

CHRE-News

Changing times

The 'pause' in the progress of the Health & Social Care Bill will undoubtedly cause delay in its implementation. We do not now expect the proposed Professional Standards Authority for Health and Social Care to come into being until at least July 2012. The Government is going through a 'listening exercise' led by a forty-strong group called the NHS Future Forum. Meanwhile the Prime Minister has appointed his own health advisory panel and following the local elections in England, the Deputy Prime Minister has made clear his desire for significant changes to the Bill. Whether or not the voices of patients will be heard at all in this tumult of competing opinion remains to be seen.

In Scotland and Wales health policies are unlikely to change with the strengthening of Scottish Nationalist administration in the former and Labour administration in the latter. Health and care professional regulation must continue to be alert to the implications of increasingly different health and care services across the UK. Niall Dickson from the GMC [sets out in his article](#) how that regulator is already rising to these challenges.

We published our [Audit Report on the initial stages of Fitness to Practise](#) at the end of March. This issue also features [an article](#) on the key findings of this report. We found that all but two regulators demonstrated continued good practice and improvements in practice when compared to last year's audit.

To improve the accessibility of our work we recently launched new Easy Read versions of *Complaints Guidance in England* and *Health Professional Regulation and Me* which can be found [here](#).

This issue of CHRE-news also features an [article by the Community Health Councils in Wales](#) which discusses their unique role as the independent NHS watchdog.

In future issues of CHRE-news, we will aim to provide outlines of our top level plans for the roles proposed for us in the Bill – see our ['Latest News'](#) article. We have been working with a number of occupational and professional associations on the shape of the accreditation scheme for voluntary registers and will publish our proposals for comment shortly.

You may belong to a patient group which holds meetings for its members. If you would like a speaker from CHRE to talk about health professional regulation, please email Rachael.desouza@chre.org.uk.

Harry Cayton

Chief Executive, CHRE

Fitness to Practise audit report published

This is the second year of auditing the early stages of FtP cases across the nine health professional regulators.

In this audit we reviewed a sample of 100 cases for larger regulators and all cases closed by the smaller regulators. We considered the evidence of risk to public protection or confidence in the regulator's case-handling procedures and standards. We also looked for examples of strengths in procedures in order to share these examples with all the regulators. You can read our full report [here](#).

This year we used weighted samples to focus on cases that were most likely to present higher risks to public protection or confidence. Our risk assessments were based mainly on information gathered when we conducted the 2009/10 audits. In all but two regulators, we discovered continued good practice or improvements in practice. For example, there was evidence of good standards of record keeping, decision making and communications (where we found that decisions made were explained at a good standard).

We made some general recommendations to the regulators which included:

- Setting sufficiently demanding key performance indicators for overall case closures
- Introducing computerised casework management systems (where not present) that are linked to their computerised registration system
- Making relevant previous fitness to practise history available to decision makers, to help in risk assessments.

In the audit we identified several weaknesses in the Nursing and Midwifery Council's (NMC's) and the General Dental Council's (GDC's) processes of case management, investigation, decision making and communication. Since the audit, the NMC is already taking measures to address identified weaknesses and the GDC has assured us that it will be resolving the problems we identified.

The General Pharmaceutical Council (GPhC) took over the Royal Pharmaceutical Society of Great Britain's (RPSGB's) fitness to practise responsibilities in September 2010. We reviewed cases closed by the GPhC in the first three months of its operation (including cases closed under the special criteria for closing cases they had inherited from the RPSGB). We found the GPhC's application of the criteria to be reasonable and that it maintained public confidence.

CHCs - the independent watchdog for patients in Wales

Community Health Councils (CHCs) in Wales are independent statutory organisations representing the interests of the patient and the public in the National Health Service. We are the independent NHS watchdog in Wales reviewing all aspects of NHS care and treatment. Local CHCs consists of voluntary members, working to ensure that the needs and views of patients are considered in planning and delivery of local NHS services.

What do we do?

- We seek the views of patients and the public on local services and use that information to inform our work with the NHS in Wales. We are the link between those that plan and deliver the service and the users of the service
- We inspect NHS premises and make recommendation for improvement where necessary
- We scrutinise the NHS and work with service planners and providers to improve the patient's experience of services.

How can we help the patients of Wales?

- We provide information for patients and the public about local NHS services
- We can support patients in their dealings with the NHS
- We provide free and independent advocacy services, offering confidential support, advice and guidance for those wishing to make a complaint against the NHS.

CHCs in Wales were restructured in April 2010, when 19 CHCs became eight. The past 12 months have been exciting yet challenging and we have focused our attention on developing how we engage with the patients and public of Wales by using innovative techniques and new technologies. CHCs are committed to engaging with the 'hard to reach' groups in their area. The Public and Patient Engagement (PPE) Forum allows all CHCs to share good practice across Wales to inform National initiatives.

In the past 12 months, CHCs have enjoyed discussions with key stakeholders on developing Memoranda of Understanding (MoU) such as Healthcare Inspectorate Wales, County Voluntary Councils, Care and Social Services Inspectorate Wales, Older People's Commissioner and their respective Health Boards. CHCs continue to work alongside our key stakeholders to undertake our unique role as the independent NHS Watchdog in Wales. Please visit: www.communityhealthcouncils.org.uk

Carol Lamyman-Davies

Director, Board of the Community Health Councils,
Wales

The GMC - adapting to meet radical changes to healthcare in the UK

The regulation of health professionals is changing. The move over the last few years from professionally led regulation to regulation which is accountable to Parliament and the public has led to much soul searching within regulators and the professions for which they are responsible.

The new model is not yet fully formed, but the government Command Paper, [Enabling Excellence](#) provides sign posts for a future characterised by greater autonomy linked to greater accountability, alongside an expectation that the sector will provide greater value for money.

The demand then will be for more effective public protection without increasing the regulatory burden - a challenge neatly summed up in CHRE's '[Right Touch Regulation](#)'.

In practice it will mean redefining the relationship with those we regulate, moving from one-off interventions when things go wrong, to a continuous dialogue between professional and regulator. At the heart of this dialogue will be assurance that the professional is competent and fit to practice - and for medicine that is where Revalidation comes in.

But it must also go beyond that. The 21st century professional regulator must also know what is going on in front line practice - the dialogue cannot be with the individual practitioner alone, it must be with employers, the wider profession and importantly with patients and carers.

To begin to address this the GMC is setting up two new liaison teams to operate at local level - first we will deploy employer liaison advisors throughout the UK who will work with and support Medical Directors and the new Responsible Officers who will oversee revalidation; and secondly, we plan to have a team of regional liaison advisors who will work with postgraduate deans, medical schools, Local Medical Committees, patient groups and others working at local level. The regional team will seek to replicate what we have achieved through our offices in Scotland, Wales and Northern Ireland where we have built closer relationships and a deeper understanding of local health systems.

As well as offering support and explaining what we are trying to do, we want these teams to be our eyes and ears on the ground, helping us to understand better what is going on and how we can target our work more effectively. Radical change is coming to all the UK healthcare systems as it is to healthcare throughout the developed world - we need to adapt to meet that challenge.

Niall Dickson

Chief Executive

General Medical Council