Quality in other regulated professions

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Introduction

1. Following the Legal Services Consumer Panel's report on consumers' perceptions and understanding of quality, the Legal Services Board (LSB) undertook a literature review of quality in other professions. This was essentially a lessons-learned exercise, assessing quality assurance methods and measures of quality utilised by regulators and professional bodies. We also aimed to identify current levels of quality, where possible, to consider the impact these quality assurance methods were having.

2. The LSB decided to look at the following professions: healthcare; architects; accountants and general financial services.

Healthcare profession

3. "In services with specific 'products'…the process of (quality) measurement appears – at face value – to be relatively easy. However with other services, such as health, the definition and measurement of quality is more problematic" (Sommerlad, 2002; 357).

4. A review on the quality of the NHS (High Quality Care for All, Department of Health, 2008) calls for quality to move focus away from target, activity volumes and waiting times to one that focuses on the experience and outcomes for patients. The review suggests that quality should include the following aspects:

    - Patient safety – ensuring that the environment is safe and clean, reducing avoidable harm such as excessive drug errors.
    - Patient experience – quality of care includes quality of service – how personal care is, e.g. compassion
    - Effectiveness of care – understanding success rates from different treatments for different conditions

5. "The transition from an NHS focused on targets, activity volumes and waiting times to one that focuses on the experience and outcomes for patients has been broadly welcomed" (The Kings Fund, 2010).

6. Another review on measuring quality in the NHS (Information Centre, 2009) highlighted the importance of measurement to support improvements in the quality of services, including:

    - Local clinical teams using measures for benchmarking and day-to-day monitoring
    - Provider organisations reporting on quality to their local communities through quality accounts
    - Commissioners using information on quality in their contracting through the Commissioning for Quality and Innovation (CQUIN) scheme
    - Strategic health authorities and regional quality observatories supporting local measurement initiatives and driving improvement
    - The National Quality Board measuring national priorities and benchmarking performance against other countries

7. Information on quality can be used for various purposes, including:
    - Performance assessment and management (judgement)
    - Incentivising quality improvement (pay for performance)
    - Publication to inform the public and support patient choice
    - Benchmarking against peers for feedback and learning to support quality improvement

8. Information on quality is published by Dr Foster, to aid the public to assess the quality of the healthcare profession. Dr Foster is an independent organisation that monitors the performance of the NHS and provides information and guides to the public. The objective of Dr Foster is to empower users of health services to exercise some degree of choice in their selection of their health service provider. The Dr Foster Unit identifies potential problems in clinical performance and areas of high achievement. The Dr Foster Hospital Guide allows the public to find the hospital best suited for them by providing information, such as the waiting time for treatment and hospitals with high rates of MRSA. One measure of quality Dr Foster uses is mortality ratios as "lower mortality ratios are one marker of good quality care" (Dr Foster, 2010; 11). Out of the 147 trusts reviews, 4 had high deaths after surgery ratios, 141 were as expected and 2 were low. However "although mortality ratios are an important measure for patients when comparing hospital services, they do not tell the whole story of quality of care…to get to the heart of hospital care, patients need other information: infection rates and the staff-to-patient ratio…and the performance and outcomes for consultants and their teams" (Dr Foster, 2011; 14). The Good Hospital Guide is unable to provide the public with information on various issues which may allow the public to measure quality, such as how many people suffer blood clots following treatment and the quality of care for patients after leaving hospital, though the organisation is striving to receive the data to enable them to answer such questions. While the objective of Dr Foster is to allow patients to have a choice based on quality information, the impact may not be as great as possible; a third of patients still say they are not sufficiently involved in decisions about their care (Dr Foster, 2010).

The Council for Healthcare Regulatory Excellence (CHRE)

9. The CHRE promotes the health and well-being of patients and the public in the regulation of health professionals. It oversees nine regulatory bodies that set standards for training and conduct of health professionals:

    - 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)

10. Below, the LSB examines the quality measures and methods of the General Chiropractic Council, the General Dental Council, the General Medical Council, the General Pharmaceutical Council and the Health Professions Council.

11. All healthcare professional regulators hold registers of practitioners who are entitled to practice within a given profession. As well as being a statutory duty, the registers are a valuable tool for public protection, allowing the public and employers to identify professionals who are qualified and fit to practise.

12. Following the CHRE's consultation with the public, stakeholders and regulators, and online research study of registers; the CHRE found that some of the regulators do not provide access to information about healthcare professionals currently prevented from practising because of fitness to practice sanctions. The CHRE, therefore, made the following recommendations:
    - Regulators should provide information about all current fitness to practise sanctions on the online register
    - Regulators should provide information about health professionals who have been struck off on their online register for at least five years
    - Regulators' online registers should share common features to make them credible, useful and accessible. These include:
        - Clear signposting from the regulator's homepage
        - List of current and previous fitness to practise sanctions
        - Ease of navigation to greater levels of detail where available
        - An indication of location of practice
        - A glossary of terms
        - The absence of material that could compromise the credibility of the data, such as advertising

13. While the public are generally reassured by the existence of professional registers, an online research study conducted on behalf of the CHRE found that awareness of healthcare registers and their purpose is low among patients and the public. Many of the participants had never heard of health professionals registers and most had never used one (CHRE, 2010).

General Chiropractic Council (GCC)

14. Individuals who describe themselves as chiropractors in the UK must be registered with the GCC; it is a criminal offence for anyone to describe themselves as a chiropractor unless registered with the GCC. There are currently 2,716 chiropractors registered with the GCC. Members of the public are able to search the register to check registration status.

15. In order to be eligible for registration, individuals must have a GCC recognised chiropractic degree, be of good character, in good health and have professional indemnity insurance for claims up to £3 million. Registrants must also sign a declaration that they have read and understood the professional standards. Professional standards

are outlined in the Code of Practice and Standard of Proficiency. These standards are reviewed on a regular basis. Chiropractic students are introduced to the professional standards throughout their degree and receive copies upon registration.

16. Chiropractors have to apply for retention of registration on an annual basis. There are roughly 2,700 registrants renewing their license to practise in the UK each year. On each occasion, the Registrar must be satisfied that the applicant continues to be of good character and is mentally and physically fit to practise. To assess character, applicants are required to submit a character reference; to prove health at initial registration; applicants are required to submit a GP report – each year after that they must sign a declaration.

17. In the CHRE's performance review (CHRE, 2010) the GCC was found to list those suspended and those struck off their register, to allow members of the public and employers to identify any individuals who are not fit to practice. The GCC also conducts polls of public perception of chiropractors every five years. The latest poll (Ipsos Mori, 2009) found that 64% of the public were aware of the role of chiropractors.

Mandatory Continuing Professional Development (CPD)

18. While the GCC sets and monitors standards of education (GCC, May 2010), they take the stance that "developments within healthcare move at such a pace that no professional should be content to rest on the knowledge and skills gained through their undergraduate education and training" (GCC, 2004). As such, the GCC has developed a mandatory Continuing Professional Development scheme.

19. Individual chiropractors are responsible for identifying their own learning needs and interests. To meet the GCC's requirements, chiropractors identify why they planned to undertake particular learning and how that learning has informed their practice.

20. Chiropractors will need to undertake at least 30 hours of learning activities each year as part of the overall CPD process. A minimum of 15 hours of these must be from learning with others, the remaining 15 hours can be learning with others or on their own, including reading articles and accessing the internet.

21. Chiropractors are required to record how they meet the 30 hour requirement and complete a summary sheet each year and submit it to the GCC when applying for annual registration, declaring that the contents of the summary sheet is a true reflection of the individual's CPD that year. The GCC ensures that the form indicates that the individual has undertaken at least 30 hours learning in the CPD year (15 of which is learning with others), completed one full learning cycle in the CPD year, related their learning to improving patient care and/or the development of the profession, and signed and dated the form correctly. The GCC selects a fifth of the profession at random each year, who are required to submit evidence to prove that they are compliant with the CPD requirements. This means that all of the profession will have been audited over five years.

22. Last year two chiropractors were removed from the register for failing to comply with CPD requirements.

The Test of Competence

23. Foreign qualified applicants must pass the GCC test of competence prior to registration.

Complaints regarding chiropractors

24. The GCC can deal with complaints about chiropractors if they are regarding: treatment, care or advice; any aspect of professional or personal behaviour; and the physical or mental wellbeing of a chiropractor. The GCC cannot deal with complaints regarding companies or clinics, compensation or refund of fees; these are covered by insurance.

25. As all chiropractors are required to have a complaints process, meaning that the public are able to complain to chiropractors first. However, if consumers remain dissatisfied, or wish to make a complaint directly, they are able to complain directly to the GCC.

26. In 2010, the Investigating Committee considered 27 non-claims complaints (GCC, Annual Report 2010). Where the Investigating Committee considers there is 'a case to answer' complaints will be passed to the Professional Conduct Committee. If the Professional Conduct Committee finds the chiropractor guilty of Unacceptable Professional Conduct, they can impose one of the following four sanctions:

    - Remove registration
    - Suspend registration for any period up to three years
    - Impose a Conditions of Practice Order for any period up to three years
    - Admonish

Auditing

27. The GCC does not have the statutory power to routinely conduct an inspection or audit of individual registrants' performance. The GCC shall first need evidence to support concerns about an individual's conduct or performance before looking at the specific matters of concern through their statutory fitness to practise procedures. The GCC, like other healthcare regulators, is considering revalidation, an example of which is discussed later, though the GCC will develop its own requirements.

General Dental Council (GDC)

28. All dentists, dental nurses, dental technicians, clinical dental technicians, dental hygienists, dental therapists and orthodontic therapists must be registered with the GDC to work in the UK.

29. Registration with the GDC depends upon certain criteria. The overseas registration exam (ORE) is a two part exam which tests the clinical skills and knowledge of dentists who are not eligible for registration or assessment.

30. Everyone who joins the register must demonstrate that they possess specified qualifications (or pass an assessment), and that they meet health and character requirements.

31. The CHRE's performance review of healthcare regulators' registers (CHRE, 2010) found that while the GDC's register listed individuals who had been suspended it did not list those who had been struck off.

Specialist Lists

32. Dentists registered with the GDC may apply to join one of 13 Specialist Lists. Dentists are required to meet conditions to entitle them to use a specialist title. Dentists do not have to join the list to practise any particular speciality, but can only use the title 'specialist' if they are on the list.

33. To obtain entry on the list, dentists must hold full GDC registration and complete a specialist training programme approved by the GDC, allowing them to apply for the award of a certificate of completion of specialist training (CCST) and entry onto the relevant list.

Compulsory Continuing Professional Development

34. CPD is compulsory for all those in the dental profession. Dentists must complete at least 250 hours of CPD over a five year cycle. A minimum 75 of these must be verifiable CPD. Dentists are able to use their own judgement when choosing subjects and activities, though the GDC recommends the following:
    - Medical emergencies – 10 hours per CPD cycle
    - Disinfection and decontamination – 5 hours per CPD cycle
    - Radiography and radiation protection – 5 hours per CPD cycle

Employing trainees

35. Much of a dental nurse's or dental technician's training is carried out on the job. If employing a trainee, a named supervising registrant must take responsibility for supervising a dental nurse of dental technician in training.

36. A dentist is the key registrant, responsible for the behaviours and activities of the dental team. A dentist is legally responsible for employing an unregistered nurse, or other dental care professional, and could be the subject of fitness to practise proceedings in the event of something going wrong.

Indemnity

37. All registrants are required to make sure that there are adequate and appropriate arrangements in place so that patients can claim any compensation they may be entitled to. There is no GDC rule that says individuals must have their own indemnity policy if

they are covered by an employer, but registrants are responsible for checking that they are fully covered by their employment contract.

Revalidation

38. The Revalidation Working Group is developing a system of revalidation in dentistry to be introduced in 2015; a similar system has been developed by the GMC (discussed later), though the GDC's may differ.

Dental Complaints Service (DCS)

39. The DCS is an independent arm of the GDC, charged with complaints resolution for private dental patients.
40. After patients have complained to their dental practice or practitioners, they are able to contact the DCS. The DCS are unable to deal with complaints about NHS treatment, staff matters or commercial issues. For complaints about the competence, conduct or behaviour of clinical staff that raise questions of patient safety, the DCS may decide to recommend that the patient approaches the GDC.
41. From May 2008 to April 2009 the DCS dealt with 1,870 complaints and took 11,483 calls to the complaints hotline. The majority of complaints were caused by treatment pain (31%), followed by cost (19%) and general practice (19%) (DCS, 2009).

Fitness to Practise

42. If dentists or dental care professionals' fitness to practise is called into question by means of a complaint, a conviction or caution, they may be subject to the GDC's fitness to practise processes. Referrals to the GDC's fitness to practise department go through an initial process to establish whether they need further investigation. Matters are then referred to an Investigating Committee, if needed.

General Medical Council (GMC)

43. Doctors must be registered with a license to practice with the GMC to practise medicine in the UK. Only doctors registered with the GMC are allowed to: work as a doctor in the NHS or in private practice; write prescriptions; and sign death and cremation certificates. Organisations, such as the NHS, are required to ensure that the doctors they employ have a license to practise.
44. As expected, the registration process for doctors is the most stringent out of all other professions. There are four main types of registration:

    - Provisional registration – this allows newly qualified doctors to undertake the general clinical training needed for full registration. A doctor who is provisionally registered is entitled to work only in Foundation Year 1 posts
    - Full registration – this is a licence to practise for unsupervised medical practice in the NHS or private practice in the UK. Generally, doctors who have

undertaken a satisfactory period of experience under provisional registration may apply for full registration. Some doctors qualifying from outside the UK may be eligible to apply directly for full registration.

- Specialist registration – since 1 January 1997, it has been a legal requirement that to take up a consultant post in a medical or surgical specialty in the NHS a doctor must be included on the Specialist Register. It is not possible to be entered on the Specialist Register without holding full registration. Some doctors will have completed a period of formal specialist training in the UK certified by the Postgraduate Medical Education and Training Board (PMETB) or its predecessor the Specialist Training Authority (STA). Others will have been awarded qualifications in specialised medicine in the European Economic Area. Others will have been found eligible by the PMETB or the STA following an assessment of the specialist training undertaken.
- GP registration – all doctors working in general practice in the health service in the UK, other than doctors in training such as GP Registrars, are required to be on the GP Register. It is not possible to be entered on the GP Register without also holding full registration.

45. To apply for registration, applicants need to complete an application, pay a fee, provide evidence of their identity, qualifications and good standing and attend an identity check.

46. The general public are able to check whether a doctor is on the Register and if they are licensed to practice. The general public are also able to search the register to identify those who have been suspended and those who have been struck off (CHRE, 2011). If a doctor does not meet the standards set by the GMC, the GMC can limit a doctor's practice, ask them to undertake further training, or stop them from practising altogether.

Maintaining and improving performance

47. According to guidance issued by the GMC in Good Medical Practice, in the view of maintaining and improving performance, doctors are required to:
    - Maintain a folder of information and evidence, drawn from medical practice
    - Reflect regularly on standards of medical practical according to GMC guidance on license and revalidation
    - Take part in regular and systematic audit
    - Take part in quality assurance and quality improvement
    - Respond constructively to the outcome of audit, appraisals and performance reviews
    - Help to resolve uncertainties about the effects of treatments
    - Contribute to confidential inquiries
    - Report suspected adverse drug reactions
    - Co-operate with legitimate requests for information from organisations monitoring public health

Revalidation

48. In late 2012, doctors will be required to regularly demonstrate to the GMC that they are up to date and fit to practise by renewing their license every five years. Public opinion surveys suggest that people expect health professionals to participate in the revalidation

of their registration and that many believe that this already takes place (Secretary of State, 2007).

49. The revalidation process will work as follows:

    - Licensed doctors will be required to link to a Responsible Officer. They will make a recommendation to the GMC, usually every five years, about whether the doctor should be revalidated. The recommendation will be based on the outcome of a doctor's annual appraisals over the course of five years
    - Licensed doctors will be expected to participate in a process of annual appraisal based on their portfolio of supporting information
    - Licensed doctors will need to maintain a portfolio of supporting information which demonstrates how they are continuing to meet the principles and values set out in Good Medical Practice Framework for appraisal and revalidation including:
        - General information – providing context about what they do in all aspects of work
        - Keeping up to date – maintaining and enhancing the quality of professional work through CPD
        - Review of practice – evaluating the quality of professional work. Doctors will need to detail quality improvement activities including clinical audits, review of clinical outcomes or case reviews and detail a significant event (any unintended or unexpected event, which could or did lead to patient harm)
        - Feedback on practice – colleague feedback, patient feedback or review of complaints and compliments

General Pharmaceutical Council (GPhC)

50. The GPhC is the independent regulator for over 70,000 pharmacists, pharmacy technicians and pharmacy premises in England, Scotland and Wales.

51. The GPhC aims to operate a risk-based system of regulation, focusing resources where they believe they are most needed.

52. In order to practise in Great Britain, pharmacists and pharmacy technicians must be registered with the GPhC, proving that they have met the GPhC requirements. It is a criminal offence for anyone to practise as a pharmacists or pharmacy technician if they are not registered with the GPhC.

Education

53. The GPhC requires that all staff working in a pharmacy are appropriately trained for the role they undertake.

54. Qualifying as a pharmacist takes a minimum of five years and includes the following steps:

- Completion of a GPhC accredited Master of Pharmacy Degree (MPharm)
- Completion of one year's pre-registration training, a period of paid employment in a community or hospital pharmacy
- Successful completion of the GPhC's registration exam
- Meeting the fitness to practise requirements for registration as a pharmacist.

55. To become a pharmacy technician, the training consists of two years consecutive work-based experience under the direction of a pharmacist. To qualify as a pharmacy technician, one must complete both a competency-based qualification and a knowledge-based qualification, accredited by the GPhC.

56. Any member of staff involved in the dispensing process, a dispensing assistant, must undertake the relevant modules of the Level 2 certificate in pharmacy service skills.

57. Since 1996, anyone working in a pharmacy who supplies medicine as part of their role, medicines counter assistant, must undertake an accredited medicines counter assistant course, usually around three to six months in length.

Registration

58. Prior to joining the register, a trainee must pass the registration examination, as well as meeting all other registration criteria. In the examination the trainee is required to demonstrate knowledge and understanding by analysing and evaluating practice-based problems.

59. Pharmacists, pharmacy technicians and registered pharmacy premises must renew their registration with the GPhC every year. This involves them completing a declaration stating that they meet the professional, fitness to practise and ethical standards.

Registration of pharmacy premises

60. In order to lawfully conduct a retail pharmacy business, a registered pharmacist must be in charge of the registered pharmacy as the responsible pharmacist.

61. The GPhC will only register pharmacy premises if the principal activity at the premises is the sale of pharmacy medicines and/or prescription only medicines. Owners and superintendent pharmacists of retail pharmacy businesses must adhere to the standards published by the GPhC, including making sure all professional activities undertaken are covered by professional indemnity cover, and having an accessible method of recording incidents.

Securing the safe and effective running of the registered pharmacy

62. The GPhC has strict requirements and recommendations on the running of a pharmacy business.

63. Responsible pharmacists must establish the scope of the role and responsibilities; only take on the role if this is within their professional competence; only be the responsible pharmacist in charge of one registered pharmacy at any given time; and secure the safe and effective running of the pharmacy business at the registered pharmacy before it can undertake operational activities.

64. The pharmacy is legally required to keep a pharmacy record, showing who the responsible pharmacist is on any given date and at any time, meaning that in the event of an error it shows who was accountable.

65. The responsible pharmacist may be absent for up to a maximum period of two hours during the pharmacy's business hours.

The Inspectorate

66. The GPhC, unlike other healthcare professional regulators, has its own Inspectorate. The inspectors have two main roles:

    - Inspection visits – to inspect registered pharmacy premises in order to monitor and secure compliance with relevant legal requirements and professional standards. Every pharmacy will receive a visit at least once every five years.

    - Investigations – to investigate complaints and allegations involving registered pharmacist or registered pharmacy technicians.

67. In addition to the above, inspectors provide advice on compliance issues and liaise with other regulatory and enforcement agencies as well as local Primary Care Organisations

Health Professions Council (HPC)

68. The HPC regulates 15 health professionals: arts therapists, biomedical scientists, chiropodists/podiatrists, clinical scientists, dieticians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists/orthotists, radiographers, and speech and language therapists.

69. All of these professionals have at least one professional title that is protected by law, meaning that only those on the HPC Register can legally use one of these titles.

Register

70. In order to remain registered with the HPC, registrants must meet the following standards:
    - Character – information is required on any criminal convictions and whether they have been subject to a decision by any other regulator. The health professional is required to submit a character reference when first joining the register, signed by someone "of professional standing in the community." After initial registration, the health professional is required to sign a declaration to confirm they are still of good character.
    - Health – assure they are of good health
    - Standards of conduct, performance and ethics – registrants must read and abide by the Standards of Conduct, Performance and Ethics
    - Standards of Proficiency – health professionals must meet these standards, adapted according to each profession

- Standards of education and training – successful completion of an approved programme
- Continuing professional development – all registrants are required to engage in CPD activities. Registrants will need to record their activities in their portfolio and if selected for audit, to complete the CPD profile which will then be assessed by CPD assessors.

71. The HPC is the only regulator we have focused on that requires registrants to renew their license every two years, rather than annually. There is no data to say whether this impacts on the quality of the profession.

Architects

Architects Registration Board

72. The ARB is the UK's statutory regulator of architects. All architects are required to join the register, which is searchable online. In 2009, the ARB prosecuted seven people for misusing the title "architect". There are around 33,000 architects currently registered with the ARB. Architects are required to renew their license annually.

Maintaining competence

73. The ARB requires architects to demonstrate competence on application for registration and throughout an architect's time in practice. After initial registration, demonstrating competence is reliant on the assumption that when existing architects renew their annual ARB registration, they are automatically deemed to have confirmed that they are competent to practise. Applying for retention on the Register is deemed by the ARB as confirmation that competence has been maintained in the previous year. The ARB will only ask an architect for details of activities undertaken if it has reasonable grounds for believing that competence has not been maintained.

74. The Architects Code indicates that architects "are expected to keep their knowledge and skills relevant to their professional work up to date and be aware of the content of the guidelines issues by the Board from time to time." It is believed that architects, and those who intend to register, who can demonstrate that they have the prescribed practical experience are likely to be able to demonstrate that they are competent to practise. The 'prescribed practical experience' is considered to be the undertaking of activities in the practice of architecture, during the period of two years immediately prior to the application. Those wishing to be readmitted to the Register after a period of two or more years out of practice will need to consider relevant activities to present to the Board in support of their application. These could include CPD, teaching or the study of architecture.

75. Other than the competence guidelines and the Code of Conduct, the ARB does not have any formal system of quality assurance.

Complaints and Professional Conduct Committee

76. In 2009, the ARB dealt with 414 potential complaints. The most common complaints about architects are a failure to set out their terms of engagement properly in writing and failing to deal with complaints or disputes about their professional work.

77. The Professional Conduct Committee (PCC) is the disciplinary tribunal to hear allegations of unacceptable professional conduct and serious professional incompetence against architects. From July 2010 to June 2011, 15 architects were found guilty of either unacceptable professional conduct or serious professional incompetence. Out of these, seven were fined, five were reprimanded, two were 'erased' and one was suspended (cited on ARB website).

The Royal Institute of British Architects (RIBA)

78. The RIBA is a professional body for architects in the UK. Around 70% of registered architects are RIBA members (cited on ARB website). RIBA Memberships culminates with professionals becoming an RIBA Chartered Architect. Accreditation to the scheme confirms that practices or individuals have achieved the “gold-standard” in architecture.

79. To become an RIBA Chartered Practice the firm will need to demonstrate the following:

- At least one of the full-time directors or partners are RIBA Chartered Members and on the ARB register
- All architectural work must be supervised by an RIBA Chartered Member who is on the ARB register
- At least one in eight staff must be on the ARB register, or an Associate Member of the RIBA or a CIAT member with RIBA Affiliate Membership
- At least one in ten of all staff must be an RIBA Chartered Member of Associate Member of the RIBA
- A commitment to paying at least national minimum wage to students
- All practices with two or more staff will be required to take part in the RIBA Business Benchmarking Survey by 31 December 2011
- A Professional Indemnity Insurance Policy
- A written employment policy in place which addresses the principles of the RIBA policy statement on employment
- An appropriate CPD framework in place
- Must operate a Quality Management System
- Must operate a Health and Safety Policy
- Must operate an Environmental Management Policy

80. All chartered members must carry out at least 35 hours of Continuing Professional Development (CPD). The RIBA use the CPD record as evidence of the steps architects take to maintain competence. From September 2011, the RIBA CPD Core Curriculum states that of the required hours, 19 ½ will need to be from amongst the syllabus listed below, plus two hours on health and safety. The subject matter of the remaining hours is up to the individual:

    - Climate: sustainable architecture
    - External management: clients, users and delivery of services
    - Internal management: professionalism, practice, business and management
    - Compliance: legal, regulatory and statutory framework and processes
    - Building procurement and contracts
    - Designing and building it: structural design, construction, technology and engineering
    - Where we live: communities, urban and rural design and the planning process
    - Context: the historic environment and its setting
    - Access for all: universal/inclusive design

The RIBA Quality Management System

81. The RIBA offers Chartered Practices the RIBA Quality Management Toolkit which was developed as a self help tool to assist businesses to install their own quality management system. Use of this toolkit aims to help businesses produce a system suitable for external assessment and third-party certification

Accountants and actuaries

The Financial Reporting Council (FRC)

82. The FRC oversees the regulatory activities of the professional accountancy bodies and operates independent disciplinary arrangements for public interest cases involving accountants and actuaries. The FRC's functions are exercised by their operating bodies:
    - The Accounting Standards Board
    - The Auditing Practices Board
    - The Board for Actuarial Standards – which sets actuarial technical standards in the UK
    - The Professional Oversight Board – which oversees the way in which the Profession regulates its members acting in their professional capacity
    - The Financial Reporting Review Panel
    - The Accountancy and Actuarial Disciplinary Board (AADB) – which operates an investigation and discipline scheme in relation to matters involving members of the Profession that raise issues affecting the public interest in the UK.

83. All these operating bodies aim to "contribute to the achievement of the FRC's own fundamental aim of supporting investor, market and public confidence in the financial and governance stewardship of listed and other entities." The attempts of the operating bodies' to ensure quality are discussed below.

The Actuarial Quality Framework

84. Following the central recommendation of the Morris Review of the Actuarial Profession (2005) that self-regulation of the actuarial profession did not protect the interests of consumers and should be subject to independent oversight and standard setting by the FRC, the FRC assumed responsibility in 2006.

85. There are nearly 6,000 active UK Fellows of the Institute or Faculty of Actuaries, working primarily in life and general insurance. While some actuarial roles in insurance and pensions are reserved to qualified actuaries, other work undertaken by actuaries can also be performed by non-actuaries (FRC, 2008).

86. This framework was developed by the Professional Oversight Board and the FRC following a belief that "It is not enough to tell practising actuaries they must be competent and must act ethically" (The Actuary, 13 January 2011).

87. In the discussion paper (FRC, 2008) prior to the development of this framework it was concluded that actuarial quality was difficult to assess by reference to outcomes, because of the long-term nature of the work undertaken. The 'understanding gap' (identified by the Morris Review, 2005) suggests that users are dependent on actuaries and are restricted to assess actuarial quality. It has been suggested that non-actuaries can rarely rely on a detailed assessment of the actuarial work, but are reassured by factors such as the actuary's professional qualification, the reputation of the actuary's firm and the regulatory regime that applies to actuaries and actuarial information.

88. The FRC, in this framework, developed six main drivers which contribute to actuarial quality:

- Reliability and usefulness of actuarial methods – threats to quality include problems about underlying data and assumptions, poor model design and controls, unforeseen risks and sensitivity of outputs to the assumptions used.
- Technical skills of actuaries – including relevant ability, actuarial training and industry knowledge. Threats include lack of experience and not keeping up to date with the latest academic developments.
- Communication of actuarial information and advice – including transparency and decision-usefulness, and the extent to which it explains the basis for the actuary's work and the uncertainties relating to it.
- Ethics and professionalism of actuaries – including actuaries' integrity and courage, independence of mind, and acting in the public interest. Threats include conflicts of interest, lack of clarity over the actuary's role, and unreasonable pressure to provide the answer sought by the immediate client.
- Working environment for actuaries – including whether this encourages professional quality control. Threats include isolation without effective quality control of individuals or small groups of actuaries.
- Other factors outside the control of actuaries – such as regulation and the demands of non-actuaries. Threats include inflexible regulatory requirements and lack of challenge by non-actuaries.

89. The POB has suggested the Profession might look for:

- A senior actuary or actuaries to provide professional leadership within a firm
- Arrangements for handling conflicts of interest and confidential information
- Controls on competence and quality control, such as checks on individual actuaries' work
- Management of customer relationships, including terms of references, complaints handling and compensation
- Arrangements to support communications with regulators and whistle-blowing (The Actuary, 13 January 2011)

90. This framework is designed as guidance to the profession, and is not a statutory requirement. It has been argued that the specialist training of actuaries means that they are comparatively well prepared for work in particular sectors, compared with other professionals such as accountants who receive a more general training (FRC, 2008).

Quality levels of audit

91. The most common definition of audit quality in academic research is "the market-assessed joint probability that a given auditor will both (a) discover a breach in the client's accounting system and (b) report the breach" (DeAngelo (1981)). This refers to the auditor's technical competence and independence.

92. The extent to which the methodology influence the quality of audit supplied is an area with little research. There is limited research into the link between what methods auditors use and audit quality. One survey study has reported evidence that faced with difficult

technical choices, auditors will favour a compliance approach rather than apply high standards of reporting (Martens et al (1992)).

93. Surveys of members of audit teams have identified that quality threatening behaviours, such as reducing audit work to meet budgets, occur in practice. However, the consequences of such behaviour are difficult to establish due to the data collection method (Pierce et al (2006)).

94. An additional method of firms demonstrating their quality status is through specialisation. An auditor with more specialist industry expertise is likely to be perceived to deliver higher quality audits, with evidence supporting the relevance of expertise as a quality signal (FRC, 2006).

The Audit Quality Framework

95. In 2003, the UK Government undertook reviews of audit and accounting issues. Reforms were announced aimed at raising the standard of corporate governance of listed companies, strengthening the audit profession and providing a more effective system of regulation of the profession. The key elements of the reforms included:
    - Financial reporting – including a requirement for auditors to review and report on an increased amount of the information contained in a company's annual report
    - The regulation of audit – the AIU was created, as described above; the larger audit firms agreed to disclose publicly information regarding their governance and quality control mechanisms; the APB issued new ethical standards for auditors

96. Despite these improvements, concerns were raised about how the changing business environment has made it difficult for companies to reflect the state of their business in financial statements in a way that can be comprehended by non-accountants. Concerns were also raised about the relationship between executive management and auditors; initiatives have been implemented to address this concern, for example, with the requirement set by the APB that lead audit partners rotate every five years (FRC, 2006).

97. It has been argued that it is difficult to determine audit quality as "the essence of an audit report…is a subjective opinion" (FRC, 2006; 17). The audit report informs a reader that, in the opinion of the auditor, the financial statements in question show a true and fair view and have been prepared in accordance with the applicable law. No information is provided about the way in which the auditor has approached the audit, the extent of the audit evidence obtained and the key judgments that have been made. This means that users are reassured by other factors such as the professional qualification, the reputation of the firm and the regulatory regime (FRC, 2006).

98. In the Audit Quality Framework, the FRC believes that the four main drivers of quality are:

- The culture within an audit firm – quality can be driven by firms creating an environment where achieving high quality is valued, invested in and rewarded. Indicators of audit firm cultures that enhance quality include:

- Leadership of firms emphasising the importance of auditors discharging their professional responsibilities
- Respect for the principles underlying auditing and ethical standards
- Partner and staff development systems that promote personal characteristics essential to quality auditing
- Not letting financial considerations drive decisions with a negative effect on audit quality

Threats to an audit firm's culture include:

- Audit leadership having insufficient input into the firm's management decisions
- Over-emphasis on winning and retaining audits
- Over-emphasis on non-audit services
- Excessive cost cutting
- Insufficient importance placed on technical training

- The skills and personal qualities of audit partners and staff – training needs appropriately coordinated with audit work, at all levels, mentoring provided by managers and partners and post-qualification training focused on audit related issues.

- The effectiveness of the audit process - a combination of ethical, auditing and quality control standards together with the firms' audit methodology. High quality technical support needs to be available when the audit team encounters a problem it is not used to. The audit methodology needs to be well-structured. Threats include:
  - Increased use of computerised audit methodologies
  - Insufficient emphasis placed on tailoring audit procedures
  - 'Inhibiting the exercise of judgment'

- The reliability and usefulness of the audit reporting – good communication with audit committees, with the auditor's report being highly standardised

  Factors outside the control of auditors affecting audit quality are good corporate governance, the contribution made by audit committees and the high quality staff of regulators.

The Audit Inspection Unit (AIU)

99. The AIU, part of the Professional Oversight Board, was created to undertake the independent monitoring of audit quality of listed companies and major public interest entities. The AIU was set up following the Government's post-Enron 2003 review of the regulation of the UK accountancy profession.

100. The professional accountancy bodies continue to register firms to conduct audit work with their regulatory activities being overseen by the POB. The audit registration committees of the accountancy bodies receive formal reports from the AIU.

101. Audits of the following entities are within the scope of the work of the AIU. The AIU will review a sample of relevant audit engagements at each firm selected for an inspection visit. The AIU will normally review the last completed audit of an entity.

- All UK incorporated companies with listed equity and/or listed debt
- AIM or Plus-quoted companies incorporated in the UK with a market capitalisation in excess of £50 million
- UK incorporated banks not already included in any other category
- UK Building Societies
- Private sector pension schemes with either more than £1,000 million of assets or more than 20,000 members
- Charities with incoming resources exceeding £100 million
- Friendly Societies with total net assets in excess of £100 million
- UK Open-Ended Investment Companies and UK Unit Trusts managed by a fund manager with more than £1,000 million of UK funds under management
- Mutual Life Offices whose "With-Profits" fund exceeds £1,000 million

102. The AIU allocates its resources according to the relative levels of public interest involved. There are three categories of firms: the Big 4 Firms (consisting of Deloitte & Touche LLP, Ernst & Young LLP, KPMG Audit Plc and PricewarerhouseCoopers LLP); Other Major Firms; and Smaller Firms. The Big 4 Firms are all inspected on an annual cycle, while the Other Major Firms are subject to an extended inspection cycle involving the phasing of work over a period of approximately two years.

103. In addition to the Big 4 Firms, there are currently five other firms undertaking a significant number of audits (more than ten) with the AIU's scope "Other Major Firms". Both the Big 4 Firms and the Other Major Firms are subject to full scope AIU inspecting including a review of their firm-wide procedures.

104. For all other firms which have one or more audit falling within the AIU's scope ("Smaller Firms"), the AIU's work focuses on the review of one or more of these audits.

105. The AIU's monitoring approach intends to be challenging for the firms, based on the following characteristics:

- Focus on the quality of auditing
- Thorough, robust and challenging approach to inspection visits
- Wide-ranging reviews of firm-wide procedures, including an assessment of how the culture within firms impacts on audit quality
- Risk-based selection of individual audits for review
- In-depth reviews of individual audits, addressing identified areas of risk and including critical assessment of key audit judgments made in reaching the audit opinion
- An assessment of the quality of communications with the Audit Committee

106. The AIU reviewed 70 audits at Major Firms (including the Big Four Firms) and found that of these eight were considered to require significant improvement in certain areas (AIU, 2009). In the AIU's review of Other Firms, the extent of issues identified and the

proportion of audits requiring significant improvement was greater than at the major firms; out of the 11 individual audits reviewed significant improvements were identified in certain areas on five of these audits.

107. The AIU's reviews of individual audit engagements of the Big Four Firms indicated that the key audit judgments in relation to financial reporting issues appeared to be appropriate. However, as a result of insufficient documentation, an oral explanation was often required to form a view on the appropriateness of such judgements. It was concluded that insufficient audit documentation reduced the effectiveness of firms' own quality control processes and makes it more difficult to adopt a monitoring approach focusing on key audit judgments. In this report, the AIU inspections found no overall weaknesses in the overall policies, procedures and systems of quality control operated by the firms, and indicated that such procedures and systems should provide reasonable quality assurance. However, the AIU identified certain areas in which it considers that improvements should be made to achieve compliance with relevant standards or to enhance audit quality. The AIU believes that the risks posed should be addressed by each firm.

Other financial services

Financial Services Authority (FSA)

108. The FSA is the independent body that regulates the financial services industry in the UK. They regulate most financial services markets, exchanges and firms. The FSA currently regulates 29,000 firms.

109. The FSA operates as a risk-based regulator. For something to be considered a risk, it must have the potential to cause harm to one or more of the FSA's statutory objectives:

- Market confidence – maintaining confidence in the UK financial system
- Financial stability – contributing to the protection and enhancement of stability of the UK financial system
- Consumer protection – securing the appropriate degree of protection for consumers
- The reduction of financial crime – reducing the extent to which it is possible for a regulated business to be used for a purpose connected with financial crime

The FSA Register

110. Most firms and individuals can only conduct regulated financial activities[1] in the UK if they are 'authorised' by the FSA to do so. However, there are certain firms that can instead be 'registered' with the FSA. The Register is a public record of all the firms, individuals and other bodies the FSA regulates. The Register enables the public to determine whether a firm is authorised by the FSA.

111. Both authorised and registered firms must meet standards and provide the FSA with information so they can monitor the business. Some payment services providers and electronic money institutions can be registered by the FSA instead of authorised. A payment services firm can choose to be registered instead of authorised, where it transfers an average of less than €3 million a month to people or businesses in the preceding 12 months. Registration instead of authorisation causes a potential threat to quality as registered firms do not have to provide the FSA with as much detail about their business or safeguard the funds received from consumers for payment services; the FSA has less power to check on the firm.

Competent employees rule

112. The 'competent employees rule' requires a firm to employ personnel with the necessary skills, knowledge and expertise to discharge the responsibilities allocated to them. The FSA expects firms to assess such individuals as competent (FSA, 2010).

113. In the consultation paper 'Effective corporate governance', the FSA considered whether to apply specific qualification requirements to senior management of regulated firms and decided that their approach to significant influence controlled functions (SIF) is stringent enough to mitigate against the lack of any specific qualification requirements for senior management. The FSA expects the competency that needs to be demonstrated by the SIFs to reflect:

[1] A list of regulated activities can be found here http://www.fsa.gov.uk/Pages/Doing/Do/index.shtml

- The type and size of firm
- The role to be performed
- The mix of skills within the management team in which they are operating

114. A report conducted by the Cattellyst Consultancy on behalf of the FSA sought firms' view on the current training and competence regime. This found that the style of training and competence arrangements varied among firms. Larger firms tended to have a more rigid structure while smaller firms had a more flexible approach. In several firms, training and competence is considered as a compliance requirement rather than as a lever for competitive advantage. However, firms called for greater detail, including examples the FSA considers good practice, as they find it difficult to determine what is sufficient to meet regulatory training and competence expectations (FSA/Cattellyst Consultancy, 2010).

115. The FSA considers the role of a supervisor within a firm as "paramount in ensuring good quality competence assessments within firms" (FSA, 2010; 9). While the FSA allows firms to decide on the most appropriate arrangements, they believe that merely a file check is not adequate supervision.

Consumer protection strategy

116. In 2010, the FSA launched their consumer protection strategy. It set out their approach to be more proactive, with an outcomes-focused style of conduct supervision. The mechanisms for achieving consumer protection include:

- Improving the long-term efficiency and fairness of the market, including initiatives such as the Mortgage Market Review and the Retail Distribution Review, as discussed below

- Delivering intensive supervision of firms, including earlier interventions, as discussed below
- Where failure occurs, securing the appropriate level of redress, and achieving credible deterrence by taking action against firms who fail to meet our standards

117. Historically, the FSA waited for clear evidence that a product had been miss-sold and consumers harmed before it took action.

Supervision

118. The nature and extent of supervision of firms is dependent on how much of a risk the FSA considers them to be. The framework used to assess the risk is called the Advanced Risk-Responsive Operating framework (ARROW). There are two basis approaches within ARROW to supervise firms:

- The ARROW Firms approach – used when assessing risks in individual firms

- The ARROW Themes approach – used when assessing cross-cultural risk (i.e. those involving several firms or relating to the market as a whole).

119. If a firm is assessed as high or medium impact, the FSA coordinates its work through a relationship manager, who carries out a risk assessment on a cycle of one to four

years, determining a risk mitigation programme proportionate to the risks identified. Planned ARROW visits to the firms are also undertaken throughout the regulatory period.

120. The FSA also applies baseline monitoring activities, undertaken for all firms regardless of their impact scores, involving analysing a firm's financial and other returns.

121. If a firm is assessed as low impact it does not have a specific risk assessment or risk mitigation programme. They are usually required to send regulatory reports twice a year. Small firms are given the Firm Contact Centre as a primary contact, instead of a relationship manager. To regulate over 20,000 small firms, the FSA collects information, analyses the data to identify collective risks and investigates matters further, where necessary. The results are communicated through the website and press.

Mortgage Market Review (MMR)

122. The aims of the MMR are to make the market is suitable for all participants and that there is a flexible market which works better for consumers. Essentially, the proposals set out a robust and interventionist approach to constrain irresponsible high-risk lending and borrowing, without restricting flexibility or access for those consumers who can afford to borrow.

123. The proposed changes are:

- Reducing the number of unaffordable mortgages by banning self-certification and requiring income verification for all mortgages
- Making lenders responsible for affordability assessments.
- Strengthening the FSA's arrears rules and banning firms from imposing arrears charges on borrowers who have agreed arrangement in place.
- Improving standards of fitness among individual advisers and "cracking down on rogue individuals" and mortgage fraud by expanding the FSA's Approved Person regime to cover mortgage intermediaries
- Considering banning mortgage loans to borrows who have combinations of risky characteristics.

Retail Distribution Review (RDR)

124. The RDR was launched in 2006 as "a key part of consumer protection strategy." The impetus for this review was the problems with the way investment advice products from financial advisers are designed and distributed, with many products having complex charging structures which are unclear to consumers, and consumers left to rely heavily on advisers, often without the ability to assess the quality of advice. The main reason consumers use a financial adviser is because the adviser provides an easier and more convenient route to finding the best place to invest money. Also, many consumers like to engage with someone who has more experience of the financial market than them. The objective of the RDR is to provide better outcomes for consumers in the form of a market which allows more consumers to have their needs met and for them to understand the products and services available to them.

125. To achieve this, the FSA published new rules requiring:

- Advisory firms to tell consumers how much their services cost and agree with the consumer how much they will pay
- Advisory firms to clearly describe their services as either independent or restricted.
- Individual advisers to adhere to consistent professional standards, including a code of ethics.

126. This means that from 31 December 2012, advisers will either offer totally independent advice from across the market, or restricted advice. Where they offer restricted advice, they will have to explain the nature of the restriction.

127. As the changes will come into effect on 31 December 2012, we are unable to discuss the benefits this will have for consumers. However, consumer research commissioned by the Financial Services Consumer Panel (2008) shows that currently consumers are confused about the type of advice they receive, unable to distinguish between the different types of advisers. Many people are "resigned to not getting the best advice when they talk to a financial adviser" (Consumer Panel Website). The Consumer Panel call for a need to distinguish between "truly independent advice…and mere sales." The RDR, therefore, has the potential to drive up quality of outcomes for consumers, by increasing transparency and consumer understanding. The concept was well received in the consumer research. The idea of a tier system, proposed by the RDR, was also well-received, with the concept of a basic, middle and advanced level of service (according to qualifications and independence) making sense.

Complaints

128. The Financial Ombudsman is the independent body responsible for dealing with complaints that consumers and financial businesses have been unable to resolve themselves.

129. In 2010-11, the Financial Ombudsman handled 206,121 formal disputes/new cases, the majority of which were regarding payment protection insurance (PPI) (51%) followed by banking and credit (31.5%) (Financial Ombudsman, 2010).

Conclusion

130. A key theme that has featured across the regulated professions is the concern caused by the inability of consumers and/or clients to assess the quality of service provided, as found in our literature review on quality of the legal profession. Some regulators, such as the FSA, have tried to address this issue by requiring a more transparent environment and regulating titles such as 'independent' (FSA) and 'specialist' (GMC) while other independent organisations, such as Dr Foster, aim to provide the public with enough information to enable them to judge quality.

131. Some regulators rely heavily on quantitative data to assess quality, for example the FSA who look at financial and other returns of firms; while other regulators rely more on qualitative data, for example the ARB do not have concrete quality assurance systems apart from the competence guidelines and Code of Conduct. It is difficult to say which approach is the best, as some professions' work is easier to assess. The lack of assessment of the quality assurance methods across the professions means that we cannot consider lessons-learned from these professions.

132. A comparison can be made between the quality assurance mechanisms for running a pharmacy and the requirements for running a legal firm. With the emergence of alternative business structures, allowing owners of legal services providers to be open to non-lawyers, the SRA is developing standards for such individuals. Non-lawyer owners with a 10% interest in an ABS will still need to demonstrate their suitability. Many requirements reflect those placed upon solicitors entering the profession, however, there are additional requirements relating to financial status and corporate behaviour. Solicitors are normally deemed fit to manage a firm, however, other managers will need to demonstrate their suitability, with the same test applying to non-lawyer managers and owners.

133. The General Pharmaceutical Council is the only regulator we have covered who requires all potential entrants to sit a registration examination.

134. Overall, it has been difficult to assess the quality and quality methods across the professions. Many rely on generic systems such as Continuing Professional Development and self-declaration. However, others are introducing new schemes, such as 'revalidation' in the healthcare profession, to ensure quality remains once individuals have entered the profession.

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