



**Regulation Matters:
a CLEAR conversation**

Episode 12: Current Research Interests at the Professional Standards Authority **January 8, 2019**

Line Dempsey: Welcome to our podcast, Regulation Matters: a CLEAR conversation. I'm your host, Line Dempsey. For those that may not know me, I'm the senior investigator with the North Carolina State Board of Dental Examiners. I'm on the CLEAR Board of Directors as well as the current chair of the National Certified Investigator Training Committee and Vice-Chair of the Annual Conference Program Committee with CLEAR.

As you may know, the Council on Licensure Enforcement and Regulation, or CLEAR, is an association of individuals, agencies and organizations that comprise the international community of professional and occupational regulation. Our podcast is a chance for you to hear the latest and greatest in our community. Today, I am joined by Douglas Bilton, Assistant Director of Standards and Policy with the Professional Standards Authority in the UK. We're glad to have you with us today. Welcome.

Douglas Bilton: Hello, Line, and thank you very much for inviting me to take part in this conversation.

Line: Absolutely, and thank you for joining me. Today's topic that we'd like to talk about is the current research interests at the Professional Standards Authority. I guess, let me start by asking the first question: Why is the authority interested in research?

Douglas: Well, more than anything else what we're trying to establish is that professional regulation is an evidence-led area of public policy, one where when we develop and improve, we're informed by the best evidence that we can possibly get hold of. We realised a few years ago now that most of the research going on in the sector in the UK was fragmented; it tended to focus internally on regulators' internal processes. What we've been trying to do at the Authority is build better links between the academic world and the world of regulatory practice and to encourage research which really breaks new ground. That could be research which we commission or undertake ourselves, it could mean research which is undertaken or commissioned by the regulators we oversee and they could either do that themselves singly or together in some sort of collaboration, or it could mean bringing research in another field to bear on current regulatory issues that we're looking at where maybe that wouldn't have happened otherwise. Or, alternatively to that, it could just involve getting academics who might

not even have thought about professional regulation as an area of study to be interested in it. What we've tried to do is to commission, and to encourage other people to commission, research which really addresses the big questions in regulation, like, how do we shift the focus so that we're more about preventing professional misconduct rather than reacting after things have gone wrong. And it's been great to see how positively and enthusiastically the sector is engaging with this.

Line: Well, that's great. You mentioned earlier that you're trying to encourage research that would break new ground. Can you give an example of research that is groundbreaking, if you would?

Douglas: Yeah, absolutely. One example that comes to mind is the research that we commissioned from Professor Rosalind Searle of Glasgow University (although she was at Coventry University when she did this piece of work for us, she's doing a bit more which I'll talk about in a moment in her new role at Glasgow). Professor Searle came to us with the idea to look at the data we hold at the Authority about regulators' final fitness to practise hearings (these are the nine health and care regulators that we oversee). The final fitness to practise hearing might be the equivalent in other countries of a discipline committee. What the Authority's role is in relation to these hearings is to review the outcome (that's one of our roles, I should say) and we can take action if we think the decision - a sanction, for example, that's been applied to a registrant - has not protected the public adequately. So, say someone is suspended temporarily from the register when we think they should have been removed, there are various courses of action we can take. Now, because we do this, we've got a huge database of thousands of cases going back several years. And for each of those cases on our database, we have what we call a determination - it's a record of how the panel that heard the case reached a decision, it's a summary of the evidence that was considered and various facts and circumstances about the case.

Professor Searle analysed these as a psychologist, looking at what themes or trends could be observed in the data and looking at questions like, are there any discernible behavioural traits that emerge on the parts of registrants who get into trouble. In doing so, she was drawing on the whole academic literature of Counterproductive Work Behaviour. And the reason we think this work was groundbreaking is we don't think in asking questions in regulation about why people can go wrong in the workplace, we don't think that that particular whole field of literature had been applied before. The report is called "Bad apples? Bad barrels? Or bad cellars?" which pretty much sums up what Professor Searle found - she looked at cases, one, where individuals had been instrumental in breaching professional standards (which are the bad apples). She also talked about bad barrels, where otherwise well-intentioned individuals have been brought down in the standards of their practice for example by being part of a dysfunctional team. And finally bad cellars, which is where problems in the wider system for providing health and care to the public have caused some kind of breakdown in performance at the individual level.

You might ask why we do this, as the Professional Standards Authority which has oversight of the professional regulators of health and care in the UK. I mentioned earlier that one of the things that

we are trying to achieve is a shift in the focus of regulation so that it looks forward and anticipates problems rather than reacting after the fact. When things go wrong, as we all know, it causes harm and it costs time and money, as things are put right but also in the process of referrals to regulators, investigating, holding hearings...the costs just mount and mount to everyone involved. The best way to stop things going wrong is to understand the real reasons and circumstances which result in these situations occurring in the first place, and this may – I say, may; I think I really mean, will inevitably - involve digging very deep into issues of social and individual psychology.

Line: Well, that's very interesting. So, with so many people interested in regulatory development around the world, obviously that's something that CLEAR is very heavily involved with. How do you bring all these things together?

Douglas: Well as you said, the international organisations such as CLEAR and also organisations such as IAMRA are obviously increasingly popular and their events are increasingly well attended. There's a busy scene internationally of people in regulation and in research who are really keen to learn from each other and to help improve regulatory practice. One basic thing that we do to contribute to this discussion at the Authority is publish everything; we've got a policy to publish everything that we do on our website and try and keep colleagues around the world informed about what we're up to.

Also, we've been organizing (I think it's currently our sixth) an annual academic and research conference which has seen increasing attendance from outside the UK. It's held near London, but we've seen more and more people coming from overseas, which is great. Our next one is on 7 & 8 March 2019. We work with an academic partner to help us agree a theme for the conference, we call for presentations to hundreds of people we know as a part of this network, and we put together a programme which we hope speaks to our theme. This year, the theme is "what is it to be a good regulator," working with an academic partner from St George's Medical School in the University of London, who is Professor Deborah Bowman, Professor of Bioethics, Medical Ethics and Clinical Law. That event brings together about 100 people, a mix of people working in regulatory bodies, and academics, and government officials, regulatory lawyers, maybe some management consultants working in the field, and what results has always been a fascinating and rich discussion about current research and ideas for the future. And that's really what we're hoping for - that people go away from the conference thinking with new insights from the research they've heard about that's already happening, but also thinking about ideas for new possibilities for future work.

Finally, just one thing to mention which isn't really about bringing people together, but is about supporting learning across countries. And maybe we don't make too much of this, and possibly we could do more with it. People may know that for a few years now the Authority has been undertaking commissioned performance reviews of regulators outside the UK. So for example, we've worked with the College of Registered Nurses of British Columbia and the Royal College of Dental Surgeons of Ontario, and our reports on their performance are on our website. In those reports that we publish, we always include a section which describes regulatory arrangements in that country for health and

care professionals more generally.

Line: So, why do you do that?

Douglas: We've found that it's a long-standing challenge that if you try and compare different regulatory systems that you quickly run into difficult territory because of the different legislation, different powers, different names for the same thing and the opposite (which can be more confusing) where within that regulatory community a word is used to mean one thing, and it means something completely different somewhere else. So, for example, 'quality assurance' has several different meanings depending where you are in the world when you say it.

What we're trying to do with putting those chapters into the reports is to build up some plainly worded accounts which try and overcome those linguistic barriers and describe in a really straightforward plain language how regulation is delivered, what the relevant law is, and who the organisations are with responsibility for regulating and that kind of thing. And in doing so, what we're hoping to do is to create a set of relatively easy to compare descriptions. At some point it would be really helpful to do something more formal, I mean, with a more rigorous methodology to make sure that when we try and learn from each other (and this is what this is all about) we really are comparing like with like. So when people meet at a conference and talk about the different things that they do, there's a way more formally to take those examples and say, Well, you do this here and it works really well and people are interested in it, but if we're trying to lift it up and transplant it somewhere else, will it work equally well there or what might need to be done to prepare the ground to make something work equally well somewhere else.

Line: Gotcha. Going back to your data and research, when the Authority is thinking about commissioning research, how do you decide what gets taken forward?

Douglas: We get ideas from all sorts of sources, actually. The work I was talking about earlier by Rosalind Searle, the situation was there that she came to us with an idea saying that she'd really like to look into this. We then think about, well what do we think of that? Do we think it will be a useful contribution to the evidence base, do we think it will contribute to patient safety, and of course, do we have the budget available to fund it?

Another source of recommendations for the research that we take forward is reports and investigations, and there's a recent example of this, which is the rapid policy review that's been carried out by Sir Norman Williams into gross negligence manslaughter in healthcare, published in June 2018. And that made a number of recommendations specific to the work of the Authority. One of these was actually very opportune because it's something that's been an issue of concern to us for a while now - to look across professions and look at the consistency of the outcomes of fitness to practice procedures (just to reiterate, that's our equivalent of complaints, investigations and discipline). It's often said that the outcomes are not consistent, in that for some professions they appear to receive

more or less harsh or more or less lenient treatment than others through the processes of the different regulators.

But it's not as straightforward as just looking at cases which are about similar kinds of professional misdemeanor and looking at what happened in the end because there are a lot of factors at play, just to give you some examples....there is the fact that the different regulators are operating to different legislation; individual professions have a different span of responsibility, both generically and in relation to specific jobs they have at that time; there is the fact that through the fitness to practice process there are different provisions for representation (i.e. by lawyers, trade unions or others). These are just a few of a long list of different variable factors that could have an impact on the outcome of a case, and what we don't have at the moment is a methodology specifically designed to adjust for all of these different variables. What we're hoping to move on soon is to work with an academic to really explore all of those different variables and work out what the potential impact is and then to hopefully in the future progress to a full-on research study that looks at the question of the processes being consistent or not. So that was my second area.

And the third is where we at the Professional Standards Authority have decided it's really important to pursue something that we're leading and we're looking for academic researchers to help take things forward. An example of this that we're looking at at the moment is that listeners may know that a few years ago we developed a method for generating advice on the right kind of regulation for any particular group, and we call that method right-touch assurance. In the past, as we all know, there are many examples of the decision about which professional group or which occupation becomes regulated being a political one, or it's determined by other factors such as how well organised the profession is or how skillful they are at lobbying, in pursuit perhaps of the perceived prestige of being statutorily regulated. As the Authority, we can only advise when we are asked on what we think the right form of regulation is, and that could be statutory regulation, that could be a register that's accredited or it could be some other system, an employer-led set of standards, for example. But what we're trying to do is develop that model that we call right-touch assurance so that what it generates is advice that's based on an assessment of risk. This is where we think the right form of regulation should arise from - what is the best way to manage the risks that arise from the practice of a particular profession?

So to come back to your question, we're taking our methodology forward a step, and what we're currently doing is that we're out to tender for an academic or a group to work with us specifically to create a risk calculator which can look at all of the areas of risk that a particular group's work creates and take that, crunch it, and produce advice at the end as to what we think the best form of regulation is.

Line: Well, that's very interesting and quite an undertaking, especially when you consider going across multiple different disciplines. I know with other regulatory bodies, sometimes it's just challenging to have a historical recall of what kind of discipline happened on a particular case 15 years ago in order

to stay consistent with the board's policies moving forward. So that's quite an undertaking. I certainly look forward to hearing more about that. You've talked about research which is quite technical and focused on regulators. Do you also do research directly with the public itself?

Douglas: We do, and there's one piece of work that we're in the early stages at the moment that I was very keen to talk about. And what we're hoping to do, which maybe doesn't sound all that public-focused, but it's about advancing regulatory theory. And in this case, it's about how patients and the public keep themselves safe when they are going through a health or care process. But put like that, that sounds quite technical, but as I'll try to explain, we think that this is something that's going to be really impactful for patient safety in future.

People may be familiar with the fact that in 2015, we re-issued "Right-touch Regulation," which is one of our keynote publications about how we think about regulation. In there, we talked about how different agents of patient safety work together and interact to keep people safe. And those different agents include regulators, employers, health and care professionals, the law, and of course, patients and the public themselves. In different situations, we talk about how those different parties each play their own different part in ensuring that what happens is safe. Now, if we think for example, if someone was going to a professional who they had chosen themselves, such as a private osteopath or a chiropractor maybe for something that was relatively minor, where they the patient were relatively in control and very involved in decisions about what happened. In that kind of situation, you might expect that they would be playing a larger role in keeping themselves safe – more, say than somebody having an emergency process in hospital.

But we've never really taken that idea any further to think about what that role might be or what it might mean to keep yourself safe and what it might be reasonable to expect patients to do. Last year, I was lucky enough to work with Samantha Peters, who until quite recently at the time had been the Chief Executive of the UK General Optical Council, and we worked together on a chapter for a book that was being published by Routledge on trust in different settings. We contributed a chapter on trust in health and care.

Out of that piece of work came the idea of constructive distrust – and we talked about this as being an attitude on the part of the patient where the patient enquires, not in a hostile or aggressive way, but an attitude where the patient feels encouraged and even comfortable to ask questions about what's happening and also to challenge things or to raise their concerns where things don't look right. So it's a frame of mind where the patient would be pretty beady-eyed in looking after their own interests, but not one where they would be obstructive or un-cooperative, which would inevitably lead to problems in delivering care to them.

Having developed this idea a bit, back at the Authority, we started thinking about whether constructive distrust might be a way in to thinking a bit more about what we really meant about patients playing a part in keeping themselves safe. And this is going to be one of our next research

projects. We're at the moment going out to tender to find a company who can work with us to run some public focus groups and do some structured interviews with members of the public to find out what they think of this idea of being constructively distrustful – would they find that an empowering idea, or is it possible by promoting an idea like constructive distrust we might actually undermine people's confidence in the care that they're receiving? Of course the answer to that question will be different for different people, but what we're hoping is that out of the discussion, we understand more about what it is that makes people feel comfortable about speaking up when something doesn't look right, and what it is that makes people feel inhibited. So why do people speak up and why don't think speak up when they maybe think, I don't know why this is happening to me; I can feel that this is happening to me but it doesn't feel right; or I think a mistake is about to be made of some kind.

You might ask again, why are we getting into this so deeply? It's interesting when you talk to people about this idea of constructive distrust, initially that might seem like a quite alien concept which people don't feel easy about and feel that somehow they're taking on too much responsibility for what happens. But then also, when you start talking about it a bit more, people often will tell you about situations where they or somebody close to them have seen something go wrong when they've been receiving healthcare and have or haven't done something about it. And you only need to look at lots of cases where things have gone very badly wrong in health and care and there's almost always someone who knew - and that someone is often the patient. We think that with more insight into what it is that keeps people feeling that they can or can't speak out, and what would make them feel able to speak out where currently they don't – we might be really onto something which could be very impactful in future, because it would help us to target those very specific reasons and by doing so, help us to mobilize patients to possibly prevent things going wrong in the future, without adding or giving them an unreasonable burden. We would only be looking to do something which patients are comfortable with.

Line: Well, I've always been a big fan of constructive distrust. Part of that has probably come over 16 years that I've been working as an investigator with the Dental Board. Obviously being involved in healthcare, you tend to question things and certainly as an investigator, I see plenty of people that have not questioned things as they probably should have, so I really am a fan of that. Finishing up, how can people find out more about what you do?

Douglas: I would suggest the first stop is our website, because we publish everything, all of our completed work there, and that's not just our policy and research reports, but also the work of all of the teams at the Authority, including those who review regulators' final hearing decisions, and also the reports that we publish about the performance of regulators in the UK and outside the UK when we are commissioned to do so. Anyone is very welcome to email me, on douglas.bilton@professionalstandards.org.uk. If anyone is interested in attending our academic conference, to be honest it's not likely I could get you in this year because it looks like we're already full, but I'd be very happy to put you on our list to be invited to future events and to be kept informed about things that we're doing. And we're always happy to receive ideas for the future and to talk

about them with anybody who'd like to talk to us – so please do get in touch.

Line: Well, I'm certainly excited and interested in hearing more about how the research goes in the future, but I do want to take time to thank you for being a part of this podcast with us today. I think it's always wonderful to be able to hear new ideas and have a conversation with other professionals. So, thank you for speaking with us today.

Douglas: Thank you.

Line: And thank you also to those that are listening. We'll be back with another episode of Regulation Matters: a CLEAR conversation very soon. As I'm sure you are aware, we are available on a lot of different podcast apps through Podbean, iTunes, Apple Podcasts, Google Podcasts and Google Play, Stitcher, Spotify, or TuneIn. If you enjoyed this podcast episode, please leave a rating in the comments of the app. Your reviews help us improve our ranking and make it easier for new listeners to actually find us. You can find more information about Douglas and information about our organization, CLEAR, at www.clearhq.org for additional resources and a calendar of upcoming events and training programs that we have coming.

Thank you also to our staff, specifically Stephanie Thompson; she's our content coordinator and editor for this program. I'm Line Dempsey. I'm so happy to bring this podcast to you and I hope to be speaking to you again soon.

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