hcpc health & care professions council

Agenda Item 10

Enclosure 5

Health and Care Professions Council
06 December 2017

Professional Standards Authority for Health and Social Care Performance Review Report 2016-17 and HCPC's future plan

For discussion and endorsement

From John Barwick, Acting director of Fitness to Practise

Council, 6 December 2017

Professional Standards Authority for Health and Social Care Performance Review Report 2016-17 and HCPC's future plan

Executive summary and recommendations

Introduction

The Professional Standards Authority for Health and Social care (PSA) oversees the nine regulators for health and social care professionals in the UK and it is accountable to Parliament. The PSA is required by law to assess the performance of each of the regulators and to publish a report of its findings each year. The process seeks to check how effective the regulators have been in protecting the public and promoting confidence in health and care professionals. It also seeks to identify strengths and areas of concern in order to enable improvement. The PSA reports its assessment of the regulators' performance each year to the UK and Scottish Parliament and to the devolved administrations.

The PSA sets standards of good regulation (the standards), against which it assesses the performance of the regulators. The standards are grouped under the four regulatory functions: guidance and standards; education and training; registration; and fitness to practise.

In October 2017, the PSA published its annual (2016/17) performance review of the HCPC.

The PSA concluded that the HCPC met all of the standards relating to: guidance and standards, education and training and registration. This included standard two (relating to registration) which was assessed as not being met in the 2015-16 performance review. Of the ten fitness to practise standards, six were judged as not being met.

The attached paper provides the Executive's response to the PSA conclusions in relation to the fitness to practise standards, and an outline action plan which includes the consideration of both operational and strategic changes necessary to address the issues identified.

Decision

The Council is invited to discuss the attached paper and approve the proposed action plan.

Background information

The performance review report for 2015-16 and the Executive's response was considered by Council in December 2016.

http://www.hcpc-uk.org/assets/documents/1000523EEnc01-ProfessionalStandardsAuthorityperformancereviewreport2015to2016.pdf

An update on the activities relating to fitness to practise undertaken following the 2015-16 performance report is provided at Appendix B.

Resource implications

- These are discussed in Annex A.

Financial implications

- Provision of for an additional seven posts has already been identified and reflected in the month 6 budget reforecast. Recruitment to these posts has commenced.

- Further financial implications will be assessed as part of the proposed improvement plan and included in budget planning for 2018/19.

Appendices

- Appendix A: Response to the Professional Standards Authority (PSA) performance review report 2016/17 and proposed improvement plan- Fitness to Practise
- Appendix B: Update on the activities planned in 2016
- Appendix C: Outline plan of activity in response to 2016/17 performance review
- Appendix D: PSA performance review report 2016/17

Date of paper

21 November 2017

Appendix A: Response to the Professional Standards Authority (PSA) performance review report 2016/17 and proposed improvement plan - Fitness to Practise

Introduction

1. Each year the Professional Standards Authority (PSA) reviews the performance of the nine health and care professions regulators and publishes a report of its findings. The performance review period for the HCPC for the year 2016/17 began in January 2017 and concluded with the publication of the final report in October 2017. The period covered by the performance review was 1 January to 31 December 2016. The final report is attached at Appendix D.

2. The focus and extent of the PSA's performance reviews differs between regulators each year. It is determined by a number of factors which include whether there have been any significant changes to the regulator's practices, processes or policies and whether the PSA has any concerns about the regulator's performance against one or more of the Standards of good regulation (the Standards). The decision is also informed by a standardised data set which each regulator provides every quarter.

3. This year's performance review for the HCPC included a targeted review of our performance against five of ten the fitness to practise standards. This involved us providing information in response to the PSA's targeted written questions. The PSA also carried out a comprehensive audit of 100 of our fitness to practise cases that had been closed between 1 May 2015 and 31 January 2017. This included cases that had been opened and actioned before May 2015.

4. Following its audit and targeted review, the PSA concluded that the HCPC had met all of the standards for all areas of its work, except fitness to practise. The PSA concluded that the HCPC had not meet six of the ten fitness to practise standards.

5. The standards not met are:

    - Standard 1 – anybody can raise a concern, including the regulator, about the fitness to practise of a registrant.

    - Standard 3 – where necessary, the regulator will determine if there is a case to answer and if so, whether the registrant's fitness to practise is impaired or, where appropriate, direct the person to another relevant organisation.

- Standard 4 – all fitness to practise complaints are reviewed on receipt and serious cases are prioritised and where appropriate referred to an interim orders panel.

- Standard 5 – the fitness to practise process is transparent, fair, proportionate and focussed on public protection.

- Standard 6 – fitness to practise cases are dealt with as quickly as possible taking into account the complexity and type of case and the conduct of both sides. Delays do not result in harm or potential harm to patients and service users. Where necessary the regulator protects the public by means of interim orders.

- Standard 8 – all fitness to practise decisions made at the initial and final stages of the process are well reasoned, consistent, protect the public and maintain confidence in the profession.

6. The performance review has identified a number of significant issues. We accept the areas of concern identified by the PSA and acknowledge that an extensive programme of activity is needed to ensure the required improvement. This includes both strategic and operational changes. This paper sets out:

   - the areas of our fitness to practise work that have been the cause of concern (Section A);

   - the improvement work that was already underway or immediately implemented in relation to the concerns highlighted by the PSA (Section B); and

   - plan of further improvements. (Section C)

Summary of areas of concern

7. For ease of reference the following table provides a high level summary of the issues identified by the PSA - referenced against the relevant standards of good regulation that have not been met - and the actions intended to address each area of concern. The remainder of the paper provides a more detailed explanation of issues identified and the proposed action plan.

Summary of issues identified	**Standards of good regulation**
Standard of Acceptance Policy (SOA) and its application	1,3,5,8
Quality of our fitness to practise investigations	3

Investigating Committee Panel (ICP) decision-making	3, 8
Quality of our risk assessments	4
Interim Order (IO) applications	4
Identification and investigation of potential health cases	5
Timely progression of FTP cases	6
Discontinuance process	5,8
Disposal by consent decisions	5.8

SECTION A: Areas of concern

Standard of Acceptance

8. The Standard of Acceptance Policy (SOA) sets the threshold, which allegations must normally meet before they will be investigated by the HCPC. It is applied by our Case Managers to all newly received concerns and a decision is taken as to whether or not the SOA has been met. That decision is approved or rejected by a Case Team Manager.

9. The SOA policy has operated since 2009 and has developed as the volume and nature of our fitness to practise work has changed. Revisions were made to the SOA in May 2015 to reflect the changing nature of cases, particularly in relation to social workers. Minor changes to the SOA were then made in July 2016, to reflect the change in law for rehabilitation of offenders. Whilst the current version has been effective from July 2016, it is the more substantial changes made in May 2015 on which the PSA has commented.

10. The PSA had not previously raised any concerns regarding the SOA. However, through the audit of cases the PSA was able to take a closer look at the application of the SOA.

11. The need for triage threshold to ensure that only matters that require regulatory intervention are taken forward is acknowledged by the PSA. There is concern, however, that the SOA is contributing to an inappropriately high threshold being applied and that there is inconsistent application of the policy. This has contributed to some cases being closed prematurely, including cases that should have proceeded to the Investigating Panel (ICP) for consideration.

Quality of our investigations

12. In some cases there is an overreliance on employer investigations, which affected the quality of the allegations drafted by the HCPC and subsequently considered by the ICP. This overreliance has also led to an insufficient investigation and not all relevant allegations being identified and investigated. The PSA concluded that this had resulted in some incorrect decisions being made both at the SOA and ICP stage.

Potential health cases

13. The case audit highlighted that we had not always identified when we should investigate an allegation that the registrant's health may impair their fitness to practise.

Risk assessments

14. This standard was not met in 2015-16 due to concerns about the frequency and quality of risk assessments. This year, the PSA recognised the significant improvements we have made in this area and appear satisfied with the frequency and timeliness of our risk assessments. However, some concerns about quality and remain. The use of risk assessments to prioritise the higher risk cases was also identified as requiring improvement.

15. Risk assessments have been a key focus of our internal audit activity. Although our own internal audits have identified improvement, concerns around quality have been identified. The findings of our own internal audits have informed the focus of our training and activities that we have undertaken which are outlined in appendix B.

Interim order applications

16. No concerns were raised about the timeliness within which we seek an Interim Order (IO) and the increased number of applications made was recognised.

17. Some analysis of the success rate of our IO applications had been undertaken by the PSA, which caused it to conclude that we base our decisions on whether to apply for an IO on the certainty of an order being imposed instead of where the risk indicated that a review by a committee was appropriate.

18. Last year, the PSA reported concerns about the volume of IO application hearings that had been adjourned. This was 21% in the first three quarters of 2015/16. This year, the PSA recognised that this had reduced to 13% in 2016/17. Importantly, the PSA does not say that this rate is of any concern. They did, however, comment that the wording of the *Proceeding in absence of the registrant* practice note was unclear.

Investigating Committee Panels' decision-making

19. Informed by their conclusions regarding the quality of investigations, the PSA concluded that it could not be assured that the Investigating Committee Panels' (ICP) decision were always fully informed. For example, the case audit had seen cases where the ICP had not requested further investigation when this would have been appropriate.

Timely progression of cases

20. Progress against this standard is acknowledged, in particular the reduction of the number of open older cases (those over a year old) and the improvement in the time taken from receipt to ICP decision.

21. The PSA concluded that standard six had not been met this year because of what it perceived to be a decline in our performance. This was attributed to increases in the median length of time taken for cases to progress through the post-ICP stages of the fitness to practise process. This is a result of our focus on concluding the oldest cases. These median figures are taken from closed cases and the more aged cases that are concluded, the higher the median number will be.

22. Delays in case progression identified through the case audit also informed the judgement that standard six had not been met. The PSA indicated that more evidence of a positive impact on timeliness from the various measures that we have put in place is required before they can conclude that we have met this standard.

Discontinuance process and practice note

23. We operate a process that provides for the Conduct and Competence Committee to decide to discontinue an allegation in part or in full. This process is set out in the Discontinuance of proceedings practice note, dated 22 March 2017.

24. The following concerns about this process were identified:

- the panel considering the discontinuance application was not in possession of the full document bundle presented to the ICP or the ICP decision;

- decisions to discontinue an allegation in part or full were being made when there had not been any significant change in the evidence that had been before the ICP originally considering the case; and

- the practice note does note make clear that discontinuance is only likely to be appropriate where there is a material change in the state of the evidence after the ICP's decision original case to answer decision.

Disposal by consent decisions and practice note

25. An important part of the process for disposing of a case by consent is the registrant's acceptance of the allegation. Allegations will often contain a number of particulars, which set out the events that are alleged to have occurred and which it would be said amount to the ground of impairment – misconduct, for example. Previously a registrant would be required to accept the allegation in full before their case could be disposed of by consent - that is accepting each particular that is alleged. A change was made to the HCPC's policy on consensual disposal, which is annexed to the Disposal of cases by consent practice note. This change, which occurred in December 2016, provides for a case to be disposed of consensually if the registrant admits the substance of the allegation. This change meant the registrant is no longer required to admit each and every particular. Disputes about a minor aspect of the allegation would not prevent a consensual disposal.

26. There is concern that the practice note does not give any guidance to panels about the terms 'substance of the allegation' or 'minor aspect'. This may mean that registrants who lack insight into the full effect of their misconduct may be subject to an inappropriate sanction.

27. There was also concern about the transparency and brevity of the determinations from the disposal by consent process, and the extent to which these decisions provide adequate assurance that the outcome was sufficient to protect the public.

SECTION B

Improvement work initiated prior to 2016/17 performance review

28. Many of the areas of concern identified by the PSA have been identified through our own quality assurance activities and work was already underway to address these. This includes activities initiated following the 2015-16 performance review when the PSA concluded that we had not met standard four (risk assessment and interim orders) and standard six (timeliness). This was outlined in the performance review paper considered by Council on 8 December 2016. The full impact of this work will not have been seen in the sample of cases audited by the PSA as the sample included cases closed between May 2015 and January 2017. It is important, therefore, that we do not conclude that this work has not had the desired effect but continue with its implementation and the assessment of its impact.

29. Significant changes intended to bring about improved performance include the realignment of the fitness to practise department, which was implemented in December 2016. The objective of the new structure was to create specialised teams to focus on specific areas of the fitness to practise process. This includes the application of the SOA, the investigation of cases, preparation of

allegations, risk assessments and decisions to seek an Interim Order. An initial review of the realigned structure took place in early 2017 to provide assurance the transition to the new structure had been effective and that the new teams were becoming established. A more detailed evaluation of the impact of the realignment is part of the current 2017/18 departmental work plan. The evaluation will consider the impact the new structure has had on quality and the progression of cases, as well as the impact on employees. The evaluation may identify some areas where further change is needed to optimise the operation of the new structure.

30. Appendix B provides a detailed update on the activities that have been completed or initiated in response to the issues identified in the 2015-16 performance review as well as our own quality assurance activities. An overview of the progress and impact of these activities is provided below.

Risk assessments and interim orders

31. The progress in relation to the frequency and timeliness of our risk assessments has been recognised by the PSA. The timeliness within which we seek an IO and the increased number of applications made was recognised and no concerns raised.

32. The volume of adjourned IO application hearings reduced from 21% (first three quarters of 2015/16) to 13% in 2016/17. The PSA does not say that this rate is of any concern.

Timeliness

33. The progress in reducing the volume of older cases and improvements in the timeliness with which new and old cases are moving through the process is recognised in the performance review.

Quality of our investigations

34. As part of the 2016 /17 FTP work plan, we have initiated a project to improve our investigations and the drafting of allegations. The project includes research into how other regulators approach investigations and piloting new support tools for Case Managers. We anticipate that this new investigation approach will ensure that we identify all the relevant issues that have the potential to become a fitness to practise allegation, including potential health allegations.

Investigating Committee Panels' decision-making

35. In June 2016, the Executive Management Team endorsed proposals to improve the ICP process. This includes the introduction of ICP specific chairs, improved information for registrants and more active management of the ICP's work.

36. We have also implemented the following actions in relation to ICPs:

- more proactive management of the flow of cases to enable better management of the volume of cases listed, which takes into account the complexity of the case, the volume of documentary evidence and the age of case.

- enhanced training for Hearing Officers supporting the ICPs on the ICPs role and responsibilities to improve the support for the ICP and improve consistency in approach and quality.

- additional guidance and training for ICP panel members about their role and the ICP process, and the importance of adequate reasoning

- reduction in the number of cases to be considered at each ICP sitting to ensure the ICP has sufficient time to consider the cases and formulate well-reasoned decisions.

37. We will be undertaking an initial review of the impact of these measures in January 2018.

Immediate actions taken in response to the 2016-17 performance review

38. On receipt of the PSA's draft performance report for 2016/17, immediate steps were taken to evaluate whether the higher risk concerns remained current. Where this was the case, steps have been taken to manage the risk whilst we developed a longer-term improvement plan.

Resources

39. Current resourcing levels have been reviewed. Additional resource has been identified to ensure the department has sufficient capacity to address the key concerns, whilst maintaining the ongoing management and progression of cases. As part of the month 6 budget reforecast, budget for the recruitment of four additional Case Managers, two additional Case Team Managers and one additional Quality and Compliance Officer has been set aside. The process of recruiting these additional posts is underway.

40. To help improve the retention of case management employees and the ability to fill vacancies, FTP employees on fixed term contracts due to the potential social worker divestment have been offered permanent contracts.

41. Further analysis of the case management resources within the fitness to practise department will be undertaken to ensure that we can manage the volume of work (cases) and achieve an appropriate balance between timeliness and quality. Additional resource requirements may be identified through this analysis and will be reflected in the draft budget for 2018/19.

Recruitment and retention

42. The turnover of our Case Managers is higher than we would wish. It is a role that often attracts those at the early stages of their careers and who then naturally progress either within the HCPC's fitness to practise team or take up external opportunities. For example, in the last year seven of our Case Managers have successfully developed in to other roles within the fitness to practise department. To help manage this, as part of our realignment, we created a new Case Officer role. One of the objectives of creating this role was to provide a progression route to Case Manager. There are three Case Officer posts and all three employees in these posts have recently progressed to new roles within the fitness to practise department. Two have moved into Case Manager roles.

43. Our experience of the turnover of case management colleagues is no different to other health care regulators and we are already working with them to identify how we can make this role more attractive and improve retention of these key members of staff.

44. When Case Manager vacancies arise, we rely heavily on temporary colleagues to provide cover whilst recruitment is undertaken. This reliance on temporary colleagues presents risks, causes delays and can have an impact on quality. It is essential, therefore, that when a vacancy arises we are able to fill it quickly. It is also essential that we attract high quality candidates to these roles to allow for an effective recruitment campaign.

45. We are working with our colleagues in Human Resources to renew our recruitment strategy for case management colleagues to attract sufficient candidates with the right knowledge, competencies and skills. We will also be looking at how we can manage the recruitment process going forward to enable us to fill vacancies quickly and reduce our reliance on temporary colleagues.

Standard of Acceptance

46. A number of steps were taken immediately to manage this risks identified by the PSA in relation to the SOA policy and its application. These include:

    - introduction of a more senior sign off of SOA case closure decisions. Decisions now require the approval of a Head of function and a sample is reviewed by the Director of Fitness to Practise;

    - internal and external audit (using our external legal services provider) of recent SOA decisions to help identify causes and solutions to the concerns raised about the SOA and its application; and to provide a benchmark against which we can measure the impact of improvement activities;

    - enhanced the guidance provided to our case management colleagues and revised decision record forms and template letters;

- case team manager development day to consider the findings of the audits and how they can be supported as they have a critical role in ensuring the quality of our case management work and decision making.

- new SOA training for Case Managers. This training was led by our relevant Heads and our Case Team Managers and it also focussed on our overriding objective to protect the public and exploring how the application of the SOA should support this objective.

47. A review of the SOA policy will be undertaken as part of the wider improvement plan. This will be an opportunity for us to consider whether the threshold is set at the right level and supports and enables our case management colleagues to make informed and appropriate decisions.

Health cases

48. It is common for fitness to practise cases to contain information that relates to the registrant's health. This may be presented, for example, as mitigating factors to the behaviour or events that are alleged to have occurred. This information does not often indicate that the registrant's fitness to practise is impaired by their physical or mental health. The skill, therefore, is identifying when this information should cause us to raise a health allegation.

49. We do not consider that the PSA's view that health assessments should be routine when a registrant has been convicted for a drug or alcohol related offence is proportionate and we propose to maintain a case by case approach. We recognise, however, there is a need for a clear policy statement or specific guidance that allows us to identify when a health allegation should be raised and investigated. We have begun work on the development of a policy that will clearly identify our approach as well as the development of associated guidance.

Quality Assurance

50. Each of the HCPC's core functions has a quality assurance team and programme dedicated to improving the quality of our work. These teams meet on a regular basis to share ideas and best practice. Steps have been taken to improve the visibility and oversight of our quality assurance work, which includes enhanced reporting to the Executive Management Team, with increased monitoring of the delivery of improvements across the HCPC.

51. The focus of the FTP directorate's quality assurance activity is informed by a range of factors. They include ensuring: ongoing compliance with operational processes and case management protocols; issues identified by previous performance reviews; PSA learning points and appeals; decision reviews,

stakeholder feedback and specific individual or team performance issues. Our approach to the prioritisation of quality assurance activities has been to shift the balance away from a routine case file audit approach, to a more thematic and risk based approach. To this end, our focus has been looking at those issues identified in previous performance reviews such as risk assessment, discontinuance and disposal by consent.

52. Further details of the immediate steps we have taken is provided in Appendix B.

SECTION C: Future improvement plan

53. We recognise that the issues raised by the PSA are significant and that a managed programme of improvement activity is required to ensure that the HCPC meets the FTP standards for good regulation, whilst maintaining the ongoing efficient management and conclusion of cases through the fitness to practise process. The Executive has initiated an FTP Improvement project to address the areas of improvement identified in this paper. This will be managed as a major project. This will ensure regular reporting and oversight by the Executive and Council as well as the consideration of potential resource impacts and impact on other departments, for example Human Resources.

54. As outlined, improvement work has already begun and the project will include the areas that are yet to be completed and the necessary evaluation of their impact. It will also include more detail of the steps required to deliver the improvements identified and a more precise timeline for delivery. An indicative timeline is provided at Annex C. The project will become the FTP department work plan for 2018/19.

55. We have taken into account the planned changes to the regulation of social workers when considering the improvements needed where this has been possible in view of the lack of certainty around the transition timeline. However, the concerns identified by the PSA relate to the quality of our fitness to practise work and some of our policies and practice. These apply to all cases, including those arising from the professions that we will continue to regulate. We therefore consider it essential that the programme of improvement is needed regardless of the eventual social work divestment.

56. To achieve a sustained change, the improvements identified include both strategic and operational changes. The need for continued communication with key stakeholders and evaluation of the impact of change is also identified. We will need to be able to provide the PSA with evidence that assures them that we are meeting the standards, and the ability to gather this evidence is built into the plan.

57. What follows is a description of the more significant and strategic changes that we propose to take. Annex C provides more detail for these areas and indicative timelines as well as an indication of the more operational changes that we are taking and plan to take. The improvements identified go beyond

those areas identified in the PSA performance review report. They also include areas of learning identified by the PSA audit of our fitness to practise cases, the PSA learning points and our own internal audits.

Review, develop and maintain core competencies

58. The quality of the work we do and the speed at which we do it is dependent on the competencies of the colleagues we have within the fitness to practise team being aligned with the work we do and processes that we need to operate. We will, as part of the improvement plan, review the competencies for the case management roles we have within the team and reflect on whether these remain suitable for the work and decisions we expect those in these roles to do. This may identify the need for different competencies, which we would need to develop for existing employees and seek from candidates at recruitment. We will also need to consider how we assess the required competencies through the recruitment and selection process.

Communication

59. To ensure the successful delivery of the improvement engagement with our key stakeholders will be critical.

60. The fitness to practise directorate have been and will continue to be directly affected by the PSA's conclusions about our performance. They will also be directly affected by the changes that we will be making as part of the improvement plan. It is essential that we keep them both informed about and involved in these developments. We will also need to ensure that our colleagues are properly supported so that they remain resilient and adaptable and able respond to change in a positive way.

61. We will continue to engage with the PSA, ensuring that they are informed of our developments and the impact of these on their areas of concerns. This will include meetings between our Director of Fitness to Practise and the PSA's Director of Scrutiny and Quality, as well our continued engagement in PSA led initiatives. Our 2017/18 performance review cycle will commence shortly and we will ensure that the PSA is informed about our planned improvements.

62. We have and will continue to keep our partners updated on the improvement plan and particularly in relation to those areas that will affect them. These will include the ICP decisions and development with health cases.

Case management quality manual

63. Currently, our operational guidance takes of the form of separate Fitness to Practise Operational Guidance (FOG) documents. These predominately provide information about the processes that should be followed to carry out certain functions. For example, we have FOG that sets out the steps required to log a newly received case. These FOGs have been developed over time and by

different people within the fitness to practise team. They have become inconsistent in some places and some do not fully reflect the processes that we operate today.

64. We propose to review all our operational guidance and produce one manual that provides a step-by-step guide through the complete fitness to practise process. This document will be interactive and indexed to ensure ease of use as well as supporting the development of e-learning modules.

Efficient and effective working

65. A key feature of the plan is to ensure that we are working as efficiently and effectively as we can. Efficiency savings will be identified by a review our processes and how we use IT systems to support our case management work.

66. Effective working will be enhanced by the development and support of our Case Team Managers, who will play a crucial role in the implementation of the changes we will make. Our Case Team Managers provide vital support to our Case Managers and manage their performance and development.

Employee and partners development

67. We have and will continue to operate a programme of development for our fitness to practise teams and partners. This year's programme will be aligned to the improvement plan and focussed on addressing the areas of concern that have been identified.

68. We have invested this year in software and other tools that allow us to develop training that is more interactive and available on an ongoing basis. We have the ability to produce online training that provides for colleagues to undertake the training on more than one occasion and continually refer to it as they implement the learning into the day-to-day work. We have begun developing an online risk assessment training, which will be delivered in Q4 of 2017/18. This will be made available to all case management colleagues, including temporary staff in these roles. This online training will be compulsory element of induction programme for case management colleagues. This software provides for an assessment of learning, which will enable to us to better record the impact and to also identify those colleagues that may need additional learning and support.

69. We intend to hold further Case Team Manager development days focussed on these key members of our team. This development will include a blend of job specific topics, such as the application of the SOA, as well as management development to help them build and develop their own teams.

70. As outlined above, the programme for the current round of partners' training is already aimed at tackling the concerns raised by the PSA. This will continue into 2018.

System development

71. We operate a case management system, which is crucial to the work we do. This system will need to reflect the operational approach and processes that we wish to develop. It needs to support and not restrict effective and efficient working. The system we have was implemented in 2012 and the functionality has at time been a restriction on developments.

72. We will consider what options we have to either develop our existing system to improve its function or replace with a new system that provides greater flexibility and ease of working. A business case has already been developed to review current and future system requirements with a view to developing a fully costed business case for replacement case management system or significant enhancements to the current CMS.

Standard of Acceptance

73. We will review the SOA policy in light of the PSA's findings and concerns. We believe, and the PSA accepts, that it is necessary for us to operate a threshold that allows us to identify those cases that raise a fitness to practise concern and require investigation. It is important that this threshold it set at the right level so that it allows us to manage our resources effectively and ensure that these are deployed only to those cases that warrant investigation in pursuit of our public protection objective.

74. The review may result in the development of revised threshold policy. Any revisions to the threshold policy would require new guidance and processes to be developed in conjunction with the development and training of colleagues who will be applying the policy to cases.

Health allegations

75. We will develop policy that sets out our approach to the identification and investigation of allegation that a registrant's fitness to practise is impaired by their physical or mental health.

76. Guidance on how to identify a health allegation and how to investigate will also be developed.

Risk Assessments

77. Progress has already been made in this area. We will continue to evaluate the quality of our risk assessments and ensure identified further quality improvements are achieved.

Discontinuance process

78. When developing the current discontinuance process, we met with the PSA and they provided input into that process. We note that it now reports concerns about two aspects of this process and we will, therefore, review our approach. We have recently carried out an audit of our discontinuance cases and will reflect on the findings of that audit and take them into account as part of our review.

Measuring improvement

79. Progress has been made to improve the time it takes to progress our fitness to practise cases and this needs to continue. In addition, we need to ensure that we achieve the optimum balance between timeliness with quality.

80. We will be making many changes over the course of the next year and need to be sure that these changes achieve the identified objectives and do not negatively impact on the quality or timeliness of other areas of our work and processes.

81. We also need to be able to assure ourselves, and the PSA, of our performance in the future by providing evidence to demonstrate that we meet the Standards of good regulation. We have begun a review of our fitness to practise quality assurance activities to ensure that we strike the right balance between ongoing quality assurance and the evaluation of the impact of changes made. We have also increased the resources in this area as well as the visibility and oversight of this work. We will incorporate into our fitness to practise quality assurance framework a means of measuring ourselves against the ten fitness to practise Standards of good regulation.

82. The improvement plan includes a number of evaluation activities to measure the impact of the improvement actions. These evaluation activities are included in italics in the plan at Annex C where they have already been identified.

83. We are developing performance indicators for key milestones in the fitness to practice processes. These will allow us to continue to monitor the progression of cases through the process and ensure that we maintain the timeliness improvements we have made. As we develop these performance indicators we will review the optimum case length of time.

Reporting and monitoring progress

84. The management of the FTP Improvement Plan as a major project will ensure regular reporting to, and oversight by, the Executive and Council. Key outputs from the improvement plan, for example proposed revisions to existing policies and new policies relating to our fitness to practise work will be brought to Council. The Tribunal Advisory Committee will also been kept informed of progress and their expertise utilised to consider developments in those areas relevant to HCPTS, for example revisions to Practice Notes, and training for

panels.

85. Council will be kept informed of progress through the Chief Executive's performance report. It is also proposed that a more substantial progress update is provided to Council periodically.

86. The PSA has already commenced the assessment stage of its 2017/18 performance review. Our focus will be on implementing the improvements necessary to meet the standards of good regulation. However, the performance review timetable, coupled with the time it takes to develop, implement and evaluate changes, may mean it takes more than one performance review cycle before the PSA is satisfied that there is sufficient improvement to warrant a particular standard being met.

Appendix B: FTP improvement work completed or already underway

The PSA's performance review in 2015/16 concluded that we had not met two of the fitness to practise standards - standard four (risk assessments and interim orders) and six (timeliness). A number of activities were identified to address these concerns and these were considered by Council in December 2016. An update on the progress made against those actions is provided below.

Our work plan for 2017/18 also included a number of improvements that are relevant to the PSA's concerns. Updates on these areas are also provided.

We took a number of immediate steps, following the PSA's audit of our fitness to practise cases and its conclusion that we had not met six of the fitness to practise standards. These steps were taken to manage risk in some areas, whilst we undertake the improvements required. These are also included below.

Risk assessments

Date	Event/Change
April 2016	Process update and new management control: introduction of a new action on our case management system (CMS) to ensure that an Operational Manager reviews cases where a risk profile of A or B is given, providing for greater oversight and progression of these cases.
May 2016	Training: Risk Assessment and Interim Order Workshop, attended by all Case Managers. This included training on understanding risk and why we undertake risks assessments, a review of the interim order threshold and criteria, the findings and learning from our risk assessment audit and a review of the process for undertaking a risk assessment and referring a case for an interim order.
May 2016	Quality Assurance: audit of a sample of risk assessments completed on cases opened between May 2015 and February 2016. Recommendations included improvements to the operational guidance.
June 2016	Process update: updated risk assessment form introduced, which included additional headings for clarity and requirement to identify risk factors.
July 2016	Process update: Risk profiling and interim orders operations guidance updated to provide guidance on the requirements in the new risk assessment form.
July 2016	Systems update: relabelling of an action on our CMS to include the term 'Risk Assessment' as a prompt to Case Managers to undertake a risk assessment, if required.
July 2016	New management control: Case Team Managers create a risk assessment action in CMS for the Case Manager to undertake

	an assessment, if one has not been undertaken within the last eight weeks. This ensures that all cases have a valid risk assessment present, regardless of whether any new information has been received on a case.
July 2016	Laminated copies of the risk assessment process provided to all Case Managers to use as an aide memoire
July 2016	Process update: four process forms updated to encourage the completion of a risk assessment and review of the risk profile at key stages of the process – two case transfer forms; case handover form; and submission of draft allegation for approval form.
October 2016	Management Control: introduction of an Operational Manager review when a risk profile changes to A or B and an interim order approval request is not made.
October 2016	Quality Assurance: audit of a sample of risk assessments completed on cases opened between December 2015 and September 2016. Recommendations included creation of an Operational Manager action on the case management system when there was an increase in risk profile, revisions to the risk assessment form and that temporary case management staff should be trained on the completion of risk assessments.
November 2016	Training: Risk Assessment and Interim Order Workshop, attended by all Case Managers, including temporary case management staff. New case studies were used for the practical application of the learning.
November 2016	Process update: the risk assessment form template was updated to make the consideration of the grounds on which an IO can be sought more prominent and improvements to format to clarify how the form should be used.
December 2016	Realignment: Case Reception and Triage and Investigations teams established.
December 2016	Process update: a new combined case logging and risk assessment form introduced and used by CRT on all newly received concerns.
March 2017	Training: workshop on approving Interim Order requests for Operational Managers.
April 2017	Quality Assurance: audit of a sample of cases that were opened on or after 1 January 2017, resulting in one recommendation that the risk assessment form be enhanced to improve clarity.
May 2017	Training: Risk Assessment and Interim Order Workshop, attended by all Case Managers, including temporary case management staff. Training enhanced by a closer look at the findings made by the PSA in its 2015/16 performance review and the findings made in our internal risk assessment audits.

	New case studies were used for the practical application of the learning.

Interim Orders

Date	Event/Change
August 2016	Process update: revised operational guidance for Case Managers who present at Interim Order hearings to ensure a consistently robust approach is taken when contesting adjournment requests.
September 2016	Process update: revised Proceeding in absence of the registrant practice note.

Timeliness

Date	Event/Change
January 2016	Process update: implemented changes to our scheduling process to reduce the time taken from the ready to fix a hearing date to the actual hearing. This included monthly review of 'ready to fix' cases, assigning a priority rating and frequent telephone conferences with our external legal supplier.
July 2016	Training: Panel Chairs and Legal Assessors provided with guidance on planning the hearing time and informed about the impact on timeliness of part-heard cases.
August 2016	Management control: introduction of a new process for escalating delayed cases to relevant Case Team Managers, then on to Operational Managers and ultimately to Head of function, if necessary.
September 2016	Realignment: Case Preparation and Conclusion team goes live.
September 2016	Process update: revised Proceeding in absence of the registrant practice note.
November 2016	Process update: revised Case Progression operational guidance produced.
November 2016	Management control and systems update: introduction of RAG ratings for older cases.
December 2016	Realignment: Case Reception and Triage and Investigation teams go live.
December 2016	Process update: introduced a RAG rating process at both the investigations and case progression stages of our fitness to practise processes.

December 2016	Assurance: developed the concept of the optimum length of time, which includes realistic measures for the progression of cases through different stages of the fitness to practise process.
December 2016	Assurance: new management information pack aligned with the new fitness to practise department structure created and presented to Council. This provided key length of time metrics, more information about our adjudications activities. A supplementary pack provided operational management information including performance against the optimum case length and RAG rating of pre-ICP cases.
February 2017	Quality assurance: a review of the realignment and key processes was undertaken to ensure no immediate issues had arisen.
March 2017	Process update: introduced case progression planning for all cases over five weeks from receipt.
April 2017	Realignment: Health and Care Professions Tribunal Service (HCPTS) goes live.
June 2017	Training: case transfer training provided to the Case Reception and Triage team to ensure clarity on when and how cases should be transferred from the Case Reception and Triage team to Investigations Team.
September 2017	Process update: Review of substantive orders on the papers Trend analysis of types and durations of reviewable sanctions completed. Results discussed at Tribunal Advisory Committee, with suggestions for enhancements for training for Panel Chairs and Legal Assessors. Systematic review of existing orders, with enhanced guidance for preparation and presentation, and demonstration of HCPC's efforts to engage with process.

Standard of Acceptance

Date	**Event/Change**
July 2016	Process update: Standard of Acceptance Policy updated to include information about convictions.
March 2017	Training: Case Reception and Triage team workshop on applying the Standard of Acceptance.
August 2017	Quality assurance: internal audit of Standard of Acceptance decisions.
August 2017	Process update: Head of function sign off for all pre-ICP case closures introduced.

September 2017	Quality assurance: external audit by legal provider of Standard of Acceptance decisions.
November 2017	Training: Case Team Manager development day to reflect on the Case Team Manager role and how they can achieve the best from their people, including a focus on the application of the Standard of Acceptance.
November 2017:	Training: applying the Standard of Acceptance training provided to all case managers.

Investigations

Date	**Event/Change**
January 2016	Training: a selection of Case Managers complete the Bond Solon BTEC Level 5 Professional Award in Complaints Handling and Investigation
February 2016	Training: Introduction to child social work law, provided to all Case Managers.
July 2016	Training: allegation drafting training provided to Case Managers.
November 2016	Process update: revised Case Progression operational guidance produced.
November 2016	Process and systems update: new template letters developed and implemented in the CMS, which are for use when cases are received in Investigations team.
December 2016	Policy development: HCPCs Approach to Fitness to Practise policy introduced
December 2016	Realignment: Investigations team goes live.
December 2016	Training: allegation drafting training provided to Case Managers.
May 2017	Quality assurance: audit of Investigation team's work, including the quality of allegations, efficient case progression,
July 2017	Quality assurance: allegations audit, to review the quality of the allegations that are drafted.
July 2017	Training: allegation drafting training for Investigations team, including the introduction of an evidence matrix.
October 2017	Training: investigation planning training provided to pilot participants.
November 2017	Process update: pilot of a new approach to investigation planning and allegation drafting launched.

Investigating Committee

Date	Event/Change
June 2017	Process update: Executive Management Team considers a range of proposals aimed at improving the quality of the Investigating Committee Panels' work.
September 2017	Training: Hearings Officers receive training focussed on the Investigating Committee Panels' role and responsibilities.
November 2017	Management control: introduction of more proactive management of the flow of cases to Investigating Committee panels to take account of mix of case types, age of cases and complexity.
November 2017	Process update: additional guidance provided to Investigating Committee Panels about their role and the ICP process.
November 2017	Training: Panel Chairs received training on the role and responsibilities of the Investigating Committee Panels.

Appendix C: Outline plan of activity in response to 2016/17 PSA performance review

Area	Activity	Started	Timeline (completed by end of)	Success indicator	Relevant standard of good regulation
Resourcing and recruitment	Review our approach to the recruitment of our case management staff.	Yes	Q4 2017/18	Ability to recruit sufficient high quality case management staff quickly. Reduction in reliance on temporary staff.	1, 3, 4, 5, 6, 8
	Review of the skills, knowledge and competencies required for our case management roles, amending these where necessary.	No	Q1 2018/19	Competencies aligned with requirements of different functional case management roles. Improved performance against performance indicators.	1, 3, 4, 5, 6, 8
	Develop and support our existing case management staff to achieve any revised competencies.	Yes	Ongoing	Improved retention. Improved performance against performance indicators. Employee surveys indicate improved job satisfaction and motivation.	1, 3, 4, 5, 6, 8

Area	Activity	Started	Timeline (completed by end of)	Success indicator	Relevant standard of good regulation
	Analysis of case management resources required for the volume of case management work required.	No	Q4 2017/18	Improvements against performance indicators Reduction in reliance on temporary staff. Employee surveys indicate improved job satisfaction and motivation.	1, 3, 4, 5, 6, 8
	Expand our permanent case management staff to reinforce operational activity and build resilience for improvements.	Yes	Q4 2017/18	An appropriately resourced case management team. Improved retention and decreased reliance on temporary employees.	1, 3, 4, 5, 6, 8
Communication	Ongoing and open engagement with the PSA, keeping it informed of developments and progress	Yes	Ongoing	Good working relationship with the PSA maintained and informed dialogue about the focus and likely conclusions of future performance reviews.	1, 3, 4, 5, 6, 8
	Regular reporting to Executive and Council including the development of performance indicators and enhanced reporting mechanisms	Yes	Ongoing	Effective oversight and scrutiny of improvement activities including understanding impact and projected future performance.	1, 3, 4, 5, 6, 8

Area	Activity	Started	Timeline (completed by end of)	Success indicator	Relevant standard of good regulation
	Programme of internal communication with colleagues in the fitness to practise team.	Yes	Ongoing	Informed, motivated and engaged fitness to practise colleagues. Improved retention.	1, 3, 4, 5, 6, 8
Efficient and effective working	Development of our Case Team Managers to ensure they have the management skills required to ensure quality, challenge and embed changes and learning.	Yes	Ongoing	Highly competent and motivated Case Team Managers. Improved performance against performance indicators.	1, 3, 4, 5, 6, 8
	Support managers in managing under performance effectively.	Yes	Ongoing	Improved performance against performance indicators. Employee surveys indicate improved levels of motivations and job satisfaction within the case management team.	1, 3, 4, 5, 6, 8
	Explore ways in which we can streamline our processes to support efficient working.	No	Q2 2018/19	Performance improvements through streamlined processes. Reduction in costs.	1, 3, 4, 5, 6, 8

Area	Activity	Started	Timeline (completed by end of)	Success indicator	Relevant standard of good regulation
	Review how we use our IT systems to support our case management work.	Yes	Q3 2018/19	Performance improvements through effective and innovative use of IT systems. Improved levels of employee satisfaction with support systems.	1, 3, 4, 5, 6, 8
Legal services	Review our approach to provision of legal advice.	No	Q3 2018/19	Improved decisions and case progression.	1, 3, 5, 6, 8
	Review of our approach to the preparation and presentation of final hearing cases.	No	Q3 2018/19	Improved case preparation and presentation including reducing the number of part heard or adjourned cases.	3, 5, 6, 8
Producing guidance and developing tools to support the team	Produce one composite quality manual setting out the powers, procedures and guidance to manage our fitness to practise work.	No	Q4 2018/19	Consistent application of process and procedures evidenced through audits.	1, 3, 4, 5, 6, 8

Area	Activity	Started	Timeline (completed by end of)	Success indicator	Relevant standard of good regulation
	Introduce controls to manage the development of guidance and process documentation to ensure that it remains of good quality, comprehensive and consistent.	No	Q4 2018/19	Consistent application of process and procedures evidenced through audits.	1, 3, 4, 5, 6, 8
	Review process maps to ensure they accurately reflect the key parts of the FTP process, the functional teams responsible for those processes, overlap/link with other teams and key decision points and responsibility	N	Q4 2018/19	Clearly defined processes and lines of responsibility/accountability. Consistent application of processes.	1, 3, 4, 5, 6, 8
Standard of Acceptance Policy (SOA)	Review the SOA Policy and the threshold.	No	Q1 2018/19	Assurance that an appropriate threshold is set and applied at the 'triaging' stages of the fitness to practise process. Improvement in the consistency of decision-making at this stage.	1, 3, 5, 8

Area	Activity	Started	Timeline (completed by end of)	Success indicator	Relevant standard of good regulation
SOA (threshold) policy application	Development of guidance for case management colleagues on the application of the threshold.	No	Q2 2018/19	Consistent and accurate application of the threshold.	1, 3, 5, 8
	Review and develop the process documentation that relates to the SOA and threshold	No	Q2 2018/19	Consistent and accurate application of the threshold. Good quality and well-reasoned case closure decisions with clear audit trail.	1, 3, 5, 8
	Training for case management colleagues on the threshold and its applications	No	Q2 2018/19	Consistent and accurate application of the threshold. Good quality and well-reasoned closure decisions with clear audit trail.	1, 3, 5, 8
	Review and develop the oversight/approval of the threshold decisions	No	Q2 2018/19	Only accurate, appropriate and well-reasoned decisions are approved.	1, 3, 5, 8

Area	Activity	Started	Timeline (completed by end of)	Success indicator	Relevant standard of good regulation
Cases arising under Article 22(6) (self-referral cases)	Review the triaging process for cases that arise under this article	N	Q1 2018/19	Clarity as to the need and purpose of the legal advice Clarity as to how the threshold policy is applied in these cases Streamlined process.	1, 3, 6, 8
	Produce guidance for registrant's on what to self-refer and what information to provide when making a self-referral	No	Q2 2018/19	Reduction in unnecessary self-referrals.	1, 5, 6, 8
	Ensure operational guidance refers to and identifies how matters arising under Article 22(6) should be managed	No	Q1 2018/19	Consistent and improved management of these cases.	1, 3, 4, 6, 8
Quality of our investigations	Post-pilot evaluation of the new investigation approach	Yes	Q4 2017/18	Evaluation of impact against objectives. Identification of further development.	3, 6, 8

Area	Activity	Started	Timeline (completed by end of)	Success indicator	Relevant standard of good regulation
Identification and investigation of health allegations	Develop a policy that sets out our approach to the identification and investigation of health allegations.	Yes	Q4 2017/18	Clearly defined and published approach to the management of health cases.	3, 5, 8
	Develop guidance for case management colleagues on how to identify a health allegation and investigate it.	No	Q1 2018/19	Clearly defined approach and process. Improved and consistent management of health cases.	3, 5, 8
	Establish a process for the identification and investigation of health allegations.	No	Q1 2018/19	Clearly defined approach and process. Improved and consistent management of health cases.	3, 5, 8
	Provide training to case management colleagues on the identification and investigation of health allegations.	No	Q2 2018/19 and Q4 2018/19	Improved and consistent management of health cases.	3, 5, 8

Area	Activity	Started	Timeline (completed by end of)	Success indicator	Relevant standard of good regulation
	Define and document the ICP referral route for cases that involve both health and one other ground of impairment	No	Q2 2018/19	Clearly defined path for the referral of cases involving both health and one other ground of impairment. Improved ICP decision-making.	3, 5, 8
	Evaluate the impact of the new policy, process, guidance and training.	*No*	*Q3 2018/19 and Q1 2019/20*	*Assurance that objectives have been met.*	*3, 5, 8*
Risk assessments	*Evaluation of a sample of recently completed risk assessments.*	*No*	*Q3 2017/18*	*Assurance that objectives have been met.*	*4*
	Develop and roll out risk assessment e-learning and assessment for existing case management colleagues.	Yes	Q4 2017/18	Improved risk assessment quality. Maintain improvements and consistent approach.	4

Area	Activity	Started	Timeline (completed by end of)	Success indicator	Relevant standard of good regulation
	Introduce risk assessment e-learning and assessment as a mandatory part of the induction process for all (including temporary) case management staff.	No	Q1 2018/19	Improved risk assessment quality. Maintain improvements and consistent approach.	4
	Use the information gained from the e-learning assessments to target development and support for those who need it.	No	Q1 2018/19	Targeted use of development resource. Improved risk assessment quality.	4
Prioritising high risk cases	Review processes to identify opportunities to prioritise higher risk cases.	No	Q2 2018/19	Higher risk cases are prioritised.	4
	Develop a process that provides for the prioritisation of higher risk cases.	No	Q3 2018/19	Higher risk cases are prioritised.	4

Area	Activity	Started	Timeline (completed by end of)	Success indicator	Relevant standard of good regulation
Timeliness and case progression	Develop realistic but challenging performance indicators for key milestones in the fitness to practise processes and review the optimum case length of time.	No	Q4 2017/18	Improved case progression and performance.	4, 6
	Undertake a length of time review of cases older than 18 months and establish projections for their conclusion	No	Q4 2017/18	Reduction in aged cases.	6
	Analyse existing case load and projected new case-loads to calculate volume throughput required to ensure we met performance indicators and optimum case length.	N	Q4 2017/18	Performance indicators achieved Improved case progression and timeliness.	6
Measuring success	*Evaluate the realignment of the fitness to practise department.*	*Yes*	*Q3 2017/18*	*Assurance that original objectives achieved.* *Identification of further development.*	*1, 3, 5, 6, 8*

Area	Activity	Started	Timeline (completed by end of)	Success indicator	Relevant standard of good regulation
	Revise the FTP QA Framework so that it is aligned to the standards of good regulation and effectively measures the quality of our work.	*No*	*Q4 2017/18*	*Effective assurance of quality of key areas of our fitness to practise work.* *Ensure continuous improvement.*	*1, 3, 4, 5, 6, 8*
	Develop a mechanism for measuring the effectiveness of new and revised policies	*No*	*Q3 2018/19*	*Assurance that objectives of new/revised policies are achieved.*	*1, 3, 4, 5, 6, 8*
	Ensure a clear timeline for the introduction of changes, new process and policies to provide for the effective measurement of impact	*Yes*	*Ongoing*	*Clearly defined points from which to measure impact.*	*1, 3, 4, 5, 6, 8*
	Engage legal advisors to provide external validation, including audits of key areas of our fitness to practise work that need to be improved.	*No*	*Q4 2017/18 and Q3 2018/19*	*Independent assurance of the quality of key areas of our fitness to practise work.*	*1, 3, 5, 8*

Area	Activity	Started	Timeline (completed by end of)	Success indicator	Relevant standard of good regulation
	Pilot more significant changes and evaluate the impact before full run out.	*N*	*Ongoing*	*Assurance that objectives will be met before full roll out.* *Managed risk of significant change on key parts of the fitness to practise process.*	*1, 3, 4, 5, 6, 8*
Standards of conduct, performance and ethics and Standards of Proficiency	Raise awareness of the Standards amongst fitness to practise colleagues, their purpose and how they should be used in fitness to practise.	Yes	Ongoing	Improved decision making at all stages of the fitness to practise process.	3, 5, 8
	Ensure that the standards are referred to in relevant guidance and procedure documents and used in training, where relevant.	Yes	Ongoing	Improved decision making at all stages of the fitness to practise process.	3, 5, 8
Investigating Committee Panel	*Evaluate the impact of the changes made to manage the ICPs workload and improve its support and guidance.*	*No*	*Q4 2017/18*	*Assurance that the changes have achieved their objective.*	*3, 8*

Area	Activity	Started	Timeline (completed by end of)	Success indicator	Relevant standard of good regulation
	Continued focus on the ICP's role and responsibility at the Partner's induction and refresher training.	Yes	Ongoing	Improved ICP decisions and reasons	3, 8
	Introduce ICP specific Chairs and enhance the management of the ICP's case load.	No	Q3 2017/18	Improved ICP decisions and reasons	3, 8
	Improve the information provided to registrants about the referral of their case to the ICP and the information that they may provide to the ICP.	No	Q4 2017/18	Improved quality of information received from registrants. Reduction in requests from registrants for extensions to time provided to supply information. Improved ICP decisions and reasons.	3, 6, 8

Area	Activity	Started	Timeline (completed by end of)	Success indicator	Relevant standard of good regulation
	Review of the active management of cases at the pre-ICP stage (observation stage) and our approach to the request for extensions of time from registrants	No	Q4 2017/18	Reduction in requests from registrants for extensions to time provided to supply information. More efficient progression of cases through this stage of the process.	3, 6, 8
Discontinuance of allegations	Review our approach to discontinuance and supporting guidance.	Yes	Q4 2017/18	Assurance that approach is appropriate. Improved discontinuance decisions.	5, 8
	Audit discontinuance cases and decisions to identify any learning and development required.	*Yes*	*Q3 2017/18*	*Assurance that the approach is appropriate.* *Improved discontinuance decisions.*	*5, 8*
Disposal by consent process and practice note	Review our approach to agreeing to disposal of cases by consent, the decisions made and any previous learning points/challenges provided by the PSA.	No	Q1 2018/19	Assurance that approach is appropriate. Improved decisions.	5, 8

Area	Activity	Started	Timeline (completed by end of)	Success indicator	Relevant standard of good regulation
Proceeding in absence of the registrant practice note	Review the practice note.	No	Q1 2018/19	Assurance that approach is appropriate. Improved consistency in decision making.	4, 5

Annual review of performance 2016/17

Health and Care Professions Council

October 2017

professional standards authority

About the Professional Standards Authority

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

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

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

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

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

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

2 *Right-touch regulation revised (October 2015)*. Available at http://www.professionalstandards.org.uk/policy-and-research/right-touch-regulation

Contents

About the Health and Care Professions Council

The Health and Care Professions Council (the HCPC) regulates the practice of arts therapists, biomedical scientists, chiropodists / podiatrists, clinical scientists, dietitians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists / orthotists, radiographers, speech and language therapists in the UK and social workers in England.

The work of the HCPC includes:

- Setting standards for the education and training of practitioners and assuring the quality of education and training provided
- Setting and maintaining standards of conduct, performance, and ethics for practitioners and standards of proficiency for each professional group
- Maintaining a register of practitioners ('registrants') who meet those standards
- Setting standards of continuing professional development to ensure registrants maintain their ability to practise safely and effectively
- Taking action to restrict or remove from practice individual registrants who are considered not fit to practise.

As at 31 March 2017, the HCPC was responsible for a register of 350,330 practitioners. The annual registration fee is £90.

1. The annual performance review

1.1 We oversee the nine health and care professional regulatory organisations in the UK, including the Health and Care Professions Council.[3] More information about the range of activities we undertake as part of this oversight, as well as more information about these regulators, can be found on our website.

1.2 An important part of our oversight of the regulators is our annual performance review, in which we report on the delivery of their key statutory functions. These reviews are part of our legal responsibility. We review each regulator on a rolling 12-month basis and vary the scope of our review depending on how well we see the regulator is performing. We report the outcome of reviews annually to the UK Parliament and the governments in Scotland, Wales and Northern Ireland.

1.3 These performance reviews are our check on how well the regulators have met our *Standards of Good Regulation* (the Standards) so that they protect the public and promote confidence in health and care professionals and themselves. Our performance review is important because:

- It tells everyone how well the regulators are doing
- It helps the regulators improve, as we identify strengths and weaknesses and recommend possible changes.

The Standards of Good Regulation

1.4 We assess the regulators' performance against the Standards. They cover the regulators' four core functions:

- Setting and promoting guidance and standards for the profession
- Setting standards for and quality assuring the provision of education and training
- Maintaining a register of professionals
- Taking action where a professional's fitness to practise may be impaired.

1.5 The Standards describe the outcomes we expect regulators to achieve in each of the four functions. Over 12 months, we gather evidence for each regulator to help us see if they have been met.

1.6 We gather this evidence from the regulator, from other interested parties, and from the information that we collect about them in other work we do. Once a year, we collate all of this information and analyse it to make a recommendation to our internal panel of decision-makers

[3] These are the General Chiropractic Council, the General Dental Council, the General Medical Council, the General Optical Council, the General Osteopathic Council, the General Pharmaceutical Council, the Health and Care Professions Council, the Nursing and Midwifery Council, and the Pharmaceutical Society of Northern Ireland.

about how we believe the regulator has performed against the Standards in the previous 12 months. We use this to decide the type of performance review we should carry out.

1.7 When considering information relating to the regulator's timeliness, we consider carefully the data we see, and what it tells us about the regulator's performance over time. In addition to taking a judgement on the data itself, we look at:

- any trends that we can identify suggesting whether performance is improving or deteriorating
- how the performance compares with other regulators, bearing in mind the different environments and caseloads affecting the work of those regulators
- the regulator's own key performance indicators or service standards which they set for themselves.

1.8 We will recommend that additional review of their performance is unnecessary if:

- We identify no significant changes to the regulator's practices, processes or policies during the performance review period; and
- None of the information available to us indicates any concerns about the regulator's performance that we wish to explore in more detail.

1.9 We will recommend that we ask the regulator for more information if:

- There have been one or more significant changes to a regulator's practices, processes or policies during the performance review period (but none of the information we have indicates any concerns or raises any queries about the regulator's performance that we wish to explore in more detail) or;
- We consider that the information we have indicates a concern about the regulator's performance in relation to one or more Standards.

1.10 This targeted review will allow us to assess the reasons for the change(s) or concern(s) and the expected or actual impact of the change(s) or concern(s) before we finalise our performance review report.

1.11 We have written a guide to our performance review process, which can be found on our website www.professionalstandards.org.uk

2. What we found – our judgement

2.1 We reviewed the HCPC's performance from 1 January 2016 to 31 December 2016. Our review included an analysis of the following:

- Council papers, including fitness to practise reports
- Internal audit reports not intended for publication, and other reports or documents supplied by the regulator which are referred to in the relevant parts of the report.
- Policy and guidance documents
- Statistical performance dataset (see sections 2.7 to 2.10 below)[4]
- Third party feedback
- A check of the HCPC register

Information available to us through our review of final fitness to practise decisions under the Section 29 process.[5]

2.2 As a result of this analysis, we carried out a targeted review of Standards 2 and 5 of the *Standards of Good Regulation* for Registration and Standards 1, 4, 5, 6 and 8 of the *Standards of Good Regulation* for Fitness to Practise.

2.3 We obtained further information from the HCPC relating to these Standards through targeted written questions. We also audited 100 fitness to practise cases closed by the HCPC between 1 May 2015 and 31 January 2017. The cases audited were divided into the following five sample categories:

- Cases from receipt of complaint to Investigating Committee Panel[6] (ICP) decision
- Cases closed for not meeting the Standard of Acceptance[7]
- Cases closed after they have met the Standard of Acceptance but before an Investigating Committee meeting

[4] We use the statistical data we consider to assess the regulator's performance against itself over time. Where appropriate, we will also make comparisons with the performance of other regulators.
[5] Each regulator we oversee has a 'fitness to practise' process for handling complaints about health and care professionals. The most serious cases are referred to formal hearings in front of fitness to practise panels. We review every final decision made by the regulators' fitness to practise panels. If we consider that a decision is insufficient to protect the public properly we can refer them to Court to be considered by a judge. Our power to do this comes from Section 29 of the NHS Reform and Health Care Professions Act 2002 (as amended).
[6] When a Fitness to Practise case has been investigated and allegations raised all the case information is referred to an Investigating Committee Panel. The committee reviews the information and decides whether there is a case to answer or not. If there is a case to answer the committee refers the case to the Health Committee or Conduct and Competence Committee. If there is no case to answer the case is closed.
[7] The Standard of Acceptance details the criteria a case has to meet to be investigated. If a case does not meet the Standard of Acceptance, it will be closed. If it does it will be referred to a Case Manager to investigate.

- Cases closed by the Investigating Committee
- Cases involving allegations of substance/alcohol abuse.

2.4 Further detail on these sample categories can be found in the relevant sections below.

Summary of the HCPC's performance

2.5 For 2016/17 we have concluded that the HCPC:

- Met all the *Standards of Good Regulation* for Guidance and Standards
- Met all the *Standards of Good Regulation* for Education and Training
- Met all the *Standards of Good Regulation* for Registration
- Met four of the ten *Standards of Good Regulation* for Fitness to Practise. The HCPC did not meet Standards 1, 3, 4, 5, 6 and 8.

2.6 In the last two performance reviews of the HCPC we identified areas of concern in respect of its Fitness to Practise (FTP) procedures. Following our review this year, we continue to have these concerns. Moreover, our audit of cases has identified further areas where the HCPC may not be ensuring that its fitness to practise function ensures public protection. The HCPC has indicated that it has undertaken significant work to improve performance. The results of this were not evident in the cases that we considered. We will review the impact of these changes in future performance reviews, but we recommend that the HCPC examine closely the concerns raised in this report as it undertakes this improvement activity.

Key comparators

2.7 We have identified with all of the regulators the numerical data that they should collate, calculate and provide to us, and what data we think provides helpful context about each regulator's performance. Below are the items of data identified as being key comparators across the Standards.

2.8 We expect to report on these comparators both in each regulator's performance review report and in our overarching reports on performance across the sector. We will compare the regulators' performance against these comparators where we consider it appropriate to do so.

2.9 Set out below is the comparator data provided by the HCPC for the period under review, 1 January 2016 to 31 December 2016. Annual data for the period is 1 April 2016 to 31 March 2017.

	Comparator	Q4[8]	Q1[9]	Q2[10]	Q3[11]	2016/17[12]
1	The number of registration appeals concluded, where no new information was presented, that were upheld	1	0	2	3	6
2	Median time (in working days) taken to process initial registration applications for					
	UK graduates	7	3	7	9	5
	EU (non-UK) graduates	53	43	33	49	38
	International (non-EU) graduates	45	46	30	48	41
3	Time (in weeks) from receipt of initial complaint to the final Investigating Committee/Case Examiner decision					
	Median	39	35	34	31	34
	Longest case	174	155	229	168	285
	Shortest case	8	8	2	10	7
4	Time (in weeks) from receipt of initial complaint to final fitness to practise hearing			2016/2017[13]		
	Median			97		
	Longest case			296		
	Shortest case			12		
5	Median time (in weeks) to an interim order decision from receipt of complaint	12.5	19.5	12.6	20	18.9
6	Outcomes of the Authority's appeals against final fitness to practise decisions			2016/2017		
	Dismissed			0		
	Upheld and outcome substituted			0		
	Upheld and case remitted to regulator for re-hearing			0		

[8] Q4 2015/16 is from 1 January 2016 to 31 March 2016.
[9] Q1 2016/17 is from 1 April 2016 to 30 June 2016.
[10] Q2 2016/17 is from 1 July 2016 to 30 September 2016.
[11] Q3 2016/17 is from 1 October 2016 to 31 December 2016.
[12] The HCPC's annual data covers the period 1 April 2016 to 31 March 2017
[13] Annual data available only

	Settled by consent Withdrawn	1 1
7	Number of data breaches reported to the Information Commissioner	2016/2017 0
8	Number of successful judicial review applications	2016/2017 0

2.10 Where we had concerns about the data provided we considered these as part of our targeted review. These are discussed in the relevant sections below.

3. Guidance and Standards

3.1 The HCPC has met all of the *Standards of Good Regulation* for Guidance and Standards during 2016/17. Examples of how it has demonstrated this are indicated below each individual Standard.

Standard 1: Standards of competence and conduct reflect up-to-date practice and legislation. They prioritise patient and service user safety and patient and service user centred care

3.2 In January 2016, the HCPC published revised *Standards of Conduct, Performance and Ethics* (SCPE) which is the core guidance for registrants. Following this, in June 2016 the HCPC published revised *Guidance on conduct and ethics for students* to reflect the updates made to the SCPE for registrants.

Standard 2: Additional guidance helps registrants apply the regulator's standards of competence and conduct to specialist or specific issues including addressing diverse needs arising from patient and service user centred care

3.3 In November 2016, the HCPC published the *Standards for the use by orthoptists of exemptions to sell and supply medicines.* The standards were released further to the changes to the Human Medicines Regulations 2012. There was an omission in the regulations in that they failed to require an annotation to be added to the names of those orthoptists on the HCPC register who are authorised to sell and supply certain medicines. Consequently, the standards aim to explain the requirement for an annotation[14] on the HCPC register for those orthoptists who have completed approved training to sell and supply

[14] The annotation for the exemptions for orthoptists is 'Prescription only medicines – sale / supply (POM-S)'

specific medicines. We examine this issue further at Standard 5 for Registration.

3.4 As well as the overarching SCPE which apply to all registrant groups the HCPC regulates, the HCPC sets profession-specific Standards of Proficiency. Following a public consultation, the revised *Standards of proficiency for social workers* were published on the HCPC website on 9 January 2017. The standards were effective from that date. They concentrate on the identification and application of strategies, information governance and leadership.

3.5 In January 2017, the HCPC issued revised *Guidance on health and character*. It is designed for existing and potential registrants and education providers. The revisions to the guidance focus on the processes used by the HCPC when they assess registrants' health and character.

Standard 3: In development and revision of guidance and standards, the regulator takes account of stakeholders' views and experiences, external events, developments in the four UK countries, European and international regulation and learning from other areas of the regulator's work

3.6 The HCPC has engaged with stakeholders over this period of review and has conducted a number of public consultations:

- In October 2016 the HCPC carried out a consultation on its *Revised guidance on confidentiality*. The guidance was designed to provide advice to registrants on how they handle and share information about service users. The changes were designed to reflect changes made to the SCPE in January 2016. Further to the consultation, the HCPC further decided that a summary of the guidance should be published to convey the key messages to readers. It is anticipated that the guidance will be published later in 2017.
- In October 2016, the HCPC launched a consultation on draft *Guidance on social media*. The development of this guidance was initiated in response to feedback from health professionals that they would welcome further guidance on meeting the HCPC's requirements when using social media. The consultation closed on 13 January 2017 and the guidance was subsequently published on the HCPC website.
- From April to June 2016 the HCPC carried out a consultation on the revised *Standards of proficiency for social workers*, as referred to at paragraph 3.4 in Standard 2.

Standard 4: The standards and guidance are published in accessible formats. Registrants, potential registrants, employers, patients, service users and members of the public are able to find the standards and guidance published by the regulator and can find out about the action that can be taken if the standards and guidance are not followed

3.7 The HCPC continues to publish its guidance and standards on its website. Information on how to make a complaint if the standards and guidance are not followed is also clearly available. The standards and guidance are available in large print and easy to read formats. The HCPC continues to promote awareness of its standards and guidance work by means including blogs, events, newsletters, webinars and social media activity.

4. Education and Training

4.1 The HCPC has met all of the *Standards of Good Regulation* for Education and Training during 2016/17. Examples of how it has demonstrated this are indicated below each individual Standard.

Standard 1: Standards for education and training are linked to standards for registrants. They prioritise patient and service user safety and patient and service user centred care. The process for reviewing or developing standards for education and training should incorporate the views and experiences of key stakeholders, external events and the learning from the quality assurance process

4.2 In June 2017, the HCPC released its revised *Standards of education and training* (SETs) and guidance. Guidance was also produced to accompany the revised standards and this is accessible on the HCPC website. The revised standards have new requirements relating to learner involvement and support and inter-professional education. They are designed to strengthen the link between the SETs and the SCPE.

4.3 Further to the HCPC's review of returning to practice arrangements at the end of 2014, it carried out a consultation on updated guidance from July to October 2016. The HCPC published revised *Guidance on returning to practice* in June 2017. The guidance concentrates on clarification of the returning to practice process.

Standard 2: The process for quality assuring education programmes is proportionate and takes account of the views of patients, service users, students and trainees. It is also focused on ensuring the education providers can develop students and trainees so that they meet the regulator's standards for registration

4.4 The HCPC requires all education providers who have not been visited since September 2014 to demonstrate how they are involving service users and carers in their approved programmes for the 2016/17 academic year.

4.5 The HCPC requires a declaration that approved education and training programmes for certain professions have incorporated the revised standards of proficiency into their teaching and learning. Revised standards of proficiency have been published by the HCPC every year since 2012, with a focus on different professions each year. The declaration is made through the annual monitoring process for 2016/17. A list of the professions affected is in the education section of the HCPC website.

Standard 3: Action is taken if the quality assurance process identifies concerns about education and training establishments

4.6 The HCPC's education annual report 2015, published during this period of review, states that the HCPC received five concerns about educational establishments in 2014/15, two of which met its threshold for further investigation. At the end of October 2016, the HCPC reported five open concerns: three at the initial enquiry stage and two under investigation. All five of these were recorded as closed in November and December 2016.

4.7 The HCPC recorded a higher number of concerns requiring further investigation in 2016/17 than previous years.

4.8 The HCPC reports regularly on activity in this area and we did not identify any significant concerns with the way the HCPC is managing its work in this area.

Standard 4: Information on approved programmes and the approval process is publicly available

4.9 The HCPC continues to publish information on approved programmes on its website. It also provides details of its approval and quality assurance process, including programme approval reports. The information on the programmes is available through a searchable register of approved programmes.

5. Registration

5.1 The HCPC has met all of the *Standards of Good Regulation* for Registration during 2016/17. Examples of how it has demonstrated this are indicated below each individual Standard.

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

5.2 We have not seen any information which suggests the HCPC has added anyone to its register who has not met the registration requirements.

Standard 2: The registration process, including the management of appeals, is fair, based on the regulator's standards, efficient, transparent, secure, and continuously improving

5.3 The HCPC did not meet this Standard last year due to concerns we identified about the registration appeals process. This year, we carried out a further review in order to understand changes to the HCPC's performance against this Standard.

Registration appeals process

5.4 Last year, we identified some concerns about the HCPC's approach to registration appeals in relation to the process being operated by the HCPC, and the transparency of that process both internally and for those making an appeal.

5.5 The HCPC was operating a process where some final registration appeals decisions were being made at case conferences by the Education and Training Committee (ETC) rather than by the Appeal Panel. Where legal advice given to the ETC indicated that the appeal would likely be successful, the applicant would be registered and the appeal closed. The HCPC's legislation sets out that decisions on appeals are made by an Appeal Panel, and we were concerned that the ETC was making decisions which should have been made by the Appeal Panel.

5.6 In its response to us last year, the HCPC informed us that it was changing the registration appeals process. It told us that for the future, if the ETC was given legal advice not to defend an appeal, the consent of the Appeal Panel must be given to allow registration and for the appeal to be closed. If consent is not given, then the appeal will proceed to a hearing in front of the Appeal Panel. We agreed that this was a pragmatic approach which addressed our concerns, and that we would follow the HCPC's progress with this new approach.

5.7 During this review period, we followed up with the HCPC on its revised approach to registration appeals. We looked at an internal HCPC audit report completed in November 2016, data on the outcomes of registration appeals for 2016/2017 and internal procedural and guidance documents. We asked the HCPC about the revised process, appeal outcomes and its communications with appellants. We also enquired about any processes the HCPC had put in place to ensure there was an exchange of learning between departments following the appeals process and the resulting decisions.

5.8 The HCPC's response provided reassurance that all 49 appeal decisions up until the beginning of March 2017 resulting in dismissed, upheld, remitted or substituted outcomes were made by the Registration Appeals Panel, and so were not determined solely by the ETC.

5.9 The HCPC internal audit report, completed in November 2016, recorded that every decision as part of the appeals process had been agreed by

an Appeals Panel. This information provided further reassurance that the process being followed was as described to us by the HCPC.

5.10 Our review of the correspondence sent to appellants showed that the revised process the HCPC now operates is being communicated more clearly and that there is a clearer distinction being made between the role of the Council (as the Registration Appeals Committee) and the ETC (as the respondent in any appeal). The HCPC may wish to further review the correspondence with appellants to ensure that the role of the ETC in deciding not to contest an appeal is clear.

5.11 Based on the evidence we saw, the HCPC's revised process appears to be operating as the HCPC told us it would last year.

Registration processing times

5.12 We expressed concerns in the 2015/16 performance review about fluctuations in the time it took the HCPC to process international applications and that the way the HCPC were resourcing their registration processes may unfairly impact on international applicants. The difference between the HCPC's service standards for UK applications and for overseas applications contributed to our concerns about the disparity of the processing times for UK and overseas applicants.

5.13 As part of our targeted review this year, we enquired about the times taken for processing registration applications, how the progression of applications is monitored and how applicants are kept updated about the progress of their application.

5.14 The HCPC explained that, for overseas applicants, it measures the number of working days between receipt of an application and the first assessment decision. It clarified that the first assessment decision involves verification of the documents provided by the applicant in support of their application, and the determination of any further action required in respect of tests or adaptation periods. From the information on the HCPC website, there are three stages to the point of first assessment. No time is given for the initial stage which is receipt of the application. However, the times for completion of stages two and three are given on the website as four weeks and '*within 60 working days*', respectively, for both European Mutual Recognition and international applicants.

5.15 We reviewed the 2016/17 data relating to registration processing times, and there is a reduction in the fluctuations in processing times since our last report.

Registration	Q4 2015/16	Q1 2016/17	Q2 2016/17	Q3 2016/17	2016/17 annual
Median time (in working days) taken to process initial registration applications for:					
UK graduates	7	3	7	9	5
EU (non-UK) graduates	53	43	33	49	38
International (non-EU) graduates	45	46	30	48	41

5.16 Based on the information we have reviewed, the fluctuations we saw in the last PR period seem not to have been repeated this year. Furthermore, the time taken for processing of all applications is within the HCPC service standards and the HCPC has informed us that applicants are kept updated about the progress of their applications.

Conclusion against this Standard

5.17 The HCPC's responses to our questions appear to demonstrate that the registration appeals process has been revised so that the registration appeals process does operate as the HCPC told us it would last year. In the main, the documents provided demonstrate increased transparency with appellants. There is also evidence that the HCPC has undertaken activities to improve exchange of learning and to identify methods to improve consistency of decision-making. We consider that there could be scope for greater transparency with registrants about the appeal process but this is a minor concern.

5.18 In respect of the processing times for international and EU applications, the data provided to us for 2016/2017 demonstrates less variation in processing times for EU and international applications over this period.

5.19 In conclusion, the information provided by the HCPC as part of the targeted review has assured us that it has taken steps to improve its performance against this Standard. We therefore consider that this Standard is met.

Standard 3: Through the regulator's registers, everyone can easily access information about registrants, except in relation to their health, including whether there are restrictions of their practice

5.20 This year, we identified one error relating to the information displayed on the online register. A registrant was subject to a caution which was not recorded on the online register. We notified the HCPC of our finding and the error was rectified.

5.21 We carried out a check of a sample of the entries on the HCPC's online register. This check did not identify any concerns about information displayed on the register. This suggests that the error identified was isolated and not sufficient to call into question the HCPC's performance against this Standard.

Standard 4: Employers are aware of the importance of checking a health professional's registration. Patients, service users and members of the public can find and check a health professional's registration

5.22 The HCPC register remains prominently displayed on its website and is easily accessible. A multiple registrant search function is provided to assist employers who may need to check the registration status of numerous registrants.

5.23 The HCPC uses social media to promote awareness of the register among employers and the public. Registration deadlines, reminders and articles are provided on a variety of social media with links to the HCPC's website. Videos about registration are provided on YouTube.

Standard 5: Risk of harm to the public and of damage to public confidence in the profession related to non-registrants using a protected title or undertaking a protected act is managed in a proportionate and risk-based manner

5.24 In October 2016, the HCPC published its prosecution policy regarding protection of title. There are no significant changes to the approach taken, and the policy now includes some further information about the process of enforcement.

5.25 We carried out a targeted review of this Standard to obtain further information about the HCPC's response to a legislative error relating to orthoptists.

Orthoptist annotations

5.26 New legislation in the Human Medicines Regulations 2012 (the Regulations) has enabled orthoptists to sell and supply certain medicines. However, the legislation failed to stipulate that only orthoptists annotated on the HCPC's register were eligible do so. This error was identified by the HCPC after it had drafted the relevant standards for orthoptists who wished to sell and supply medicines.

5.27 We asked the HCPC what steps it had taken to ensure that the risk of orthoptists selling and supplying the relevant medicines without having met the HCPC's standards was managed.

5.28 The HCPC told us that it has taken the following steps to manage any risks arising from the legislative error:

- It identified the error in the Regulations and notified the Medicines and Healthcare Products Regulatory Authority (MHRA) and NHS England about it

- To address the legislative error, the HCPC decided that an annotation should, notwithstanding the absence of this requirement in the Regulations, be included on the register for those registrants who are qualified to sell and supply the relevant medicines. This requirement was reflected in the dedicated *Standards for the use by orthoptists of exemptions to sell and supply medicines*, effective from November 2016
- A requirement was put in place that HCPC-approved post-registration training should be completed by an orthoptist before the addition of any annotation on the register. This was also stipulated in the dedicated standards mentioned above
- Any communications from the HCPC or the British and Irish Orthoptist Society[15] (BIOS) have been clear that the post-qualification training, and requirement to be annotated on the register, are necessary before any orthoptist can sell or supply medicines.

5.29 The HCPC told us that it considered that there was limited risk associated with this issue. We understand that no applications have to date been received for the approval of training courses. The HCPC has informed us that the revised timescale for amendment of the Regulations is October 2017.

5.30 Based on the information provided by the HCPC, we are satisfied that it is managing the risk posed by the legislative error, and has taken a pragmatic and proportionate approach to ensure public protection and minimise any risk to public confidence through the error it has identified. We conclude that this Standard is met.

Standard 6: Through the regulator's continuing professional development / revalidation systems, registrants maintain the standards required to stay fit to practise

5.31 We reported in our last report that the HCPC proposed to carry out a consultation to establish any changes that might be necessary to the HCPC's continuing professional development (CPD) scheme. The consultation on revised guidance on CPD was carried out between October 2016 and January 2017.

5.32 The consultation received 80 responses, including 53 responses from HCPC registrants and 22 from health organisations.

5.33 The outcome of the consultation was reviewed by the HCPC in March 2017. The results of research carried out by the Department of Health into the costs and impact of the HCPC's CPD system were reviewed at the same time. The resulting changes to the CPD guidance aimed to clarify existing CPD requirements rather than amend them.

[15] BIOS is a professional and educational body for the UK and Republic of Ireland representing orthoptists.

5.34 Following this review the HCPC published revised CPD and registration guidance in June 2017. A link to this document is provided on its website.[16]

5.35 The HCPC has taken appropriate action to identify that its CPD scheme remains fit for purpose, and has taken steps to make the requirements clearer for registrants. We therefore conclude that this Standard is met.

6. Fitness to Practise

6.1 The HCPC has met four of the Standards of Good Regulation for Fitness to Practise during 2016/17. Examples of how it has demonstrated this are indicated below each individual Standard.

6.2 This year, we conducted a targeted review of Standards 1, 4, 5, 6 and 8. The information we received in the targeted review also raised concerns about the HCPC's performance against Standard 3, and we concluded that Standards 1, 3, 4 ,5 ,6 and 8 are not met. The reasons for our judgements are set out below.

Standard 1: Anybody can raise a concern, including the regulator, about the fitness to practise of a registrant

6.3 This Standard is not met. We have particular concerns about the way in which the revised Standard of Acceptance (SOA), which the HCPC uses in deciding whether or not to investigate a complaint, is being applied.

6.4 The HCPC revised its SOA for complaints in May 2015 and again in July 2016. The SOA is the threshold that the HCPC has set in order to establish whether a complaint should be investigated. It requires a complaint to be made in writing, to identify the registrant about whom the complaint is made, to be clear as to the allegation being made, and to provide credible evidence. Where appropriate, the HCPC will make further enquiries to satisfy itself that the complaint does not raise fitness to practise concerns. Complaints which do not meet the SOA are closed without further investigation.

6.5 In our last report, we noted the revisions to the SOA in May 2015, and said that we would look at how it was being applied when we next carried out an audit of the HCPC's initial stages fitness to practise process.

6.6 This year we decided to undertake a targeted review of performance against this Standard for the following reasons:

- There has been a considerable increase in the number of complaints closed for not meeting the SOA since its revision in May 2015. The increase has continued since its further revision in July 2016

[16] Link as follows: HCPC - Health and Care Professions Council - Our standards

- This increase has been above that forecast by the HCPC
- As a result of the higher rate of initial closures, fewer complaints than forecast have been considered by the Investigating Committee
- The HCPC's internal reports on corporate complaints have identified the standard of acceptance as a source of such complaints throughout 2016/17
- We have also received a small number of concerns about the SOA.

6.7 The HCPC Fitness to Practise report to its Council in May 2017 identified that the number of complaints closed in 2016/17 because they did not meet the SOA had increased by 12 per cent from the previous year (against a 6 per cent increase in the number of new concerns received) and was 6 per cent above the forecast.

6.8 The report also identified that this number has continued to increase since the revision of the SOA in May 2015. According to the data in the report, the HCPC received 2259 complaints in 2016/2017. In the same period, 1854 complaints were closed for not meeting the SOA. The figures can be seen in the table below:

Year	Complaints received	Complaints closed as SOA not met
2014/15	2170	1042
2015/16	2127	1661
2016/17	2259	1854

6.9 The HCPC Fitness to Practise report from May 2017 (which covers the period to March 2017) identified that 17 per cent fewer complaints were considered by the Investigating Committee Panel (ICP). We noted that the HCPC's Review of Feedback and Complaints covering the period April to December 2016 said that the SOA '*that was put in place in May 2015 means that the threshold for referring cases to a Panel is higher*'.

6.10 The Review of Feedback and Complaints also identified that decisions not to progress complaints to the ICP stage were a source of corporate complaints made to the HCPC every month throughout that period. The report explained that more than half of the complaints received about registrants from members of the public '*are closed at the earliest stage pre-ICP stage when these concerns are not deemed to have met*' the SOA.

6.11 We received information about the HCPC's SOA from complainants who had raised concerns with the HCPC in relation to their complaints being closed because '*credible evidence*' was not provided. From the information provided, the HCPC's definition of '*credible evidence*' appeared to differ from complaint to complaint. These concerns contributed to our decision to carry out an audit to review the issues raised.

Our audit findings and the HCPC's response

6.12 We undertook a review of 100 closed complaints. Of these, 90 were closed by the HCPC between 1 August 2016 and 31 January 2017. The remaining 10 complaints were closed between 1 May 2015 and 31 July 2016. These 10 complaints were reviewed to assess the impact of the revised SOA on 1 May 2015. Our audit included complaints that had been closed by the HCPC because the SOA had been deemed not to be met.

6.13 We found that, throughout the period 1 May 2015 to 31 January 2017, the application of the SOA in the complaints we reviewed was inconsistent. We found 79 complaints where the way the SOA was being applied caused us concern, both in relation to the decision to close some complaints as well as how the closure decisions were communicated. We identified the following issues:

- In 18 complaints we reviewed the SOA was recorded as met then subsequently recorded as not met, with no substantive reason given for why the status had changed.
- In 52 complaints, we noted that information given about the SOA to relevant parties was confusing, inaccurate or lacked transparency, for example:
    - Complainants were advised that their complaints were not pursued because '*credible and independent*' evidence was not available, importing an additional requirement to that in the SOA.
    - Complainants were asked to specify the statutory grounds under which they were making their complaint.
    - Complainants were informed that, as the HCPC has the burden of proof in fitness to practise proceedings, that it was unable to draft allegations based solely on the complainant's account of what had happened.
    - Complainants were told that it was not for the HCPC to create a "climate of fear" among registrants.
    - Complainants were closed for not meeting the SOA because the HCPC stated that '*documentary evidence*' had not been provided to support the concerns raised.

6.14 The HCPC told us that the SOA sets out a '*moderate and proportionate threshold*' designed to ensure public protection while avoiding resources being used to investigate complaints that do not indicate fitness to practise concerns. It explained that the SOA was revised in May 2015 to provide more detail and clarification on the types of complaints that should be progressed as well as the evidence required. It listed a number of safeguards to ensure the quality and consistency of SOA decisions and told us that there was ongoing monitoring of complaints where the standard of acceptance was not met, which it acknowledged had increased since its revision in May 2015. The SOA was further revised in July 2016 but the changes were not substantial.

The HCPC informed us that training has been provided to staff on SOA decisions and communications since the revision, as part of ongoing staff development.

6.15 The HCPC further informed us about the new structure of the Fitness to Practise Department. In December 2016, a new Case Reception and Triage Team became operational. It anticipates that this team will provide a more specialist approach to increase consistency in the way the SOA is applied. The HCPC informed us that a dedicated audit programme was being developed to review the impact of the new fitness to practise structure and to ensure continued improvement of quality and consistency.

6.16 In respect of corporate complaints made to the HCPC about cases closed at the SOA stage of their process, the HCPC told us that it reviews these complaints on a case-by-case basis and in its complaints reports. It explained that the increase in cases being closed for not meeting the SOA has resulted in an increased number of complaints about those cases, but added that the increase in complaints does not necessarily mean that the SOA decisions were wrong, which we accept. It told us that the percentage increase in complaints received was less than the percentage increase in the cases closed for not meeting the SOA. It is not clear to us that this is relevant.

6.17 Prior to our audit, the HCPC told us it was confident that correct SOA decisions were being made. It provided us with details of the process and procedural changes it has made to its fitness to practise function throughout 2016/17 and details of staff training that took place before and after the performance review period. It also sent us specific details of SOA training and process development from March to August 2017.

Standard of Acceptance guidance

6.18 We do not think the way in which the SOA threshold is described by the HCPC in its guidance on how to apply the SOA is sufficiently clear.

6.19 The HCPC has told us that the purpose of the revision of the SOA in May 2015 was to provide greater detail and clarity on the types of complaints that should be progressed and the evidence required. We reviewed the SOA document in our last performance review and, again, this year, as a result of our audit findings. After further study of the SOA guidance, in the context of our audit findings, we consider that the drafting of the document is contributing to the inconsistency in the decisions being made.

6.20 The SOA document refers to the '*modest and proportionate threshold which allegations must normally meet before they will be investigated by the HCPC*'. The document then goes on to describe the ways in which this threshold should be applied. One section sets out that '*the applicable test is that fitness to practise is impaired* […] *the need to establish impairment at the time a case is heard is often an important factor in deciding whether to pursue fitness to practise allegations*'. The subsequent section sets out that an allegation meets the SOA if '*it*

provides credible evidence which suggests that the registrant's fitness to practise is impaired'. Later in the document (in a section entitled '*Matters resolved locally*'), a list of instances where current impairment is unlikely to be found is provided, including the demonstration of insight by the registrant and where the behaviour is unlikely to be repeated, or relates to relatively minor conduct, competence or health issues. This emphasis on current impairment suggests to us an application of the realistic prospect test. The realistic prospect test is the test applied by the Investigating Committee Panel (ICP)to determine whether there is a case to answer or not. It is for the IPC to make that judgement.

6.21 A large part of the SOA document provides guidance on how to decide whether complaints meet the SOA threshold. In our view, the focus throughout the document on the various ways a complaint may not meet the SOA has further contributed to the inconsistent approach we identified through our audit of closed cases. As mentioned at 6.20, the wording in the guidance implies a consideration of the realistic prospect test when deciding whether or not the SOA is met. It is not the appropriate test at the SOA stage, where often the information provided may raise concerns about a registrant's fitness to practise, but is not yet sufficiently detailed for a conclusion to be reached as to whether there is current impairment. The guidance may, therefore, be contributing to an inappropriately high threshold being required for some complaints by the HCPC.

6.22 We considered the inconsistency in the interpretation of the term '*credible evidence*' and how it is further impacting on the SOA threshold.

6.23 We note that there is a section in the SOA guidance that refers to evidence being "*more likely to be regarded as credible"* if it is supported by contemporaneous notes or other documents. While it may not be the intention, this may also be contributing to complaints being prematurely closed because no documentary evidence has been provided. We saw a number of complaints that were closed as being not credible due to the lack of documentary evidence to support the complaint, but where the subject matter of the complaint made was such that either the HCPC should have requested further information or undertaken some investigation before deciding to close the complaint, or it should have taken the view that the complaint met the threshold from the information provided in the initial referral.

6.24 In our view, and from the evidence we saw in our audit, the way in which the SOA document is set out and is being used in practice, has led to inconsistent and often incorrect interpretations of the test to be applied when assessing complaints. As we set out at 6.13 above, complainants have been informed that their complaints have been closed for reasons that go beyond the guidance in the SOA document and ignore the 'moderate and proportionate' approach that the documents seeks to apply. In some of the complaints we reviewed, text from the SOA document has been quoted directly but inappropriately in

support of the decision to close the complaint at the initial stage. While we recognise that this may not be the intention of the document, using it in such a way has meant that the test has been inappropriately applied.

6.25 There is no reference to the HCPC's standards of conduct, performance and ethics (SCPE)[17] anywhere in the SOA document. The SCPE is a crucial statement of what is expected of registrants. It is, therefore, surprising that there is no reference to the SCPE in the document.

Conclusion against this Standard

6.26 People who wish to raise concerns to the regulator must be able to do so. Regulators need to ensure that these complaints are considered fairly and proportionately, and investigations taken forward where there are matters that may require regulatory intervention.

6.27 The HCPC's aim was that the SOA should provide a '*moderate and proportionate threshold*' for complaints to pass through at the start of any fitness to practise investigation. We agree that such a threshold is necessary in order that only matters that require regulatory intervention are taken forward by the regulator. We recognise that the HCPC clearly sets out for complainants how to raise concerns, and explains how it decides whether to take forward a complaint using the SOA.

6.28 However, in the complaints that we looked at as part of our review, we saw many instances where the SOA was inappropriately applied, and complaints closed for reasons inconsistent with the '*moderate and proportionate*' threshold set out in the SOA. This meant that the SOA acted as a barrier to complainants, and prevented cases that should have passed the threshold for investigation from doing so. We were particularly concerned that a small number of the complaints appeared to raise significant concerns about a registrant's fitness to practise and these were not taken forward. Included in these complaints were concerns relating to dishonesty, alcohol abuse and inappropriate behaviour with patients. In others, the decision to close at an early stage, due to the absence of what the HCPC deemed to be '*credible*' evidence, meant that the matters that should have been pursued by the HCPC were not.

6.29 We think that the HCPC's application of the SOA is, in some cases, resulting in complaints being closed when they should instead progress to the ICP. Closure of these complaints at this early stage potentially poses risks to patient safety and may affect public confidence in the HCPC.

6.30 We recognise that the HCPC has made structural and procedural changes aimed at improving the process, and appreciate that it is continuing to develop its processes and to train staff. We will review the results of these changes in the next performance review.

[17] The standards of conduct, performance and ethics (SCPE) are the ethical framework within which HCPC registrants must work

6.31 We welcome the additional measures the HCPC has outlined to us. However, based on the findings of our audit and the increase in the number of complaints closed for not meeting the SOA, our view is that the threshold being applied at the SOA is inconsistent and often inappropriately high, and is therefore creating a barrier to complaints being accepted into its fitness to practise process. For this reason, we have concluded that this Standard is not met.

Standard 2: Information about fitness to practise concerns is shared by the regulator with employers/local arbitrators, system and other professional regulators within the relevant legal frameworks

6.32 In May 2016, the HCPC signed a Memorandum of Understanding (MoU) with the States of Jersey Health and Social Services Department. The MoU outlines how the two organisations will share information about possible allegations of impaired fitness to practise.

6.33 We have considered the impact of the concerns we have identified relating to the SOA and risk assessments throughout our review of this Standard. We are concerned that, if a case fails to meet the SOA and is serious, then it means that other regulators will not be informed of the issue and opportunities to protect the public may be missed.

6.34 Despite this risk we have seen no evidence to suggest that the HCPC is not sharing fitness to practise information with other organisations in accordance with its protocols. We have concluded that this Standard is met.

Standard 3: Where necessary, the regulator will determine if there is a case to answer and if so, whether the registrant's fitness to practise is impaired or, where appropriate, direct the person to another relevant organisation

6.35 This Standard is not met.

6.36 We set out (under Standard 1 for Fitness to Practise above) our concerns that the way in which the HCPC is applying its SOA is creating a barrier for complaints.

6.37 We have concluded that the problems we have identified with the HCPC's approach to applying its SOA mean that the HCPC is failing to appropriately and consistently determine whether there is a case to answer in the complaints it receives, because a number of complaints will not reach the appropriate stage.

6.38 As part of our audit of 100 cases, we reviewed 50 complaints where the HCPC had decided that the SOA was not met. In six of these complaints, our view was that the information provided by the complainant was sufficient to determine that the SOA threshold was met, and the complaint should have progressed to the ICP. In 26 complaints, we were of the view that further investigation should have been undertaken by the HCPC before reaching a conclusion about

whether the SOA was met, and so the complaint was closed before an appropriate decision could be made.

6.39 Where registrants have self-referred, the HCPC seeks legal advice as to whether these matters should proceed or whether they should be closed. The HCPC told us that the role of the legal advice was to assist decision-making and it did not constitute a case management decision. However, we found that in 21 of the 36 self-referral cases we reviewed there was no record of any decision about proceeding with or closing the self-referral apart from the legal advice itself, or the legal advice was cited as the sole reason for closure or for proceeding. There was no evidence of a decision-maker actually assessing the legal advice. In our view, therefore, this advice is, in effect, the decision.

6.40 This is problematic because legal advice is not intended to determine whether a case should proceed or whether it should be closed. Its purpose is simply to provide background advice for a decision-maker to consider.

Investigating Committee Panel decisions

6.41 In fitness to practise complaints where it is decided that the SOA is met, allegations are drafted, and these, together with the evidence obtained during the investigation, are reviewed by the Investigating Committee Panel (ICP) at a meeting. The ICP then determines whether there is a case to answer. If the ICP finds there is no case to answer, the complaint is closed. If there is a case to answer, the ICP will refer the case to a final hearing by either the Conduct and Competence Committee (CCC) or the Health Committee (HC) as appropriate.

6.42 The HCPC told us that its operational guidance document outlines how investigations should be carried out in complaints where the SOA has been met and the complaint is progressing to an ICP meeting. It explained that, at this stage, HCPC investigations should be objective and fair and that detailed investigations may need to be carried out in many complaints prior to allegations being drafted.

6.43 However, in the complaints we reviewed, we saw very little evidence of any independent HCPC investigation. In some complaints, we found that information about employer investigations had been relied upon to determine the finding that the SOA was not met, without any independent investigation by the HCPC. We saw instances where the wording of the drafted allegations was taken directly from the employer's investigation, which affected their quality and, potentially, the consideration of the complaint by the ICP. In some complaints we saw, due to the over-reliance on the employer's documents, the allegations did not accurately reflect the full facts of the matter which, in turn, led to the ICP finding there was no case to answer. In our view, if a proper HCPC investigation had been completed in these cases and the allegations drafted accordingly, the findings of the ICP may have been different.

6.44 These findings reflect learning points from our Section 29 process which has identified cases where, at final fitness to practise hearings, allegations have to be amended or dropped. We have also noted failures to investigate issues and provide evidence to panels which reflect similar issues we identified in our audit.

6.45 In cases where we found there was inadequate investigation up to the SOA decision, there were corresponding omissions in some of the allegations raised and/or the evidence submitted to the ICP. We cannot, therefore, be assured that the ICP decisions are always fully informed and that they are making the appropriate decisions about whether there is a case to answer.

Conclusion against this Standard

6.46 We consider that the HCPC's approach to the SOA means that complaints where there may be a case to answer are being closed at too early a stage. We saw evidence that decisions made by the ICP were based on allegations drafted where the HCPC investigation was insufficient and overly reliant on employer investigations. Consequently, in some instances, the allegations were poorly drafted and did not reflect the full facts of the complaint, which may have affected the ICP's review of the case and its decision. In other instances, the HCPC's lack of investigation may have, resulted in cases being closed prematurely at the ICP stage instead of being referred for a final hearing. In addition, we saw a number of occasions where in our view the ICP failed to request further investigation where this would have been appropriate. We, therefore, conclude that this Standard is not met.

Standard 4: All fitness to practise complaints are reviewed on receipt and serious cases are prioritised and where appropriate referred to an interim orders panel

6.47 This Standard is not met.

6.48 This Standard was not met in the 2015/16 performance review for the following reasons:

- The HCPC's internal audit reports identified failures and delays in carrying out risk assessments
- The HCPC's internal audit reports identified concerns about the quality of risk assessments
- The concerns around risk assessments identified in the internal audit reports appeared to be ongoing since our 2014/15 report
- The number of adjournments of interim order hearings had significantly increased
- The high success rate of interim order applications to orders being imposed suggested that interim order applications were only being made when there was certainty that an order would be imposed, instead of when a case presented a risk that warranted interim order review.

6.49 We undertook a targeted review against this Standard to consider any changes or improvements to the HCPC's performance in this area.

Risk assessments

6.50 The HCPC provided to us a copy of its internal audit report from October 2016. The internal audit looked at risk assessments completed in the three months prior to the internal audit. It identified that in 81 per cent of cases risk assessments had been carried out when required, compared to 50 per cent in the previous internal audit in May 2016. This indicates a significant improvement in risk assessments being completed at specified stages of the FTP process. The audit report also recorded that the majority of risk assessments were completed to a satisfactory timescale. However, the report recorded issues relating to the quality of 77 per cent of the risk assessments it reviewed. The report indicated that while the risk assessments demonstrated consideration of whether an interim order was required, a number of them did not record any assessment of the risk or any rationale for the conclusion reached. The report records that 13 per cent of the issues identified were severe.

6.51 Further to the findings from the internal audit, the report made recommendations that there should be training for all staff in completing the risk assessment form, the forms should be revised and there should be increased monitoring of high priority cases. The HCPC told us that all these recommendations have been implemented. It revised its guidance for risk assessments in June 2016 and December 2016. It also explained its new Fitness to Practise Department structure, which became operational in December 2016, will enable increased oversight and prioritisation of higher risk complaints upon their receipt. It told us that it will continue to evaluate the impact these changes have on the risk assessments and that it has further training and an internal audit planned for 2017.

Our audit findings

6.52 As set out above, we reviewed 100 complaints where risk assessments were undertaken. 90 of these were closed between 1 August 2016 and 31 January 2017 and the remaining 10 complaints were closed between 1 May 2015 and 31 July 2016. In 73 of these complaints we had concerns relating to risk assessment.

6.53 We were reassured that risk assessments were being completed when required and in line with the HCPC's process in the majority of instances. However, we found that the risk assessments often appeared to be case summaries with little analysis of available information or identification of the risks. In some cases, there was little or no explanation recorded for the risk rating given. We found there was limited recognition of serious concerns, and that complaints were given the lowest risk rating based on a lack of information provided to the HCPC at the time of the assessment, instead of the risk profile reflecting the seriousness of the concerns raised, and identifying the

need to prioritise the complaint. We saw a number of examples where the risk category applied to complaints would change over the course of the investigation, but with no reasoning to explain why the risk rating had changed.

6.54 This meant that it was difficult for us to ascertain from the assessment why a particular risk rating had been given, or why the rating had changed from one assessment to the next. Therefore, we could not be satisfied that the risk assessment process being undertaken was consistently identifying the risks identified from the information available.

6.55 We found that consideration of whether an interim order application was required was usually evident in the assessment, but this was being used to determine the risk rating without any consideration of any other features of the complaint. This meant that where a decision was taken that an interim order should not be sought, there was little if any consideration of the risks presented by the complaint that might still require prioritisation by the HCPC. This, in our view, suggests that the risk assessment process is being used solely as a method to determine whether an interim order should be sought, rather than as a tool for ensuring that complaints where there is greater concern are managed and prioritised effectively.

6.56 We are concerned that risk assessments completed by the HCPC are failing to identify risks and prioritise complaints accordingly. These omissions may result in registrants whose fitness to practise is impaired continuing to practise without required conditions or orders being in place and, thereby, may be jeopardising public protection.

6.57 The issues we found in the HCPC's risk assessments are very similar to the findings of its own internal audit report from October 2016. We recognise the efforts the HCPC has told us it is making to improve risk assessments and will review the 2017 internal audit report when it is available.

Interim orders

6.58 The HCPC provided us with annual data for the time taken from receipt of a complaint to an Interim Order Committee decision. The data recorded that the median time for this process in 2016/17 was 18.9 weeks, which is longer than three of the quarterly medians in 2015/16 (of 23.8, 13.8, 6.4 and 12.5 weeks respectively) but an improvement on 2014/15, when it was 20.4 weeks. The time taken for 2016/17 is similar to that of other regulators.

6.59 The HCPC also provided us with data for the times taken from the decision that there is information indicating the need for an interim order to the Committee's decision. According to the data, the median time for this process has increased to 2.9 weeks in 2016/17 from quarterly medians in 2015/16 (of 3.1, 2.8, 2.5 and 2.1 weeks respectively) and 2.4 weeks in 2014/15.

6.60 In our last report, we noted that the HCPC told us that it does not apply for an interim order where it does not think the threshold for an order is met or where it does not believe there is a realistic prospect of the panel making an order. We were concerned that applications for interim orders were only being made where there was a certainty that an order would be imposed, instead of where the risk indicated that an interim order should be sought. As a result, cases which ought to be subject to an interim order may not be being put before panels. We reviewed this area as our concerns from last year persisted.

6.61 The table below records the figures for the number of interim order applications made to orders granted since 2013/14:

Year	2013/14	2014/15	2015/16	2016/17
Applications considered	97	80	89	142
Applications granted	85	71	78	128
Applications refused	12	9	11	14
Percentage granted	88%	89%	88%	90%

6.62 There has been a steep increase in the number of interim order applications considered in 2016/17. The HCPC told us that the focus on risk assessments in 2016/17 may be the reason for the higher number of applications considered.

6.63 Our audit identified 11 complaints where we could not see that an application for an interim order was made, when, in our view, such an application was appropriate, or insufficient information was assessed to determine whether an interim order was required.

6.64 The inconsistent approach to risk assessment we describe in this section of the report suggests that not all complaints where an order might have been sought have been taken forward by the HCPC, notwithstanding the increase in applications considered. This raises concerns that only in complaints where there is compelling evidence that an order would be made are orders being sought. This adds to our view that the HCPC's approach to risk assessment does not focus appropriately on the nature of the risks of the complaints they receive.

Interim order adjournments

6.65 In our last report we expressed concerns about the number of interim orders hearings that were adjourned. The HCPC has confirmed that the guidance for proceeding with a hearing in the absence of a registrant applicable to final hearings was also applicable to interim order hearings. This provides some assurance to us that there is relevant guidance for the interim orders panel when making decisions about whether to adjourn.

6.66 We set out in our last report that the rate of adjournments of interim order hearings was 21 per cent for the first three quarters of 2015/16.

Data provided by the HCPC for 2016/17 indicates that the rate of adjournments had dropped to 13 per cent.

6.67 The HCPC provided us with reasons for the interim order panel adjournments. It told us that it had reviewed the decisions made and was satisfied that the reasons demonstrated the panel was appropriately considering the risk when deciding whether to allow an adjournment. The HCPC informed us that revised guidance on proceeding in the absence of the registrant for staff and the panel became operational in September 2016 and, again in March 2017. However, we found the wording in the revised practice note unclear. We explore the practice note in greater detail at paragraph 6.87 below. The HCPC also informed us that the training programme for the panel has been amended to include a session on this issue and that the additional session will start in 2017/18. We will consider the impact of the revised guidance and training in the next performance review

Conclusion against the Standard

6.68 The information and data provided by the HCPC, and our audit findings, identify that there has been an improvement in the regularity and timeliness of risk assessments in fitness to practise cases since our last report. It also indicates that there is an improvement in the proportion of interim order hearing adjournments.

6.69 However, both the HCPC's internal audit and the findings from our review of complaints identify continuing concerns about the quality and consistency of risk assessments. In order that serious complaints are prioritised, risk assessments need to ensure that even where an interim order may not be necessary the risks presented by the information received are properly assessed so that any other necessary actions can be taken in a timely manner. From the evidence we have seen, we are not satisfied that the HCPC is undertaking this in a consistent manner.

6.70 We continue to have concerns about HCPC's approach to interim order applications. As we said in our previous report, the HCPC appears to base its decisions as to whether to apply for an interim order on the certainty of an order being imposed instead of where the risk indicates that review by an interim orders committee is appropriate. We accept that the HCPC is revising its training and guidance documents but have not seen evidence of the impact of these changes during this review.

6.71 We have therefore concluded that this Standard is not met.

Standard 5: The fitness to practise process is transparent, fair, and proportionate and focused on public protection

6.72 This Standard is not met.

6.73 Over the course of this review period, we identified a number of areas relating to the HCPC's approach to its fitness to practise work that raised concerns relevant to this Standard. We therefore carried out a

further review of these areas. The areas we looked at, and what we found, are set out below.

The standard of acceptance

6.74 We have set out above our concerns about the HCPC's approach and application of its SOA, and how it is in our view preventing complaints being taken forward by the HCPC appropriately. As we mention at paragraph 6.13 above, in 18 cases we audited, the SOA was recorded as met then subsequently recorded as not met with no substantive reason for why the case status had changed. Our understanding of the HCPC's process is that once the SOA decision has been taken, then cases should progress to the ICP for a decision to be made. In the 18 complaints we saw where this did not happen, we are concerned that the decision to close the complaints in this way was neither transparent nor fairly applied. It also prevented the complainant from properly having their complaint considered by the ICP.

The HCPC's discontinuance process

6.75 If a Practice Committee Panel decides that an allegation cannot be established and should not be pursued they can 'discontinue' the allegation or the relevant part of it so that it will not be reviewed at a final hearing. For a case to be eligible for discontinuance, it needs to have been reviewed by the ICP and a decision made by it that there is a case to answer. The HCPC's discontinuance practice note[18] explains that discontinuance of part or all of an allegation may be considered where there is no longer a realistic prospect of the HCPC being able to establish the allegation.

6.76 We identified that the HCPC had discontinued cases where in our view a full hearing may have been appropriate in the public interest. In particular, we saw cases where the panel had granted discontinuance without any significant change in the evidence available since the ICP referred the case to a final hearing. We were also concerned that the panel reviewing the discontinuance application was not in possession of the full document bundle presented to the ICP or the ICP decision when considering the application.

6.77 We explained our concerns to the HCPC. It responded that it does not consider it essential for new information to have been received for a discontinuance application to be considered, as the panel may examine the evidence in greater detail. It said that if there is no additional evidence received since the ICP decision, it does not agree that the discontinuance panel needs to see all the original documents and the ICP decision.

6.78 In addition, the HCPC told us that three applications to discontinue were approved in January 2017 since the revision of the practice note: two relating to the discontinuance of part of the allegations and one relating

[18] The HCPC issue a number of practice notes for guidance of Panels and to assist those appearing before them

to the full allegations. The HCPC explained that it has safeguards in place to ensure that only suitable cases are recommended for discontinuance applications. It also informed us that it would initially be auditing 100 per cent of discontinuance decisions following the change to the FTP Department structure in December 2016. The purpose of the audit is to provide assurance that the decisions are appropriate. The HCPC told us the resulting audit data and recommendations would be regularly reviewed and actions taken, as required. The HCPC made a second revision to the practice note in March 2017.

6.79 Notwithstanding the changes made by the HCPC to the practice note, our concerns relating to the HCPC's approach to discontinuance remain. The revised practice note does not address our view that discontinuance is only likely to be appropriate where there is a material change in the state of the evidence since the ICP's decision to refer the case for a hearing. We are concerned that the approval of discontinuance applications made by the HCPC (with no additional evidence since the ICP decision) may indicate that the ICP is failing to identify that there is no case to answer. We are also concerned that cases that should have progressed to a full hearing are being closed too soon and that, in doing so, there has been insufficient consideration of the allegations against the registrant to ensure protection of the public.

6.80 We will review the outcome of its audits, and any resulting actions taken, when they are available, in addition to our analysis of the data recording the number of discontinuance applications and approvals. Our Section 29 scrutiny will continue to identify any concerns with the HCPC's applications for discontinuance or approvals of it.

Disposal by consent cases

6.81 In addition to the process for discontinuing cases above, the HCPC can close cases without a full hearing with the consent of the registrant and the agreement of an FTP panel. Disposal by consent is only an option after the ICP has found there is a case to answer. The process requires a registrant and the panel to agree an appropriate outcome to the case. If either party is not in agreement the case will proceed to a full hearing.

6.82 The HCPC's practice note for disposal by consent explains that the process can reduce the time taken to deal with allegations. The guidance explains that a case should not be resolved this way unless the panel is satisfied that the outcome ensures an appropriate level of public protection and takes account of the wider public interest.

6.83 The HCPC's internal Fitness to Practise report from March 2017 records that 36 cases were disposed of via consent in 2016/17, which is consistent with the figure of 38 cases in 2015/16.

6.84 The HCPC revised its practice note on disposal by consent in December 2016. The previous version required the registrant to '*admit the allegation in full*', whereas the revised version requires him or her '*to admit both the substance of the allegation and that his or her fitness to*

practise is impaired'. A footnote to the new version specified that '*a registrant should not be prevented from resolving a case by consent simply because he or she disputes a minor aspect of the allegation*'. The practice note does not give any guidance for panels about the terms '*substance of the allegation*' or '*minor aspect*'. This may mean that registrants who lack insight into the full effect of their misconduct may be subject to an inappropriate sanction.

6.85 We were also concerned about the transparency and brevity of determinations from the disposal by consent process in three cases determined between January and March 2017. The determinations, in our view, did not demonstrate that the panel considered the full facts of the case, nor how they approved the sanctions imposed. In our opinion, the panel's determination did not provide adequate reassurance that the outcome was sufficient to protect the public. We also had concerns about whether the documents presented to the panel fully reflected the facts of the case and were, therefore, sufficient to enable the panel to make an informed decision. In addition, we were concerned that where allegations referred to '*misconduct and/or lack of competence*', the panel's determination did not record its findings in this regard.

6.86 The HCPC further revised the practice note in March 2017. As this falls outside of this period of review we are not yet able to assess the impact of the revisions on disposal by consent cases. The HCPC has told us that it revised the practice note following a thorough review of its consensual disposal processes over recent years. It explained it had publicised the review to a range of stakeholders and taken input from the Authority. It told us that, as with its discontinuance cases, it would initially be auditing 100 per cent of disposal by consent decisions to ensure that the decisions are appropriate.

Proceeding in absence

6.87 The HCPC revised its practice note for proceeding in absence in September 2016. In our view, the revised practice note does not make it clear whether the Panel's priority should be fairness to the registrant or protection of the public when considering proceeding with a Tribunal in the absence of the registrant. This lack of clarity poses the risk of adjourning cases unnecessarily. The HCPC has confirmed that this practice note applies to interim order (IO) hearings as well as final hearings. We have examined the issue of IO adjournments at paragraph 6.65 at Standard 4. While providing some reassurance that there is guidance for IO hearings, this information simultaneously added to our concerns that public protection may not be prioritised when adjournments of interim orders are considered. The HCPC revised its practice note again in March 2017, but the wording remains.

6.88 The table below records the number of final and IO hearings that were adjourned, part heard or cancelled in 2015/2016 and 2016/17 compared to the overall number of cases listed for a final/IO hearing.

	Listed final hearings	Final Hearings Adjourned/ Part Heard/ Cancelled	Listed IO Hearings	IO Hearings Adjourned/ Part Heard/ Cancelled
2016/2017	**554**	**108**	**160**	**17**
2015/2016	**403**	**82**	**103**	**14**

6.89 These figures demonstrate an improvement from the previous year.

The HCPC's approach to potential health concerns

6.90 In the CHRE19 Fitness to Practise Audit Report published in 2010, we recommended that regulators should routinely arrange health assessments of registrants who were convicted of drug/alcohol offences, to establish whether they have an underlying health problem which might impair their fitness to practise. We continue to take the view that problems with drugs and alcohol can significantly affect patient safety and that regulators should satisfy themselves that there is no underlying problem in such cases.

6.91 The HCPC has declined to follow that recommendation and in addition, they have rejected the findings of independent research that recommended the HCPC should undertake routine health assessments in cases arising from drug/alcohol convictions. The HCPC informed us that it made the decision not to act upon the findings because it had concerns about the quality of the study and felt that many of the recommendations demonstrated a misunderstanding of professional regulation.

6.92 The HCPC has told us that it deals with these complaints on a case-by-case basis. Consequently, we reviewed some of these complaints during our targeted review to better understand the HCPC's approach to fitness to practise matters involving drugs and/or alcohol.

6.93 As part of our audit, we reviewed 34 complaints that progressed to an ICP hearing and where the panel determined there was no case to answer. Of these 34 complaints, we found 10 complaints relating to drink-driving convictions where there was no or very limited consideration of whether the conviction may indicate an underlying problem with alcohol. While we acknowledge that not all of these complaints will reflect health problems, in the majority we saw there was no evidence of any consideration by the HCPC whether they might do so and allegations were drafted on the grounds of the conviction only. We saw some complaints where the circumstances of the drink-driving conviction strongly indicated that the registrant had underlying problems

[19] The Council for Healthcare Regulatory Excellence (CHRE) was a UK health regulatory body set up under the National Health Service Reform and Health Care Professions Act 2002 - CHRE has now changed its name to the Professional Standards Authority for Health and Social Care (the Authority) under the Health and Social Care Act 2012 section 222.

with alcohol, but most of these were progressed as a conviction allegation with little to no consideration of any associated health risk.

6.94 In one of the complaints we saw, the concerns raised related directly to health issues. However, the drafted allegations referred only to misconduct with no reference to the health conditions. The ICP considered the complaint only on the grounds of the alleged misconduct and found there was no case to answer but sent learning points20 to the registrant regarding ensuring their health did not affect their performance or pose a risk. The potential repercussion of this is that registrants with serious health concerns may not be appropriately managed by the HCPC in order to prevent risks to patients and to themselves.

6.95 Furthermore, the HCPC told us that it does not approach drink-driving convictions differently according to the registrant's profession. Thus, professions where driving is likely to be a pre-requisite for the role, such as paramedics, are treated in the same way as those where driving is less likely to be required, such as hearing aid dispensers. In our view this raises concerns that the HCPC is not considering the greater risks attached to professions where driving is an essential part of the role.

6.96 We also saw complaints which did not relate to convictions where the concerns raised related directly to the registrant's health. Nevertheless, in these complaints, none of the drafted allegations addressed the health concerns. Instead, they alleged misconduct. In these complaints, there was inadequate investigation into the registrants' health and the allegations did not reflect the concerns raised. We saw no evidence in these complaints of any referrals to a medical expert for a report or assessment being made, and very few referrals in general by the ICP to the Health Committee. Consequently, the registrant's condition at the time the case is assessed is unknown and may continue untreated.

6.97 By considering complaints which might raise concerns about registrants' health as misconduct only, the HCPC risks neglecting to address potential health problems, which may have an impact on patient safety.

Conclusions against this Standard

6.98 In addition to our concerns about the consistency and fairness of the HCPC's SOA and risk assessment processes, we cannot be satisfied that its discontinuance, disposal by consent and proceeding in absence decisions adequately focus on public protection. We will continue to monitor the outcomes of cases where these processes are adopted, in light of the revisions to the relevant practice notes.

6.99 Our findings from the audit suggested continuing lack of consideration by the HCPC of risks where there are indications of drug or alcohol

[20] In 'no case to answer' decisions, if there are matters arising which the Panel considers should be brought to the attention of the registrant, it may include a learning point. Learning points are general in nature and are for guidance only.

misuse, or other health issues. As we have described, the absence of consideration by the HCPC of any underlying health issues in a number of complaints may mean that potential fitness to practise concerns may not have been explored, with resulting risks to patient safety and to the registrant themselves.

6.100 On this basis, this Standard is not met.

Standard 6: Fitness to practise cases are dealt with as quickly as possible taking into account the complexity and type of case and the conduct of both sides. Delays do not result in harm or potential harm to patients and service users. Where necessary the regulator protects the public by means of interim orders

6.101 This Standard is not met.

6.102 This Standard was not met last year for the following reasons:

- In the 2013/14 and 2014/15 performance reviews, we noted an increase in the time taken to progress complaints through the fitness to practise process. In 2014/15 we concluded that the HCPC was at risk of not meeting the Standard in future if it did not demonstrate improvement
- In 2015/16 we undertook a targeted review to understand the reasons for the continuing decline in timeliness and to assess measures that were being undertaken by the HCPC to improve its performance in this area. These measures included a number of activities to monitor the length of time taken for fitness to practise cases and to enable case progression. The HCPC also told us it had carried out two pilot schemes aimed at reducing the time taken between a case being ready for a hearing and the hearing taking place, and an FTP departmental restructure. The HCPC informed us that learning from the former has been applied in practice and the latter has now been implemented
- However, we were not satisfied that the HCPC had taken sufficient action to address the causes of the decline in 2015/16. We said that we would continue to monitor the impact of changes the HCPC told us it was making to improve timeliness.

Our findings in 2016/17

6.103 The HCPC told us that its hearing scheduling pilot had been successful and learning from it had been applied more widely. It expected that this would lead to savings in the time taken to list cases for hearings. The HCPC said that it was focusing on older cases, adjourned cases and part-heard cases, but also ensuring that newly referred cases progress in line with its optimum case length targets.

6.104 From the data provided by the HCPC, we can see that it has successfully reduced the number of older cases (those over a year old) in 2016/17. At the end of 2015/16, there were 765 open cases that were more than a year old21 whereas there were 668 at the end of 2016/17.

[21] That is, combining the returns for cases older than 52, 104 and 156 weeks in the dataset.

6.105 The HCPC told us that it was too soon to evaluate the impact of the revised FTP team structure, which became effective in December 2016. It said that it was undertaking one review of the change in structure at the start of 2017 and another after six months of its implementation. We accept that it is too soon to identify the impact of the changes and look forward to receiving the outcome from the HCPC's reviews.

6.106 The HCPC informed us that the age of cases concluded in 2016/17 was unlikely to be significantly different to those in 2015/16.

6.107 The HCPC also told us it had several initiatives under way to address the timeliness of case handling. These initiatives include greater oversight, changes of procedural guidance and monitoring processes to reflect the FTP restructure and training and guidance for panels and legal assessors for planning the hearings.

6.108 Data provided by the HCPC records its performance against the timeliness measures. The data for the last three years is shown in the table below:

Measure	2014/15	2015/16	2016/17
Median weeks from receipt to ICP decision	33	37	34
Median weeks from ICP decision to final panel decision	39	44	49
Median weeks from receipt to final panel decision	73	88	97
Number of open cases >52 weeks old	472	533	475
Number of open cases >104 weeks old	94	189	142
Number of open cases >156 weeks old	14	43	51

6.109 The dataset shows a mixed performance compared with last year. There have been some improvements in the HCPC's performance since 2015/16, especially in the overall number of older cases:

- The median number of weeks from receipt of a case to the decision by the Investigating Committee Panel (ICP) has reduced from 37 weeks in 2015/16 to 34 weeks in 2016/17.
- At the end of 2016/17, 475 cases were over 52 weeks old compared to 533 cases at the end of 2015/16.
- At the end of 2016/17, 142 cases were over 104 weeks old compared to 189 at the end of 2015/16.

6.110 However, the data also records a decline in performance in some areas:

- The median number of weeks for the full term of cases, from receipt to final panel decision, increased from 88 weeks in 2015/16 to 97 weeks in 2016/17.
- The median number of weeks from ICP decision to final hearing increased from 44 weeks in 2015/16 to 49 weeks in 2016/17.

- The number of cases which were more than three years old (156 weeks) increased from 43 to 51.

6.111 We recognise that closing older cases can affect the median times to close cases. However, although the data records that although there have been improvements since last year, timeliness is worse in all areas than in 2014/15.

Our audit findings

6.112 We did not specifically audit the timely progression of cases as part of our targeted review. However, in the 100 cases we reviewed, we identified 19 cases where, in our view, there were instances of delay in the HCPC's progression of these complaints. Our findings included complaints where there were significant periods of unexplained inactivity, delays with case progression because required information was not sought promptly, or information was requested when it had already been received. We also saw instances where requested information was not received, but the request for this information was not followed up by the HCPC for a very long period of time, or the matter was not escalated internally. We saw very few instances where there was any evidence that the progression of a complaint was being monitored.

Conclusion against this Standard

6.113 In reaching a decision about how any regulator meets this Standard, we consider carefully the data we see, and what it tells us about the regulator's performance over time. We consider (where appropriate) any trends that we can identify, as well as contextualising performance against other regulators where we consider that the context is justified.

6.114 The HCPC has described a number of measures it has taken to improve performance in relation to FTP timeliness but we have little evidence available about their impact to date. According to its data, there has been improvement since last year in certain aspects of performance, principally the reduction in the number of old cases. However, although better than 2015/16, the performance in these areas remains worse than 2014/15. Furthermore, in other areas there has been a continuous deterioration in timeliness since 2014/15.

6.115 In addition, during our audit we found numerous instances of delay in the cases we reviewed. In response to our findings, the HCPC told us it has planned measures to improve timeliness in FTP. These include further planning and monitoring around the progression of cases within the new FTP structure, review and improvement of scheduling processes and identifying and implementing mechanisms to address delays in obtaining documentary evidence. The HCPC informed us it also plans to explore the use of case examiners. We support the HCPC in its efforts to improve the timeliness of cases and will review the impact of these measures throughout the 2017/2018 period.

6.116 However, from the evidence available, the performance in respect of timeliness remains below that in 2014/15, when we advised the HCPC it was at risk of failing the Standard if there was further deterioration. Furthermore, our audit findings identified concerns around timeliness in a number of complaints we reviewed. On this basis, we conclude that this Standard is not met.

Standard 7: All parties to a fitness to practise case are kept updated on the progress of their case and supported to participate effectively in the process

6.117 We have considered the impact of our concerns about the application of the SOA and the transparency of the SOA correspondence on this Standard. These concerns may impact on the information about the progress of FTP complaints shared with stakeholders and the support they are given to enable them to participate in the FTP process.

6.118 However, the findings of our audit revealed that, although registrants were not always notified that the SOA had been met prior to the ICP notification being sent, they were sent holding letters in the period between the notifications. The HCPC told us that a dedicated SOA factsheet is sent out to relevant parties in the early stages of FTP cases. This document provides an explanation about the purpose of the SOA, the criteria for meeting it and briefly explains the FTP process in SOA met cases.

6.119 We have also considered the relevance of our concerns about customer service on this Standard. Some of the complaints we reviewed were not progressed efficiently and, in a number of instances, the quality of the correspondence was of concern. We saw letters that contained mixed font size or type and sections that were illegible. Conversely, however, we also saw some examples of good customer service where the HCPC appeared to have made additional efforts to clarify the FTP process or to assist vulnerable parties.

6.120 In the complaints we reviewed, most notifications of ICP referrals and deadlines given for registrants' observations were timely. These complaints demonstrated that registrants' requests for extensions to observations deadlines were approved and responded to efficiently.

Conclusion against this Standard

6.121 Following our audit, we have some concerns about the quality of the HCPC's correspondence and the clarity with which its decisions are communicated. However, we have seen no significant evidence to suggest that relevant parties are not being kept updated. Furthermore, we are satisfied that guidance documents and communication with parties in respect of the FTP process are effective. On balance, therefore, we have concluded that this Standard is met.

Standard 8: All fitness to practise decisions made at the initial and final stages of the process are well reasoned, consistent, protect the public and maintain confidence in the profession

6.122 This Standard is not met.

6.123 We carried out a targeted review of this Standard to assess the impact of the following changes made by the HCPC:

- The launch of the Health and Care Professions Tribunal Service (HCPTS)
- Revisions of the guidance documents for panel hearings

6.124 In addition, through our Section 29 scrutiny we identified a number of cases where we had concerns about the evidence submitted to the panel, or the panel decisions.

The Health and Care Professions Tribunal Service (HCPTS)

6.125 The HCPTS is the HCPC's new fitness to practise adjudication service. All the HCPC's hearings panels (tribunals) now come under the HCPTS. The HCPC has informed us that the governance, management and quality assurance arrangements in place prior to the HCPTS being formed will remain. On this basis, the HCPC will retain responsibility for the panels.

6.126 A Tribunal Advisory Committee (TAC) was established to advise the Council on the recruitment, training and assessment of Tribunal panellists, panel chairs and legal assessors. The TAC is also responsible for providing guidance to the Tribunal on practice and procedure.

6.127 The HCPTS became operational in April 2017 and the Tribunal Advisory Committee (TAC) had its first meeting in May 2017. The HCPC informed us it reviewed all its practice notes in March 2017 in preparation for the launch of the HCPTS. We cannot as yet, therefore, assess the impact of the HCPTS on the HCPC's tribunals. We will monitor development of the HCPTS and TAC in the next performance review period.

Revision of practice notes

6.128 The HCPC revised a number of its guidance documents for tribunals in 2016/17 and reviewed all its practice notes in March 2017 in line with the HCPTS becoming operational in April 2017. We have identified concerns about the practice notes for discontinuance, disposal by consent and proceeding in absence which are explained in more detail at Standard 5.

Section 29 case reviews

6.129 Through our Section 29 scrutiny of final hearings, we identified learning in 13 cases between October 2016 and March 2017. Five of these cases related to insufficient evidence being presented to the panel, including two that related to insufficient evidence about the registrants'

health. Three of these cases related to the panel neglecting to consider all the available evidence, three related to allegations which did not reflect the full facts or the seriousness of the case and two related to the brevity of the panel determination.

Our audit findings

6.130 We set out (under Standard 1 for FTP) our concerns that the HCPC's inconsistent approach to the application of the SOA is impacting on its decision-making. Consequently, it appears that some complaints are being closed for not meeting the SOA when it would be more appropriate to refer them to the ICP.

6.131 We have further set out at Standard 5 for FTP our concerns about decisions made to discontinue cases, or close them by consent.

6.132 The HCPC's FTP operational guidance requires panels to give clear and detailed explanations for their decisions, to enable the reader to understand how they reached their conclusion. During our audit we reviewed 34 cases where the ICP decided there was no case to answer and the cases subsequently closed. In 15 of these cases we found that the ICP determination either failed to demonstrate that the panel had understood the facts of the case or indicated that it had neglected to address important evidence when making the decision. In seven cases, in our view, the determination was too brief to understand how the panel reached its decision. There was, therefore, no demonstration that the panel had fully considered the case.

6.133 The HCPC told us that the role of the ICP involves active case management. This requirement is further recorded in its guidance. However, as set out above, we have identified a number of concerns relating to HCPC investigation and decision-making at the SOA stage. The concerns we have about the quality of the HCPC investigations impact directly on the allegations and the evidence submitted to the ICP. The HCPC's reference to the ICP undertaking active case management indicates that the panel should identify cases where insufficient evidence is presented to it or the allegations do not reflect the full facts of the case, and recommend appropriate actions to address these issues. However, in a number of the cases we reviewed, the ICP appeared to rely on the evidence and allegations presented to it without question. Furthermore, in some cases, our audit findings identified that the ICP's decisions were inaccurate or unclear.

Conclusion against this Standard

6.134 In conclusion, based on the cases we reviewed, we have concerns about the reported reasoning and consistency of the HCPC's FTP decision-making at both the SOA and ICP stages and in cases where decisions were taken to discontinue cases or close them by consent. On this basis, we cannot be satisfied that the HCPC's decision making throughout the FTP process is sufficiently informed and consistent to

ensure public protection or to maintain confidence in the professions regulated by the HCPC.

Standard 9: All fitness to practise decisions, apart from matters relating to the health of a professional, are published and communicated to relevant stakeholders

6.135 We experienced some delays in receiving complete and accurate transcripts of decisions from HCPC final hearings in 2016/17. We have notified the HCPC about these issues. However, this was only in a small number of cases and we did not identify a risk to public protection from these delays. We have therefore, concluded the Standard is met.

Standard 10: Information about fitness to practise cases is securely retained

6.136 The HCPC did not report any data breaches to the Information Commissioner's Office in 2016/17. In early 2017, the HCPC was re-certified against ISO 10002, the ISO standard for complaints management. Following an annual audit the HCPC is awaiting ISO 27001:2013 re-certification, which is the international standard for information security management. It originally obtained certification in 2015. This provides assurance to us that the HCPC has robust systems for identifying, classifying, reporting and remediating data breaches. Therefore, this Standard is met.

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