on CHRE learning points to continue to improve decision making in adjudication.

8.24 Regulators should work together to improve the operational efficiency of adjudication by

- Getting more value from the time, people and resources invested in adjudication, for example, through
  - Joint training of panellists
  - Better use of pre-hearing case management
  - Shared use of hearing rooms
- Providing greater support to witnesses throughout investigation and adjudication to allow them to participate fully in the process.

8.25 CHRE will facilitate a wider programme of work, in partnership with regulators and other interested parties, dedicated to improving adjudication in the future. This programme will include:

- Developing and agreeing a common statement on the purpose of fitness to practise.
- Working to deliver greater consistency across regulation, through
  - Shared adjudication services
  - Harmonised sanctions
  - Shared indicative sanctions guidance for panellists in relation to common issues
  - Exploring the options for a joint pool of panellists and clarifying the accountability and roles of panellists (in the interests of greater separation and continuous improvement).

8.26 We recommend that the Law Commission simplification review of health professional regulation includes exploration of other ideas that OHPA proposed that received some support in our engagement exercise. This includes, for example, limiting the use of oral hearings, considering wider use of ‘consensual disposal’, and how costs powers can be used in adjudication. These may have a positive impact on the delivery of high-quality adjudication decisions in line with

our vision within a wider review of legislation that considers investigation alongside adjudication but we are conscious that these proposals also have disadvantages and therefore that the overall picture needs to be considered in more detail.

8.27 In some of the above, legislation, rules and procedures may need to be altered. However, to demonstrate commitment to effective and efficient regulation it is important that early action is taken in those areas that can be changed without the need for changes in legislation and rules. This would help to signal the regulators' commitment to improving their practice in line with modern processes and agreed good practice. Based on the feedback we received during this project, we understand that greater collaboration in the area of training for panellists would be one area for action. All regulators have the scope to introduce greater use of pre-hearing case management into their adjudication process and where this is possible, it would be in the interests of a modern and efficient system to allow this to happen.

8.28 The work that OHPA completed before the decision not to proceed with its establishment has offered an opportunity to review the current approach to adjudication in the light of the expectations, experience and knowledge of a wide range of interested parties. Through this work we consider we have described a practical vision for adjudication that is consistent with existing good regulatory and legal practice. Ultimately adjudication in health professional regulation is about making good decisions in the public interest and by embedding this fundamental principle within our vision for the future, we hope to have identified the direction and development of the reforms the regulators will undergo in the next few years.

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