

Audit of the General Dental Council's initial stages fitness to practise process

September 2011

About CHRE

The Council for Healthcare Regulatory Excellence promotes the health and well-being of patients and the public in the regulation of health professionals. We scrutinise and oversee the work of the nine regulatory bodies¹ that set standards for training and conduct of health professionals.

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

Our aims

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

Our values and principles

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

Our values are:

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

Our principles are:

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

Right-touch regulation

Right-touch regulation means always asking what risk we are trying to regulate, being proportionate and targeted in regulating that risk or finding ways other than regulation to promote good practice and high-quality healthcare. It is the minimum regulatory force required to achieve the desired result.

¹ General Chiropractic Council (GCC), General Dental Council (GDC), General Medical Council (GMC), General Optical Council (GOC), General Osteopathic Council (GOsC), General Pharmaceutical Council (GPhC), Health Professions Council (HPC), Nursing and Midwifery Council (NMC), Pharmaceutical Society of Northern Ireland (PSNI)

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1. Overall assessment

Introduction

- 1.1 In June 2011 we audited 100 cases that the GDC had closed at the initial stages of its FTP processes during the previous six month period.
- 1.2 In the initial stages of their fitness to practise (FTP) processes the nine health professional regulatory bodies decide whether complaints which they have received should be referred to a hearing in front of a fitness to practise panel, or whether some other action should be taken, or whether they should be closed.
- 1.3 Our overriding aim in conducting audits is to seek assurance that the health professional regulators are protecting patients and the public, and maintaining the reputation of the professions and the system of regulation. We assessed whether the GDC achieved these aims in the particular cases we reviewed. We considered whether weaknesses in handling any of these cases might also suggest that the public might not be protected, or confidence not maintained, in future cases.

Summary of findings

- 1.4 The audit revealed weaknesses in the GDC's processes, some of which were the same as those highlighted in our two previous audits. For example, we found cases showing:
 - Incomplete information gathering by GDC FTP staff
 - Decision letters that did not fully address all the issues or properly explain why the GDC was taking no further action
 - Unexplained delays in the FTP processes
 - Poor record keeping
 - Non-compliance with the GDC's policy that cases cannot be closed by a single caseworker unless their decision is appropriately authorised.
- 1.5 We were pleased that in this audit we found no evidence of cases that had been closed too early, or of closure decisions that we considered were unreasonable.
- 1.6 At the end of this report we refer to the changes that the GDC is already implementing to its FTP processes, which we hope will help to address the weaknesses we have identified during our audit.

Method of auditing

- 1.7 We reviewed 100 cases that had been closed by the GDC between 1 November 2010 and 30 April 2011². These were selected from the 729 cases that the GDC closed in the period without referral for a hearing by either the Professional Conduct Committee (PCC) or the Health Committee (HC).

² In fact one of the cases that we reviewed was still open, but was included in our audit sample because it was incorrectly shown on the GDC's system as closed. The case had been referred to another organisation to investigate, and the GDC intended to make a final decision after that investigation had been completed.

- 1.8 We selected 50 cases at random, in proportion to the number of cases that had been closed by the GDC at each of the various closure points within the initial stages of its FTP processes. The other 50 cases were selected at random from categories of cases that we consider are likely to be 'higher risk'. When auditing regulators, we base our assessment of the risk associated with each case on the information we have gathered during previous audits, on the information we are provided with during our annual performance review of the regulators, as well as on complaints we receive and other relevant information that comes to our attention.
- 1.9 In March 2010 CHRE led a meeting of representatives from all of the nine health professional regulators to agree a 'casework framework'. This was a description of the key elements that should be present in the different stages of a good fitness to practise process. A copy of this is at Annex 1. When auditing a regulator, we assess the handling of a case against the elements of the Casework Framework

The GDC's FTP framework

- 1.10 The structure of the GDC's FTP process means that there are two points at which cases may be closed without referral to a formal hearing in front of a fitness to practise panel:

1. By GDC FTP staff without referral to an Investigating Committee

- 1.11 Cases will be closed by the GDC at the initial stages of the FTP process if they do not amount to an allegation that a GDC registrant's fitness to practise is impaired.³ Decisions to close cases on that basis are made on the recommendation of GDC FTP department staff, following an assessment that is carried out by 3 staff at a case assessment meeting (CAM).

2. By an Investigating Committee

- 1.12 The GDC's Investigating Committee's membership is made up of both dental professionals and lay people. The Investigating Committee's role is set out in legislation. The Dentists Act 1984, (27A)(1) explains that the Committee's role is to:
- '...investigate the allegation and determine whether the allegation ought to be considered by a Practice Committee [that is, the Professional Conduct Committee or the Health Committee]'
- 1.13 In order to carry out its role, the Investigating Committee assesses 'whether there are grounds to say that an allegation, if proven at a practice committee, would amount to impairment of fitness to practise...' ⁴. The test is similar to the test used by some other health professional regulators' decision makers, and is commonly referred to as the 'realistic prospect' test. It means that a case will not be referred for a hearing by a fitness to practise panel unless there is a 'realistic prospect' that

³ Paragraphs 2 and 3, 'The General Dental Council (Fitness to Practise) Rules Order of Council 2006'

⁴ GDC, 2009. *Guidance for the Investigating Committee November 2009*. London: GDC. [Guidance document withdrawn 21 July 2010]

the panel at such a hearing would make a finding that the practitioner's fitness to practise is impaired.

- 1.14 In the event that the Investigating Committee decides not to refer a case for a hearing by a fitness to practise panel, it can decide to:
- send a warning letter to the registrant (which may be published against their name on the GDC's register that is available from its website) or to
 - send an advice letter to the registrant or any other person involved in the case.

2. Detailed findings

Receipt of initial information stage and customer service

- 2.1 We found evidence of sensitive and helpful handling of some cases by GDC FTP staff, both in the way that their letters were expressed and the way that complainants were referred on to other bodies.
- 2.2 However, we also found three examples of cases in which standard letters had not been appropriately adapted for the individual circumstances. In two cases the letters asked complainants for further information that they had in fact already supplied. In the third case, a letter contained several basic errors.
- 2.3 The GDC has acknowledged that these examples demonstrate the need for further staff training.

Gathering information

The process of gathering information

- 2.4 Gathering the right information early enough in the FTP process is essential in enabling a regulator to assess the risks that a registrant may pose to patient safety, and in ensuring that appropriate action can be taken promptly (including, where necessary, applying for an interim order).
- 2.5 In our audit we found some cases that demonstrated a pro-active approach by GDC FTP staff to information gathering, including:
- Examples of active liaison by GDC FTP staff with Primary Care Trusts (PCTs) to gather and share information. Sharing of information between regulators and employers (or commissioners) is important for public protection
 - An example of the GDC seeking further information from the police in relation to one case, rather than simply accepting the information the police had originally provided at face value
 - Examples of cases in which GDC FTP staff had made multiple attempts to obtain information or consent from complainants.
- 2.6 However, we also found several cases where we considered that the GDC's information gathering had been inadequate, and where the GDC therefore could not reasonably have assured itself of the level of risk posed by the registrants concerned. For example:

- One case in which the patient had complained about an error by a dentist, and had identified a second dentist who had corrected the error. The GDC did not try to obtain evidence from that second dentist about the error. In our view, gathering that evidence might have strengthened the GDC's assessment of the case.
- One case that the GDC referred to the Dental Reference Service (DRS) (an organisation that assesses dental practitioners' competence to assist the GDC in its assessment of a registrant's fitness to practise). We were concerned that the registrant had been allowed to select the sample of patient records that would be reviewed by the DRS as part of the assessment process. In our view, allowing a registrant to select the records to be reviewed could undermine public confidence in the assessment process. The GDC has responded to our concerns about this case by stating that it has worked with the DRS to make the selection process more robust.
- A case in which: a patient had been caused concern by a registrant's comment that there may be signs of serious underlying ill health; and where there was a question over whether the registrant had appropriately followed this up. The case was closed by GDC staff at the assessment stage. We do not consider that the decision to close the case was unreasonable. However, we think that the GDC should have obtained and assessed the relevant medical records before taking the decision to close the case. The GDC has acknowledged that this case would have benefited from further investigation to establish the sequence of events and level of risk to the patient.
- A case in which GDC FTP staff made a decision⁵ at the assessment stage, without the benefit of clinical input, in circumstances where we considered that it would have been helpful for someone with dental expertise to review the case. The GDC FTP staff during the case assessment meeting in their analysis of the case, speculated that damage to a patient's teeth might have been the result of a common side-effect of a standard procedure. This case raises a wider issue relating to the availability of clinical dental expertise at the initial stages of the GDC's FTP process. Currently there is no provision for the GDC's FTP staff to obtain a dental professional's view about a particular case before the Investigating Committee consider the case. This means that cases which are closed by GDC FTP staff without referral to the Investigating Committee are not assessed by anyone with clinical expertise at any point. This raises the possibility that some cases involving allegations of clinical incompetence may be closed inappropriately by GDC FTP staff. The GDC is now developing a system to allow its FTP staff to access clinical advice where necessary.

Providing FTP history to decision makers

- 2.7 In our audit we found some examples of cases where it was not clear that information about a registrant's FTP history had been provided to the Investigating Committee (or that if the information had been provided, that it had been taken into consideration).

⁵ This case was not closed at this stage, but was referred to a PCT for further investigation. We comment on that aspect of this case at paragraph 2.16, bullet point two.

- 2.8 We think that it is important for decision makers to be given sufficient information to enable them to take a fully-informed decision – including information about previous allegations (and their outcomes) where this may demonstrate a pattern of misconduct or incompetence. Such information may be important in assessing the risk presented by a registrant.
- 2.9 The GDC has told us that it plans to issue new guidance in October 2011 which will include proposals for full disclosure of FTP history to the Investigating Committee. We would encourage the GDC to ensure that the guidance provides clarity for its FTP staff about the information that should be provided to the Committee.

Dealing with substance abuse cases

- 2.10 We found several examples of allegations involving misconduct associated with alcohol, where the GDC had not investigated whether there was an underlying health condition impairing the registrant's fitness to practise.
- 2.11 The experience of other health professional regulators is that routine medical testing in such cases often reveals an underlying substance abuse problem, which may itself be impairing the registrant's fitness to practise. We recommended in our recent performance review of all the regulators that they should adopt the practice of requiring any registrant who has been convicted or cautioned for a drink or drug-related offence to undergo a routine medical examination in order to establish whether their fitness to practise is impaired as a result of ill-health.
- 2.12 We are pleased that the GDC has now adopted a policy of referring cases involving drink-drive convictions for medical assessment. In line with the recommendations made in our performance review, we consider that this policy should also require a medical assessment in cases involving police cautions, as well as in cases concerning drug-related offences (including possession or theft of drugs) or cases where drink or drugs have been a possible cause of alleged misconduct or criminal behaviour. We would encourage the GDC to expand its policy in this area in line with our recommendations.

Evaluation and giving reasons for decisions

- 2.13 In our audit we found some examples of well-drafted closure letters that had been sent to complainants and registrants. These addressed all the allegations and explained in sufficient detail why the GDC had decided not to take further action. However, the quality of closure letters was not consistent across the entire caseload, and we were concerned by the evidence we found of ongoing weaknesses in explaining the reasons for decisions to close cases.
- 2.14 Providing detailed reasons for the decisions taken either by GDC staff or by the Investigating Committee, and ensuring that those reasons clearly demonstrate that all the relevant issues have been addressed, is essential to maintaining public confidence in the regulatory process. Requiring decision makers to provide detailed reasons also acts as a check to ensure that the decisions themselves are robust.

- 2.15 We identified weaknesses in explaining the reasons for closing individual cases. These weaknesses occurred both in cases that were closed by the Investigating Committee, and those closed by GDC FTP staff without referral to the Committee:
- Some letters did not make it clear that all relevant aspects of the allegations had been considered. In some cases that involved more than one GDC registrant, the letters sent to communicate the reasons for closure did not make it clear that each aspect of the case against each registrant had been properly addressed.
 - We found several examples of cases where the Investigating Committee had not explained why it was not referring a case for a hearing, despite the Committee finding some evidence to support some aspects of the allegations. Often in such cases the matter was dealt with by issuing a warning letter or a letter of advice. We do not think that the decisions to close these cases in this way were unreasonable. However, we are concerned that the failure to provide complainants with sufficient details about the reasons for the outcome of their cases in these circumstances could undermine their confidence in the regulatory process.
 - We noted that the standard letter that the GDC sends to complainants informing them that the Investigating Committee has decided to issue a warning letter does not make it clear whether or not the warning will be published. The GDC plans to review its standard letters to make it clear which warning letters will be published and which will not be published.
- 2.16 We had some minor concerns about the consistency of the GDC FTP staff's decision making at the initial assessment stage. A case can only be closed by GDC FTP staff without referral to the Investigating Committee if it does not amount to an allegation that a GDC registrant's fitness to practise is impaired. However, we audited two cases which, in our view, concerned potential allegations of impaired fitness to practise - but which were not referred to the Investigating Committee by the staff at the initial assessment stage:
- The first case concerned (amongst other matters) an allegation of treatment without consent. The GDC FTP staff wrote to the complainant to say that the complaint did not amount to an allegation of impaired fitness to practise. We consider that the letter did not explain how the GDC had reached this view, and this is of particular concern given our view that the complaint did in fact appear to concern a fitness to practise issue.
 - The second case⁶ concerned an allegation of clinical incompetence and deliberate mistreatment, causing injury. The GDC FTP staff decided to refer the matter to the PCT for 'local resolution'. The letter that was sent to the complainant to explain how the GDC were dealing with the matter said that the PCT 'would be best placed to establish the events that took place and could possibly question [the dentist] and his dental assistant... The Council will re-assess your complaint once the PCT has completed its investigation'. We consider that as the complaint clearly concerned a fitness to practise

⁶ This case was audited by us because it was wrongly identified on the GDC's system as having been closed. In fact the GDC were continuing to monitor the case following referral to the PCT, before reaching a final decision. We consider that, under the GDC's processes, the matter should have been referred to the Investigating Committee for a decision about whether to investigate the case.

issue, it should have been referred to the Investigating Committee – which could have decided whether further investigation was required, and who should carry it out.

- 2.17 We have a further concern that there were delays in contact with the PCT, and no evidence on file of immediate follow-up to ensure the PCT was taking action. There was no evidence that the complainant had been updated about the case by the GDC, seven months after the GDC told the complainant that it was referring the case to the PCT.
- 2.18 We acknowledge that it is unlikely that either of these cases would have been referred by the Investigating Committee for a hearing.

Case management

Timeliness

- 2.19 We found some examples in which cases were referred promptly to the Investigating Committee or to an Interim Orders Committee.
- 2.20 However, we also found several cases in which there was extensive unexplained delay. The following are some examples:
- In two cases, delay in initial consideration appears to have led to the complainants withdrawing their complaints and taking alternative action.
 - One case that was referred promptly to the Investigating Committee was not considered by the Committee for a further five months due to the Committee's workload.
 - In another case, there was a gap of two and half months before the GDC asked the complainant to clarify some information, followed by a further 3 month period of inactivity – which only ended when the complainant chased the GDC.
 - In another case, FTP staff decided to refer a case to the Investigating Committee, but that referral took several months due to the failure to chase up a request for the complainant's consent for the GDC to obtain their medical records.

Risk assessment

- 2.21 Robust risk assessment on receipt of a new complaint and on receipt of further information is necessary to enable the regulator to assess what action should be taken and how the case should be prioritised. In some circumstances the regulator may need to take immediate action – including applying for an interim order preventing the registrant from practising unrestricted while the matter is under investigation, or sending information to another interested body such as a PCT or employer.
- 2.22 In most cases that we audited there was no clear evidence that risk assessment had been ongoing throughout the lifetime of the case. In two cases, although risk assessment had been recorded on the file, we found significant delays in referral

of matters to an Interim Orders Committee. In our view these delays raised risks for both public protection and public confidence in the regulatory process:

- One case (that was eventually referred for an interim order application) was not risk-assessed until three months after receipt. There was then a further delay of eight months before the interim order application was heard by an Interim Orders Committee. The case concerned a number of serious issues with the safety of a registrant's practice in relation to a number of patients.
- In another case (which was referred to the GDC by a PCT) GDC FTP staff decided on initial assessment to refer the case for an application for an interim order. However, there was then a delay of three weeks before the GDC wrote to the PCT to ask them to obtain the patients' consent for release of medical records. There was then a further five month delay before the GDC responded to the PCT's request for assistance on how best to obtain the patients' consent. The allegations concerned poor standards of treatment towards a large number of patients.

2.23 In a third case (concerning an allegation of poor cross-infection control and other clinical competence issues) there was no evidence that GDC FTP staff risk-assessed the case, and there was an unexplained delay of six months before the GDC sought further information from the PCT to help with its assessment of the case. There was a further 10 month delay before the PCT supplied the results of a practice inspection. In our view the delays in this case similarly raise issues about public protection and public confidence.

Quality control in decision-making

2.24 We found one case that had been closed by a single caseworker without validation from another authorised individual. This is contrary to the GDC's policy, which does not permit a single caseworker to close a case. This is a particularly disappointing finding in light of the recommendations we made in our previous two audit reports. We do not consider that the decision to close the particular case raises any public protection concerns. However, we are concerned about the potential implications for public confidence in the GDC of this further failure by GDC staff to comply with the GDC's systems of control. We hope that the GDC will ensure that its new computerised case management system is designed to make such unauthorised case closures impossible in future.

Record keeping

- 2.25 Maintenance of a single comprehensive record of all actions and information on a case is essential for proper management of cases and for good quality decision making.
- 2.26 We found cases where there was evidence of telephone conversations that had taken place and emails that had been sent or received which were not recorded on the file, or where case management information was recorded on a 'post-it' note.
- 2.27 We also found evidence of poor records management in some cases. In one case the GDC had lost a complainant's original document, without having made a copy of it. In other cases, we found that it was not always possible to distinguish

between draft and finalised versions of GDC-generated documents from the case files. This applied both to letters that the GDC had sent and to records of case management meetings.

3. Recommendations

- 3.1 Following our last audit (and the previous one) the GDC gave us assurances that it would take action to address weaknesses in its FTP processes. It is unfortunate that not all of the actions that the GDC intended to take had been fully implemented or had had a noticeable impact on the cases we reviewed during this audit. However, we recognise that this is not surprising in light of the relatively short gap between the last audit and this audit. We also appreciate that the GDC has been going through a period of transition, with major changes to its senior management taking place late in 2010, including the appointment of a new Director of Regulation (who has responsibility for its FTP function). We are confident that the GDC is now aware of the work it needs to do to achieve the necessary improvements to its FTP processes, and that it has plans in place to achieve those improvements within a reasonable timescale.
- 3.2 The GDC has informed us about a number of changes in its FTP processes that are already being implemented, and which we hope will help to address some of the weaknesses we have identified during our audit:

Implementing a new computerised case management system

- 3.3 The GDC plans for a new computerised case management system to be operational by November 2011. In light of our finding (repeated in all of our audits) that cases have been closed by a single caseworker without evidence of the required authorisation, we hope that the GDC will ensure that the new case management system is designed to make unauthorised case closures impossible in future.
- 3.4 The GDC also says that the new case management system, allied with further staff training, should facilitate improvement in the area of records management and that it will also improve the GDC's ability to monitor the progress of cases and the performance of its FTP staff. We consider that the success of the new system is likely to depend to a large extent on good initial design, and sufficient levels of staff engagement, training and feedback during the development, testing and implementation phases. We would encourage the GDC to take this into account in planning for the introduction of the new system.

Increasing the number of Investigating Committee meetings

- 3.5 The GDC has already implemented this measure, and says that it has reduced by 35% the number of cases awaiting first consideration by the Investigating Committee in the five months to July 2011.

Staff resource

- 3.6 The FTP department will stop using short-term “seconded” staff; by November 2011 these will have been replaced by permanent staff. The GDC considers that using secondees has created continuity issues and has presented problems in ensuring adequate staff training.

Improving support for the Investigating Committee

- 3.7 The GDC has recently appointed legally-qualified Committee Secretaries to assist the Investigating Committee. It expects this to result in improvements to the quality and consistency of the Committee’s decision letters.
- 3.8 The GDC will introduce (in the autumn of 2011) guidance to be used by the Investigating Committee in decision making, and by staff in handling cases to be considered by the Investigating Committee. The GDC has told us that this will include proposals for full disclosure of FTP history to the Investigating Committee.
- 3.9 We encourage the GDC to ensure that the guidance provides clarity about the information to be provided. The GDC says that the Investigating Committee has already improved the quality of its decision making, by referring routinely to the ‘realistic prospect’ test when explaining its decisions. We would encourage the GDC to ensure that the guidance assists the Committee to explain the reasons for its decisions about whether or not the ‘realistic prospect’ test has been met in individual cases. This should help to improve consistency and quality of decision making.

Introducing standard operating procedures and quality assurance

- 3.10 The GDC plans to put a permanent Quality Assurance team in place from October 2011. We consider that introducing quality assurance of decisions made by both staff and the Investigating Committee will help the GDC to improve the quality and consistency of those decisions, as well as its communications with complainants and registrants. This should also be assisted by the implementation of standard operating procedures for FTP staff (from October 2011).
- 3.11 We would also hope that the GDC’s new quality assurance process will result in a generalised improvement to the standard of record-keeping on case files. We would recommend that the GDC considers including within its standard operating procedures a requirement to copy and scan letters as signed and sent, and retaining those copies on the file (or taking other steps to ensure that it is clear which version of a document is the finalised one).

Providing staff with access to clinical expertise

- 3.12 The GDC plans to provide FTP staff with access to clinical expertise (the implementation date is not yet confirmed). We consider that this will assist staff.

Medical assessment in drink-drive/drug cases

- 3.13 The GDC plans to introduce a policy of routine medical assessment of registrants who are convicted of drink-drive offences (implementation date not yet confirmed). We consider that this policy should also require a medical assessment in cases

involving police cautions, as well as in cases concerning drug-related offences (including possession or theft of drugs), or cases where drink or drugs have been a possible cause of alleged misconduct or criminal behaviour.

Monitoring of 'high risk' cases

- 3.14 The GDC implemented a new system in April 2011 to monitor high risk cases separately from the rest of the caseload. The GDC also says that the new electronic case management system (CMS) that it is introducing will enable it to impose targets on the management of medium risk cases.

Reviewing standard letters

- 3.15 The GDC plans to carry out a review of its standard letters – in particular to make it clear which warning letters will be published and which will not be published. We recommend that the GDC puts in place clear criteria relating to the publication of warning letters.
- 3.16 We recommend that the GDC ensures that each of its planned improvements clearly addresses the issues we have raised in this and previous audit reports. We will expect to see evidence of the impact that all the GDC's planned changes have had on improving areas of current weakness in the GDC's FTP process in our next annual performance review.

Annex 1: Fitness to practise casework framework – a CHRE audit tool

The purpose of this document is to provide CHRE with a standard framework as an aid in reviewing the quality of regulators’ casework and related processes. The framework will be adapted and reviewed on an ongoing basis.

Stage specific principles

Stage	Essential elements
Receipt of information	<ul style="list-style-type: none"> • There are no unnecessary tasks or hurdles for complainants/informants • Complaints/concerns are not screened out for unjustifiable procedural reasons • Provide clear information • Give a timely response, including acknowledgements • Seek clarification where necessary.
Risk assessment	<p><u>Documents/tools</u></p> <ul style="list-style-type: none"> • Guidance for caseworkers/decision makers • Clear indication of the nature of decisions that can be made by caseworkers and managers, including clear guidance and criteria describing categories of cases that can be closed by caseworkers, if this applies • Tools available for identifying interim orders/risk. <p><u>Actions</u></p> <ul style="list-style-type: none"> • Make appropriate and timely referral to Interim Order panel or equivalent • Make appropriate prioritisation • Consider any other previous information on registrant as far as powers permit • Record decisions and reasons for actions or for no action • Clear record of who decided to take action/no action.

Stage	Essential elements
Gathering information/evidence	<p><u>Documents/tools</u></p> <ul style="list-style-type: none"> • Guidance for caseworkers/decision makers • Tools for investigation planning. <p><u>Actions</u></p> <ul style="list-style-type: none"> • Plan investigation/prioritise time frames • Gather sufficient, proportionate information to judge public interest • Give staff and decision makers access to appropriate expert advice where necessary • Liaise with parties (registrant/complainant/key witnesses/employers/other stakeholders) to gather/share/validate information as appropriate.
Evaluation/decision	<p><u>Documents/tools</u></p> <ul style="list-style-type: none"> • Guidance for decision makers, appropriately applied. <p><u>Actions</u></p> <ul style="list-style-type: none"> • Apply appropriate test to information, including when evaluating third party decisions and reports • Consider need for further information/advice. • Record and give sufficient reasons • Address all allegations and identified issues • Use clear plain English • Communicate decision to parties and other stakeholders as appropriate • Take any appropriate follow-up action (eg warnings/advice/link to registration record).

Overarching principles

Stage	Essential elements
Protecting the public	<ul style="list-style-type: none"> • Every stage should be focused on protecting the public and maintaining confidence in the profession and system of regulation.
Customer care	<ul style="list-style-type: none"> • Explain what the regulator can do and how, and what it means for each person • Create realistic expectations. • Treat all parties with courtesy and respect • Assist complainants who have language, literacy and health difficulties. • Inform parties of progress at appropriate stages.

Risk assessment	<ul style="list-style-type: none"> • Systems, timeframes and guidance exist to ensure ongoing risk assessment during life of case • Take appropriate action in response to risk.
Guidance	<ul style="list-style-type: none"> • Comprehensive and appropriate guidance and tools exist for caseworkers and decision makers, to cover the whole process • Evidence of use by decision makers resulting in appropriate judgements.
Record keeping	<ul style="list-style-type: none"> • All information on a case is accessible in a single place. • There is a comprehensive, clear and coherent case record • There are links to the registration process to prevent inappropriate registration action • Previous history on registrant is easily accessible.
Timeliness and monitoring of progress	<ul style="list-style-type: none"> • Timely completion of casework at all stages • Systems for, and evidence of, active case management, including systems to track case progress and to address any delays or backlogs.

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