

Categorisation of fitness to practise data

A description of UK health and care professional regulators' categorisation of fitness to practise allegations

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About the Professional Standards Authority

The Professional Standards Authority for Health and Social Care¹ promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and voluntary registration of people working in health and care. We are an independent body, accountable to the UK Parliament.

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

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

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

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

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

² The Professional Standards Authority. 2015. *Right-touch regulation – revised* [Online] Available at: <http://www.professionalstandards.org.uk/policy-and-research/right-touch-regulation> [Accessed: 31/10/2016]

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1. Introduction

- 1.1 Recently there has been growing interest in considering how regulators can help to resolve or prevent a problem before it becomes so serious that it requires a regulatory response. In *Regulation rethought*, we observed that regulators have shifted focus towards ‘the prevention of harm and the maintenance of standards ... to achieve greater effectiveness, efficiency, and a reduction in harm to patients’.³ The General Dental Council (GDC) noted that ‘good regulation does not rely on waiting for things to go wrong then taking action after harm has occurred. It focuses effort on reducing the risk of harm occurring in the first place’.⁴ We have observed that data about complaints to the regulator can be used to yield insights that help regulators or others closer to problems to take preventative action.⁵
- 1.2 Health and care professional regulators in the United Kingdom have four main functions: setting standards, maintaining a register, setting standards for and quality assuring education and training and investigating and hearing allegations that a registrant is not fit to practise. The fourth function, known as the fitness to practise (FtP) process, is the focus of this report.
- 1.3 If a complaint is made to the regulator about a registrant, their regulator can initiate an investigation that may result in the regulator taking action against that person’s registration. This is what is known as the fitness to practise (FtP) process. In order to manage FtP cases, all regulatory bodies we oversee record the nature of the case or the allegations within a case. This report seeks to understand how this information is recorded and categorised, implications for improving categorisation (including whether greater consistency would be desirable) and using it to support the reduction of harm. The publication of all of the regulators’ categorisation lists, as part of this project, is an opportunity for regulators to conduct their own analyses and learn from each other.
- 1.4 Part of the Professional Standards Authority’s remit is to encourage improvement in the regulators it oversees. This report shares expertise from all nine regulators on categorising FtP allegations.⁶
- 1.5 The project aims to:
 - Publish all regulators’ category lists for regulators and other organisations to learn from
 - Describe possible future uses for the data held in these lists

³ Professional Standards Authority, *Regulation rethought*, pg.2. Available at: <http://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/regulation-rethought.pdf?sfvrsn=14> [Accessed 28/07/2017]

⁴ General Dental Council, 2017, *Shifting the Balance: a better, fairer system of dental regulation*, pg. 15.

⁵ Professional Standards Authority, *Regulation rethought*, pg. 8. Available at: <http://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/regulation-rethought.pdf?sfvrsn=14> [Accessed 28/07/2017]

⁶ The project looks only at FtP allegation categorisation. For example, it does not analyse how cases are prioritised (this is when a case is categorised according to the urgency with which it needs to be responded to), at quality control or consider other parts of the fitness to practise process, unless they affect or are affected by the allegation categorisation.

- Set out regulators' views on the future of FtP categorisation.
- 1.6 Regulators have different categories and different numbers of categories. The categories have numerous uses such as enabling regulators to judge the success of newly introduced standards, identify the areas of concern for a profession's practice. There are different ways to manage categories such as having more than one category per case, or just one. Sharing this variety gives the opportunity for regulators to learn and advance their own processes where appropriate and translate this data to aid regulatory processes and informing other healthcare stakeholders.
- 1.7 The report is split into four parts. The first part focuses on the current uses of categories, the second analyses the differences in regulators' category lists, the third part looks at the rationales for managing categories, and the fourth considers the future of categorisation. The report also includes an annexe listing the categories used by each regulator. The Authority is grateful for the regulators' assistance in producing this report, through completing questionnaires and discussions.

2. Managing and using categories

Number of categories per case

- 2.1 Each case that passes through the fitness to practise (FtP) process will be categorised under one or more labels depending on the regulator. Seven out of nine regulators permit more than one category attached to a case. The General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) both stated that ‘most cases’ do have more than one category. The General Osteopathic Council (GOsC) ‘categorise and log each concern or allegation within every case’. Meanwhile, the Health and Care Professions Council (HCPC) said that its case management system ‘allows for three different categories of allegation and statutory ground per case’. The General Pharmaceutical Council (GPhC) can have multiple alleged impairment type categories as well as multiple allegation categories assigned.⁷
- 2.2 In contrast, the General Chiropractic Council (GCC) and the General Optical Council (GOC) only attach single categories to a case. The GOC explained that it records the category of the allegation ‘on the basis of the most serious allegation or category that it is associated with’. The optical regulator explained further that if allegations are wide-ranging then a referral can be recorded under ‘multiple (clinical)’ for example. In a review of the GCC’s FtP process, Sally Williams (an independent researcher) observed that more than one allegation could be recorded in a single case, but the ‘case will only have one outcome...and the outcome may reflect some allegations but not others’.⁸ This interesting observation shows that the single categorised outcome of a case may not adequately shed light on the multitude of problems with practice that be found in each FtP case.

How category lists are developed

- 2.3 Regulators have a difficult balancing act in choosing the number of categories they use, and deciding how specific they should be. For example, from the perspective of analysing data to find trends, narrow categories offer detailed views of data but can pose challenges for both identifying wider trends and assigning categories: data analysts sifting through many categories may find numbers too small to be meaningful, whilst category list users may need to sift through a large selection of categories). Meanwhile, if categories are too broad then there will not be enough detail to create meaningful trend analysis. A way to address this quandary is the use of sub-categories. The HCPC noted that it has ‘broken down the broader categories into sub-categories to make sure there is some specificity’. The NMC uses main categories and sub categories as a way of making the data serve

⁷ An alleged impairment type category is assigned at the point a potential case is first assessed, whilst the allegation categories are added as the investigation progresses along with a free text case description field.

⁸ Sally Williams, 2014, *Independent Review of General Chiropractic Council Fitness to Practise Cases 2010 – 2013*, General Chiropractic Council, pg. 10. Available at: <http://www.gcc-uk.org/UserFiles/Docs/Thematic%20review%20of%20ftp%20cases%202010-2013%20PUBLIC%20FINAL.pdf>

multiple purposes. For example, the high level simplified categories are used for 'public reporting' whilst the more detailed lower level categories are used for 'intelligence'. However, three regulators (GOC, GPhC and the Pharmaceutical Society of Northern Ireland) do not use sub-categories.

- 2.4 The need for sub-categories may be determined by how many complaints populate a category. The more complaints there are in a category, the more worthy it is of being broken down into sub-categories. In her review analysing the GCC's FtP allegations, Sally Williams used a category list broken down into the following ascending order of specificity: 'category', 'type' and 'sub-type'. Williams noted: 'Due to the nature of the profession some types of complaints occur much less frequently; for such categories allegations were not broken down'.⁹ This is evident in the GCC's category list where some allegations can be drilled down through multiple categories such as 'Rudeness to patient' below:



Figure 1: Diagram displaying GCC's category parentage for 'rudeness to patient'

- 2.5 The GDC and GMC stressed that their category lists were designed to match guidance and standards expected of registrants. For the GMC this stemmed from *Good Medical Practice*: 'allegations are broken down into the domains of *Good Medical Practice*' and are further broken down to 'ensure clarity'. Health allegations are not dictated by Good Medical Practice but reflect ICD-10 codes.¹⁰
- 2.6 The GDC's allegation category list is aligned to its *Standards for the Dental Team*. The GDC record each allegation under three groups: 'group', 'sub-group' and 'particular'. These operate as so:
- 'Group': corresponds to one of the nine overarching principles of the *Standards* and is the broadest level of allegation category,
 - 'Sub-group' corresponds to particular standards or issues,
 - 'Particular' relates to specific types of treatment or areas within a standard or issue.
- 2.7 Two regulators, GOsC and NMC, worked with other organisations to formulate their lists. The GOsC worked with the National Council for Osteopathic Research (NCOR), the Institute of Osteopathy (professional membership organisation for osteopaths) and the major providers of professional indemnity insurance to osteopaths; these organisations deal with 'virtually all concerns' raised about osteopaths. Working together they formulated a list under the rationale of

⁹ Sally Williams, 2014, *Independent Review of General Chiropractic Council Fitness to Practise Cases 2010 – 2013*, General Chiropractic Council, pg. 9. Available at: <http://www.gcc-uk.org/UserFiles/Docs/Thematic%20review%20of%20ftp%20cases%202010-2013%20PUBLIC%20FINAL.pdf> [Accessed 14/03/2017]

¹⁰ The International Classification of Diseases is a medical classification list which contains codes for diseases, symptoms and other health items.

understanding in detail the circumstances that give rise to a complaint, claim or other concern about an osteopath. The NMC commissioned researchers to look at a sample of 900 cases from the NMC fitness to practise process. The researchers analysed the data to find the most common types of allegation before working with the NMC to create sub-categories.

Altering and improving category lists

- 2.8 Regulators' category lists appear to change infrequently. Changes to categories usually occur because of changes to standards, for example the GMC noted that the introduction of a new English language standard to *Good Medical Practice* necessitated a change to the categories.
- 2.9 The HCPC's role as a multi-profession regulator has affected its category list, as the categories need to be broad enough to cater for the 16 professions it regulates. In 2012, when the HCPC began to regulate social workers in England, all categories were reviewed to ensure they were applicable to social workers.
- 2.10 The GOsC's categories are driven by a collaborative approach between organisations with very different remits. The Data Collection Working Group, which is comprised of the GOsC, the National Council for Osteopathic Research, the Institute of Osteopathy and indemnity insurance providers, meets annually to review the categories, and revise if necessary. The origins of the Working Group lie in research that recommended a common classification system adopted by all osteopathic stakeholders (since 2013), to give a more accurate picture of the nature and prevalence of issues:
- 'The use of a common classification in future would facilitate regular monitoring of complaints, making it simpler to combine datasets, to compute frequencies, and to speedily identify those areas within the Code of Practice that generate most complaints. This will mean that information can be fed back promptly to the profession so that remedial action, such as targeted training and education, can take place'.¹¹*
- 2.11 The collaborating organisations count the number of concerns in each category they have received each year. This numerical data is sent to NCOR who produces a public report analysing the aggregated data.
- 2.12 The NMC commissioned external researchers to undertake research for a new category list. The NMC noted that the original sample of 900 cases, that were analysed and used to create the current category list, may not have included categories which could have been shaped by 'recent external events, legislation changes and policy developments', for example Female Genital Mutilation. The NMC noted that any changes to its case management system and the data structures is restricted by the capabilities of its systems.
- 2.13 The GCC has not changed its category lists since 2013 but it is currently looking at taking the sexual boundaries sub-categories out of the larger category they are

¹¹ Consortium for Delivering Osteopathic Research, 2011, *Complaints and claims against osteopaths: a baseline study of the frequency of complaints 2004–2008 and a qualitative exploration of patients' complaints*, National Council for Osteopathic Research, pg. 11.

currently contained within: 'relationships with patients'. Similarly, it is rare for the GOC to change its category selection as the 31 categories it has cater for all concerns it receives, the last category it added to its category list was 'tumour' about two years ago. The GOC also stated that no external events had shaped its category selection, however in April 2016 'candour' was added to the GOC's standards.¹² The GOC recognises that its category list needs to be revised to 'perhaps incorporate the changes to the new standards' and help cases be categorised by the standards which registrants have breached.

- 2.14 The GPhC observed that over the last year they had received media queries on allegations relating to 'potentially fraudulent misuse of Medicines Use Reviews' within pharmacies. The GPhC's structured allegation categories did not capture this information, thus making it 'challenging and time-consuming' to respond to queries. The GPhC considers its new approach of 'capturing more unstructured data directly' in addition to using the existing structured categories should help to address this problem. When fully rolled out its new Case Tracker system will capture this data.

Using the categories

- 2.15 We asked the regulators: 'Can the categorisation of a case change as it progresses? If so, why?'. In response, a majority (seven) considered that this was possible. However, the HCPC and the GOC cautioned that they were unlikely to change the categorisation for a case during an investigation. For the HCPC, this may be on a case-by-case basis if a Case Manager reconsiders the categorisation of a case, there is no requirement to do so. The GOC changes a category as and when the need arises, the circumstances for this happening is when a more serious allegation outweighs the originally listed allegation. Only a minority of regulators (GCC and GOsC) responded that they would not amend a category once a case was in progress.
- 2.16 The five other regulators who permit category changes mid-case cited reasons such as the possibility that a registrant might be able to 'satisfactorily explain certain elements' which would cause a consideration to be removed (GDC). The GMC explained that throughout the duration of an investigation, it receives information from various stakeholders which 'may add allegations to the case and therefore alter the categorisation'. This may occur if a member of the public complains. Also, as the investigation progresses 'investigators may realise from witness statements that there were additional concerns that could change the categorisation'. According to the NMC, allegation categories could change in a case as it captures these categories at four stages in the process.¹³ The PSNI highlighted the example of a conduct or performance case developing into a health case. The GPhC also talked about the possibility of an investigation unearthing a health issue, and mentioned that a misconduct case could be altered to 'Adverse Physical or Mental Health'. The

¹² As well as categorising allegations, the GOC also records up to two standards for each case that have been allegedly breached.

¹³ The four stages are: upon receipt of referral (screening assessment), screening decision, case examiner decision and final adjudication outcome.

GPhC also mentioned that the completion of a police investigation may result in a case being recategorised from 'Misconduct' to 'Police Caution' or 'Conviction'.

- 2.17 Finally, it is important to remember that classification of allegations is subject to human judgement.¹⁴ No matter how much thought is put into composing category lists, or care taken in producing guidance there is ultimately a dependence on the person assigning the categories to be correct.

¹⁴ Sally Williams, 2014, *Independent Review of General Chiropractic Council Fitness to Practise Cases 2010 – 2013*, General Chiropractic Council, pg. 18. Available at: <http://www.gcc-uk.org/UserFiles/Docs/Thematic%20review%20of%20ftp%20cases%202010-2013%20PUBLIC%20FINAL.pdf> [Accessed]

3. The category lists

- 3.1 The lists of categories of different regulators vary greatly in size. These can be found in the annexe to this report. In general, regulators with smaller registers have smaller category lists than regulators with larger registers.¹⁵ For example, the Pharmaceutical Society of Northern Ireland (PSNI) has three categories, whilst the GPhC has 41 and the General Dental Council has 295.^{16 17} The depth of categories in which regulators delve into specific areas also varies. There may be legitimate reasons for these differences.
- 3.2 One example of category differences between regulators is that only three of the regulators (GMC, GPhC and NMC) mention social media in their category lists. The GPhC lists it once, whilst the GMC has two specific social media categories ‘Fail to maintain trust - social media’ and ‘Breach of confidentiality - social media’. The NMC has made social media into a category with branches of sub-categories beneath.

Social media	Posting inappropriate material	Posting inappropriate material about colleagues
		Posting inappropriate material about employer or NHS
		Posting inappropriate material about general issues
		Posting inappropriate material about other specific individuals outside work
		Posting inappropriate material about patients
		Posting inappropriate material about the nature of their work
		Posting inappropriate material about themselves
		Other
	Other social media activity	Other

Figure 2: Table listing NMC’s categories relating to social media

- 3.3 Differences can be found in how issues of dishonesty manifest in the regulators’ categories. For example, seven of the regulators have categories that specifically

¹⁵ A notable exception to this guide is the HCPC. Although the HCPC has the second highest number of registrants among the nine regulators (it registers 350,333 practitioners), its category list has just 69 categories and 47 sub-categories.

¹⁶ The GPhC’s figure was calculated by adding alleged impairment type categories and current allegation classifications.

¹⁷ GDC’s figure was calculated by only counting each individual ‘detail’. This terminology is explained further in 2.6.

mention honesty or dishonesty. These range from the GCC's sub-category of 'dishonesty'¹⁸ to other regulators which breakdown dishonesty into many different categories. The GMC's category of 'Acting with honesty/ integrity' comprises of 61 sub-categories, such as 'Dishonesty with patients/colleagues' and 'Pressure to go private'. Meanwhile the HCPC breaks down 'Dishonesty' into the following sub-categories, whilst the NMC has broader sub-categories related to dishonesty.

Dishonesty	False claim to qualifications
	Falsifying records
	Fraud
	Fraudulent entry to the register
	Previous employment
	Sick leave – false claims

Figure 3: HCPC 'Dishonesty' sub-categories

Dishonesty	Employment related dishonesty	
	Non work related dishonesty	
	Patient care related dishonesty	
	Other dishonesty	Other

Figure 4: NMC 'Dishonesty' sub-categories

- 3.4 The examples above show where dishonesty is directly mentioned in a category list. Types of dishonesty can also be found in regulators' lists. For example, the NMC has the following sub-categories of employment-related dishonesty: 'Concealing or misrepresenting training or employment record' and 'Collusion to cover up information'. The GOC's category list has no specific category of dishonesty but does have types of dishonesty as categories ('theft' and 'fraud').
- 3.5 Additionally, only two of the regulators directly mention 'candour' in their category lists.¹⁹ The GOsC lists 'Lack of candour' under an over-arching category of 'Conduct', whilst the NMC lists 'Not abiding by duty of candour' under a main category of 'Communication issues'.
- 3.6 We do note that it is possible for regulators to record FtP issues of candour, without specifically mentioning 'candour', through other categories they may be using. For example, the GMC's 'Show respect for patients' category (displayed below) covers issues which could be related to candour.

Maintaining Trust	Show respect for patients	Fail to explain error/issue
		Fail to offer apology
		Fail to rectify harm

¹⁸ This is a single sub-category sitting under an overarching category of 'Probity'. There are seven other sub-categories beneath 'Probity' such as 'Removal of patient records/data from clinic'.

¹⁹ Candour relates to the responsibility of professionals to be honest with patients. Professionals have a duty of candour under the codes set by their regulators.

		Improper relationship with patient
		Inappropriate expression of beliefs

Figure 5: GMC sub-categories of 'Show respect for patients'

- 3.7 Five of the regulators mention 'discrimination' in their category lists. The GOsC has one category of 'Failure to comply with equality and anti-discrimination laws' for discrimination issues. Anti-discrimination laws are probably the basis for the NMC's categories as its category list for discrimination is broken down into the nine protected characteristics of the 2010 Equality Act.²⁰ The regulator with most sub-categories relating to discrimination is the GMC. It has a category of 'Treat patients and colleagues fairly and without discrimination' which is broken down into 30 sub-categories. The extra detail of the GMC's categories can allow a category-assigner to record whether a registrant's discrimination was towards colleagues or patients.
- 3.8 Five of the regulators have categories specifically for professional indemnity.²¹ The GCC, GMC, GOsC and the GPhC all have one category each devoted to indemnity. Only the GDC has more than one category related to indemnity insurance.

Putting patients' interests first	Indemnity	Not having appropriate insurance or indemnity
		Failure or delay in contacting provider

Figure 6: GDC sub-categories of 'Indemnity'

- 3.9 Alongside indemnity, the GCC lists 'Misleading advertising/claims made on website' under the same main category of 'probity'.²² Advertising features across five regulators' categories, featuring in various forms from the GMC's 'False or misleading advertising' to the GOC's 'Advertising Standards Authority'. The GDC has the most exhaustive breakdown of categories related to the subject.

Putting patients' interests first	Advertising	Misleading information on website
		Not displaying information required in advertising guidance
		Endorsing products inappropriately
		Misuse of specialist title
		Misleading information on advertising material

²⁰ The protected characteristics can be found in Section 4 of the Equality Act 2010: <https://www.legislation.gov.uk/ukpga/2010/15/section/4> [Accessed 25/10/2017]

²¹ Under the Health Care and Associated Professions (Indemnity Arrangements) Order 2014, all healthcare professionals are legally required to confirm that they have relevant indemnity insurance.

²² The GCC also has a main category of 'Advertising', which has no sub-categories.

Figure 7: GDC sub-categories of 'Advertising'

3.10 One of the purposes shared by the regulators is to promote and maintain public confidence in the professions they regulate. The GOsC has a sub-category beneath 'Conduct' of 'Conduct which brings the profession into disrepute', whilst the HCPC has a similar category of 'Bringing the profession into disrepute'. Unlike the GOsC's disrepute category, the HCPC's category relating to disrepute is a main category and is not broken down into further sub-categories. The only other regulator to have categories related to public confidence is the GDC. The diagrams below show the two locations within the GDC's category lists which relate to public confidence.

Putting patients' interests first	Attitude	Bringing the profession into disrepute
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Personal behaviour	Personal behaviour	Behaviour not justifying public trust in registrant or profession
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Figures 8 & 9: GDC categories relating to public confidence in the profession

3.11 This section has shown that there is variation in both quantity and content of regulators' category lists. For example, some regulators have as many as three tiers of categories, whilst others will just use one tier to categorise an issue. There are similarities and differences, some which may not be obvious at first glance of the lists, for example the difference between how the GOsC and the NMC categorise discrimination issues (see 3.7).

4. The uses of categories

- 4.1 The role of categories extends beyond simply being a taxonomy: it affects regulators' reporting, internal policies and guidance for registrants. These are broadly summarised in table below. The categorisation of FtP allegations is a fundamental means of organising the nature of allegations received, and feeds into the statutory reporting that is required of regulators. A common response from regulators about how they use categories is that they enable them to look at trends in allegations. The HCPC said this could 'assist with identifying trends and/or any specific policy or research project we are working on'. Analysing trends enables the GOsC to 'better understand patient expectations': understanding patient and public concerns helps the GOsC to 'know where more guidance is needed and the focus and target of any such guidance', and has also informed aspects of development of its new CPD scheme. As the GMC noted, categories also have a role in informing 'internal policy development'.
- 4.2 Categories can be used to measure the effect of new standards. The General Optical Council (GOC) said that it would use categories to interrogate fitness to practise information and analyse how fitness to practise 'referrals link to the new Standards of Practice' introduced in April 2016.
- 4.3 There can be operational uses for categorisation, by informing how resources are allocated to each fitness to practise case. The GCC mentioned that categories help to inform which complaints take the most or least amount of time. This can help with planning resources in the future. The GPhC also uses FtP categorisation in conjunction with a 'complexity measure' (a 'proxy for the seriousness or complexity of the case') to 'help manage individual caseloads'. Most regulators have a case weighting or risk category attached to each case.
- 4.4 The GPhC considers its new FtP case tracker once fully implemented will enable it to better forecast case progression (and the according use of resources). This system will increase flexibility in 'analysing and tracking the nature of cases referred'. The GMC identified a further operational advantage of categorisation, saying that it can be used as a mode of assurance that operations have been completed, as decision makers use detailed categorisation to 'ensure all the allegations have been properly investigated'.
- 4.5 Finally, categories can be of use for regulators when interacting with external stakeholders. Two regulators (GMC and HCPC) noted that categorisation is necessary for regulators to respond to external queries like freedom of information requests. Meanwhile, the GOsC told us that it makes recommendations to education providers, the professional body and insurance providers based on information shaped by categorisation. Documents published to wider public spheres make use of categorisation data, for example the GCC's annual statistics report, the GOC's annual report and the GOsC magazines and ebulletins. The table below has grouped the categorisation uses listed above into three areas: operational (management of regulator's own processes), regulatory (fulfilling the regulator's public protection role) and external (provided to other bodies and the public).

Current uses of categories by the regulators			
	Operational	Regulatory	External
Reporting	X	X	X
Management of resources for cases	X		
Forecasting case progression	X	X	
Assurance that correct information has been collected in a case	X	X	
Measuring the effect of new standards		X	
Identification of trends		X	
Freedom of information requests			X
Publications			X

Figure 10: Table listing grouping category use by area

5. The future of categories

Future uses and trends in categorisation

- 5.1 The scope for categorisation to be used in more innovative ways was highlighted by a few of the regulators. The NMC considered that allegations could be used to establish heat maps of risk areas such as:
- geographical areas
 - settings
 - employers
 - learning environments
 - Accredited Education Institutions
 - and practice areas.²³

The NMC also suggested that intelligence could be used to judge the efficacy of different facets of regulation from 'FtP consistency and sanction effectiveness' to 'registration/revalidation'. The GPhC also aim to improve their data analysis. It hoped its new approach would allow it to analyse FtP cases at a 'greater level of detail: support policy development, identify new issues and support the protection of patients'.

- 5.2 The GMC observed that the information gathered in the FtP process can be used to 'help educate and inform the profession'. More specifically, both the GDC and NMC mention the potential importance of the categories in developing and enhancing feedback loops. A feedback loop in this context is the process by which information collected by a regulator is fed back to registrants in order to improve compliance with standards. The GDC explained that this manifests itself through feeding back into education, quality assurance and continuing professional development.
- 5.3 Operationally, categorisation of FtP could be used for 'informing areas for process change in FtP, generally relating to case lengths'. The GCC believe that this could help it prepare for a more efficient case process. Ideas to use categories for operational improvement purposes were shared by the NMC who suggested that categories could be used for the 'automation of some of [their] processes, management information and corporate reporting'.
- 5.4 Looking ahead, the GOC suggested that the more it and other regulators are publicised, then the higher the referral rate of cases to regulators. With a higher rate of referral comes the possibility of 'more wide ranging' cases than are currently being recorded. Therefore, category lists will need to change to accurately categorise these referrals.
- 5.5 The NMC has suggested changes to midwifery supervision legislation could mean there is a rise in referrals to the NMC about midwives. The NMC suggested that

²³ An Accredited Education Institution is any organisation approved by the NMC to operate nursing and midwifery courses.

they may start to see categories they had not previously seen, as these would originally have been resolved by the Local Supervising Authority. As a result, the NMC said it would monitor all cases where 'Other' had been used for categorisation to ensure the category list is 'fit for the future'.

- 5.6 Categorisation may also have a role in enabling future innovative research. Recently, a team from Coventry University applied a quantitative cluster analysis technique to the Authority's fitness to practise database. The Authority's database is populated by fitness to practise determinations it receives from the nine regulators it oversees. The research used the categorisation that is applied to determinations when they are received for review by the Authority. The research has shown how the different kinds of departure from professional standards group together for the different professions amongst other results.²⁴

Consistency of categories across regulators

- 5.7 All but one of the regulators responded that more consistency of categorisation across regulators would produce benefits. An important potential benefit outlined by a few regulators was the pooling of FtP data to show a fuller depiction of the healthcare landscape. Improving consistency in data categorisation could make it possible to see if certain types of case were shared across multiple professions or isolated to one profession (HCPC). The use of multi-disciplinary teams in healthcare and trajectory towards greater integration of services mean that different professionals are more likely to work together rather than operating in isolation. Consistency of categorisation could bring about a greater understanding of developing issues that touch on more than one profession:

'It would also ensure that we are aware of emerging regulatory issues that could involve different types of healthcare professionals, particularly where allegations arise that involve the different overlapping responsibilities of nurses, doctors and pharmacists for example'

- 5.8 On a similar note, the GDC pointed out that regulators in similar fields can identify common issues and possibly work together on shared solutions. It pointed to the shared 'business element' between pharmacy, dentistry and optical areas as an example of regulatory grouping that could benefit from consistent categories. The PSNI remarked that the 'development of learning and sharing best practice may be facilitated' as a result of more consistency across regulators. This was echoed by the GPhC who thought that it would be 'useful see how the overall shape and nature of caseloads varies between regulators'. Meanwhile, the GCC thought that 'likeminded approaches [to categorisation] across regulators could be used for large scale stats collection'.
- 5.9 However, caution should be applied when making comparisons between regulators with FtP data. The GMC thought that 'different regulators have different powers and

²⁴ R.H. Searle, C. Rice, A.A. McConnell, J.F. Dawson, 2017, *Bad apples? Bad barrels? Or bad cellars? Antecedents and processes of professional misconduct in UK Health and Social Care: Insights into sexual misconduct and dishonesty*, Professional Standards Authority. Available at: <https://www.professionalstandards.org.uk/docs/default-source/publications/antecedent-amp-processes-of-professional-misconduct-in-uk-health-and-social-care.pdf?sfvrsn=0> [Accessed 06/11/2017]

different thresholds in statute'. This means it is possible that different regulators will arrive at different outcomes for the same or similar allegations. The GOsC also cautioned: 'the categories used by regulators may be very different and the nature of cases may vary greatly across different forms of healthcare delivered in many different settings'.

- 5.10 However, the GOsC went on to suggest that not all FtP categories were incomparable between regulators, but that there is likely to be some 'clear overlap' on categories such as 'convictions' and 'health'. There can be significant differences in how these two categories are broken down (if at all) by regulators. For example, the GDC has over 30 different types of conviction (covering areas as diverse as fraud and terrorism), whilst the PSNI only has the category of 'Conduct' to account for conviction allegations.
- 5.11 It is important to note that organisations beyond the professional health and care regulators could also benefit from any FtP data initiatives. The GMC argued that healthcare providers would also benefit from regulators' FtP data being used to illustrate 'areas of risk across the various professions'. Whilst the HCPC suggested that more regulatory consistency in FtP allegations could 'inform external initiatives especially within the NHS'. The HCPC also stated that more consistently categorised FtP data could be 'useful' for helping the public 'understand the concept of fitness to practise'. According to the GOC, bringing more consistency across the regulators in the categorisation of FtP allegations and cases would 'benefit healthcare regulation as a whole' from the perspective of patients' concerns: information recorded by each regulator being 'collated effectively and efficiently in order to gauge what issues/concerns are mostly affecting the public'. Doing this would identify what 'downfalls to be rectified and ultimately the public safeguard from repeated errors, regardless of what sector they relate to'.
- 5.12 It is worth noting that one professional regulator shares FtP allegation information with system regulators: the NMC's system attaches cases to healthcare providers as well as registrants. It has an agreement in place with all four UK system regulators to share details ('if there is a case to answer to or an allegation proved at adjudication') of a case with the appropriate regulator. Therefore, it might be helpful to system regulators if there was more consistent categorisation of allegation across regulators.

6. Conclusion

- 6.1 This report has found a variation in the number, and types of categories across the nine regulators. It has also shown that between regulators, there are differences in the level of detail in which areas are categorised. The differences in lists have come about due to different factors and priorities affecting each regulator.
- 6.2 Regulators operate in a large and diverse healthcare system. There are overlapping responsibilities, scopes of practice and goals. Any improvements made to the consistency and quality of FtP data quality may not just help professional regulators, but also system regulators, providers and other actors beyond the regulatory world. In *Regulation rethought* we mention the need for professional and system regulators and educators 'to share intelligence and alert each other to heightened risk of harms'. We go on to say that this intelligence will support employers in recognising harm, and 'support the development of cultures, workplaces and systems that empower registrants to comply with professional regulatory standards'.²⁵ In modern healthcare with digital tools at disposal, information should not be confined to sector silos such as education and professional regulation. Instead information can and should be shared across sectors as it frequently benefits more than one sector. Categorisation plays an important part in making this possible.
- 6.3 It is not just the outputs of well-categorised FtP data that can reap rewards and involve stakeholders external to regulation, but also the inputs. The GOsC formulated its category list in conjunction with indemnity insurance providers, the Institute of Osteopathy and others. This helped to build a category list that was useful to the entire osteopathic sector. The joint working has provided a list that allows the GOsC to understand all concerns raised and not simply issues that reach FtP, this in turn helps the GOsC fulfil its 'wider role' as a regulator by 'tackling the root cause of concerns'.
- 6.4 This paper has revealed regulators' thoughtful consideration to composing category lists which cater for a regulator's requirements. However, as we mention in 2.17, the application of categories is ultimately dependent upon the discretion of the person assigning categories and inputting data. No matter how much objectivity there is in creating the lists and in organising data, where more than one category exists and even with clear guidance, there is still a dependence on the subjective judgement of the person assigning categories.
- 6.5 Currently, regulators are looking at ways of preventing harm. Analysing cases, within and across professions may result in some useful datasets. In *Rethinking regulation* we wrote that the healthcare sector 'needs to develop a shared understanding of the risks that it is seeking to manage and the harms it is seeking to prevent'.²⁶

²⁵ Professional Standards Authority, *Regulation rethought*, pg.8. Available at: <http://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/regulation-rethought.pdf?sfvrsn=14> [Accessed 28/07/2017]

²⁶ Professional Standards Authority, *Rethinking regulation*, pg. 8. Available at: <http://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/rethinking-regulation-2015.pdf> [28/07/2017]

- 6.6 We mention in the preventive regulation chapter of *Right-touch reform* that regulators do not necessarily 'own' the hazards they may identify through their preventative regulation intelligence, but that they can indirectly mitigate harm. In particular, regulators can provide information to those that can directly mitigate harm: employers, managers, teams, professionals and patients.²⁷ More effective use of category lists might encourage more effective local resolution.
- 6.7 To make FtP data useful for preventative regulation it needs to be capable of generating information that is useful to regulators and organisations upstream in the healthcare system. It is reasonable to hypothesise that greater consistency of categories may help. Generally, we received a positive response to the proposal of more consistency of categorisation.

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²⁷ Professional Standards Authority, *Right-touch reform*, pg. 15.