# Health Committee

## Oral evidence: Professional Standards Authority, HC 301

## Tuesday 5 July 2016

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Watch the meeting

Members present: Dr Sarah Wollaston (Chair); Mr Ben Bradshaw; Dr James Davies; Paula Sherriff; Dr Philippa Whitford.

Questions 1-56

Witnesses: **George Jenkins**, Chair, **Harry Cayton**, Chief Executive, and **Philip Hallam**, Assistant Director (Scrutiny and Quality), Professional Standards Authority, gave evidence.

Good afternoon. Thank you very much for coming this afternoon. Could I just say before we start that we are expecting a Division of the House shortly? Please forgive me that I may have to slip out. A couple of my colleagues might not have to leave, but I am afraid we will have to suspend the hearing shortly if there is a vote.

**Paula Sherriff:** There are two votes.

**Q1 Chair:** Right. Apologies in advance. Could we start by you introducing yourselves to those who are following this from outside the room, perhaps starting with you, Mr Hallam?

***Philip Hallam***: Yes. I am Philip Hallam. I am the assistant director of scrutiny and quality at the authority and I am responsible for the performance review process.

***Harry Cayton***: I am Harry Cayton. I am the chief executive.

***George Jenkins***: I am George Jenkins. I am the chairman.

**Q2 Chair:** Thank you. For those of you who are following this, we are speaking today to the Professional Standards Authority. Could we start, perhaps, Mr Cayton, by exploring what is in the "Rethinking Regulation" report that you have published, the whole area about that boundary between regulation and registration, and where you feel that we are currently getting that wrong?

***Harry Cayton***: The paper we published, just less than a year ago, was the culmination of several years of work and thinking with our colleagues in the regulators and drawing on some of our international work in regulation. Our primary concern can be summed up in one

of the phrases in the paper, which is that we have a regulatory system designed in the 19th century, implemented in the 20th century and no longer fit for purpose in the 21st.

My primary concern is workforce; we need a much more flexible and differentiated workforce in the health service, particularly if we are going to extend healthcare into community care. Professional regulation tends to work on boundaries; it sets the limits of an occupation; it makes it harder for people to enter an occupation and harder for us to change the way in which occupations work. The third point to make would be the interface between professional regulation and system regulation, and the difficulties which we have had, which were shown up in the Francis inquiry, of communication between regulators. I would just add that in practice the regulators have made huge efforts to improve their communication. There is a regular meeting now between chief executives, including the CQC, the Ombudsman, the main regulators such as the GMC and the NMC and ourselves, but there is still a long way to go. We are working against the legal framework rather than with it.

**Q3 Chair:** I very much accept the point you make that some professions view regulation as being a badge of status and that is absolutely not what it is about; it is about protecting patients and going forward into the future. Could I refer to page 11 of "Rethinking Regulation" and the graphic that you have on that, which, if you like, sets out going from low risk to high risk? That is a very useful graphic, in going from low risk where you are thinking of having codes of conduct, through to the higher risk end where you are looking at statutory regulation, and then, in the middle, that area of accredited registers. Is not one of the key issues though that with accredited registers, as we have seen, for example, in the "Unsafe Spaces" report, where you have a register, those who are struck off the register are simply able to pop up elsewhere? If I quote from their report on page 3, which is really quite alarming, where they searched to see what had happened to those individuals who had been struck off, they found that nearly one in four were still practising. These were individuals who sometimes had been struck off for very serious offences—for example, sexual offences. Does it concern you that although you think of this as being relatively low risk and being an accredited register, sometimes these are individuals who are in very intimate contact with very vulnerable individuals and we are not able to protect them in this way?

***Harry Cayton***: Yes. There are two separate points there. The point is, first of all, whether or not regulation is necessary for certain occupations, which is a separate question from whether accredited registers are a valuable contribution. The question for me would be: should some occupations be regulated and not on accredited registers, and some occupations that are currently regulated might move to accredited registers?

I would just make one point though, which is that although what you say is absolutely true, it is also true to some extent with statutory regulation, because statutory regulation works through protection of title, and so someone who has been struck off who can change their title can still continue to work. We know of one individual who was struck off by both the Health and Care Professions Council, or then the Health Professions Council, as a physiotherapist, and by the General Osteopathic Council as an osteopath, but has cropped up again working under the title of manipulative therapist. It is probably an appropriate title, you might say. Even statutory regulation has limits on how much it can absolutely stop people working, but I take your point entirely. I do not think that devalues the continuum of assurance model. It does raise questions about who should be where on that continuum.

**Q4 Chair:** What about a vetting and barring type arrangement so that people can have a searchable register for those individuals who have been found to be guilty of malpractice? Is that how you envisage it across all the professions, because the boundaries are changing?

***Harry Cayton***: Exactly. We would like to see vetting and barring availability to accredited registers. There are a number of recognitions that accredited registers could be given through the system, both by HMRC for annual subscriptions and by the Human Tissue Agency, by a number of bodies, and, if they recognise the validity of accredited registers, we would get greater leverage on those issues, certainly.

**Q5 Chair:** Would you envisage having a single register that applied across the spectrum of health and care, so that at any point somebody could be searched? It is the example you gave earlier.

***Harry Cayton***: One of the ideas that we have been thinking about when my board has approved it, which it has not yet, when we publish in the summer, will be a suggestion that there could be a single register and a series of different licensing arrangements, depending on the level of risk that an occupation presented.

**Q6 Mr Ben Bradshaw:** Can I press you on this, Mr Cayton, because the whole direction of travel of your organisation seems to be for less regulation? As policy makers and legislators, almost all the pressure that we get from the public is for more regulation, whether you are talking about cosmetic surgeons or tattoo artists. I can think of numerous examples in my time as a Health Minister and as a Back Bencher in opposition. The Chair has already raised psychotherapists. I have had a very controversial case in my own constituency—it may have been the one you were referring to—of people being seriously harmed and, basically, nothing happening. Why are you going in the opposite direction from where the public feels you should be going?

***Harry Cayton***: I do not think, to be honest, that we are arguing for less regulation; we are arguing for smarter, more intelligent, more targeted regulation. Regulation is a very blunt instrument for dealing with risk, and what we are arguing for is a much more nuanced use of regulation. I am certainly not arguing that dangerous occupations should be deregulated. We are saying that many occupations that are regulated do not need to be and that regulation is an expensive and rather self-perpetuating industry. If you looked at our principles of right-touch regulation, which have been taken up around the world, if I can say so, those principles are based on the principles of the Better Regulation Task Force. I do not think what we are saying is outwith the general public debate about what the place is of regulation in society.

**Q7 Mr Ben Bradshaw:** We used to say that about the banks, did we not, and we got it wrong about the banks? Harm caused to people is also very expensive for the NHS, and the taxpayer, ultimately. Perhaps we are a little bit out of date in terms of the direction of travel.

***Harry Cayton***: I do not think I would accept that, if I can say so. I think we are ahead of the curve in terms of thinking about how best to use regulation. It is not about deregulation and it is not about weakening regulation. It is about really focusing regulation on the harms that regulation can deal with. There are lots of harms, I absolutely agree. Regulation is not always the solution to those harms.

**Q8 Mr Ben Bradshaw:** Can I ask you specifically about psychotherapy, because psychotherapy is, of course, statutorily regulated in other countries—Germany for example. Would you favour it being statutorily regulated here?

***Harry Cayton***: One of the propositions that we are working on at the moment—it will sort of answer the question—is a model of how you assess the risk of occupations. We have been working with the Department of Health on that over the last few months. We hope to publish that very shortly. That would be a relatively objective mechanism for Ministers to use in deciding which occupations should be statutorily regulated. If that were the case with psychotherapists, I would certainly agree they should be. We have seen that report, of course, and we share some of the concerns. We are talking with the psychotherapy registers that we currently oversee about improving their complaints processes at the moment, which is all we can do within the current legislation.

**Q9 Mr Ben Bradshaw:** We are talking about a growing number of people—it is a good thing that psychotherapy is now taken seriously and you can even get it on the state in at least one form—many of whom are quite vulnerable.

***Harry Cayton***: Yes, and with rather unclear different levels of education and training.

***George Jenkins***: Chair, could I perhaps just make a comment about that and to your point, sir?

**Chair:** Certainly.

***George Jenkins***: With regard to one of the issues in comparing us with another sector that did not do so well, hopefully by the end of the afternoon we will have reassured you with the activity that we put in, the continuing process, the continuing monitoring and, indeed, some of the things that Harry has outlined with our plans moving forward. We are very dynamic and very active as an oversight body, on your behalf, of the regulators. I am almost new to this role. I have only been appointed over the last few months. What I have seen is a body that is very engaged, very active, as opposed to some that might not have been.

**Mr Ben Bradshaw:** It may be better to use the term "smart regulation" rather than "light touch", because "light touch" has acquired a bad reputation. *[Interruption.]*

**Chair:** I do apologise. I am afraid we are going to have to break for a few minutes. As we are expecting two votes, that might be about 20 minutes. Thank you.

*Sitting suspended for Divisions in the House.*

*On resuming—*

**Q10 Chair:** Thank you for your patience. We will resume the session now. Can we just carry on from where we left off, talking about that boundary between registration and having a register? As you will be aware, there are a number of new professionals coming on stream—nursing associates and physician associates. Where do you see them on this continuum, and what is your view on whether or not they should be regulated or on a register?

***Harry Cayton***: If I may; I do not want to dominate this, so maybe my colleagues will come in. I do not just want to repeat the fact that we do not yet have a coherent model for deciding which occupation should be regulated, so what I would argue in this case is the new model that I hope we will publish very shortly. It will be a two-stage process. We will triangulate the risk of an occupation to produce what we call a risk profile, taking into account the risks of the intervention, the context in which it takes place and the vulnerability

of the patient or service user. We will then move on from that to a series of criteria against which we would measure whether or not regulation was the best way of managing that particular risk of harm, but we would argue that ultimately it is a matter for Ministers to decide which occupations should be regulated because it is a statutory matter—but that should be done on the basis of good evidence.

My off-the-top-of-my-head assumption, at the moment, looking at the job description of physician associates, for instance, is that they probably tip over the line into statutory regulation, but that would depend on how much of the work they do will be unsupervised and how much of it will be directly supervised by a regulated doctor.

**Q11 Chair:** Going back to your graphic where you talk about the gradient of risk, within that graphic you have healthcare assistants, for example, at the very lowest risk end, but are they not dealing with the most vulnerable clients on their own, very often unsupervised? Therefore, how does that assessment take into account what you were saying just now about the vulnerability—

***Harry Cayton***: That is exactly why we want to have this risk profile. You might say in that case the intervention that they are carrying out is relatively low risk—it is mostly helping people to dress, to bathe and so on—but the client is extremely vulnerable; so they are at the high-risk end and they are working alone in the community. So you get a triangular shape that shows you where the risks of that particular occupation lie. It may be that that occupation does have high risks, but we have to think about other ways of managing it. You have mentioned the vetting and barring scheme. My belief is that, if those people were on a register and were also subject to vetting and barring, then we might be able to manage that risk without bearing the full step of statutory regulation. If you look at that group, there is about 30% turnover per annum within that group; they are very low paid. They would be unable themselves to pay the cost of regulation. Our cheapest statutory regulator is about £80 a year. I have talked to people who run home care services who say, "Even if it was £10 a year, our workers couldn't pay it. We would have to pay it." That is a cost to the home care service. You have to take regulatory costs into account, not for any other reason than that it is one of the public policy issues you have to bear in mind when you are deciding on how to manage a risk.

**Q12 Mr Ben Bradshaw:** You said in the end that it will be Ministers who decide. So, whatever you say, if the current Government continue to pursue their deregulatory agenda, it is going to be very difficult for you to extend regulation to areas that you may think merit it.

***Harry Cayton***: Over many years I have argued for what I think are the right things to do in various different contexts. Of course you have to respect the decision that Ministers make, but we have argued successfully over several years in ways that we can improve regulation, and I will continue to make those arguments. Of course Ministers decide, and different Ministers take different views. That is really all I can say.

***George Jenkins***: When I come into this role what I do see is a lack of evidence—evidence for Ministers, for us—to decide exactly where people would sit on that scale. This model will drive out the evidence to do that. Moreover, we want to test that model robustly, to ensure that it is dynamic and fit for the future—future-proof—because we would all agree, with the speed with which medicines and therapists are being delivered at the moment, that

we do not want to be reinventing this frequently, so we need to be dynamic enough that they can be assessed quickly and briefly by that dynamic model.

**Q13 Mr Ben Bradshaw:** Perhaps you could help us. It is a bit difficult to know what Government policy is at the moment in the current hiatus, but do they still have this "one in, more than one out" rule overall Cabinet Office instruction across Departments, when it comes to regulation?

***Harry Cayton***: If I may say so, the current view is relatively settled on the position that is set out in a paper called "Enabling Excellence", which predates the 2012 legislation. That is a general position that the Government do not intend to regulate additional occupations, and they asked us to set up the accredited registers programme as a mechanism towards improving oversight of those occupations. There was none before, so we can say there is at least some now. The Government also said they would review the working of that over a period of time. Chair, if I can say so, the issue you raise around psychotherapy in particular, but one might include counselling in that where you have particularly vulnerable clients, may be one of the areas that Government would wish to review. We would like, as my chairman says, to build the evidence base so that we have some fairly rational means, otherwise you finish up just responding either to campaigns by groups of professionals who want to be regulated or campaigns as a result of some harm that has happened.

**Q14 Chair:** Of the nine statutory regulatory bodies that you oversee, which of those do you see on that spectrum of risk that you would be recommending come out of regulation?

***Harry Cayton***: That is a horrible question. We would not say that at the moment about particular bodies, although we have taken a view, which is not secret, that very small regulators are unlikely to be cost-effective, and we could see reasons, for instance, for the chiropractors and the osteopaths to work closely together and not be separate regulators. However, I would be more inclined to say that within those regulators there are a number of occupations covered— for instance, dental technicians—that are regulated. I am not sure that they could not be within an accredited register. There are some occupations covered by the Health and Care Professions Council, such as arts therapists. I am only aware of one, ever, fitness to practise case involving an arts therapist, and that was for theft or dishonesty, rather than competence.[1] Do we need to statutorily regulate arts therapists? Music therapists are not regulated. Play therapists are within accredited registers. What I suppose I am saying is that we do not have a coherent system and it would be good to move towards one that was more objective.

**Q15 Chair:** Do you think as well that it is right for some people to be concerned that when somebody is registered, say, with the Health and Care Professions Council, where there is not an evidence base at all for their practice, that it can somehow lend them a credibility that some feel they do not merit and imply that there is an evidence base?

***Harry Cayton***: We have discussed this ourselves at some length, and the board has discussed it. We have taken the view, in terms of our regulatory oversight, that we will not take a view on the efficacy of treatments because that does not fall within our expertise. I would not be able to make a judgment on any healthcare as to whether it was efficacious or

[1] Harry Cayton CBE wrote to the Committee on 17 October 2016 to say: "Having now reviewed the HCPC's fitness to practice statistics, I note that there have been three findings against Arts Therapists between 2012 and 2016. I said that I was only aware of one, which was true but I am happy to correct the record and acknowledge that the number as reported by the HCPC is three."

not, except as a rational person. There are therapies that are within this that are not considered by many people to be wholly evidence based or wholly scientific. They are legal; they are used by the public; they are wanted by the public. The value we add with our scheme is a consumer protection value. We are making sure that people are registered; that they have signed up to a code of ethics around price and around behaviours; they have a complaints system that people can use. We are not over-claiming for it but we think it is a modest contribution to public protection.

**Q16 Chair:** Can I pick you up on that? If you say that part of what you are doing is around consumer protection value, if you are presented with compelling evidence that there is no benefit for a particular course of action, is that not mis-selling, if you like, if you are looking at protecting consumers?

***Harry Cayton***: There is a difference, is there not, between compelling evidence that it is no benefit to some and compelling evidence of harm? If there was compelling evidence of harm, that would be a matter of concern. People will tell you, "I benefit from this treatment; I benefit from aromatherapy." You might or might not believe that aromatherapy is of value, but some people want and use aromatherapy. It is certainly not within our power to decide that. It is not within our legislation to allow us to decide that. If people are going to use aromatherapy, I would rather that they go to an aromatherapist who is on a register, who has at least had some training and who has signed up to a complaints system.

**Q17 Chair:** If you are looking for evidence of harm, what about, for example, the issue of so-called homeopathic vaccines, which you could argue have a serious harm if they encourage people to think that it is effective as a vaccine and then it displaces something that is an effective, genuine treatment? We know that there are examples of people being sold so-called homeopathic vaccines. Should you, as an overseer of regulators, be making sure that the regulator responsible is taking action in those cases?

***Harry Cayton***: We have, in that case. I do not know whether, George, you want to come in. We only oversee one homeopathic register, and, within that register, the standards are very clear about the need, for instance, to refer to conventional medicine. I do not believe it would be within their standards to allow that kind of claim around homeopathy.

***George Jenkins***: I would agree with that. We recently held a convention of everybody involved in the accredited registers, and I was certainly taken by the very professional approach that they took and the comments they made. To your point regarding whether this is a tick in the box that this is a good service, I think because we are overseeing those accredited registers at least it means that that tick in the box has some value.

**Q18 Chair:** How does it have any value?

***George Jenkins***: Because, basically, we have assured that they are appropriately managing their practice, they meet certain standards and they are fit to practise.

**Q19 Chair:** But if they are selling something to consumers for which there is no evidence of benefit, how is that protecting consumers?

***George Jenkins***: There comes a point at which regulation, in its loosest term, cannot replace process over bad management and bad clinical practice, because, while we can regulate, as Harry has said, we cannot be qualified to make a decision about the efficacy of that. What we should therefore see is people complaining about that. Obviously, there is a

route to the regulator, to the accredited register and to us by people who are dissatisfied with those services.

***Harry Cayton***: I would say that, if it is believed that these therapies that are offered are so inappropriate for the public, then that is a matter for Government and not for us. It is not within our oversight power to determine that.

**Q20 Chair:** You are not able, yourself, to say, "There is a group where we feel there is not sufficient evidence of value that we can justify the credibility of being on a register."

***Harry Cayton***: We would, we imagine, be subject to judicial review if we tried to do that, because the argument would be that we did not have the expertise to make that particular discrimination between, say, therapeutic massage and some complementary practice.

**Chair:** Right. I do not know whether either of you wants to come in on that point.

**Q21 Paula Sherriff:** Not on that one. Thanks, gentlemen. I would like to move on to the issue of revalidation, if you can allow us to understand how the revalidation process is being addressed by yourselves. First of all, are you, as an organisation, satisfied that revalidation represents a proportionate approach to ensuring that doctors and nurses are able to fulfil the requirements of their job? To expand on that, do you feel that the current revalidation process that is in place translates into what patients would perceive to be a safeguarding that their medical professionalism is both competent and safe?

***George Jenkins***: Could I make a start, Harry, by simply saying, in principle, how can we exist without a revalidation process? It is absolutely essential. We could have a situation where somebody literally qualifies at a very young age and goes their entire career without some form of supervision or validation of their practice and what risk they may perceive to the public. Certainly, having been in charge of difficult hospitals and seeing some of the effects of that makes me really sure that I do not want to see that again, believe me.

As to the revalidation process, it is well under way with doctors and is now starting with nurses and midwives.

***Harry Cayton***: We have said that we should have continuing assessment of competence to practise. We do not believe that revalidation, as such, is necessary for all groups. It is a rather onerous and complicated system. The GMC has recently published an interim report on revalidation. What is interesting to me is that it has certainly shown some improvements, but one of the main improvements it has shown is that doctors are getting appraisals rather more effectively than they were in the past. That is, really, a side effect of revalidation. They should have been getting appraisals in the first place. What it is helping doctors to do and what doctors are reporting is that they are having to think harder about their own performance because they have to fill in their portfolio annually. We understand that the responsible officers that the GMC has in trusts are receiving larger numbers of complaints or concerns that they can act upon sooner, so it is having a preventive effect.

We would argue, though, that that elaborate system is not necessary in all occupations. I have said this before, but I would hold up the General Osteopathic Council, which has taken a really interesting view of peer review in revalidation, because these are people who do not work in a managed environment. They have done some really quite

innovative and interesting work in developing a different kind of way of measuring continuing competence, which I think is more proportionate.

**Q22 Paula Sherriff:** That leads on to my next question, because, as somebody who was a healthcare manager for many years prior to becoming an MP, I was responsible for ensuring that the revalidation was done. It was not necessarily an easy task, I have to say. Much of the criticisms were that it was burdensome, it was a hindrance and it was ambiguous. Would you consider more of a move towards a continuous assessment, as opposed to every three or every five years conducting some sort of process, if you like, that arguably could be manipulated?

***Philip Hallam***: As Harry mentioned before, with the nine health and care regulators we look to ensure that they are taking a proportionate approach to continuing fitness to practise. Depending on the professions they are regulating and the risk they are identifying, through our performance review process each year, we will look to see that they continue to ensure that their continuing fitness to practise process, whether it is a revalidation model, a peer review model or a mixture of those aspects, continues to be effective for them. We would want to see, as part of our review, that they continue to review for themselves whether their continuing fitness to practise model is appropriate.

**Q23 Paula Sherriff:** I remember working with a doctor, who shall remain unnamed. I worked in his hospital for many years and we would ask him periodically for his certificates to prove that he had completed his mandatory training. He said, "I will make you one on the computer." I said, "No, I do not want you to make me one." I appreciate he probably did not do that, but it does seem that moving towards a process of continuous evaluation or a 360-degree peer review model may be the optimum case in what is not particularly obvious and straightforward, because we do acknowledge that there has to be some sort of process in place.

***Harry Cayton***: You are absolutely right to raise the issue of proportionality and workability in people's busy professional lives. Remembering how hard it was to bring this in in the first place, and it took 10 years to bring in revalidation for doctors, we should applaud what the GMC did, in the end, to achieve that, because it was difficult. I hope we will see that playing out over time and becoming much more sensitive and appropriate to where the risks of harm lie and to the need for people to focus their daily lives on looking after patients, rather than keeping records about looking after patients.

**Q24 Paula Sherriff:** Absolutely. That sense of proportionality has to be absolutely up there in how this revalidation is addressed, because it is all very well with the current revalidation, "Have you attended your fire training? It is very, very important." In translating that into safe patient care, what are the health professions being assessed on?

***Harry Cayton***: We all know, from continuing professional development, that you go to a conference and you get a certificate. I have a wonderful collection of certificates for dentistry, nursing and medicine, depending on the conference I was speaking at. We need something more robust than that, but we do not necessarily need a full revalidation model for every occupation.

**Q25 Paula Sherriff:** What lessons identified by the GMC's introduction of revalidation do you expect the NMC to act on for revalidation of nurses and midwives?

***Harry Cayton***: The NMC's pilots and their introduction of revalidation has been well managed. It has been welcomed by most nurses. There is still an argument that it might be

heavier than it needs to be. Phil, do you have response data on the way that has gone down with nurses?

***Philip Hallam***: Through the work we are doing this year to look at the NMC's performance in the round, we have seen that it has seemed to have been well received by the profession and the professional groups. As part of our performance review process we look at continuing fitness to practise for every regulator, so we would be commenting, when we publish the report for the NMC on what we think about their revalidation scheme at this point, because, as Harry said, of course it is how it is at this point and whether it is appropriate now. We would look, as we do with every regulator, to see if they continue to develop it over time.

***George Jenkins***: Can I make a point on that as well? This is absolutely outside our remit, but the comment I would make is that you cannot regulate for everything and it cannot replace performance management. Those responsible for running hospitals have to run the hospitals; the regulations they have to sit alongside and manage as well. We cannot control every issue that happens 24/7 in a hospital, or a community environment, unless it is being managed well and those people are valued, performance-managed, appraised, and so on.

**Q26 Mr Ben Bradshaw:** What is your assessment of the current state and competence of the NMC generally?

***Harry Cayton***: Improving.

**Q27 Mr Ben Bradshaw:** Because it was absolutely dire.

***Harry Cayton***: You were Minister, Mr Bradshaw, when we did our first report on the NMC.

**Mr Ben Bradshaw:** Indeed.

***Harry Cayton***: I have to say they have improved immeasurably since then. We did a second report, which we called a strategic review. We made 14 recommendations. We said it would take them at least three years to implement those, and I can say, with some confidence, that they have done so. Last year they probably had the best performance review we had given them for many years. They struggle still with the sheer volume of fitness to practise cases. Is that fair, Phil?

***Philip Hallam***: It is. As I say, we are still in the process of reviewing their performance this year, so I am not able to comment on the outcome of that review as yet. Our last performance review identified some issues that we are working through with them and we want to see how they have moved forward since our last report. But as Harry said, they are an organisation that over time has made some improvements.

**Q28 Mr Ben Bradshaw:** Congratulations on what you have achieved. As a matter of interest, what is their current time for dealing with fitness to practise cases, or backlog?

***Philip Hallam***: In relation to their last report, I can find that figure for you, but we have not yet finalised the figures for this report.

***Harry Cayton***: The backlog has virtually gone.

**Q29 Mr Ben Bradshaw:** Very good.

***Harry Cayton***: It really went last year. What we said last year in the performance review was that they were now getting most things right some of the time, but they were not consistent in their performance. I do think they have made great progress and I would pay tribute to their chief executive Jackie Smith.

**Q30 Mr Ben Bradshaw:** Excellent. What about the leadership and the constant sort of backstabbing that used to dominate it?

***Harry Cayton***: The leadership has changed massively. The council has changed. They have a strong chair in Dame Janet Finch, so the leadership is much strengthened. They would admit they still have a way to go, and we have continuing concerns with their fitness to practise decisions on occasions and are quite unhappy about some of them.

**Q31 Chair:** One of the roles of this Committee is to provide oversight for the bodies that you regulate as well. So I am interested to know, of those, which of their performance concerns you the most at the moment?

***Harry Cayton***: I have said this to this Committee on another occasion: the most important thing to remember is that most of our regulators are doing a competent job and that, mostly, our annual reports are rather dull and say, "Regulatory organisation is really quite good, with some problems." I do not want to overstate our concerns at the moment. Mr Bradshaw has rightly reminded us of the journey the NMC has come on. I would say that the GMC, the HCPC and the GOsC are consistently regulators that meet most or all our standards and which cause us very little concern. We do have concerns about the General Chiropractic Council and about the uncertainty of its performance. We are currently doing a performance review of them. We have the concerns that we have mentioned around fitness to practise in the NMC. The GDC has had a very difficult time over several years. They too now have an action plan to put that right, which we consider meets the recommendations we made in our last investigation report on the GDC, but they too have quite a way to go in terms of rebuilding particularly the confidence of the dental profession in their performance as the regulator.

**Q32 Chair:** Certainly over the last year we have received a huge volume of correspondence from dentists about the GDC. Do you feel satisfied that they are making progress on the issues that have been raised, both with ourselves and with yourselves?

***Harry Cayton***: I cannot answer that question either in the affirmative or the negative at the moment. They produced their action plan in January of this year and we said we would review it in the performance review, which Philip is currently doing.

**Q33 Chair:** When will you be reviewing their performance?

***Philip Hallam***: We have been reviewing their performance, as we do with all the regulators, on an ongoing basis internally, but we will be moving to a position where we make a decision as to the level of review we may wish to undertake with the GDC this year, this month.

**Q34 Chair:** Would you contact this Committee if you feel that there were regulators that we need to call to account in this setting?

***Harry Cayton***: We could certainly do that, yes.

**Q35 Chair:** Thank you. You mentioned earlier that you were satisfied with the Health and Care Professions Council, but we have had a very distressing case raised with us,

which was first raised with them in 2009 and was first heard in 2013, and still has not reached a final decision. We were told that the family concerned had raised this with you but were told that you could not take action until the case had been completed. They are caught and trapped in a very distressing situation. I can share that with you afterwards. It would not be suitable for me to do so in a public setting.

***Harry Cayton***: I am pretty sure I am aware of that case. It is an appalling case, but the delay, if I am thinking of the right case, is to do with the health of the registrant, as well as issues to do with the family; but everyone would accept that is far too long a time both for the family and for the registrant. It says in our legislation that we must not intervene in a case while it is still live.

**Q36 Chair:** It is still active. However, the general point is made in this case that, while the family are not allowed to delay their attendance at hearings, the registrant is. Is there a point at which that is allowed to happen to an unreasonable extent?

***Harry Cayton***: There must be some point at which a regulator can either continue the case without the presence of the registrant or have to abandon the case entirely, but they are caught into a legal framework that would mean that fairness to the registrant is one of the fundamental elements of the investigation.

**Q37 Chair:** We would all agree with that, but sometimes the extent of the delay becomes entirely unreasonable to those who are making a complaint. Therefore, do you feel that you need to see a change in your own powers to enable you to intervene and insist that action is taken? How can this be moved on, because otherwise it can simply be used as a device for preventing an outcome being reached?

***Harry Cayton***: That is an interesting question. Phil, do you want to try to answer that? I would just be slightly hesitant. It is the old thing about hard cases make bad law.

**Q38 Chair:** But they do illustrate, sometimes, a wider point, and there is this very distressing case on which I would like to correspond with you separately.

***Harry Cayton***: Please, do.

**Q39 Chair:** It is a wider point that sometimes there is a balance to be struck, obviously, between justice to the registrant, but also it can come to a point where it is grossly unfair on the families who make the complaint.

***Harry Cayton***: There are mechanisms that regulators can use to proceed with cases in the absence of the registrant. Have those been used correctly in this case? I cannot answer that now. Do we need additional mechanisms to do that, which is what you are raising? That may be possible.

***Philip Hallam***: More generally, with all the regulators, one of the things we do look at every year is both their timeliness and how they move from decision point to decision point so that we can check there is not, in general terms, undue delay or that they are not moving things through as quickly as possible. As Harry says, we recognise it in individual cases and there may be individual circumstances.

***George Jenkins***: You made a very good point that it is the wider issue, is it not? It is not necessarily a single case, because when you have, in that particular regulator, 342,000 registrants, in round numbers, one case itself is not significant, but that could be a position

across a number of regulators. It is something I would like to take an interest in and it is very useful for you to raise that point with me.

**Chair:** Thank you, and, as I say, illustrating a wider point that we need to see a balance of fairness here as well.

**Q40 Mr Ben Bradshaw:** Can you explain how giving the GMC the right to appeal MPTS panel decisions has developed inefficiencies and duplication within the system?

***George Jenkins***: That is before my time, Harry, so I am going to pass that one to you.

***Harry Cayton***: We have had, since 2002, the power to appeal cases against any of the regulators where we think their decisions have failed to protect the public. In the last 10 years we have appealed about 76 cases, and a significant but not large number of those would be GMC cases. I do not think anyone has suggested over that time that we were not doing that properly, and our track record, in that we have won very much the vast majority of those cases—currently, there are only two certain failures out of that 76—suggests we are getting that pretty right. The question for me then is: what is the added value of the GMC having a right of appeal in addition to ours? Since the GMC got that right of appeal, they have considered something like five cases and they have finally now decided to appeal one. We have considered seven of their cases and we are now in a position of having to consider the one they are appealing and join with that appeal. The point I am making is that there is duplication of effort with, to my view, no obvious public benefit. That is not to say the GMC is doing a bad job or a good job—we do not know yet. It is just that it is doing the same job that we have been doing, and now we are doing the same job at the same time. That has always been our position on this. As the GMC suggested previously, there might be a much larger number of appeals coming from us and somehow they would be more critical of themselves than we were, but that has not, so far, come about.

**Q41 Mr Ben Bradshaw:** Can I ask you about some of the value-for-money issues around your organisation. Does the funding that the PSA receives from the fees paid by regulators directly fund or cross-subsidise any non-statutory activity that you do?

***George Jenkins***: No.

**Q42 Mr Ben Bradshaw:** Is there any likelihood that in the near future you will generate a surplus that will allow the fee charged to the regulators to be reduced?

***George Jenkins***: Of course, these fees are set by the Privy Council. Each of the areas of our income is ring-fenced. We take the fees for the following year to each of the regulators. We report back to the Privy Council. The Privy Council then double-checks with the regulators and then makes a decision, so it is a very transparent and open-book process.

***Harry Cayton***: We reduced our costs by 9% this year. I had a budget meeting with my team this morning and I will just add the pressure on them that I put this morning, so I hope I will be able to reduce our budget again this year, or at least to keep it where it is. Can I give you an efficiency gain because it is important? People talk about the cost of our oversight role. When I started at the authority we had four staff reviewing cases. They reviewed 915 cases a year. That is a pretty heavy caseload of 229 cases each. This year we have seven staff doing that, but they reviewed 3,756 cases. That is a caseload of 537 per member of staff. That is a fantastic efficiency gain on our part, in relation to the volume of cases that we have to

review within a statutory deadline. I do not think many of the regulators could show that level of efficiency gain.

**Q43 Mr Ben Bradshaw:** To what extent is income derived from elsewhere in the PSA used to meet the costs of operating the accredited registers programme?

***Harry Cayton***: All our work streams are self-contained, so the accredited registers programme is self-funding. It is not yet totally self-funding because the income does not cover the expenditure. As you are building a model starting from scratch you have fixed costs, but the whole scheme costs in the region of £360,000 a year. The registers pay upwards of £12,000 to be accredited and £9,000 each year to be renewed. Currently, the Department of Health is giving us a diminishing subsidy of £110,000 a year. We hope to break even on that scheme by the time we have reached 30 or so registers. We are at 20; we will be at 25 this year.

**Q44 Chair:** Can I just come back slightly to the point about appealing decisions? You have set out the position of appealing fitness to practise decisions with the GMC. Is that something that you are able to do with the General Pharmaceutical Council as well? Was that a yes?

Can I just ask your views on the decision around Pharmacy2U, which was quite a controversial decision? We know that Pharmacy2U was selling data that included age, gender, address and last order with Pharmacy2U. The chief executive was not aware, I understand, of the agreement to rent out data but the commercial director made the arrangement. In fact, the penalty seemed, to many people, to be very small. The Information Commissioner ordered a fine of £130,000 for breaching the Data Protection Act, but the General Pharmaceutical Council's fitness to practise committee gave a warning to the chief executive and a three-month suspension to the commercial director. It seems to very many people that this is not in any way going to act as a deterrent for others in the future to misuse data. Looking at the kind of data that was being sold, this is appalling, with huge implications for trusts. Is this a decision that you now intend to review?

***Harry Cayton***: We will be reviewing it; I do not know the outcome of that review yet. We review all decisions, and I am quite sure that decision is under review. I have had a conversation with the chief exec of the General Pharmaceutical Council about those behaviours, which we all think are completely unacceptable. I know that the GPhC is thinking hard about how it can improve its standards and make sure that that kind of thing does not happen again, although, as you rightly say, it also falls within the remit of the Information Commissioner. I can undertake, if it is helpful, to report to the Committee what our decision is in that particular case.

**Q45 Chair:** This Committee is interested in the decision, because, taking you right back to the beginning of your evidence session, you have talked about the need not just to regulate individuals but systems. It strikes me that this is an example where you can give albeit what seems to be a very small penalty to an individual, but there is nothing to stop that individual being replaced, if necessary, within a company. Do you feel there is a place for saying that regulation should extend sometimes to the entire organisation, by way of sending a message that some practices are wholly unacceptable, such as selling people's personal data in this way? Would you care to comment on how you think perhaps you could change to having a system-wide form of regulation for this kind of business, which is a growing area?

***George Jenkins***: You are absolutely right. It is something that Harry and I have been discussing, from a strategic point of view, because we have a growing number of those who are regulated working in a different environment, i.e. the corporate environment, whether they be pharmacists, opticians and, to an extent, a very rapidly growing cohort of dentists. We do need to review how we look at that, and I have already started a conversation this morning with the CQC so that we get an overlap of our views and discussions over that. There is a risk that we need to understand, where the pressures on those working within a corporate environment are different from those working directly within a healthcare environment. That is not to say that the corporate environment is completely wrong and outrageous. I am not saying that. We need to be sure of that and we need to understand how we can address that.

**Q46 Chair:** This is about protecting the public and the implications that has for—
***George Jenkins***: Which is why we exist.

**Chair:** Yes.

***George Jenkins***: You are absolutely right on that.

**Q47 Chair:** When you come forward with the consultation, you will be specifically addressing this issue of systems and individuals, in order to protect the public.
***Harry Cayton***: We do have good models, not perhaps as strong as they yet need to be, but in the General Optical Council and the General Pharmaceutical Council we do have regulators who have an interest in the business and the premises, as well as in the people. That gives them a certain strength. It is slightly tangential, but there is a working party of NHS England at the moment looking at conflicts of interest in NHS England, of which I am a member. I have asked the Pharmaceutical Council and the secretariat of that working group to share the information that the GPhC has on inspecting premises and regulating people.

**Q48 Paula Sherriff:** Do you believe that it is an appropriate use of resources for the PSA to continue to review all fitness to practise panel decisions? It seems incredibly laborious. Do you feel that it is entirely necessary and an appropriate use of your resources?
***George Jenkins***: Coming into this role, I have had the opportunity to look at this as a completely objective individual, haven't I? History is only a guide to the future; that I accept. But, absolutely, it is a good guide in this case. It sets trends and it sets data that can be analysed. I do think we need to look back to ensure that we protect the public against the future.

**Q49 Paula Sherriff:** What have you gleaned from doing these reviews? What outcomes and what lessons have you learned, and do you have the power to overturn the fitness to practise panel decisions?
***George Jenkins***: Because we can then appeal those decisions.

**Q50 Paula Sherriff:** How many and what percentage have you chosen to appeal, out of all of the ones that you have reviewed?
***Harry Cayton***: We appealed 14 cases last year.

**Q51 Paula Sherriff:** Which is what, as a percentage?
***Harry Cayton***: It is 14 out of 3,700.

**Paula Sherriff:** Okay.

***Harry Cayton***: However, we also write to the regulators what we call learning point letters, so we respond to a very large number of cases other than that. I just want to correct a slight misapprehension about what we do. Any case where a registrant has been struck off cannot possibly be unduly lenient or, in terms of our new test, insufficient to protect the public. Those cases we do not have to look at. We discard those cases very rapidly. We also then just look at every case once, in order to ensure whether the sanction appears to be appropriate. The Chair has just given a good example of a case where the sanction might not be appropriate. That requires us then to get the whole case papers, which we get from the regulator, to read them, to analyse them and to put them through a fair process.

We have looked very seriously at doing this in different ways. We had an independent review by a distinguished lawyer a few years ago, and we looked at nine different models of dividing them up. We looked at whether we took out low risk occupations. It does not help us, because with the low risk occupations there are hardly any cases anyway. Do we take out highly performing regulators? That might help us, but would you really say to us that we should never look at any cases involving doctors because the GMC is generally a good regulator? I do not think we would be protecting the public if we did that.

We have encouraged the regulators to draw to our attention cases that go wrong. We think that is a good idea. The judges have said they have a duty to do that. They do not all do it, and if they do it they do not do it consistently. They are not going to come and confess to us about under-prosecution of cases, where the fault lies with the regulator and not with the panel. We are trying to engineer our internal systems so that we can speed up and be as efficient as possible, within our 40-day deadline, to be sure that the public have been protected. I would welcome anyone who can suggest to us a way of doing that that does not involve looking for the needles in the haystack by turning over the haystack.

**Q52 Paula Sherriff:** Two further questions from me, following your response. Of the 14 that you chose to review or that you reviewed, how many of those 14 were given different sanctions as a result of your review?

***Harry Cayton***: So far, 12.

**Q53 Paula Sherriff:** Right. You alluded, just a moment ago, to the fact that the individual regulators were inconsistent in terms of their own scrutiny, if you like. Do you not think it would be a better opportunity to provide those regulators with training and ensure that they were performing robust introspection of their own regimes, rather than you reviewing every fitness to practise decision?

***Philip Hallam***: We do both. The process we follow for deciding whether to appeal a case is one aspect of our work. The performance review process, of course, takes a view of each regulator in the round, so it is not just cases that we have decided to appeal but all those other cases that we have reviewed and where we may have decided to send a letter of learning to the regulator or we may have some other things we want to discuss with them. We will use that as part of our performance review process, along with all our other evidence as well. We would look to see, through the performance review process, whether the regulator has mechanisms in place to make sure they are identifying, as best they can, where things may be going wrong, things they need to improve or things they need to look at. It is not just

about the cases we appeal; it is also about the whole range of our scrutiny and quality work, including the performance review.

**Q54 Chair:** As we are nearing the end of the formal questions that we had decided in advance we wanted to raise with you, are there any issues that you would like to bring to our attention, either about any of the bodies that you regulate or other issues, moving forward into looking into the review of the way that we regulate the professions?

***Harry Cayton***: Perhaps I could just say a couple of things, if it would help the Committee. We have re-engineered our performance review process this year, and Philip has taken charge of that. I hope it is beginning to help us to focus our attention on particular areas within regulators and, for regulators that are performing well, to finish the performance review and move out and leave them alone much quicker and more effectively. It is beginning to show that it does that, and I hope that, as we produce reports during the year instead of a single large report once a year, that will be more timely.

The other element of that that is really important and showing value already is that we are no longer collecting data on an annual basis as a kind of snapshot, but we are collecting it on a quarterly basis, so we have trend data. Mr Bradshaw has almost raised this already; what you can see then is whether a regulator's timelines are going up or down, whether their backlog is going up or down and whether their volumes are going up or down. That is much more interesting than knowing, at any particular point in time, what their performance is.

The third thing to add to that is we have noted that one or two of those who have submitted to your Committee have said, "What about the standards themselves?" We did review the standards in 2010, and we are going to look at them again, just to make sure that the standards are also fit for purpose for the future.

**Chair:** Thank you.

**Q55 Dr Whitford:** I apologise for coming in at the tail end. We are not usually this quick and I got caught up elsewhere. It was really just coming back to the discussion around revalidation, particularly of doctors. Having been in the profession myself, I am conscious of people who in the past, after retirement, would have worked at least for several years. I do not mean we are wanting people working when they have lost all touch, but I know people who are not doing that now. They maybe do one year at the most because they do not have an automatic appraisal system and they do not have access to, or even the wish to go through, revalidation. Are we not losing people with a lot of skill who used to quite enjoy coming back, not doing all the management, all the headache, but just doing pure clinical work? They used to really help us out and really teach younger specialists.

***George Jenkins***: One of the things, certainly, in running a trust, as I have done, is that one looks to the end of someone's career to ensure that you can maintain best value from that individual, while absolutely tying up with their aspirations for perhaps a more gentle entry into retirement. Certainly, some of the management performance appraisals that I can recollect very clearly were just to facilitate that. However, it comes back as well to risk. While one might be thinking that there are certain areas one would be very happy to see somebody working on, I have personally seen an experience where a surgeon has come to the management board and said, "I would like to stay on, but my skills are getting to the end" of some of the incredibly acute, delicate, life-saving work that this individual has done.

I agree with you; there is a method by which we can capture some of that experience. Depending on the access and profitability—I use that word loosely in the current situation with NHS trusts—certainly they have incredible value and experience to use in education, to deal with some of the time stretch that some of the individual leaders might have in doctors in training and so on. If we are going to expose individuals—called the public—to doctors, irrespective of whether they are junior doctors or those at the very end of their life experience in the medical services, we have to have a standard, and that standard has to be met. Does that help you?

**Q56 Dr Whitford:** Not really. It is just the system that they can be gauged. I have no problem if someone says, "We do not want you doing that rare operation because you are now hardly doing any, but you can do this." At the moment, they would still have to go through exactly the same appraisal, exactly the same revalidation, as everyone else. Very quickly, people are going, "How do you collect all the data on what you have done? How do you do your appraisal? How do you bring your folder together if you are just helping out?"

***Harry Cayton***: It is the point that Ms Sherriff was making earlier: is revalidation proportionate? This is a matter for the GMC, not for us, but our overview would be, as I have already suggested, that over time we would like to see the regulators fine-tuning and adjusting revalidation so that it focuses, in the most proportionate way, on getting certainty that doctors are fit to practise. I agree, in any circumstances, that if you are driving out good people because of the burden of regulation, that is undesirable; but if you are driving out bad people because of the burden of regulation, that is its purpose.

**Chair:** Thank you. If there are no further points that any of the panel would like to make to us, thank you very much for coming this afternoon.