Response to government consultation – *Promoting professionalism, reforming regulation*

January 2018

1. Introduction

1.1 The Professional Standards Authority for Health and Social Care promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and registration of people working in health and care. We are an independent body, accountable to the UK Parliament. More information about our work and the approach we take is available at www.professionalstandards.org.uk

1.2 As part of our work we:

- Oversee the nine health and care professional regulators and report annually to Parliament on their performance
- Set standards for and accredit registers of practitioners working in health and care occupations not regulated by law
- Conduct research and advise the four UK governments on improvements in regulation
- Promote right-touch regulation and publish papers on regulatory policy and practice.

2. General comments

2.1 We welcome the opportunity to respond to this government[1] consultation on reforming professional regulation in health and social care across the UK. This is a unique opportunity to address the structural and legislative issues that are holding back our regulatory framework. We need a new statutory framework that is fit for the future and allows for a range of models of assurance, to improve public protection for the benefit of patients, the public and service users.

2.2 We encourage the Government to be bold in its reform so that regulation is proportionate to harm and the public are protected. As part of that reform, we urge the Government to close the public protection gap that has arisen as a result of final fitness to practise decisions being taken outside the hearings forum, and therefore beyond the current remit of our Section 29 appeal powers. This means they cannot be challenged if they are insufficient to protect the public. While we support the increased use of consensual disposal these outcomes must be subject to review and appeal in the same way as panel

[1] We use the term 'Government' in this response to refer collectively to the four UK Governments that have put their name to this consultation.

decisions are currently. This layer of assurance is if anything even more important for decisions that are made outside the public forum of the formal hearing. As we know both from our own experience, and from research with members of the public, in the absence of real-time public scrutiny the quality of decisions can be variable, and public confidence harder to maintain.

2.3 We hope that the Government will make changes as a result of this consultation to enable regulation to adapt to fast-evolving health and social care practice and to future workforce needs. We are encouraged to note that this consultation is endorsed by all four UK Governments, and we support the continued UK-wide approach to developing professional regulatory policy.

Preventative regulation

2.4 We were pleased to see that in Question 12, the Government was considering the role of regulators in supporting professionalism, which is an important objective of right-touch regulation. In *Regulation rethought* the Authority recommended that 'protecting patients and reducing harms' should be one part of the shared purpose of the regulatory system. This is a growing area of interest in regulatory research and policy development, and the Authority is keen to progress and clarify thinking in the sector about what is the proper place of regulation in this respect.

2.5 As we said in our 2015 publication *Rethinking regulation*[2] we understand the challenge of harm prevention to mean 'how can regulators, through their interventions and insight, reduce the prevalence of instances of non-compliance with their standards?' Another way that we put the question in *Right-touch reform*[3] was 'how and to what extent can regulators shrink the amount of harm, both through their own interventions and those which are achieved through collaboration'?

2.6 It is important to recognise that the core regulatory functions of registration, quality assurance of higher education, fitness to practise and setting standards are by their nature preventative. Additionally, regulators are all taking forward, through their continuing fitness to practise programmes, ways to prevent harm to patients by supporting and encouraging registrants to remain compliant with regulatory standards throughout their careers. However, there is more that can be done, in particular in the area of data analysis and insight, to assist early identification and action in problematic situations, and to recognise patterns in the circumstances where things go wrong. This analysis should be supported by a number of relevant theoretical frameworks, which we have discussed further

[2] Professional Standards Authority, 2015, *Rethinking regulation*. [Online] Available at: https://www.professionalstandards.org.uk/publications/detail/rethinking-regulation [Accessed 21/12/2017]

[3] Professional Standards Authority, 2017. *Right-touch reform.* Available at: https://www.professionalstandards.org.uk/what-we-do/improving-regulation/right-touch-regulation/reforming-regulation [Accessed 05/01/2018]

in our answers to specific consultation questions, and in detail in *Right-touch reform*.[4]

A single assurance body

2.7 In *Regulation rethought* and *Right-touch reform* we developed our proposal for a single UK-wide assurance body for all health and care professions and occupations. Such a body wold hold a single shared register, would set out common standards, and would receive, investigate and prosecute concerns about breaches of standards. This continues to be our position. We have summarised the arguments in favour of this proposal in response to specific consultation questions, but overall, we believe it would benefit patients, the public and service users by creating a simpler, more efficient regulatory framework that fulfils its public protection role effectively and proportionately.

Right-touch assurance

2.8 We are pleased that the Government is consulting on giving the Authority a formal role in advising on the appropriate type of regulatory oversight for different health and care occupations. The Authority developed *Right-touch assurance: a methodology for assessing and assuring occupational risk of harm©*[5] as a method for assessing the risk of harm presented by different health and care occupations. This method is intended to be used to provide objective advice on what form of assurance is needed to manage the risk of harm to patients and service users arising from the practice of an occupation.

2.9 Regulation must be proportionate to the likelihood of actual harm occurring, rather than an assessment of theoretical harm or a basic assessment of activities that might have the potential for harm.[6] Regulation must not be used for the wrong reasons, such as to enhance the professional status of a particular group or as a knee-jerk reaction to public pressure to regulate. This is because the traditional model of statutory regulation is not always the best way to protect the public. It can be counterproductive if used inappropriately, and wasteful of public resources.

2.10 In *Right-touch assurance* we described a two-stage process to assess the risk of harm and identify the most appropriate solution to mitigate the harm. In the first, we identified three groups of hazards relating to the practice of an occupation from which harm might arise: intervention (the complexity and inherent hazards of the activity); context (the environments in which the intervention takes place); and agency (service user vulnerability or autonomy). The advantage of this approach is that it disciplines us to probe hazards thoroughly and create a risk profile. In the second stage we consider the risk

---

[4] Professional Standards Authority, 2017. *Right-touch reform.* Available at: https://www.professionalstandards.org.uk/what-we-do/improving-regulation/right-touch-regulation/reforming-regulation [Accessed 05/01/2018]

[5] Professional Standards Authority, 2016, *Right touch assurance*. [Online] Available at: https://www.professionalstandards.org.uk/publications/detail/right-touch-assurance-a-methodology-for-assessing-and-assuring-occupational-risk-of-harm [Accessed 21/12/2017]

[6] Professional Standards Authority, 2015, *Right-touch regulation*. [Online] Available at: http://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-regulation-2015.pdf?sfvrsn=16 [Accessed 21/12/2017]

profile against extrinsic factors to establish the level of assurance needed to manage the risk of harm.

2.11 We have previously described a 'continuum of assurance'[7] which shows how, as the risk of harm increases, the regulatory force required to manage that risk also increases. It is important not to see this process as a binary decision of whether or not to apply statutory regulation. Different levels of regulatory oversight range from employer controls, assured registration[8], through to statutory registration in its different forms, and licensing. Different occupations will require differences level of regulatory oversight based on risk of harm.

Fitness to practise

2.12 We support the Government's move to reform fitness to practise, but in our view the proposals do not go far enough. As we have stated in previous publications, and most recently in *Right-touch reform*, [9] the current framework is costly, slow, inflexible, and unnecessarily adversarial. The human cost is felt on both sides – complainants, or referrers as they are more accurately described, are often left feeling dissatisfied and emotionally affected by the process. Registrants also describe being adversely affected by the process in ways that are not necessarily justified by their own behaviour.

2.13 It has become clear to us through our own work and listening to other stakeholders, that there is an appetite among members of the public, registrants, and regulators to move to a less adversarial model for fitness to practise. This is to an extent already taking shape, generally in the form of consensual disposal, through undertakings agreed by case examiners at the end of the investigation. The GMC model, which can be considered the most comprehensive among the nine regulators we oversee, is the model that is proposed in the consultation document for expansion to all. We do not consider this to be sufficient to address the issues identified above.

2.14 What is needed is more radical reform, with the introduction of a model in which all the sanction options are available to the regulator outside the hearing forum, provided the registrant consents. This would involve the registrant admitting the facts and accepting the finding of impaired fitness to practise, along with the sanction offered by the regulator. Any disagreement would lead to referral to a hearing.

2.15 In addition, and this is a crucial point of difference from the current models, outcomes agreed at this earlier stage would need to be scrutinised by an independent body, such as the Authority, with power to appeal it to the Courts if it is insufficient to protect the public. Greater autonomy must be balanced by continued accountability. Previous public inquiries have identified that such accountability needs to be independent of the regulators. As highlighted above,

---

[7] Professional Standards Authority, 2015, *Rethinking regulation*. [Online] Available at: https://www.professionalstandards.org.uk/publications/detail/rethinking-regulation [Accessed 21/12/2017]

[8] Registration of a practitioner on an accredited register.

[9] Professional Standards Authority, 2017. *Right-touch reform.* Available at: https://www.professionalstandards.org.uk/what-we-do/improving-regulation/right-touch-regulation/reforming-regulation [Accessed 05/01/2018]

the absence of this layer of assurance, both under the current undertakings models, and any future more radical reforms, creates a public protection gap, and risks undermining public confidence. Reform of our Section 29 powers so that they cover consensual disposal is therefore necessary whether or not the Government is in a position to bring about more radical reform in fitness to practise.

Education and training

2.16 We note that there are no specific questions on education and training in the consultation. However, the document does reference the Authority's previous comments on the regulators' role in this area and endorses our proposal for a review of regulatory approach and responsibilities for the education of healthcare professionals. Healthcare is provided today by multi-disciplinary teams yet the education sector remains largely uni-professional albeit with some element of inter-professional training. A modern regulatory system would seem to require adjustment also be made to education and training.

2.17 In *Right-touch reform*,[10] we described the range of regulators' approaches to education, and the multiple agencies involved in this area. Whilst the professional regulators' role is seen as very important, many education providers are covered by a range of quality frameworks and are required to supply data to multiple agencies.

2.18 Whilst we acknowledged that progress has been made within the existing legislation to reduce burden and streamline processes, we also highlight a number of challenges. Among these are the changing roles and responsibilities of other bodies, which creates a risk of overlap, and the development of new roles and pathways to training to meet workforce demands. We also set out how higher education regulation is going through a period of substantial change, and discuss the potential impact of leaving the European Union.

2.19 In *Right-touch* reform we also laid out a series of principles to guide further change or wider reform and restate our recommendation of an exercise to map roles and responsibilities in this area. We endorsed the recommendations made by the Law Commissions for a simplified legislative framework in this area which would allow regulators more flexibility to respond to future challenges and adapt their regulatory approach for education and training as required. We highlighted the potential impact of changes in regulatory approach in other areas, such as shared functions and the introduction of a common statement of professional practice.

Registers

2.20 We have found that regulators' registers are generally consistent and clear in how they present information about registrants. We commend this and recommend that regulators continue to maintain a pared-down approach[11] to registers. However, there are variations between regulators' registers such as in

[10] Professional Standards Authority, 2017. *Right-touch reform.* Available at: https://www.professionalstandards.org.uk/what-we-do/improving-regulation/right-touch-regulation/reforming-regulation [Accessed 05/01/2018]

[11] This means regulators should only hold information on the register for public protection purposes.

the length of time registrants' fitness to practise details are displayed. Another area of variation between regulators is the ability to search for erased registrants. Currently only four of the nine regulators have functionality on their registers which allows a register-user to search for an erased registrant and immediately view details about the erased registrant. We believe that public protection would be improved by all nine regulators offering this function.

2.21 The public may benefit from regulators working more closely together, as suggested in question 13 of the consultation document. This could help reduce differences in how registers are presented. We also observe that variation between registers can be eliminated by reducing the number of regulators and incorporating them into a single assurance body (SAB).[12] The SAB would hold a single register of all professionals, this contrasts to the nine registers being held at the moment.

Accredited Registers

2.22 Much of the consultation document focuses on how statutory regulation can be reformed. However, this is a good opportunity to draw attention to possible changes that can be made to improve non-statutory registers of practitioners, specifically accredited registers. We set standards for and accredit registers of practitioners working in health and care occupations not regulated by statute. Public protection could be further improved through changes to the Rehabilitation of Offenders Act and Safeguarding Vulnerable Groups Act to allow accredited registers to require practitioners on their registers to supply a Disclosure and Barring (DBS) check. This would strengthen public protection as registers could more accurately determine if an individual complied with a register's practice requirements or if an individual posed a risk to the safety of service-users.

3. Questions

Q1: Do you agree that the PSA should take on the role of advising the UK governments on which groups of healthcare professionals should be regulated?

3.1 **Response**: Yes. We believe that the Professional Standards Authority combines a level of independence and impartiality with extensive expertise in regulatory policy. This unique position would allow it to provide advice based on an assessment of the evidence of risk of harm to the public. It would be similar to the role it now has now of advising the Privy Council on appointments to Councils.

3.2 We would stress that the purpose of the methodology that we have developed and described in *Right-touch assurance* is to provide well-founded, objective advice and Government will ultimately make decisions on what the most appropriate level of oversight is for an occupation.

[12] See *Regulation rethought* for more information on the single assurance body and a single register. The report can be found here: https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/regulation-rethought.pdf?sfvrsn=16 [Accessed 08/01/2018]

3.3 We do not suggest that the Authority can develop such advice without input and evidence from a range of organisations including those with clinical and workforce expertise. However, in order for such advice to be impartial and based on the best available evidence it is necessary to have a clear separation between those compiling and presenting evidence and those analysing the evidence and developing recommendations on the appropriate response. We therefore also envisage that if the Authority was given this responsibility, the final advice to the Department of Health and Social Care would be provided by an independent panel. This mirrors good practice in many contexts including scientific disciplines to separate data collection or investigation from adjudication or decision making on an issue.

Q2: What are your views on the criteria suggested by the PSA to assess the appropriate level of regulatory oversight required of various professional groups?

3.4 **Response**: *Right-touch regulation* describes the approach we adopt in the work we do. We encourage others to adopt it too.[13] It means understanding the problem before deciding on the solution. It makes sure that the amount of regulatory force is proportionate to the level of risk to the public and that any consequences of regulation are properly considered.

3.5 The phrase 'appropriate level of regulatory oversight' is an important part of this question. The problem to be addressed is the risk of harm to the public, but it is worth noting that there are a range of potential solutions. All too often discussions around regulation fall into presenting it as a binary choice – to regulate or not. Instead we have described in *Rethinking regulation* a 'continuum of assurance'[14] which includes:

- Employer controls - refers to any requirements that employers might put in place to provide assurance of minimum standards of practitioners such as training, qualifications, codes of conduct, supervision and appraisal
- Credentialing - refers to developing a consistent method of validating the identity and legitimacy of external employees with access to healthcare settings. (This is distinct from the General Medical Council (GMC) use of the term credentialing for specific areas of medical practice for doctors who are already on a register)
- Assured registration - refers to the Accredited Registers programme operated by the Professional Standards Authority. The Authority accredits organisations that hold registers of health and social care practitioners who are not regulated by law, against 11 standards

[13] Professional Standards Authority, 2015, *Right-touch regulation*. [Online] Available at: http://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-regulation-2015.pdf?sfvrsn=16 [Accessed 21/12/2017]

[14] Professional Standards Authority, 2015, *Rethinking regulation*. [Online] Available at: https://www.professionalstandards.org.uk/publications/detail/rethinking-regulation [Accessed 21/12/2017]

- Statutory registration and licensing - refers to the legal requirement for registration of health and care professionals who are currently covered by the nine statutory regulators.

3.6 The purpose of regulation is to minimise risk of harm to the public and reduce the likelihood of actual harm occurring. Calls for statutory regulation are often based on a simplistic assessment of theoretical rather than actual risk of harm, misunderstanding of the purpose and extent of control effected by regulation or other reasons such as the desire to enhance the professional standing of a particular group.

3.7 Furthermore, as we have highlighted in our response[15] to the Department of Health consultation on regulation of medical associate professions (MAPs), the assessment carried out on the four MAPs relies primarily on theoretical risk based on the scopes of practice as well as evidence of stakeholder demand for regulation, rather than evidence of actual risk of harm.

3.8 The model we have developed and described in *Right-touch assurance*[16] established clear criteria for assessing the appropriate level of regulatory oversight. It has two stages – the first is to assess the actual risk of harm arising from three groups of hazards: intervention (the complexity and inherent hazards of the activity); context (the environments in which the intervention takes place); and agency (service user vulnerability or autonomy). The advantage of this approach is that it disciplines us to probe hazards beyond those related to the complexity of an occupation and create a risk profile. The second stage is to apply extrinsic factors in assessing the level of assurance needed to manage the risk of harm, for example the size of the professional group, potential impact on workforce and any form of risk management already in place.

3.9 We believe that the model that we have developed has the potential to provide objective advice to those making decisions about any appropriate additional levels of assurance for different occupations based on the raw risk of harm considered against other relevant factors.

Q3: Do you agree that the current statutorily regulated professions should be subject to a reassessment to determine the most appropriate level of statutory oversight? Which groups should be reassessed as a priority? Why?

3.10 **Response**: Yes, some of them. We have previously highlighted that the lack of an objective process for providing advice on the most appropriate form of assurance may have led to regulatory decisions based on incomplete or non-existent evidence of risk of harm. However, we believe that this is not a priority compared to other areas of reform. It is more important to ensure a robust system is put in place to inform future decisions to prevent the unnecessary use

[15] Professional Standards Authority, 2017, Response to consultation on the regulation of medical associate professions in the UK. [Online] Available at: https://www.professionalstandards.org.uk/publications/detail/professional-standards-authority-response-consultation-on-the-regulation-of-medical-associate-professions-(maps) [Accessed 08/01/2018]

[16] Professional Standards Authority, 2016, *Right touch assurance*. [Online] Available at: https://www.professionalstandards.org.uk/publications/detail/right-touch-assurance-a-methodology-for-assessing-and-assuring-occupational-risk-of-harm [Accessed 21/12/2017]

of statutory regulation as opposed to other methods of assurance. When reviewing professions with a view to reducing the regulatory force required it will also be important to consider the potential public protection risks arising from any unintended consequences of reducing or removing statutory regulation from a group that is currently regulated.

Q4: What are your views on the use of prohibition orders as an alternative to statutory regulation for some groups of professionals?

3.11 **Response:** Like all other forms of regulation, prohibition order schemes present both benefits and limitations. Whether or not they are an appropriate response to an identified risk of harm will depend on the level and type of hazards, risks and harms presented by the occupation in question, and existing mitigations – see our above description of the *Right-touch assurance* methodology.

3.12 The Authority's initial review of the feasibility of prohibition order schemes (sometimes known as negative registers) found no evidence to suggest that such a scheme would not be feasible in health or social care. Careful consideration would nevertheless need to be given to the limitations of such a scheme, as compared, say, to an accredited register or forms of statutory regulation. As we have set out in numerous reports, including *Right-touch regulation* and *Right-touch assurance*, regulatory solutions need to be matched to an identified problem of risk of harm.

3.13 We explained in our advice to Government that negative registers are likely to present a number of limitations:

- *'Little positive effect on professionalism and raising of standards - A prohibition order scheme inherently focuses more on what practitioners should not do than on what they should do. It is therefore unlikely to raise standards of competence or foster professionalism in any meaningful way. The scheme would neither set standards nor quality-assure arrangements for qualifying education. There would be no post-registration requirements, and no suitability checks.*
- *Negative impact on the occupation's reputation and morale - Prohibition orders focus on negative actions, and for the most part, the names of individuals whose conduct or performance has fallen short, are published. We do not believe that statutory regulation should be used as a means of enhancing the status or reputation of a profession. That said, it would be worth considering whether the introduction of a prohibition order scheme could have a negative effect on workforce morale, as a consequence of its focus on identifying people who have been removed from practice.*[17] *(We suggest that the introduction of a code of practice with some positive statements about conduct and competence might be one way of counteracting this.)*
- *Action taken under a scheme would always be reactive - Schemes of this kind would only be able to deal with the worst cases of misconduct and only*

[17] Welsh Government, *Domiciliary Care Workforce Improving the recruitment and retention of Domiciliary Care workers in Wales*. [Online]. Pg.30. Available at: http://gov.wales/docs/dhss/consultation/160119document1en.pdf [Accessed 23/01/2018]

after harm has been caused. It would prevent future danger by removing the most harmful individuals from the workforce, however any deterrent effect on other individuals is difficult to assess.

- *Cost and complexity of setting up such a scheme - A scheme in the UK would require new legislation and regulations, which could be lengthy and costly, and create a rigid framework that is difficult to amend. The costs of setting up and maintaining a scheme would be borne by the taxpayer, as there would be no registrants as such to fund the scheme. If employers were asked to contribute that would add another cost to an already financially vulnerable care sector.*
- *Need for effective communication - There would need to be a robust strategy for communicating the code and prohibition scheme to all workers who are covered by it, but also, as it would be a complaints-led framework, to employers and patients. This could add to the cost of such a scheme.*'

3.14 These limitations need to be balanced against a number of potential advantages:

- *'Public protection - An effective prohibition orders scheme would remove from the workforce individuals who present a risk to the public, provided it was effectively enforced.*[18]
- *Public confidence - A scheme would provide the public with some reassurance that any workers from a given occupation about whom concerns had been reported and who had been identified as posing a threat to public safety were unable to practise. It would include a complaints procedure so that anyone, including employers and patients could raise a concern.*
- *Potential to cover multiple occupations - The model has the potential to be applied to multiple groups of unregistered healthcare practitioners as per the established model in New South Wales.*
- *Less costly and complex than full statutory regulation - A scheme would be likely to involve less cost and legislative complexity than full statutory regulation whilst still providing a mechanism to deal with severe cases of misconduct and remove those that may be a danger to the public from the workforce.*'

3.15 In theory, there is no reason why, following a thorough occupational risk assessment, a prohibition order scheme might not present itself as the appropriate regulatory response to the level and type of risk of harm identified. However, in line *with Right-touch assurance*, we would nevertheless urge UK Governments to consider the existing mitigations for risks presented by unregulated workers, and particularly barring schemes such as the Disclosure and Barring Scheme in England.

[18] If the scheme were extended to the self-employed or independent practitioners, it is possible that the onus would be on the patient or service user to check whether the practitioner is on the barred list or refer a practitioner to the scheme, if necessary.

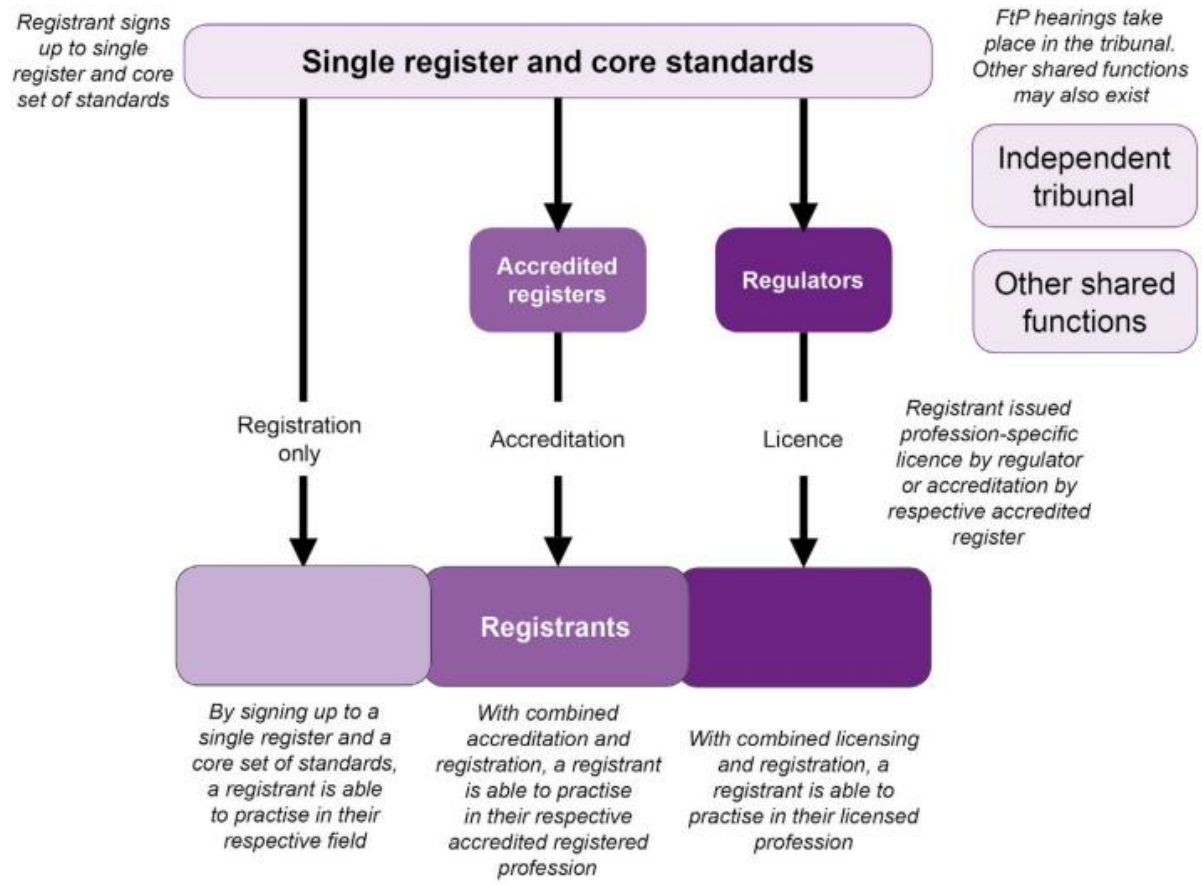
Q5: Do you agree that there should be fewer regulatory bodies?

3.16 **Response**: Yes, we agree that there should be fewer regulatory bodies.

3.17 In our recent publications *Regulation rethought* and *Right-touch reform*, we have developed our proposal that the current arrangements should be replaced with what we have referred to as a single assurance body. Overall, we believe this model would benefit patients, the public and service users by creating a simpler, more efficient model that fulfils its public protection role effectively and proportionately.

3.18 It would be a single UK-wide assurance body for all health and care occupations, responsible for a range of functions for all registered groups, to include publishing a single shared register.

3.19 The body would also be responsible for setting out a statement of professional practice, or common set of standards, which would apply to registrants in all three categories of assurance (registration, accreditation and licensing), as explained in the diagram below.



3.20 The statement of professional practice would define the standards of conduct, behaviour and ethics required of all registrants, irrespective of their profession or occupation. Profession and occupation-specific standards would also be required, tailored to the clinical practice of each.

3.21 We propose that the single body would be responsible for the receipt, investigation and prosecution of concerns about breaches of standards on a

shared basis. An independent tribunal service should perform the adjudication function across all professional groups for whom this type of approach is deemed appropriate.

3.22 Within this structure, regulatory bodies would continue to exist to provide the function of licensing and setting the profession-specific standards. A range of requirements could apply for the award and renewal of the licence, depending on the levels of assurance required, including restricting scopes of practice where necessary.

3.23 Under this proposal, the model would be underpinned by a consistent approach to assessing risk of harm, as we have previously set out in *Right-touch assurance: a methodology for assessing and assuring occupational risk of harm*©. Those presenting the highest risks would require a licence to practise their profession. A second group, those currently under the remit of accredited registers, would be both accredited and registered. In future, this would also cover credentialed groups. A third, those presenting the lowest risk of harm, would simply be required to be registered.

Q6: What do you think would be the advantages and disadvantages of having fewer professional regulators?

3.24 **Response**: We believe that a single assurance body would meet the three principles which we previously set out for change, in that it would be proportionate to the harm it sought to prevent, simple to understand and operate, and effective and efficient. It would enable greater consistency of process and outcome.

3.25 The creation of a shared public-facing register and a licensing system would provide a simple means for the public, employers, commissioners and others to find registered practitioners and to check that they are licensed. It would also provide a single destination for raising concerns. It would help to improve understanding of the purpose of regulation, since the concept of licensing is well understood by the public, in particular in relation to driving licences and the Driver and Vehicle Licensing Agency. Through the language of registration and licensing, the purpose and functions of regulation would be made clearer and more accessible to everyone.

3.26 A single body would be better placed to collect, analyse and thus use fitness to practise and other data to preventative effect across different professional groups and teams. The inconsistencies in how the regulators operate, and the legislation that underpins their work, present a huge challenge when it comes to analysing and comparing data across the different bodies.[19] It would support the development of more flexible models of training, bring greater consistency of approach, improve inter-professional collaboration and learning, and make it easier for training to meet national workforce and health priorities. It would support a consistent approach to registration. The common statement of

[19] We have recently published a report outlining the differences in how regulators categorise their fitness to practise allegation. Available at: https://www.professionalstandards.org.uk/publications/detail/categorisation-of-fitness-to-practise-data [Accessed 08/01/2018]

professional practice would help to improve public understanding of what to expect from health and care workers and when to report a concern to the regulator, and could lead to greater alignment of learning outcomes for students to ensure that joint values were translated into the approach to education and training for all professionals. It would also enable greater consistency of process and thresholds in fitness to practise, as is discussed later in our response.

3.27 We have acknowledged previously that there would be significant transition costs in moving to such a model; however, our work on cost-effectiveness and efficiency in the UK and in Australia suggests the longer-term potential to realise substantial economies of scale once established and operational.

Q7: Do you have views on how the regulators could be configured if they are reduced in number?

3.28 **Response**: The model we propose involves a single assurance body, as set out above, and in more detail in recent publications. If the regulators were reduced in number to less than nine but greater than one, this could be achieved through combinations based on a number of different dimensions of commonality. For example, basis on similarity of training might suggest the merger of the GMC and the GDC; basis on similarity of working environment might suggest a grouping based on high proportion of high-street practice (GDC, GOC, GPhC and PSNI). The smaller regulators might be merged into the HCPC.

Q8: Do you agree that all regulatory bodies should be given a full range of powers for resolving fitness to practise cases?

3.29 **Response**: Yes, although if 'the full range of powers' refers to the powers currently held by the GMC, we consider these proposals to be lacking in ambition. *Right-touch reform* includes a section on fitness to practise with proposals for both short-term and longer-term improvements.

3.30 Regulators will need to maintain their focus on the three limbs of public protection, as set out in the case of Cohen v GMC:[20]

- the protection of patients
- the maintenance of public confidence in the profession, and
- upholding proper standards of conduct and behaviour.

3.31 In time, we believe the regulators should move to a framework where all cases, however serious, can be dealt with consensually if the registrant is willing, without the need for a hearing. The outcomes available at the consensual stage would be the same as those available to a panel:

- Advice (if real prospect test not met)
- Warnings (if real prospect test not met)
- Conditions
- Suspension

[20] Cohen v General Medical Council [2008] EWHC 581 (Admin), [2008]. Available at: http://www.bailii.org/ew/cases/EWHC/Admin/2008/581.html [Accessed 03/12/2017]

- Striking off.

3.32 For maximum flexibility, some of these outcomes could be combined, for example conditions could be issued with a warning, or a suspension with conditions to be met. We support the use of remediation where failings can be effectively addressed in this way. However, before these reforms can be implemented, we need to gain a better understanding of two key aspects of the fitness to practise process:

- What works in remediation: the use of remediation is on the rise, but there is little research available into what types of failing can be remediated, particularly in conduct, and which remediation measures are most effective to address them
- How to ensure that decisions made outside the hearings forum fulfil the public interest: while decisions made behind closed doors may protect the public in the strictest sense, they may fail to maintain public confidence and declare and uphold professional standards. More work is needed to understand what regulators can do, in particular around transparency, to ensure that both the processes and the decisions fulfil the three limbs of public protection.

3.33 We note that the current trend across the nine regulators is towards increasing numbers of decisions made outside the hearing forum. Therefore, whether or not more radical reform comes about, it is essential that the Authority is given the powers to review and appeal to the Courts *all* fitness to practise disposals, both agreed consensually between the registrant and the regulator and imposed at a hearing. This would help to maintain public confidence in fitness to practise – and we know from our research with members of the public that they have less confidence in decisions made behind closed doors. It would restore accountability to the consensual disposal process, and close the loophole that currently allows consensual decisions that are insufficient to protect the public to go unchallenged.

3.34 Finally, we noted in our recent work on fitness to practise that there were significant inconsistencies and a lack of transparency in how cases were sifted out at the initial stages of the fitness to practise process, across the different regulators – both in terms of the process and the thresholds applied. With or without more fundamental reform, this is an area where we would like to see greater consistency and transparency – and in part at least, we believe this can be achieved without legislative change.

Q9: What are your views on the role of mediation in the fitness to practise process?

3.35 **Response**: We are taking mediation to have the meaning used by the Health and Care Professions Council (HCPC):

> 'Mediation is a decision-making process in which the parties, with the assistance of a neutral and independent mediator, meet to identify the

disputed issues, develop options, consider alternatives and attempt to reach a mutually acceptable outcome.'[21]

3.36 The parties between whom mediation would be most likely to occur in the context of professional regulation are the registrant and the referrer - although it is theoretically possible that it could be used between the registrant and the regulator.

3.37 Our recent review of the fitness to practise function published in *Right-touch reform* did not identify a place for mediation. The purpose of fitness to practise is to protect the public (see above), acting in the public interest – it is not to resolve disputes or complaints. This is demonstrated by the fact that the referrer is not a party to the complaint, and neither do regulators act on behalf of the referrer. In addition, there have been concerted efforts by the regulators and ourselves in recent years to move away from the terminology of complaints, to make it clearer to the public that regulation is not about resolving disputes, or finding redress.

3.38 We note that:

- the HCPC and the NMC have powers to use mediation, but do not use them,[22] and
- the GDC and GOC run complaints resolution services for consumer complaints but they are kept separate from their fitness to practise functions; the GDC acknowledges that this service could be funded and run by another body.[23]

3.39 The regulators we oversee receive a large number of complaints that do not give rise to concerns about the registrant's practice or behaviour that engage the three limbs of public protection. A number of these could no doubt be resolved through mediation, but it is not the regulator's role to resolve them in this way. We support the GDC's proposed approach to this issue, which is to encourage better local resolution of complaints, and to work with existing sector bodies, such as the CQC, to raise standards of complaints management. This fits with the view we originally set out in *Right-touch regulation*, that where possible, problems are best addressed close to where they occur.

3.40 In addition, as mentioned above, regulators should set out and publish clear threshold criteria that make sense to members of the public, to reduce the number of complaints they receive that do not have the potential to engage the three limbs of public protection. Finally, we are aware that many referrers will be in a state of distress when they contact the regulator, and suggest that the regulators we oversee continue to make their communications with referrers as

[21] See the HCPC Practice Note on mediation, available at: http://www.hpc-uk.org/assets/documents/10001DDCPRACTICE_NOTE_Mediation.pdf

[22] The HCPC conducted a pilot to explore the possible uses of mediation, and concluded in February 2017 that it had not been successful. More information can be found in the HCPC Council papers, available at: http://www.hpc-uk.org/assets/documents/100052BCEnc6-FitnesstoPractiseMediationPilotupdate.pdf

[23] As explained in the GDC's summary of responses to the proposals in *Shifting the Balance*. Available at: http://www.dentistry.co.uk/app/uploads/2017/12/StB-GDCs-response-to-your-views-and-next-steps.pdf

clear and compassionate as possible. Managing referrers' expectations from the outset about the possible outcomes of the process is an important part of the regulator's role.

Q10: Do you agree that the PSA's standards should place less emphasis on fitness to practise performance and consider the wider performance of the regulators?

3.41 **Response**: No. The Authority's focus on fitness to practise performance is justified by the fact that it is by far the most costly of the regulators' functions, and presents direct risks to the public if not carried out properly. We are currently reviewing our Standards of Good Regulation, as we do periodically, and looking at how we can increase our insight to give a more rounded picture of a regulator's performance, and consider in more detail the regulatory functions that have more of a preventative effect. This may result in a different but no less thorough review of fitness to practise performance than is currently in place.

3.42 More generally, the Authority's work necessarily has a greater focus on fitness to practise because we have powers to review and appeal final fitness to practise decisions, which are not replicable for the other regulatory functions. Our response to Question 11 explains the importance of these powers to public protection.

Q11: Do you agree that the PSA should retain its powers to appeal regulators' fitness to practise decisions to the relevant court, where it is considered the original decision is not adequate to protect the public?

3.43 **Response**: Yes. And these powers should be amended to cover any cases disposed of by case examiners or investigating committees where the allegation has met the real prospect test. This is currently not the case, and there is therefore a real public protection gap.

3.44 Although we welcome the move to a less adversarial process, our section 29 powers are fundamental to public protection and our oversight of the regulators. They were put in place to close a loophole that meant that fitness to practise decisions could be challenged by the registrant, but not by or on behalf of the public. In *Right-touch reform*, we included a review of the decisions we had successfully appealed to illustrate the positive public protection impacts of the individual appeals.[24] We also set out the numerous significant pieces of case law that are a result of our appeals, which demonstrated the broader positive impacts of our powers.[25]

3.45 These powers enable us to drive improvement even when we do not appeal. We issue learning points in cases where our threshold for referral to Court is not met, but where we have identified areas for improvement, either in the way the regulator deals with cases, or in the way panels reach their decisions. As a proportion of the overall number of cases we review, the number of cases that

[24] Professional Standards Authority, 2017, *Right-touch reform, Chapter 3: The future of fitness to practise: from incremental change to radical reform*, p92.
[25] Professional Standards Authority, 2017, *Right-touch reform, Chapter 3: The future of fitness to practise: from incremental change to radical reform*, p93-94.

we appeal and issue learning points for is falling. This shows that our work in this area is helping to improve performance.

3.46 The GMC has acquired a right of appeal over decisions made by the Medical Practitioners Tribunal Service (MPTS). It is nevertheless unable to pursue appeals on grounds of under-prosecution because it would be challenging its own prosecution decisions. This is a power that can only be given to a body like the Authority that is independent of both the regulator and the profession.

3.47 It is therefore necessary for public protection for the Authority to have power to review and appeal all fitness to practise outcomes where the real prospect test has been met. This is regardless of whether the outcome is reached by consent, or at a hearing, and applies both under the current framework, and under any future fitness to practise models. Indeed, our powers would take on even greater importance if the regulators were to be granted greater freedoms to dispose of cases without a hearing, because there would necessarily be a loss of transparency and accountability, and a heightened need to maintain public confidence.

Q12: Do you think the regulators have a role in supporting professionalism and if so how can regulators better support registrants to meet and retain professional standards?

3.48 **Response**: We agree that regulators have a role in supporting professionalism. In *Right-touch* regulation we say that 'Regulation is working in the public interest when it supports professionalism and allows it to flourish'.[26] We see supporting professionalism as one contributory element of harm prevention, which we have written about more widely and in detail in our recent publication *Right-touch reform*. Supporting professionalism and thus preventing harm means regulators encouraging their registrants to engage thoughtfully with standards, and to reflect carefully on how they apply to their specific scope of practice and their professional decision-making in everyday working life. It is a long-term ambition which should apply for the duration of a professional's career.

3.49 In part, supporting professionalism will be achieved through the regulators' initiatives to ensure continuing fitness to practise, since this is focused on professionals remaining compliant with professional standards throughout their careers. All of the regulators are progressing different schemes to this end, which we summarised in *Right-touch reform*. We are supportive of this work and of the efforts of regulators to test and improve their approaches.

3.50 We also wrote in *Right-touch reform* about a number of areas where we feel there is scope for further work to enhance the ways in which registrants engage with standards, and in doing so to support professionalism in the way we have defined. These areas support a harm prevention approach in that they encourage the identification and resolution of professional problems at an early stage. These areas of further work in harm prevention include: 'formative spaces' where colleagues can discuss problematic areas of practice (McGivern,

[26] Professional Standards Authority, 2015, *Right-touch regulation*. [Online] Available at: http://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-regulation-2015.pdf?sfvrsn=16 [Accessed 21/12/2017]

Fischer and others), 'relational regulation' where a bridge between regulators' standards and professionals' practice is constructed (Huising and Silbey), and 'interpretive vigilance', which seeks to identify emerging harm through piecing together clues from minor events (Meleyal and Macrae).

3.51 We also wish to support further research into the effects of working environments on compliance with professional standards. A recent example of work which demonstrates how analysis can generate insights into the relationship between behaviour and workplace is *Bad apples? Bad barrels? Or bad cellars?*[27] a report by Searle et al. This work was funded by the Authority and we intend to continue to support this research agenda through commissioning and collaboration.

Q13: Do you agree that the regulators should work more closely together? Why?

3.52 **Response**: Yes. Regulators should work collectively and collaboratively with each other and with other parts of the patient safety system to help maintain public protection. The cases of Mid-Staffordshire NHS Foundation Trust, Morecambe Bay, and Winterbourne View all demonstrated the need for closer collaboration and shared intelligence.

3.53 In *Regulation rethought* we proposed that in future, all parts of the regulatory system should have a shared purpose:

- Protecting patients and reducing harms
- Promoting professional standards
- Securing public trust in professionals.

3.54 We recommended that all regulatory functions and activities should be directed towards and only towards those purposes. This would ensure clarity of purpose and alignment of effort towards common goals, supported by shared professional standards. It would enable regulators and others to operate more effectively as a safety system, rather than working in silos with separate objectives and diluted impact.

3.55 Research and studies of human factors, safety science, behavioural science and organisational psychology, major inquiries and investigations incontrovertibly demonstrate the behavioural links between systems, organisations, places and people. Therefore, preventing and reducing harm, promoting professionalism, improving quality and encouraging compassionate care require a coordinated approach by regulators, employers, educators and professional bodies. Professional and system regulators and educators need to share intelligence and alert each other to heightened risks of harms. They need to use their insights to support employers to recognise the circumstances in which harm occurs, and to support the development of cultures, workplaces and systems that empower registrants to comply with professional regulatory

[27] 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 care*. Available at: https://www.professionalstandards.org.uk/publications/detail/antecedents-and-processes-of-professional-misconduct-in-uk-health-and-care [Accessed 23/01/2018]

standards. As explained above, fitness to practise data in particular can yield insights to help others who are closer to potential problems to take preventative action. Its analysis can assist in the identification of situational factors most prone to be associated with lapses in conduct or competence. It provides a starting point for further analysis and research into why such patterns exist and how they might be best addressed.

3.56 This requires the continuation of the change of emphasis by regulators from responding to complaints to contributing insight and knowledge to the active prevention and reduction of harms. Regulators will need to continue to work with stakeholders to build the relationships through which they can exert influence and achieve impact, building on the insights that are already emerging through data analysis. The focus of this work should be to support preventative measures being taken by those who are closest to problems. If there were fewer regulators problems of collaboration and collective action would be reduced.

3.57 As healthcare professionals work within teams, it is important that the standards of conduct and, where appropriate, competence to which they are held are consistent and coherent – our proposal for a common statement of professional practice would achieve this aim. In the interests of fairness and maintaining confidence in professional regulation, members of such teams and their employers should be able to anticipate them being treated in a similar way in relation to similar matters.

Q14: Do you think the areas suggested above are the right ones to encourage joint working? How would those contribute to improve patient protection? Are there any other areas where joint working would be beneficial?

3.58 **Response**: Yes, in part. We agree that there should be a single shared online register as part of a move towards the creation of a single assurance body – this is the view that we put forward in our papers *Regulation Rethought* and *Right-touch reform*. As a free-standing reform, a single register could make it simpler for the public and employers to locate and access and more likely to promote consistency in the information provided. We made a series of recommendations for improvement to registers in our paper *Maximising the contribution of registers to public protection*.[28] As we explain in *Right-touch reform*, not all have been implemented and it has taken time for improvements to occur. Regulators' public registers are now mostly consistent and clear in their presentation of data, but there are still some variations and discrepancies in how some information is displayed between regulators.

3.59 We agree there should be a single code of conduct (referred to elsewhere in this response as a common statement of professional practice). It would support multi-disciplinary working, individual and collective accountability and team-based regulation. Such a model has been operated effectively by the Health

[28] Available at: https://www.professionalstandards.org.uk/publications/detail/maximising-the-contribution-of-regulatory-bodies-registers-to-public-protection.

and Care Professions Council and is also used by the Academy of Healthcare Scientists – an umbrella accredited register covering a number of occupations.

3.60 We agree that there should be a single adjudicator. We recommended this in *Regulation rethought* and *Right-touch reform*. We anticipate that this would also be accompanied by changes in legislation to allow the regulators to adopt more flexible, proportionate ways of handling concerns about fitness to practise, which should result in a decrease in the number of cases requiring hearings. This should avoid a single adjudicator becoming overloaded by a high volume of cases causing delays. Based on the cost-effectiveness work we have carried out in the past, we agree that there are likely to be efficiencies to be gained from regulators sharing functions.

3.61 Efficiencies could alternatively be achieved by having a single assurance body, as we recommend in *Right-touch reform*.

Q15: Do you agree that data sharing between healthcare regulators including systems regulators could help identify potential harm earlier?

3.62 **Response**: Yes. As we have explained in answers to previous questions, in order to identify potential harm earlier, harm needs to be understood comprehensively. Sharing data enables regulators and other organisations to build an understanding of the causes of harm. Sharing data is necessary but not sufficient; data must be interpreted, combined with other information and used to create intelligence. In *Right-touch reform*, we suggest that both professional and system regulators can indirectly prevent harm from occurring by contributing their knowledge to those close to potentially harmful situations.[29] There are several examples of arrangements in place for professional and system regulators to share information.[30,31] This is an area where the Health and Social Care Regulatory Forum[32] has already made a great deal of progress.

3.63 We also urge regulators to consider the format in which data is shared. Our recent work on regulators' categorisation of fitness to practise allegations suggests there may be benefits to more consistent categories between professional regulators. The report mentions that this may mean better understanding of environments in which many different types of professionals

[29] Professional Standards Authority, 2017, *Right-touch reform*, pg. 22. Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-reform-2017.pdf?sfvrsn=5 [Accessed 15 December 2017]

[30] See for example, the Joint Operating Protocol between the GMC and the CQC, available at http://www.cqc.org.uk/news/stories/regulators-share-information-improve-patient-care [Accessed 02/11/2017]. The work of the Regulation of Dental Services Programme Board, available at http://www.cqc.org.uk/sites/default/files/20170411_working_together_delivering_change.pdf [Accessed 02/11/2017]

[31] The PSNI is part of the Pharmacy Network Group (PNG), which facilitates the sharing of information with different agencies of the Northern Ireland Department of Health concerning ongoing and overlapping investigations. The aim is to avoid duplication, delay, and jurisdictional issues.

[32] Members of the Forum are the CQC, PSA, GMC, GDC, GPhC, NMC, HCPC, PHSO, LGO.

work. As a result, it may be possible to find interesting trends and inform responses to preventing harm.[33]

Q16: Do you agree that the regulatory bodies should be given greater flexibility to set their own operating procedures?

3.64 **Response**: Yes, but there should still be mechanisms to ensure that regulators are taking a consistent approach, unless there is a good reason for them to diverge.

3.65 We understand the need for regulators to have greater flexibility to amend aspects of their legislation that determine their operating practices. The current framework has proved too inflexible, particularly for those regulators who have had few opportunities to update their legislation.

3.66 However, our concern is to ensure that these powers would not result in greater inconsistency, particularly where they lead to unjustifiably inconsistent outcomes. Our review of fitness to practise legislation and policy in *Right-touch reform* highlighted the vast number of unnecessary inconsistencies in the regulators' legislation and its application, and problematic differences in outcome.

3.67 The Law Commissions were asked to develop a single statute to underpin the nine regulators we oversee, in order to simplify and consolidate the legislation. The Government of the day had, in our view correctly, identified a need to bring greater consistency across the regulators. The complexity of the current landscape is one of the arguments we gave in *Rethinking regulation* and *Regulation rethought* for setting up a single assurance body. It appears however, that the drive for greater consistency has fallen away from the current Government agenda.

3.68 We would therefore recommend that the Authority be given a role scrutinising the regulators' rule-making processes, similar to our current scrutiny of the regulators' appointment processes. This would involve our setting standards, which could include a requirement for regulators to consider the approaches of the other regulators, and justify any divergence. We would ensure that the regulators' processes had met the standards, without taking a view on the content of the rules themselves, to avoid any conflicts with our performance review and s.29 powers. Over time, this approach could help to bring greater consistency to the legislation, and ultimately to the outcomes.

Q17: Do you agree that the regulatory bodies should be more accountable to the Scottish Parliament, the National Assembly for Wales and the Northern Irish Assembly, in addition to the UK Parliament?

3.69 **Response**: No. We believe that for a regulator to be formally accountable, it needs to be responsible and answerable for its actions. The regulator's accountability for actions should not be distributed or it could lead to conflicting steers from different legislatures – but we are aware that the current picture is

[33] Professional Standards Authority, 2017, *Right-touch reform*, pg. 22. Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/research-paper/categorisation-of-fitness-to-practise-data-december-2017.pdf?sfvrsn=2 [Accessed 08/01/2018]

far from simple. In addition to formal accountability, it is also worth considering the changing dynamics of devolution. These dynamics mean that regulators may need to work more closely with individual legislatures as policy differences emerge between different countries. Therefore, we recommend that there are regular opportunities for regulators to give an account of their operations to devolved legislatures.

3.70 In our view, a regulator can only be accountable to the legislature that holds the legislation determining how the regulator operates. For most regulators, this is under UK legislation. Therefore, those regulators should only be accountable to the UK Parliament.

3.71 However, the Scottish Parliament is responsible for the regulation of groups of healthcare professionals regulated since the Scotland Act 1998. This means that the GDC, GPhC and HCPC should be accountable to the Scottish Parliament for the registration of their respective devolved professions.[34] In addition, the PSNI operates only in Northern Ireland, under Northern Irish legislation passed by their Assembly.

3.72 Although not under our remit, it is also worth noting that parliaments/assemblies in Northern Ireland, Scotland and Wales have differing devolved responsibilities relating to the registration of social care workers and other roles in the social care area. Those social care regulators[35] are accountable only to their respective devolved legislatures.

3.73 If a regulator is held to account by more than one parliament or assembly over one area of regulation, there is potential for confusion. If the legislatures hold contradicting positions, the regulator could be in a difficult position to fulfil the demands of one or the other. For this reason, it is our view that for each group of professionals registered by a regulator, the regulator should only be formally accountable to the parliament/assembly that holds the legislation for that registered group of professionals. For example, the table below shows the GPhC may be accountable to two legislatures for the professional groups it regulates.

Regulated group	Accountable to
Pharmacists in England, Scotland and Wales	UK Parliament
Pharmacy technicians in England and Wales	UK Parliament
Pharmacy technicians in Scotland	Scottish Parliament

3.74 However, we consider that all UK-wide regulators should work with the four UK Governments and legislatures to ensure a joined-up approach across the whole country. Regulators should also be aware of and recognise divergence between

[34] The HCPC is accountable for the Operating Department Practitioners and Practitioner Psychologists. The GDC is accountable for Dental Nurses, Dental Technicians, Clinical Dental Technicians and Orthodontic Therapists. The GPhC is accountable for the Pharmacy Technicians.
[35] Social Care Wales, Scottish Social Services Council and Northern Ireland Social Care Council.

the four countries. There should be a regular opportunity for regulators to discuss their work with devolved legislatures.

3.75 Finally, we note that other bodies in health and care that affect the work of practitioners may be formally accountable to devolved legislatures, such as employers. In holding these organisations to account, parliaments/assemblies can exercise power and influence in other ways, to improve patient outcomes and safety.

Q18: Do you agree that the councils of the regulatory bodies should be changed so that they comprise of both non-executive and executive members?

3.76 **Response**: We agree that there should be a move away from regulatory councils to boards overseeing the functions of the regulator. We do not recommend any specific structure for the boards of regulators but point towards our work as guidance. In our paper *Board size and effectiveness*[36] we found that smaller boards of 8 to 12 members, when compared to boards of 12 to 24 members, were associated with greater effectiveness.[37]

3.77 Over recent years, there has been a shift away from self-regulation. We consider this to be a good thing. We have noted in past publications that board members should not be representative of any group, including registrants. We believe that representing registrants and their interests undermines the purpose of regulators to protect the public.[38] The presence of registrants on a board could give rise to a conflict of interest.[39] However a regulator must have the confidence of those it regulates so proper regard for registrants is essential.

3.78 Board members should still demonstrate a wide degree of knowledge of the issues that matter to registrants.[40] Additionally, a board should be fully informed about the policy and operations of the regulator. The quality of the relationship between the non-executive and the executive components of an organisation will to a large extent determine the board's performance. We recognise that 'a

[36] Available at: https://www.professionalstandards.org.uk/publications/detail/board-size-and-effectiveness

[37] Council for Healthcare Regulatory Excellence, 2011, *Board size and effectiveness: advice to the Department of Health regarding health professional regulators*, pg. 10. Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/advice-to-ministers/board-size-and-effectiveness-2011.pdf [Accessed 15/12/2017]

[38] Council for Healthcare Regulatory Excellence, 2011, *Board size and effectiveness: advice to the Department of Health regarding health professional regulators*, pg. 10. Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/advice-to-ministers/board-size-and-effectiveness-2011.pdf [Accessed 15/12/2017]

[39] Professional Standards Authority, 2013, *Fit and Proper? Governance in the public interest* , Pg.6. Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/fit-and-proper-2013.pdf [Accessed 15/12/2017]

[40] Council for Healthcare Regulatory Excellence, 2011, *Board size and effectiveness: advice to the Department of Health regarding health professional regulators*, pg. 10. Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/advice-to-ministers/board-size-and-effectiveness-2011.pdf [Accessed 15/12/2017]

relationship of confidence and challenge' between executive and non-executive board members is essential for a regulator to identify and manage risks.[41]

Q19: Do you think that the views of employers should be better reflected on the councils of the regulatory bodies, and how might this be achieved?

3.79 **Response**: No. The purpose of regulation is to protect the public, to maintain public confidence in the profession, and to uphold professional standards. Employers are one of many stakeholders who might influence or be influenced by regulators fulfilling those three objectives. The presence of employers could be seen as a conflict of interest – they are usually concerned with the supply and quality of practitioners, whilst the regulator is concerned with the competency and behaviour of registrants and protecting the public.

3.80 If the views of employers are required to enable the regulator to carry out its functions, then we encourage regulators to find different ways to engage and collaborate with employers. One such model of engagement is the GMC's Employer Liaison Service.[42]

3.81 Also, we observe that not all professions are routinely employed. For example, many chiropractors, osteopaths and practitioners on accredited registers work in private practice and are self-employed so, frequently are doctors.

Q20: Should each regulatory body be asked to set out proposals about how they will ensure they produce and sustain fit to practise and fit for purpose professionals?

3.82 **Response**: No. We find the meaning of this proposal unclear, mainly because the consultation document does not explain the problem it is intended to solve. In addition, regulators neither 'produce' nor 'sustain' professionals.

3.83 Inevitably, regulation plays a role in shaping the workforce through setting standards for entry to a profession and ongoing requirements for continuing fitness to practise, and removing from the workforce those who fall below acceptable standards. They do this to ensure that all professionals meet minimum standards of practice and conduct throughout their working lives. As we understand it, regulators already work with other bodies including royal colleges, governments, higher education institutions, employers, Health Education England, NHS Education for Scotland and other bodies. In doing so, they try to ensure that the standards they set, and the way in which they enforce them, contribute to, and do not impede, the development of practitioners who are fit to do the jobs that are required of them in the workplace. If this proposal is simply asking regulators to set out in writing how this is done, it would have been helpful if the consultation had pointed to evidence of a gap or a need for this. Without this, we cannot support this proposal.

---

[41] Professional Standards Authority, 2013, *Fit and Proper? Governance in the public interest*, Pg.10. Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/fit-and-proper-2013.pdf [Accessed 15/12/2017]

[42] General Medical Council, Employer Liaison Service. Available at: https://www.gmc-uk.org/concerns/11956.asp [Accessed 18/12/2017]

3.84 If what is behind this question is something more – namely a drive for regulators to give greater consideration to workforce issues – we advise proceeding carefully. A regulator's role is to protect the public, and asking them to consider questions of workforce supply could lead to them compromising on professional standards. However we note that in some jurisdictions professional regulators have a duty to promote access to healthcare as well as its quality. Such a change would need careful consideration in the context of a wider realignment of regulators.

Q21: Should potential savings generated through the reforms be passed back as fee reductions, be invested upstream to support professionalism, or both? Are there other areas where potential savings should be reinvested?

3.85 **Response**: Whether any savings realised are reinvested or passed back as fee reductions should be a decision for the regulator(s).

Q22: How will the proposed changes affect the costs or benefits for your organisation or those you represent?

- **an increase**

- **a decrease**

- **stay the same**

Please explain your answer and provide an estimate of impact if possible.

3.86 **Response**: We cannot comment on the matter as we do not know what the final shape of the reforms will be or where the Authority will sit within any new arrangements. We hope that our proposals, including changes to fitness to practise and the development of a single assurance body might lead to cost savings over time, however this would need to be carefully assessed before implementation.

Q23: How will the proposed changes contribute to improved public protection and patient safety (health benefits) and how could this be measured?

3.87 **Response**: Patient safety would benefit through the successful prevention of harm, with problems being identified and addressed in the right place at the right time. However if the governments do not extend our section 29 oversight to consensual disposals there will be a reduction in public protection. Clearly these changes will be difficult to measure directly, but ways to gauge improvement could include reductions in inappropriate referrals being made to regulators; greater efficiency of regulatory processes; or increased satisfaction levels reported by those raising concerns with regulators.

Q24: Do you think that any of the proposals would help achieve any of the following aims:

- Eliminating discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010 and Section 75(1) and (2) of the Northern Ireland Act 1998?

- Advancing equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it?

- Fostering good relations between persons who share a relevant protected characteristic and persons who do not share it?

If yes, could the proposals be changed so that they are more effective?

If not, please explain what effect you think the proposals will have and whether you think the proposals should be changed so that they would help achieve those aims?

3.88 **Response**: We note from our performance review work that regulators are aware of their duties under the Equality Act (and Northern Ireland equivalent). Several are researching why certain groups of registrants may be affected differently from others by their regulatory policies and practices. For example, the GPhC held a seminar to explore the issue of differential attainment for candidates who self-declare as Black-African, in its pre-registration examinations.[43] Meanwhile the GMC explored doctors' perceptions of how fair the GMC was to registrants, and whether the GMC treated BME (black minority ethnic) doctors differently to others.[44]

3.89 Better use of data could help regulators identify where their processes are resulting in direct or indirect discrimination. This could help to improve outcomes for groups of registrants that appear to be disproportionately negatively affected by regulatory approaches.

4. Further information

4.1 Please get in touch if you would like to discuss any aspect of this response in further detail. You can contact us at:

Professional Standards Authority for Health and Social Care
157-197 Buckingham Palace Road
London SW1W 9SP
Website: www.professionalstandards.org.uk
Telephone: 020 7389 8030

[43] Professional Standards Authority, 2017, *Annual review of performance 2016/17: General Pharmaceutical Council*, pg. 11. Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/performance-review-gphc---2016-17.pdf [Accessed 18/12/2017]
[44] General Medical Council, 2014, *Fairness and the GMC: Doctors' views*. Available at: https://www.gmc-uk.org/P10039_GMC_final_report_v3_to_GMC_150514.pdf_56349839.pdf [Accessed 18/12/2017]