

Response to *Regulating healthcare professionals, protecting the public*

11 June 2021

Part I: General comments from the Authority

1. Introduction

- 1.1 We welcome this programme of reform and the opportunity to comment on the proposals in the consultation document. Part I of our response sets out our general comments and observations on the consultation as a whole and on the individual sections. Part II contains our answers to the 70 specific questions.
- 1.2 We understand these reforms have been driven by the need to address the regulators' outdated legislation and to make further improvements to the effectiveness and efficiency of regulation. They have been developed on the basis that regulation has improved in recent years. We agree that there have been improvements with many regulators regularly meeting the majority, but not all, of our Standards of Good Regulation, and support much of what is in the consultation. However, in some areas we have concerns about proposals that could in our view inadvertently reduce public protection.
- 1.3 There are four particular areas we support, as follows:
 - We see advantages in giving the regulators new duties to co-operate with other regulators, and to be transparent and proportionate
 - We welcome the opportunity to achieve greater consistency in how registers work and the information made available to the public
 - We support the removal of the five-year rule that prevents taking forward complaints where events took place more than five years earlier
 - We welcome providing registrants and complainants with a less adversarial alternative to panel hearings, known as accepted outcomes. This will help to reduce the negative impacts on all involved and the money saved could be diverted to other things regulators do to prevent harm.
- 1.4 The areas where we have concerns include the following.

Oversight of accepted outcomes

- 1.5 The first of our areas of concern relates to the oversight of accepted outcomes as discussed at paragraphs 354-364 of the consultation document. A process is proposed, through which 'anyone' could ask the regulator's registrar to review a decision. We think that this would create a public protection gap, and that instead decisions of this gravity should continue to be subject to the Authority's independent review. We set out the reasons for this view in detail below and in response to question 61 in Part II of this response.

Reducing the grounds for action

- 1.6 The second area of concern relates to the proposals at paragraphs 258-266 of the consultation document about reducing the grounds for action. We think that this will make it more difficult for regulators to restrict the practice of professionals with a health condition which impairs their ability to practise safely. It also risks labelling those with health conditions as not competent. We set out our views in detail below and in response to question 44 in Part II of this response.

Oversight of rule-making

- 1.7 The third main area of concern relates to rule-making, and specifically the proposal to give regulators more freedom to decide how they use the duties and powers they will be given in law. In principle, we agree that regulators should be agile to respond to changing circumstances. However, we are concerned that this could lead to processes that are expedient for regulators but do not protect the public as well as they should. These new freedoms could also lead to major differences in regulators' ways of working, creating a regulatory system which is harder for people to navigate and more fragmented. In 2014 the Law Commissions¹ recommended a specific role for the Authority to oversee rule-making to guard against unjustifiable disparity and unsafe processes. We continue to support this recommendation. We discuss this in detail below and in response to questions throughout Part II where issues of rule-making and consistency arise from different questions.

General concerns

- 1.8 More generally, our role as the oversight body has taught us that performance of regulators can deteriorate quickly but recover slowly. There are a number of regulators that had previously been high-performing where we have identified concerns in recent years. Furthermore, what the Government is planning to do through these reforms represents a significant change to how regulators work. Significant organisational change can increase risk.² The planned reforms, together with further changes that will result from plans in the future Health and Care Bill, could therefore have a destabilising effect. This may include affecting those organisations that are currently considered to be mature and relatively high-performing.
- 1.9 We also continue to hear the view from stakeholders including patient and public groups and some registrant/professional organisations that there need to be clear, robust and effective accountability mechanisms. Greater responsibility must be matched by checks and balances so that reforms strike an appropriate

¹ Law Commissions of England and Wales, *Regulation of Health Care Professionals, Regulation of Social Care Professionals in England*, Paragraph 2.22 (Recommendation 3). Available at: <https://www.lawcom.gov.uk/project/regulation-of-health-and-social-care-professionals/>

² Chartered Institute of Internal Auditors September 2020, *Organisational Change*. Available at: <https://www.iiia.org.uk/resources/auditing-business-functions/organisational-change/?downloadPdf=true#:~:text=Significant%20levels%20of%20organisational%20change,%20For%20customer%2Fclient%20outcomes.&text=Organisations%20change%20their%20focus%2C%20which,%2C%20activities%2C%20products%20and%20services.>

balance between flexibility and accountability. In some areas we do not believe that these proposals achieve that balance.

- 1.10 Some proposals in the consultation document are not supported by enough data, analysis or information to allow us to express a view which is fully in support or against. We have highlighted in Part II where this is the case.
- 1.11 The consultation document does not address a number of points where we felt it would have been helpful to do so. We have commented on these below and in the responses to specific questions where logical to do so.
- 1.12 At the end of Part I we have set out the principles by which the reforms might be judged to have succeeded or failed.

2. Governance and operating framework

- 2.1 The reforms to governance such as the new duties, changes to regulator governance and improved reporting to the devolved Parliaments are all welcome. However, in our view, they may prove insufficient to counterbalance, in particular, the far-reaching powers that regulators will have to make changes to how they operate through their rules.
- 2.2 The greater flexibility and freedom that the regulators will enjoy increases the risk of variation in outcomes, and that some of this variation will be undesirable. Changes in governance will not, of themselves, provide additional assurance to mitigate the risks that may arise from the implementation of these reforms. These risks will be increased by a process of reform that is staggered over a number of years.
- 2.3 The intention to have no independent oversight of regulator rule-making and the removal of the role of the Privy Council could allow the making of rules which either do not protect the public or create unjustifiable variation in approach across regulators. While we note the requirements to consult on 'significant rules and standards' we are concerned that this will not provide enough of a safeguard. We believe that a proportionate way to address this immediate issue would be to implement the recommendation from the Law Commissions that the Authority be given proportionate powers to oversee the regulator rule-making process. However, in the longer term it will be important to review more fully the overall framework for assurance of the regulators and the Authority's role and powers within that.

Issues with no questions

Proposals to give regulators rule-making powers

- 2.4 We note the proposals at paragraph 45 of the consultation document to provide the regulators with 'powers to set more of their own operating procedures through rules or guidance that do not require the approval of Parliament or the Privy Council'. There is no question in the consultation on this proposal and although it was included in the last consultation there was at the time no suggestion that the role of the Privy Council would be removed entirely.

- 2.5 When Government last consulted on reform in 2017/18 a number of respondents, including the regulators themselves, acknowledged the need for increased autonomy to be accompanied by appropriate accountability mechanisms. For example, the General Medical Council stated in their response: ‘However, the increased autonomy we seek in policy and operations must be accompanied by other checks and balances to ensure that regulators’ powers are exercised appropriately. That should include (but not be limited to) strengthened measures of accountability.’³
- 2.6 We acknowledge the proposals within the consultation document that are intended to ensure greater accountability including that Government will expect regulators to work together on a common framework of governance and operating rules. However, we remain of the view that these are likely to prove insufficient, particularly in relation to increased flexibility for regulators with regard to rule-making.
- 2.7 We accept that the role of the Privy Council in approving rule changes is widely seen as bureaucratic and preventing regulators from modernising processes as required. However, without any mechanism for independent oversight of rule changes there is a risk both of unjustifiable inconsistencies in approach developing between regulators and the development of rules which do not protect the public.
- 2.8 We do not suggest that a regulator would intend to make rules which give rise to protection concerns. However, we know from our oversight that things can go wrong. A mechanism to check rules pre-emptively would help to ensure that the regulator rulemaking process is fair, transparent, avoids creating unjustifiable inconsistencies and maintains public confidence.
- 2.9 The Law Commissions did not suggest that the Authority comment on the content of such rules, rather that it ensure that the process followed was robust. We consider that proportionate oversight of this nature could be modelled on the oversight that the Authority has over the process for appointments to regulator Councils.
- 2.10 It should be possible to establish a proportionate mechanism for approving the process of rule changes, less cumbersome than the current arrangements under the Privy Council. For example, the Legal Services Board currently approves alterations to the regulatory arrangements for the legal services regulators that they oversee.⁴ We envisage a similar role for the Authority albeit not necessarily exercised in the same way.

³ General Medical Council, *Response to Promoting professionalism, Reforming regulation*. Available at: https://www.gmc-uk.org/-/media/documents/GMC_response_to_Department_of_Health_England_consultation_Supporting_professionalism_reforming_regulation.pdf_73271108.pdf

⁴ Legal Service Board, *Alterations to regulatory arrangements*. Available at: <https://legalservicesboard.org.uk/our-work/statutory-decision-making/alterations-to-regulatory-arrangements>

Consistency vs flexibility

- 2.11 There is little within the consultation document to reflect the significance of devolving to the regulators responsibility for so much of what is currently captured in legislation as is proposed. This is extensive and should prompt consideration of how and whether further oversight of regulator rule-making may be required.
- 2.12 There is also little to differentiate between smaller, more operational areas where it may be entirely appropriate for regulators to make changes with limited oversight and those where the stakes are higher if errors are made or if there is significant divergence in approach.
- 2.13 While we recognise the potential benefits of allowing greater agility we believe it would be helpful to gain a clearer understanding of:
- In which areas within rules it may be more or less desirable for there to be increased flexibility
 - Where it may be appropriate to maintain consistency in approach as far as possible
 - Which areas of rules may give rise to particular risks to public protection.
- 2.14 Agility, which is similar to flexibility, is one of the right-touch regulation principles. However, so is consistency which is drawn from the better regulation principles and is generally seen as a core principle of good regulation.
- 2.15 We know from our own and others' research and policy work that there are frequent calls for greater coherence across the regulatory system. As Charles Vincent and colleagues found, 'the regulatory landscape is unnecessarily burdensome, produces multiple unintended consequences, and, most importantly, fragments and dilutes regulatory impact'.⁵ Furthermore, as highlighted by the Williams Review, perceived inconsistencies in fitness to practise outcomes can lead to concerns about unfairness to registrants as well confusion for stakeholders.⁶
- 2.16 We have previously commissioned research as part of a commission for the Department for Health and Social Care (DHSC) responding to the Williams Review looking at the factors which may affect the consistency of fitness to practise outcomes.⁷ While the report does not seek to come to firm conclusions and instead lays out a methodology to explore in more depth, it is clear that there are a vast number of factors which may impact on this area alone.

⁵ Vincent et al, 2020. *Redesigning safety regulation in the NHS*. Available at: <https://www.bmj.com/content/368/bmj.m760.full>

⁶ Sir Norman Williams, *Gross negligence manslaughter in healthcare - The report of a rapid policy review*. Available at:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/717946/Williams_Report.pdf

⁷ UCL Medical School - Research Department of Medical Education, *Developing a methodology to assess the consistency of fitness to practise outcomes (Report for the Professional Standards Authority) 2019*. Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/developing-a-methodology-to-assess-the-consistency-of-fitness-to-practise-outcomes-2019.pdf?sfvrsn=97c57420_0

- 2.17 In order to gain a clearer idea of where consistency may be desirable in regulatory terms, we commissioned research to explore the views of patient, public and registrant views on consistency in regulation.⁸
- 2.18 The report found that there was acceptance of the need for justifiable difference but also an expectation of ‘sameness’ in areas where the regulators were seen to be carrying out certain roles which give rise to particular arguments for consistency. This includes where the regulator acts as an arbiter (such as in fitness to practise decision-making), an assurer (ensuring professionals maintain standards), a service provider (meeting the needs of service users) and team enabler (support the functioning of the team around the patient).
- 2.19 Arguments for sameness arising from these roles included:
- Whether something needs to be correct i.e. a correct decision
 - Fairness
 - Adequacy – meeting minimum standards
 - Simplicity – reducing unnecessary difference
 - Coherence – alignment.
- 2.20 These findings could help to define areas of rules where consistency matters or where particular risks may arise and therefore where additional oversight may be warranted.

3. Education and training

- 3.1 We broadly support these proposals. In *Right-touch reform* we stated in our chapter on the professional regulators’ role in education and training that the regulators’ role in this area should be underpinned by a legislative framework which is ‘sufficiently flexible to allow a risk-based approach to assuring different professional groups and to meet future challenges’⁹.
- 3.2 The proposals should remove some unhelpful and extraneous points in legislation, as well as enable the regulators to make necessary changes to standards and procedures without undue delay and to take forward key approval decisions more easily. The regulators work with a wide range of stakeholders to establish standards and quality assurance processes within varying education and training environments. Therefore, it is important for them to have the legislative framework that allows them the flexibility to tailor their systems accordingly.
- 3.3 We are aware that an individual education or training provider may be subject to inspection by a number of bodies. It is important that each of the bodies should

⁸ Simon Christmas, Fiona Fylan, Alan Cribb May 2021, *Patient, carer, public and professional perspectives on the principle of consistency in health and care professional regulation*. Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/research-paper/does-consistency-between-regulators-matter.pdf?sfvrsn=fbcc4920_4

⁹ Professional Standards Authority, 2017, *Right-touch reform: A new framework for assurance of professionals*; p.112. Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-reform-2017.pdf?sfvrsn=2e517320_7.

match its standards and quality assurance processes to its specific remit. Where the case is made for a degree of overlap in standards between different bodies, the regulators should consider joint inspections or documentation already available through other bodies.

- 3.4 An education and training provider may also be subject to quality assurance processes from the different healthcare professional regulators. There is a risk that the autonomy given to individual healthcare professional regulators to set their own standards and procedures may lead to unintended divergence; this could make it more difficult for the regulators to work together in their quality assurance activities.
- 3.5 We suggest that the future legislation expresses a clear link between ‘the outcomes of education and training for individual learners’ and the standards of proficiency required of practitioners already on the register. It should be made explicit how the regulators will ensure that both sets of standards meet the needs of patients, service users and the public. Although there is a duty to consult on significant changes to rules and standards, no specific mention is made of patients, service users and the public. It is not always possible to gain input from all key stakeholders in consultation exercises, some can be harder to reach or have constraints on resources. In addition, research and other evidence-gathering exercises, which are distinct from consultations, would normally be required to obtain objective information and data to develop the standards. We note too that there is no requirement for the regulators to include patients, service users and the public in their quality assurance processes.
- 3.6 We underlined the benefits of interprofessional education in the chapter on education and training in our publication *Right-touch reform*.¹⁰ We think there would be benefit, in addition to the proposals made in the document, to exploring how interprofessional learning should be referenced in the legislation. We note the Department’s concerns that it may not be possible for education and training providers across all professions to offer the opportunity to students and trainees to learn in this way. However, given that at some stage in their courses and programmes, students and trainees will undergo practical training (or workplace training in roles that cover management or administration), we would welcome proposals in this area.
- 3.7 Paragraph 195 of the Health and Social Care Act 2012,¹¹ refers to the ‘duty to encourage integrated working’ for Health and Wellbeing Boards. If after further consultation and research it is considered desirable for courses or programmes to include interprofessional learning, a duty to encourage may offer appropriate flexibility. Alternatively, we propose further consideration of mandating interprofessional learning when amending each individual healthcare regulator’s legislation.
- 3.8 Paragraph 127 states that regulators will ‘have a power to appoint a person(s) to carry out the quality assurance function on their behalf.’ The proposals in

¹⁰ Professional Standards Authority, 2017, *Right-touch reform: A new framework for assurance of professionals*; p.113. Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-reform-2017.pdf?sfvrsn=2e517320_7.

¹¹ <https://www.legislation.gov.uk/ukpga/2012/7/section/195/enacted>

their current form appear to allow for a single visitor or inspector to make recommendations to a regulator on the quality of education and training programmes. In addition, the role of statutory education committees and the Privy Council in decisions on approvals will no longer be set out in legislation. While it is appropriate that the regulators should have flexibility in designing their own systems, we believe there should be a way of ensuring that the processes developed are sufficient to protect the public and be fair to those providing education and training.

4. Registration

- 4.1 We support many of the proposals in the registration section of the document. However, for a number of the questions, we have not been able to express explicit agreement because we are not clear about the evidence base behind the proposal, the problem it is trying to solve, or how it would work in practice. This applies in particular to proposals related to the information published on registers, protection of title offences, administrative suspension, and the removal of registrar discretion to turn down applicants.
- 4.2 The Government proposes that regulators should be able to set out their registration processes, removal and readmittances processes for administrative reasons, and registration appeals procedures in rules and guidance. We recognise the clear case for regulators to have greater flexibility and autonomy in these areas. However, as we comment elsewhere, it is essential that greater flexibility is balanced against a sufficient level of consistency, particularly where divergent processes have possible implications for public protection or fairness to registrants.
- 4.3 The consultation does not reference proposals that have been included in previous consultations on regulatory reform. For example, there is no detail about whether statute should require regulators to register on a full, conditional and temporary basis (as was proposed by the Law Commissions and was supported by an overwhelming majority of respondents¹²), or how these different types of registration should be used. There are also some missed opportunities to close legislative loopholes and to ensure consistency between regulators in the interest of public protection.

Lapsed registration and Authority appeals

- 4.4 The consultation does not reference any proposals to address a loophole in some of the regulators' legislation, which allows registration to lapse if a registrant has not paid the necessary registration fees. This can cause significant problems if the registration in question is due to lapse during or before the Authority is able to lodge an appeal under our section 29 powers. If a registrant's registration lapses before an appeal is concluded either by consent or following consideration by the High Court, then they could seek to frustrate the Authority's appeal right, if a registrant could avoid the scrutiny of an appeal

¹² See footnote 1, paragraph 5.59

by deciding to opt for voluntary erasure (from *PSA v GMC and Dighton*, para 33).

- 4.5 This is an issue that we have raised several times, including to the previous Secretary of State, who recognised the challenges presented by this issue. The Law Commissions included a proposal to address this issue in their draft bill.
- 4.6 On several occasions over recent years we have been forced to seek an injunction from the High Court to prevent the NMC from removing individual registrants from its register before the High Court could address our referral of the relevant fitness to practise panels' decisions.¹³ Such action is costly and time-consuming. This would be a timely opportunity to close this legislative loophole.

5. Fitness to practise

- 5.1 Overall, among the different chapters of the consultation, some of the proposals in the fitness to practise section give us greatest cause for concern.
- 5.2 We support the introduction of accepted outcomes in principle. However, we do not endorse the suggested registrar review power as a mechanism for addressing outcomes which fail to protect the public, because we do not believe it will function effectively as such. Instead, it would be more like a complaints process, reliant primarily on harmed patients taking issue with an outcome. It would also rely on regulators having the insight to recognise where a decision may be wrong.
- 5.3 We propose instead that our section 29 powers should apply to these decisions in the same way they will apply to panel outcomes, as this would provide a layer of independence and accountability that would preserve current levels of public protection.
- 5.4 There is little consideration in the consultation document of the patient voice and its role in the fitness to practise process. For example, we understand that patient bodies have concerns about how cases are handled at the early stages, with complainants feeling confused and poorly informed when complaints are closed down without further action. There is little in this consultation to address this.
- 5.5 The document highlights that accepted outcomes would speed up the process, but speedy processes are not always the most effective at protecting the public.
- 5.6 We have identified a number of areas in this chapter where the lack of detail means it is difficult to understand fully the rationale for the proposals, what is being proposed, and expected impacts or effects. As a result, we have refrained from expressing a firm view in response to a number of questions. We would welcome some reassurance that when draft GMC legislation is made publicly available, the consultation will be an opportunity to influence the areas and levels of policy detail that were not clear at this stage.

¹³ Professional Standards Authority, 2016, *Review of professional regulation registration and Annual Report and Accounts 2015/2016*. Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/annual-reports/annual-report-and-accounts-2015-2016.pdf?sfvrsn=9be67120_4

6. Next steps for reform of professional regulation

- 6.1 The consultation document states that these reforms are part of a wider programme of reform to improve the regulation of healthcare professionals in the UK. This includes the proposed powers for the Secretary of State to merge or abolish regulators, move groups in and out of statutory regulation and to extend the ability of regulators to delegate functions.
- 6.2 The Authority supports simplification of the regulatory system and a risk-based approach to deciding which professions are regulated by law. We have laid out our detailed thinking in *Right-touch reform*.¹⁴
- 6.3 The Government is commissioning a review of the number of regulators which will also include consideration of the role to be played by the Professional Standards Authority. We welcome the intention to review our role to ensure that we can continue to provide robust and effective oversight following these and future reforms. We have laid out below some further comments on aspects of our powers and legislation which we believe should form part of any future review to enable us to respond to new and emerging risks arising from the reforms to regulator powers.
- 6.4 We further note the intention to review the professions which are currently regulated in the UK with a view to considering whether statutory regulation remains appropriate. We have developed a methodology as laid out in *Right-touch assurance*¹⁵ which outlines a risk-based process for considering the most appropriate form of assurance for different groups and would be happy to provide any relevant input to such a review.
- 6.5 We note that any review of which professions should be regulated by law should also take account of the alternatives to statutory regulation. We have therefore commented below on the need for the Authority's Accredited Registers programme to be included as part of the wider framework for assurance of different professional groups.

Professional Standards Authority role and powers

- 6.6 This consultation does not seek views on the role to be played by the Professional Standards Authority aside from specific questions in relation to our powers over fitness to practise decisions.
- 6.7 The Authority has been calling for reform for some time, so we welcome the progress that is being made, despite the challenges of the current time. We recognise and welcome the DHSC's commitment to continue to advance these proposals. Although we have a number of concerns, it should be understood that we will always work to make the regulatory system function in the best

¹⁴ Professional Standards Authority, 2017, *Right-touch reform: A new framework for assurance of professionals*; p.113. Available here: https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-reform-2017.pdf?sfvrsn=2e517320_7.

¹⁵ Professional Standards Authority, 2016, *Right-touch assurance: a methodology for assessing and assuring occupational risk of harm*. Available here: [https://www.professionalstandards.org.uk/docs/default-source/publications/right-touch-assurance---a-methodology-for-assessing-and-assuring-occupational-risk-of-harm-\(october-2016\).pdf?sfvrsn=f21a7020_0](https://www.professionalstandards.org.uk/docs/default-source/publications/right-touch-assurance---a-methodology-for-assessing-and-assuring-occupational-risk-of-harm-(october-2016).pdf?sfvrsn=f21a7020_0)

interests of patients and service users. We will do so by making the most of our role and powers, providing oversight and challenge, and encouraging consistency and coherence. We will work to keep the focus of the sector on continuous improvement. We recognise that our own role and working methods must constantly evolve to respond to changes in the regulatory landscape, and for that reason have recently undertaken reviews of our Accredited Registers programme and annual Performance Review process.

- 6.8 Stakeholders have told us, and we agree, that greater flexibility for regulators must be balanced by robust means of assuring accountability. The Law Commissions in their report stated: ‘Its separation from Government may put the Authority in a more authoritative position to challenge the regulators, free from direct political influence.’¹⁶
- 6.9 In our response to this consultation we have made specific proposals regarding a role for the Authority to oversee regulator rulemaking and potentially to advise the Privy Council on exercise of the default powers if a regulator fails to carry out its statutory functions. We have also argued that the Authority’s section 29 oversight of final fitness to practise decisions should be amended to cover decisions made through the accepted outcomes route to avoid opening up a significant gap in public protection.
- 6.10 We note that the Law Commissions made a number of other proposals for extension of the Authority’s powers including proposing the activation of two of the currently unmade powers within our legislation – to investigate complaints about the way that a regulator has carried out its functions and to direct a regulator to change its rules. The Department of Health previously commissioned the Authority to provide on advice on how these unused powers could be implemented but have never taken this forward.
- 6.11 We are not at this stage calling for any further specific changes to our powers beyond those we have highlighted, but will reconsider this when the Government has decided the outcome of this consultation.

Accredited registers programme

- 6.12 The Accredited Registers programme was set up in 2013 to provide assurances about roles not subject to statutory regulation, by accrediting organisations that meet our Standards. Currently, we accredit 25 registers, covering approximately 100,000 practitioners working in a range of areas including psychotherapy, health sciences and public health.
- 6.13 In July 2021 we will introduce changes to our Standards and assessment approach which will help us to make clearer decisions about whether accreditation of a register is in the public interest, based on the benefits and risks arising from the activities of registrants. This will help ensure the scope of the programme is clear, and that it remains a proportionate alternative to statutory regulation. However, there are also issues in the wider landscape that must be addressed to ensure the programme is effective in the longer term. Our recent public consultation on the future of the programme highlighted that the

¹⁶ See footnote 1, Paragraph 12.10 (Recommendation 3).

current system of multiple regulators and registers is difficult for patients and service users to navigate, and that oversight is not always proportionate to risk. There is no agreed definition for the many unregulated roles working within health and care, many of which are of increasing importance within national workforce policies.

- 6.14 We think that consideration should be given to how the programme can offer enhanced assurance for higher risk roles, so that it can offer an effective alternative for roles that may leave statutory regulation in the future. There are several ways this could be achieved, such as licensing or the creation of a single assurance body. We think that not giving due consideration to these points would be a missed opportunity for creating a more coherent overall system of regulation.
- 6.15 Before the programme was introduced, the Government's 2011 command paper *Enabling Excellence*¹⁷ committed to ensuring that any voluntary registration system would include appropriate policies on safeguarding, including, where appropriate, the ability to make referrals to relevant bodies where individuals are considered to pose a risk to the public. Clarity on the status of Accredited Registers in regard to safeguarding checks and to their broader legal status has not yet been achieved. We think it essential to resolve this issue as part of wider legislative reform, so that the programme can deliver on its original aims and the public are adequately protected whether they access care from an individual registered with a statutory regulator, or an Accredited Register.

7. Changes to the international registration processes operated by the GDC and NMC

- 7.1 We have provided comments on these amendments along with other comments on international registration in the section of our response looking at the registration proposals.

8. The regulators and public body status

- 8.1 The consultation document at paragraph 411 comments on the differences between how the regulatory bodies are classified and the potential for future reclassification by the Office for National Statistics of those regulators which are not currently classified as public bodies.
- 8.2 We would welcome any further information when it becomes available on the timings or any wider implications of such a move.

¹⁷ Secretary of State for Health, 2011, *Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216580/dh_124374.pdf

9. Conclusions – success and failure measures

- 9.1 In conclusion, the Authority believes that the proposed reforms will be a step forwards for professional regulation if they create:
- Greater coherence of the regulatory system to support modern, multi-disciplinary health and social care
 - More interprofessional working and flexibility between professions
 - A safe and appropriate balance of accountability and flexibility in the work of the professional regulators
 - A proportionate, and less adversarial way of dealing with concerns about professionals with the necessary public protection safeguards
 - Overall, a more effective public protection framework, that listens to patients and responds to their concerns, and has the confidence of the public and professionals.
- 9.2 These reforms will have failed the public if they lead to:
- Lower levels of public protection, public confidence, or professional standards
 - Less transparency or accountability for regulators
 - The same or more complexity from the perspective of the public, employers, and professionals
 - Continuing difficulties for regulators in working together
 - Continuing challenges to closer working between professions
 - Significantly increased costs that are not justified by public protection.
- 9.3 We recognise the complexity and challenges implicit in reforming and improving regulation and look forward to working with all of our stakeholders to achieve it.

10. Further information

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

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Response to *Regulating healthcare professionals, protecting the public*

11 June 2021

Part II: Authority responses to consultation questions

1. **Do you agree or disagree that regulators should be under a duty to co-operate with the organisations set out above? Please give a reason for your answer.**
 - 1.1 We agree that the regulators should be under a duty to co-operate with the organisations listed in the consultation document.¹
 - 1.2 This duty exists in different ways across some of the regulators already, however there is value in introducing the same duty for all regulators to help the regulatory system work together to protect patients and service users. As the consultation document notes, several reports have recommended that the regulators work more closely together. The response to the Covid-19 pandemic has also demonstrated the value of co-operation and collaboration in response to an emergency.²
 - 1.3 The proposed duty is broad and can be interpreted in different ways. It would be helpful to understand more clearly how it is intended that greater co-operation will be encouraged and incentivised, and what effects and impacts the Government is hoping to achieve.
 - 1.4 The Health and Care White Paper outlines similar proposals for a duty to collaborate as part of the proposed Bill: 'we intend to introduce a new duty to promote collaboration across the healthcare, public health and social care system'.³ These duties need to be aligned to avoid confusion or duplication, and to promote coherence across health and care.

¹ The proposed duty is to co-operate with organisations that are concerned with:

- the regulation of healthcare professionals;
- the employment, education and training of healthcare professionals;
- the regulation of health and care services; and
- the provision of health and care services.

² Professional Standards Authority 2021, *Learning from Covid-19 - A case-study review of the initial crisis response of 10 UK health and social care professional regulators in 2020*. Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/learning-from-covid-19-a-case-study-review-of-the-initial-crisis-response-of-professional-regulators.pdf?sfvrsn=c6ad4920_6

³ *Integration and Innovation: working together to improve health and social care for all*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/960548/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-web-version.pdf

2. Do you agree or disagree that regulators should have an objective to be transparent when carrying out their functions and these related duties? Please give a reason for your answer.

- 2.1 We agree that the regulators should have an objective to be transparent when carrying out their functions and to be subject to the related duties.⁴
- 2.2 Transparency is crucial to public confidence in regulation. This objective will help to embed the principle of transparency as a central consideration for regulators in all aspects of their work.
- 2.3 However, as with the other duties, there is likely to be a variety of ways in which this objective is interpreted. It may not by itself be a replacement for stronger mechanisms to ensure that the regulators remain accountable.
- 2.4 Particular weight has been placed on the requirement for consultation on 'significant changes to rules and standards' as a part of the case for providing regulators with flexible rulemaking powers. Paragraph 108 in the education and training section states: 'The regulators' increased powers will be balanced by the duties set out in section 1'. Some guidance on what will constitute a significant change would be useful, as would clarity from regulators as early as possible on the kinds of the circumstance in which they would propose to consult.
- 2.5 While consultation with stakeholders is valuable and should be encouraged, it may not always allow for meaningful input from stakeholders, particularly patient organisations who may struggle to participate fully in multiple large, complex and detailed consultations on rule changes. Consultation is not a substitute for oversight by an independent body.
- 2.6 We reiterate here the benefit in our view of oversight by an independent body such as the Authority to ensure that rule changes are in the public interest and do not lead to unjustifiable inconsistencies, as outlined in Part I of our response. Our independent oversight of regulators puts us in a strong position to identify inconsistencies where they arise, and to assess their impact.

3. Do you agree or disagree that regulators should be required to assess the impact of proposed changes to their rules, processes and systems before they are introduced? Please give a reason for your answer.

- 3.1 We agree that regulators should be required to assess the impact of proposed changes to their rules, processes and systems before they are introduced. Most regulators will already carry out impact assessments for any significant changes

⁴ The related duties include:

- to publish information relating to regulatory functions on an annual basis
- hold open Board meetings (unless confidential matters are being discussed)
- to hold hearings in public (unless confidential matters are being discussed)
- to make records of board meetings and hearings available to the public (but not in relation to confidential matters)
- to consult on significant rules and changes.

to their processes and therefore this is unlikely to constitute a major change in approach.

3.2 The right-touch regulation principles⁵ developed by the Authority, building on the better regulation principles, highlight the need for regulatory force to be proportionate to the risk of harm. We expect the regulators we oversee to operate in line with this principle.

3.3 In the assessment of impact, regulators' overarching objective of public protection must remain paramount. We are aware that regulators have sometimes come under pressure to review regulatory requirements due to workforce pressures. It is reasonable to expect regulators to consider impact, but this must not be at the expense of patient safety.

4. Do you agree or disagree with the proposal for the constitution on appointment arrangements to the Board of the regulators? Please give a reason for your answer.

4.1 We agree with the proposals for the constitution on appointment arrangements to the Board of the regulators, which mirror our own advice to the Department of Health in 2011.⁶ This advice was however delivered prior to current proposals to move away from the Council structure entirely to a system of unitary Boards comprising executive and non-executive members.

4.2 Professional and representative bodies will be concerned about the removal of requirements for registrant representation on the Board. However we think that Board appointments should be based on skills and merit rather than having representation from a specific profession, and that there are a range of ways in which professional expertise and experience can be sought by a regulator. We are also of the view that Board size should lend itself to efficient decision-making, which is likely to be more straightforward with a reduction in numbers.

4.3 In our 2011 advice we said that representativeness was no longer a valid concept for the constitution of a Board. However, we argued that there remains a need for a Board to be credible to stakeholders. This will require careful consideration of the balance and diversity of Board members.

4.4 The consultation intends the move to unitary boards (alongside enhanced reporting requirements) to counterbalance the additional flexibility for the regulators (paragraph 48). However it is not clear how the proposed changes of themselves will provide sufficient counterbalance as we have not seen evidence that having executive members on the Board will achieve any greater accountability than the existing Councils.

4.5 We doubt therefore whether this and the other proposals in this section are adequate to ensure accountability and public protection in the light of the

⁵ Professional Standards Authority 2015, *Right-touch regulation*. Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-regulation-2015.pdf?sfvrsn=eaf77f20_20

⁶ Professional Standards Authority 2011, *Board Size and Effectiveness*. Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/advice-to-ministers/board-size-and-effectiveness-2011.pdf?sfvrsn=d1c77f20_12

proposals for significant devolution of responsibility to the regulators. We refer again to the need identified by the Law Commissions for independent oversight of the rule-making process and the potential for the Authority to undertake this role.

Oversight role of the Authority

- 4.6 The Authority currently provides advice to the Privy Council on the processes used by the regulators when recommending candidates for appointment and reappointment to the Privy Council. Our oversight is proportionate and seeks to assess whether the process followed is fair, transparent and open, whether it inspires confidence, and whether it ensures all selection decisions are based on evidence of merit.⁷ We set guidance for regulators on how to run their processes and offer advice to regulators as issues arise. We also work with regulators collectively to improve practice, ensuring good and fair appointment recommendations are made.
- 4.7 There is no reference within the consultation document to whether the oversight of appointments by the Authority will continue following the shift to unitary Boards, but we understand that there is no intention to change our role in this respect. We welcome this as we believe that our oversight is an important part of maintaining confidence in how the regulators operate. We note that the Law Commissions previously recommended that we retain it.
- 5. Do you agree or disagree that regulators should be able to set their own fees in rules without Privy Council approval? Please give a reason for your answer**
- 5.1 We agree. The regulators should be funded to carry out their statutory functions in a way which is timely, efficient and sustainable. We are aware of the challenges that some regulators have faced in gaining approval for recent proposed fee increases which has caused significant uncertainty and has raised concerns about the ongoing ability to protect the public.
- 5.2 However, we are aware this is an area of significant concern to registrants and their representative organisations. Therefore, if this proposal is taken forward, then there is a need for a fully transparent and a robust process that includes adequate consultation with all stakeholders affected by any change to registration fees.

⁷ <https://www.professionalstandards.org.uk/what-we-do/our-work-with-regulators/appointments-to-councils>

6. Do you agree or disagree that regulators should be able to set a longer-term approach to fees? Please give a reason for your answer.

6.1 See above. If this proposal was taken forward then it would be important to ensure that the process was robust and transparent and involved full consultation with stakeholders.

7. Do you agree or disagree that regulators should be able to establish their own committees rather than this being set out in legislation? Please give a reason for your answer.

7.1 We agree with the proposal that regulators should be able to establish their own committees rather than this being set out in legislation. Committees are an important part of regulators' governance structure and decision-making. They should not contain registrant majorities.

8. Do you agree or disagree that regulators should be able to charge for services undertaken on a cost recovery basis, and that this should extend to services undertaken outside of the geographical region in which they normally operate? Please give a reason for your answers.

8.1 We do not have a firm view on this proposal. As we have said in our answer to the question on fee increases, we believe that the regulators must have sufficient funds to carry out their statutory functions. We know that this is a power that has been requested but that only the GPhC has these powers currently. If the regulators were to receive the ability to charge for services undertaken then we would expect them to exercise such powers in an appropriate manner and consider the impact on stakeholders. We note the concerns raised by stakeholders in the education and training sector including the Council of Deans of Health.⁸ We also note an EDI perspective on this, in that cost-recovery might lead to some large costs which could place minority or overseas registrants at a disadvantage.

8.2 To justify cost-recovery powers it is important for regulators to avoid duplicating activities being carried out by other regulators and agencies, and to ensure that they are taking a proportionate approach. This should be supported by proposals in this consultation and in the recently published Health and Care White Paper to allow regulators greater flexibility in delegating regulatory responsibilities where appropriate.

⁸ *Professional regulatory reform: What does the healthcare higher education sector want?* Available at: <https://www.professionalstandards.org.uk/news-and-blog/blog/detail/blog/2021/04/29/professional-regulatory-reform-what-does-the-healthcare-higher-education-sector-want>

9. Do you agree or disagree that regulators should have the power to delegate the performance of a function to a third party including another regulator? Please give a reason for your answer.

- 9.1 We agree that regulators should have the power to delegate performance of a function to a third party including another regulator. This proposal is consistent with the position we laid out in relation to regulation of education and training in *Right-touch reform* where we highlighted the potential for duplication in quality assurance activities and the need for greater flexibility to allow certain activities to be carried out by the most appropriate body.⁹
- 9.2 Some regulators, including the Nursing and Midwifery Council and the General Osteopathic Council already delegate operation of their quality assurance of education and training to third parties and we are not aware of any significant concerns with how this process operates.
- 9.3 We note that the Health and Care White Paper also outlines plans to remove current restrictions on which regulatory functions can be delegated.
- 9.4 The consultation document reiterates that regulators will remain responsible for any functions delegated to others. Relevant safeguards will need to be in place to ensure that delegation is suitable, for example to assess the competence of the third party a regulator wishes to use. There might also be a case for a duty to withdraw any delegation if the delegatee acts in ways which endanger the achievement of the regulator's objectives, or which leads to delay or additional expense.

10. Do you agree or disagree that regulators should be able to require data from and share data with those groups listed above? Please give a reason for your answer.

- 10.1 We agree that regulators should be able to require data from and share data with those groups listed in the consultation document.
- 10.2 While we welcome the inclusion of the Authority on this list, we have highlighted to the Department for Health and Social Care our legal advice suggesting that, for the Authority to be assured that it will be able to gain access to the information it needs from the regulators, there should be a duty for regulators to provide the Authority with information.
- 10.3 The changes proposed to our own powers with regards to fitness to practise decisions would mean an increased reliance on our other powers of scrutiny – namely the broad powers under which we conduct our performance reviews and, within that framework, our audits of decisions. We typically encounter very few challenges in obtaining information from the regulators under section 29, thanks to the specific nature of this power, and our well-established and understood processes. In contrast, we have encountered difficulties in obtaining information as part of the performance review process, as well as when

⁹ Professional Standards Authority 2017, *Right-touch reform - a new framework for assurance of professions*. Available at: <https://www.professionalstandards.org.uk/publications/detail/right-touch-reform-a-new-framework-for-assurance-of-professions>

undertaking special investigations because of the absence of express powers linked to the exercise of our functions.

- 10.4 Section 27(1) of our legislation¹⁰ confers on regulatory bodies a duty to co-operate with the Authority. The 2002 Act does not however contain any power for the Authority to require the disclosure of information for the exercise of its functions. In contrast, the regulatory bodies all have these powers to require information.
- 10.5 Given our shared goal to protect the public, it would seem anomalous for the Authority not to be granted the same powers that are available to the regulators, that we have demonstrated are needed. We know that the mere existence of shared goals and a duty to cooperate is not sufficient, because the information sharing legislation has at times been used as a defence against sharing information with the Authority in spite of it.
- 10.6 We understand there are challenges around providing wide-ranging sharing powers due to the limitations of data protection legislation. We recognise that this would require amendments to our own legislation, however we would welcome a commitment from Government that it will work with us to make the necessary changes.

11. Do you agree or disagree that regulators should produce an annual report to the Parliament of each UK country in which it operates? Please give a reason for your answer.

- 11.1 We agree with the proposal that regulators should produce an annual report for each UK country in which it operates. Regulators of different sizes are likely to have different levels of resource to direct towards this requirement. There may need to be some flexibility about the format and approach to reporting to avoid creating disproportionate burdens.

12. Do you agree or disagree that the Privy Council's default powers should apply to the GDC and GPhC? Please give a reason for your answer.

- 12.1 We agree that the Privy Council's default powers should apply to the GDC and the GPhC. These provide an important safety net in the case of a regulator failing to deliver its statutory functions. This will need to be joined up with the Authority's own assessment of how a regulator is performing. It may be appropriate for the Privy Council to seek the advice of the Authority on when use of such powers may be justified.
- 12.2 However, when set alongside the range of other mechanisms intended to promote regulator accountability this may be insufficient. There is a significant gap between the Authority's performance review of the regulators (retrospective, with no powers to influence processes or direct change) and the Privy Council default powers which are only intended to be used in extreme situations. With the increased autonomy for regulators to make changes to their

¹⁰ The National Health Service Reform and Healthcare Professions Act 2002, available at: <https://www.legislation.gov.uk/ukpga/2002/17/contents>

own operating processes through rules, in our view there is a need for at a minimum some form of independent, external oversight of this process.

13. Do you agree or disagree that all regulators should have the power to set: standards for the outcomes of education and training which leads to registration or annotation of the register for individual learners; standards for providers who deliver courses or programmes of training which lead to registration; standards for specific courses or programmes of training which lead to registration; additional standards for providers who deliver post-registration courses or programmes of training which lead to annotation of the register; and additional standards for specific courses or programmes of training which lead to annotation of the register? Please give a reason for your answer.

- 13.1 We agree that the regulator's role in education and training should focus on those qualifications that lead to either entry or an annotation on the register. This provides reassurance to the public and other stakeholders, such as employers, that health and care professionals have achieved appropriate standards in education and training.
- 13.2 When the policy is translated into legislation, however, we would expect the regulators to continue to have duties, rather than simply powers, in relation to education and training. It is only by setting standards for the outcomes of education and training (and carrying out quality assurance activities in relation to these standards) that the regulators can be reassured that they are registering safe and effective practitioners.
- 13.3 Therefore, in the case of qualifications leading to entry on the register, regulators should have a duty to set the standards for individual learners (the first bullet point in Question 13, typically expressed by regulators as 'standards of proficiency' or 'learning outcomes'). The regulators should also be required to have a way of checking that education/training and assessments are sufficient to ensure that those qualifying are safe and effective health and care practitioners.
- 13.4 The environments in which registrants train to achieve a qualification leading to annotation on the register may differ from those for initial qualification. However, it would be beneficial to have consistency across the two sets of standards, where possible. In the cases where education and training providers run courses and programmes for both pre- and post-registration qualifications, this may assist in enabling more streamlined quality assurance processes. Having consistent standards, where appropriate, may also increase confidence in the regulators.
- 13.5 No explicit reference is made to assessments in Question 13. We would expect the standards that fall under bullet points two to five to cover assessments, as well as education and training.
- 13.6 At this stage, it is unclear whether the powers set out in Question 13 would enable the regulators to undertake inspections of education and training provision (either one programme/course/provider or several of these at a time)

in response to a particular risk that has been identified. To be able to do so would be an important safeguard for addressing issues that may have an impact on the safety of patients or service users.

14. Do you agree or disagree that all regulators should have the power to approve, refuse, re-approve and withdraw approval of education and training providers, qualifications, courses or programmes of training which lead to registration or annotation of the register? Please give a reason for your answer.

- 14.1 We support this proposal. It is the approved qualification that enables the practitioner to join the register or have an annotation on it. However, we agree that, as part of the inspection process, the regulators should have the ability to verify and make decisions on the quality of courses, programmes of training, assessments and education and training providers. These decisions should include approval, refusal, re-approval and withdrawal of approval.
- 14.2 There is no clear provision outlined in this section for provisional approval of new qualifications where the first cohort of students or trainees has not yet completed a full education or training programme.
- 14.3 As mentioned in our general comments on the education and training section, we are concerned that the role of patients, service users and the public (as well as students and trainees) in the approvals process is not mentioned. We would support a requirement to involve patients and service users in evidence-gathering exercises/decision-making processes, although this requirement need not be prescriptive in the detail.

15. Do you agree that all regulators should have the power to issue warnings and impose conditions? Please give a reason for your answer.

- 15.1 We agree. This appears to be a reasonable proposal in principle since it will allow regulators to address concerns rather than simply approve a course or withdraw (or refuse) approval. These binary options can have significant consequences in terms of patient safety or access to education and training respectively. We would welcome, however, a better understanding of the circumstances in which it is intended that warnings would apply.

16. Do you agree or disagree with the proposal that education and training providers have a right to submit observations and that this should be taken into account in the decision-making process? Please provide a reason for your answer.

- 16.1 We agree with the proposal that education and training providers have a right to submit observations and that these should be taken into account in the decision-making process. This will help ensure fairness and transparency, as well as mitigate against a decision being made on the basis of a misunderstanding.

17. Do you agree that: education and training providers should have the right to appeal approval decisions; that this appeal right should not apply when conditions are attached to an approval; that regulators should be required to set out the grounds for appeals and appeals processes in rules? Please provide a reason for your answer.

17.1 We agree with the proposals set out in the first and third bullet points. However, we recommend exploring and mitigating against any situations where a consequent delay in suspending approval may have implications for patient safety.

17.2 We do not agree that this appeal right should not apply when conditions are attached to an approval. It is possible that the conditions themselves may have a significant impact on the education and training providers and the conclusions of the regulators could be disputed.

18. Do you agree or disagree that regulators should retain all existing approval and standard setting powers? Please provide a reason for your answer.

18.1 We recognise that there are differences in models of education and training across the various healthcare professions and this may justify the need for powers additional to those already mentioned in this part of the consultation document. We have reviewed the brief descriptions in the consultation document of the circumstances in which regulators currently have additional powers. At this time, we do not have any evidence to suggest that it would be appropriate for any of these powers to be removed.

19. Do you agree or disagree that all regulators should have the power to set and administer exams or other assessments for applications to join the register or to have annotations on the register? Please provide a reason for your answer.

19.1 We agree, but only when the assessments are not taken by students and trainees who have successfully completed an education or training programme leading to an approved or registrable qualification. The most obvious example of a justified exception is the case of international applications to the registers. In the absence of the quality assurance mechanisms described in preceding paragraphs, we can see an argument for the regulators running national assessments; in these circumstances they would provide the necessary evidence that an individual is fit to join a register.

19.2 Where quality assurance processes already exist, a national assessment would seem an unnecessary extra regulatory step that is not proportionate, introduces additional costs in the system and is not necessary for public protection. An additional assessment would have implications for flow of workforce, introduce more barriers into the system, and may prohibit mobility of professionals.

19.3 If it is deemed necessary for all regulators to have the power to set a national assessment (for example, in the case of international applicants to the register),

this should only apply where students and trainees have not already successfully completed all the required quality-assured education, training and assessments.

20. Do you agree or disagree that this power to set and administer exams or other assessments should not apply to approved courses or programmes of training which lead to registration or annotation of the register? Please provide a reason for your answer.

20.1 We refer to the point we made in our response to the preceding question that unnecessary extra regulatory steps should not be put in place for those wishing to join a professional register. Regulators should not set or administer exams or assessments that duplicate those already undertaken as part of a course or programme of training.

21. Do you agree or disagree that regulators should be able to assess education and training providers, courses or programmes of training conducted in a range of ways? Please provide a reason for your answer.

21.1 We agree that regulators should be able to assess education and training providers, courses or programmes of training in a range of ways. We know from our review of the regulators' responses in the initial stages of the Covid-19 crisis that regulators have adapted to inspecting and 'visiting' courses and programmes through a variety of methods.¹¹ We also recognise that, increasingly over the years, a greater range of robust data which could be reviewed at the desk-top has become available to inform the assessment of education and training providers, courses and programmes.

21.2 In order to reduce the regulatory burden, however, it would be beneficial for a consistent approach and standards to be applied by the regulators, where possible. Since education and training institutes may provide courses and programmes for a range of different healthcare disciplines, a consistent approach and standards would enable the regulators to draw more easily upon each other's evidence, as well as make joint inspections easier to facilitate. This would reduce the burden on education and training providers too.

22. Do you agree or disagree that the GMC's duty to award CCTs should be replaced with a power to make rules setting out the procedure in relation to, and evidence required in support of, CCTs? Please give a reason for your answer.

22.1 If the proposal is to enable other bodies to award CCTs according to rules set by the GMC, this appears reasonable. However, paragraph 134 states that 'if it

¹¹ Professional Standards Authority, 2021. *Learning from Covid 19: a case-study review of the initial crisis response of 10 UK health and social care regulators in 2020*; p.77. Available here: https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/learning-from-covid-19-a-case-study-review-of-the-initial-crisis-response-of-professional-regulators.pdf?sfvrsn=c6ad4920_6

determines that it is appropriate to do so, the GMC will be able to continue awarding CCTs...’ We would welcome clarification on whether or not the intention of the proposal is to enable the GMC, as well as other bodies, to award CCTs.

- 22.2 Paragraph 134 also states that the GMC may determine that ‘it is no longer necessary to award CCTs before registrants have qualifications annotated on the register’. We would welcome clarification on whether or not the intention of the proposal is for doctors to be eligible for annotation as a specialist without holding a CCT. It would appear reasonable to enable flexibility in training leading to annotation on the medical register.

23. Do you agree or disagree that regulators should be able to set out in rules and guidance their CPD and revalidation requirements? Please give a reason for your answer.

- 23.1 We agree, but with the caveat that the regulators should have a duty – rather than simply powers – to set out in rules and guidance their continuing fitness to practise requirements. It is essential that healthcare professionals demonstrate their continuing fitness to practise.

- 23.2 As outlined in our policy advice on this issue,¹² it is important that continuing fitness to practise requirements are proportionate to the risks arising from the professions, focusing on conduct, as well as competence. Systems should be targeted towards public protection and ensuring that registrants remain up to date in all relevant areas of practice. They should also make use of any existing local or national mechanisms, where possible.

24. Do you agree or disagree that the regulators should hold a single register which can be divided into parts for each profession they regulate? Please give a reason for your answer.

- 24.1 We agree that the way in which registers are held should be consistent across the regulators and support a simplified approach that offers greater clarity to the public and other stakeholders. However we do not have a firm view on the relative merits of whether regulators should hold a single register or multiple registers.

Types of registration

- 24.2 There are no explicit proposals about bringing consistency and clarity to the types of registration that regulators can provide. Paragraph 189 of the consultation document says that ‘legislation generally outlines the different types of registration that an applicant can apply for’, and the types of registration listed are full, temporary, and conditional (defined as ‘where a registrant can practise subject to certain conditions’). However, it is not explicit

¹² Professional Standards Authority, 2012. *An approach to assuring continuing fitness to practise based on right-touch regulation principles*. Available here: https://www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/continuing-fitness-to-practise-based-on-right-touch-regulation-2012.pdf?sfvrsn=68c67f20_6

whether the intention is for all regulators to provide these kinds of registration. Historically, conditional registration has not been available to all regulators.

- 24.3 There is also no information about how these different types of registration should be used, for example, through annotations. Paragraph 163 of the consultation document says 'where an annotation reflects a decision to restrict a registrant's scope of practice or registration, for example where a registrant holds only temporary or provisional registration rather than full registration', but nowhere is this intention made explicit.
- 24.4 The Law Commissions previously recommended that the regulators should be able to register professionals on either a full, conditional (in fitness to practise cases) or temporary basis, with powers to introduce provisional registration should they choose to do so.¹³ We supported this recommendation and called for clear definitions of the different types of registration on the face of the statute to ensure some consistency of implementation. Though these recommendations were not acted upon, we have continued to make the case for greater clarity about the use and purpose of conditional registration powers, most recently in relation to Social Work England's registration rules.¹⁴
- 24.5 If it is the intention for all regulators to provide conditional registration, clarification is needed about how these powers would fit with conditions applied through the fitness to practise process. It appears that there may be a risk of very similar cases, for example health cases, being dealt with through different channels with potentially different outcomes. With no detail about conditional registration within legislation, this could lead to inconsistencies across regulators, which may give rise to fairness concerns.
- 25. Do you agree or disagree that all regulators should be required to publish the following information about their registrants: name; profession; qualification (this will only be published if the regulator holds this information. For historical reasons not all regulators hold this information about all of their registrants); registration number or personal identification number (PIN); registration status (any measures in relation to fitness to practise on a registrant's registration should be published in accordance with the rules/policy made by a regulator); registration history. Please provide a reason for your answer.**
- 25.1 In principle we support the specification of minimum data requirements for the registers to ensure greater consistency. Though we do not hold a particular view on whether these items are necessarily the ones that should be included, we believe that all information a regulator publishes on the register should be

¹³ Law Commissions (5.59; Recommendation 32) https://s3-eu-west-2.amazonaws.com/lawcom-prod-storage-11jsxou24uy7q/uploads/2015/03/lc345_regulation_of_healthcare_professionals.pdf

¹⁴ Professional Standards Authority (2019) *Response to the Social Work England consultations on rules and standards*. Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/consultation-response/others-consultations/2019/professional-standards-authority-response-swe-rules-and-standards.pdf?sfvrsn=802e7420_4

necessary for public protection purposes. An assessment of this should guide what the registers are required to show¹⁵.

- 25.2 Regarding registration status, the document proposes that any measures in relation to fitness to practise on a registrant's registration should be published in accordance with the rules or policy made by a regulator. We believe this could contribute to inconsistencies across the registers which are undesirable from the standpoint of public protection, particularly in relation to how each regulator displays erased registrants, where there are already different approaches across the regulators.
- 25.3 In our view, a lack of consistency across the registers in displaying erased registrants has direct implications for the level of assurance available to the public or employers regarding different professions. In *Right-touch reform* and in previous work on how to maximise the contribution of registers to public protection and patient safety¹⁶, we have recommended that all regulators should display information about individuals who have been erased for a minimum of five years. This reflects our position that a minimum of five years should elapse before a registrant who has been struck off can reapply to join the register. We believe it would be relatively straightforward to introduce this in the legislation.
- 25.4 The Authority has identified numerous other disparities in the ways that regulators currently display fitness to practise information on their registers.¹⁷ This includes variations in the length of time that sanctions are displayed on registers, which has implications both for fairness to registrants and providing sufficient information for public protection¹⁸. We would encourage further consideration as to whether, for these reasons, there should be greater consistency on this point within the legislation.

¹⁵ For research with the public exploring their views on this matter, please see Professional Standards Authority, 2010. *Health professional regulators' registers: Maximising their contribution to public protection and patient safety*. Available at <http://www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/healthprofessional-regulators-registers-2010.pdf?sfvrsn=8>.

¹⁶ Professional Standards Authority, 2010. *Health professional regulators' registers: Maximising their contribution to public protection and patient safety*, pg. 24. Available at <http://www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/healthprofessional-regulators-registers-2010.pdf?sfvrsn=8>

¹⁷ Professional Standards Authority, 2017. *Right-touch reform: A new framework for assurance of professionals*; Appendix VI, pages 211-215. Available here: https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-reform-2017.pdf?sfvrsn=2e517320_7.

¹⁸ This reflects the findings of research we have recently commissioned to explore patient, registrant and the public's views about the extent to which they consider consistency valuable between the regulators across the different functions: https://www.professionalstandards.org.uk/docs/default-source/publications/research-paper/does-consistency-between-regulators-matter.pdf?sfvrsn=fbcc4920_4

26. Do you agree or disagree that all regulators, in line with their statutory objectives, should be given a power allowing them to collect, hold and process data? Please give a reason for your answer.

26.1 We agree with this proposal but note that the discretionary powers for regulators to publish additional information may result in inconsistencies across the registers. This could be confusing for those consulting registers. While we recognise that regulators may wish to hold a range of different information for different purposes, our view is that a consistent approach to the information provided on the public-facing register, with a clear focus on the public protection purpose, would be beneficial. We have provided further comment on the broader proposals around data sharing in our response to question 10.

27. Should they be given a discretionary power allowing them to publish specific data about their registrants? Please give a reason for your answer.

27.1 We agree that regulators should have a discretionary power to request and publish specific data where this is in line with their statutory objectives only.

27.2 We note that in recent months, there has been some concern about the publication on registers of registrants' protected characteristics – in particular, gender – and its implications for the rights of registrants and patients. It may therefore be beneficial to encourage regulators to consider any EDI implications of exercising this power.

28. Do you agree or disagree that all regulators should be able to annotate their register and that annotations should only be made where they are necessary for the purpose of public protection? Please give a reason for your answer.

28.1 We agree that annotation should only be used when necessary for public protection and that all regulators should be given consistent powers to annotate the register where required.

28.2 Paragraph 162 proposes that regulators should be able to charge a fee for making annotations to a register entry. It would be helpful to understand more about the intention behind this proposal. If annotations are only to be used where it is necessary for public protection or where there is a legal requirement, it is unclear why it would be appropriate to charge individual registrants for this.

29. Do you agree or disagree that all of the regulators should be given a permanent emergency registration power as set out above? Please give a reason for your answer.

29.1 We agree with this proposal, subject to further exploration of the value of emergency registration in the regulators' response to the pandemic. Our *Learning from Covid-19* review details the various approaches that regulators with emergency powers took to establishing their temporary or provisional

registration processes during the pandemic in 2020.¹⁹ We recommended that there would be benefit in reviewing the value to the pandemic response of the establishment of temporary and provisional registration set against the risks and costs, and whether value would have been added to the pandemic response by any other regulators having had these powers which did not. Such review should include the experiences of those temporarily registered, and wider impacts including on public confidence.

29.2 Although regulators clearly need to be agile in their response to an emergency, there is also potential value in ensuring consistency across approaches to temporary registration for greater simplicity and confidence. We would encourage further evaluation of the different approaches taken by the regulators in 2020, as well as their associated risks and costs, to support decisions about what level of detail about this power should be set out in legislation, and where regulators may benefit from guidance on using emergency registration powers in the future.

30. Do you agree or disagree that all regulators should have the same offences in relation to protection of title and registration within their governing legislation?

30.1 We acknowledge that this proposal would provide a level of consistency. However, we are mindful of the Law Commissions' recommendation for a root and branch review of existing provisions, which form an important part of the regulatory system but are currently often poorly defined.²⁰ We therefore welcome the commitment to review whether the current protected titles are the right ones when each regulator's legislation is reviewed (paragraph 173 of the consultation document).

30.2 When we consulted with the regulators on this topic in 2010, there was little confidence that legislative change would help to prevent unregistered practice.²¹ It is important that protected titles retain meaning and integrity in the eyes of the public. Titles are meaningless if they are not protected. If misuse of title persists unchecked, the public is at risk of harm and regulation is at risk of losing public confidence.

31. Do you agree or disagree that the protection of title offences should be intent offences or do you think some offences should be non-intent

¹⁹ Professional Standards Authority (2021) *Learning from Covid-19: A case-study review of the initial crisis response of 10 UK health and social care professional regulators in 2020*. Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/learning-from-covid-19-a-case-study-review-of-the-initial-crisis-response-of-professional-regulators.pdf?sfvrsn=c6ad4920_6

²⁰ Law Commissions (2014) *Regulation of healthcare professionals; Regulation of social care professionals in England* (13.23) Available at: https://s3-eu-west-2.amazonaws.com/lawcom-prod-storage-11jxou24uy7q/uploads/2015/03/lc345_regulation_of_healthcare_professionals.pdf

²¹ CHRE (2010). *Protecting the public from unregistered practitioners: Tackling misuse of protected title*. Available at: https://www.chre.org.uk/_img/pics/library/100208_Protecting_the_public_from_unregistered_practitioners.pdf

offences (these are offences where an intent to commit the offence does not have to be proven or demonstrated)? Please give a reason for your answer.

31.1 We support the view that title offences should be treated as intent offences, on the grounds that it is oppressive to prosecute people who are genuinely acting in good faith and out of ignorance. In practice, regulators will begin with a cease and desist letter before prosecuting and do not normally prosecute if the individual stops.

32. Do you agree or disagree with our proposal that regulators should be able to appoint a deputy registrar and/or assistant registrar, where this power does not already exist? Please give a reason for your answer.

32.1 We agree with this proposal. We are aware that the lack of ability to do so has proved challenging for some regulators in the exercise of their regulatory functions.

33. Do you agree or disagree with our proposal that regulators should be able to set out their registration processes in rules and guidance? Please give a reason for your answer.

33.1 We do not have a firm view on this proposal. Although we acknowledge the intention to give regulators greater flexibility to set their own registration processes, as it stands the proposal does not address inconsistencies that potentially undermine the coherence of the regulatory system, for example, on types of registration – see our comments under question 24 above. Our general comments about consistency and oversight of rules apply here (see response to question 2 above).

34. Should all registrars be given a discretion to turn down an applicant for registration or should applicants be only turned down because they have failed to meet the new criteria for registration? Please give a reason for your answer.

34.1 We support the intention to bring consistency across the GMC and other regulators' frameworks for registration. We do not have a firm view on whether all registrars should have discretionary powers to turn down an applicant. In the vast majority of cases appropriate and comprehensive criteria should avoid the need for the use of discretion.

34.2 We are aware that inflexible legislation currently means some regulators are unable to refuse registration to those who meet the registration requirements, despite relevant health or character declarations. They are therefore required to register applicants then refer them straight into the fitness to practise process, which potentially raises efficiency and proportionality issues. Paragraph 201 of the consultation document suggests that the intention here is for there still to be

discretion within the registration criteria, but we would welcome clarity from Government on this point.

34.3 If all registrars were given this discretion, we would hope to see clear guidance setting out its circumstances and what registrars would need to take account of if exercising it to manage the risk of discriminatory practices. This would help to ensure consistency and fairness to applicants. If the new criteria for registration are comprehensive any discretion should only apply in a very few and exceptional cases.

35. Do you agree or disagree that the GMC’s provisions relating to the licence to practise should be removed from primary legislation and that any requirements to hold a licence to practise and the procedure for granting or refusing a licence to practise should instead be set out in rules and guidance? Please give a reason for your answer.

35.1 We welcome this attempt to improve alignment across the regulators. We do not have a firm view on the merits or otherwise of this proposal, which would see the licence to practise managed as an annotation set out in rules by the GMC (paragraph 203 of the consultation document). However, we can foresee this raising numerous practical and policy challenges, as well as a risk of lack of clarity to the public and wider stakeholders about the purpose and status of annotations. We would expect to have the opportunity to discuss these challenges in due course so we have not detailed them here.

36. Do you agree or disagree that in specific circumstances regulators should be able to suspend registrants from their registers rather than remove them? Please give a reason for your answer.

36.1 We do not have a firm position on this proposal. There are a number of points of clarification which would be helpful as below.

36.2 We note that all the reasons for administrative suspension listed in paragraph 206 also feature in the reasons for administrative removal (paragraph 208). As persons who have undergone administrative removal can appeal this decision and be restored, we are unclear when and why it would be appropriate for a regulator to pursue either suspension or removal. We would welcome additional clarification about this, as well as how long suspensions should apply for or what would happen if the reasons for suspension are rectified within the time period. This proposal has the potential to lead to inconsistencies across the regulators which have fairness implications for registrants.

36.3 We would also welcome further detail about the third reason: ‘failure to provide any information reasonably required by the regulator pursuant to its statutory objectives and functions’ – in particular, what issue does this aim to address, and given its broad application, what mechanisms would be in place to ensure it is used proportionately.

36.4 The proposal would enable registrars to take the sort of decisions that panels are normally expected to take. Unless there is clear guidance about the difference between the two sanctions, panels should decide.

37. Do you agree or disagree that the regulators should be able to set out their removal and readmittance processes to the register for administrative reasons in rules, rather than having these set out in primary legislation? Please give a reason for your answer.

37.1 We neither agree nor disagree with this proposal.

On voluntary removal

37.2 While we think that in principle it is appropriate for part of these processes to be set out in rules, it would be helpful for some limits to be set in legislation on how this process can operate. This is because there should be consistency across the regulators in the circumstances in which voluntary removal can apply, and to an extent, how it works. In addition, it is not in the public interest for registrants to be able to avoid investigation or sanctions in respect of serious misconduct simply by leaving the register voluntarily unless there is good reason.

37.3 There are two categories of concerns where voluntary removal is likely to be considered. The first is the registrant who is either seriously or terminally ill with no prospect of return to practise. The second is the registrant who no longer wishes to practise. In both cases there need to be ways of ensuring that any concerns have been addressed if the registrant should either recover unexpectedly or change their mind. This means that (a) the registrant should agree the facts and (b) there should be a mechanism for ensuring that the regulator is able to assess the registrant's fitness to practise before they are returned to the register.

37.4 Therefore, voluntary removal should only be used in limited circumstances:

- Where the concerns about the registrant's fitness to practise are limited to risks to the public, not so serious as to require a public hearing or engage the public interest limbs of the overarching objective
- Where assurances that the registrant does not intend to practise again have been obtained; but at the same time there should be a clear process for any who do choose to apply to return to the register, an ideally this should be done through a robust restoration process (see our concerns above about the restoration proposals)
- Where the investigation is sufficiently advanced to ensure that no aspects of the case have been overlooked, and there is enough certainty about the concerns to inform a decision in the event of an application for restoration
- The decision must be published.

37.5 Some of the regulators we oversee operate voluntary removal processes that are not explicitly set out or allowed in legislation, and we have expressed some concerns about this. We therefore welcome the proposal that regulators should

be empowered in legislation to determine the processes in rules, but we are concerned that no limits should be put on their use to ensure that they protect the public fully.

On administrative action for health and English language concerns

- 37.6 Although not explicitly covered by the question, we wish to comment on the Government proposal that regulators should be able to make rules to allow for action to be taken where there are health or English language concerns about a registrant. We do not support this proposal.
- 37.7 We know from experience that having parallel, compartmentalised processes like this causes unnecessary complications. They can lead to unfairness where different processes produce different outcomes. They can also increase risks to the public if cases are sent down the wrong route, because this can be a deterrent to the concerns being explored more fully. We also question when these powers might be used, given that the grounds for action are intended to make regulators *'focus on the most serious concerns; those that could put patients or the public at risk or affect the public's confidence in the profession'*.

Lapsed registration and Authority appeals

- 37.8 On a separate point, we note that the consultation does not reference any proposals to address a loophole in some of the regulators' legislation, which allows registration to lapse if a registrant has not paid the necessary registration fees. This can cause significant problems if the registration in question is due to lapse during or before the Authority is able to lodge an appeal under our section 29 powers. If a registrant lapses before an appeal is concluded either by consent or following consideration by the High Court, then they could seek to frustrate the Authority's appeal right, if a registrant could avoid the scrutiny of an appeal by deciding to opt for voluntary erasure (from *PSA v GMC and Dighton*, para 33).
- 37.9 This is an issue that we have raised several times, including to the previous Secretary of State, who recognised the challenges presented by this issue. The Law Commissions included a proposal to address this issue in their draft bill.
- 37.10 On several occasions over recent years we have been forced to seek an injunction from the High Court to prevent the NMC from removing individual registrants from its register before the High Court could address our referral of the relevant fitness to practise panels' decisions.²² Such action is costly and time-consuming. This would be a timely opportunity to close this legislative loophole.

²² Professional Standards Authority (2016) *Review of professional regulation registration and Annual Report and Accounts 2015/2016*. Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/annual-reports/annual-report-and-accounts-2015-2016.pdf?sfvrsn=9be67120_4

38. Do you think any additional appealable decisions should be included within legislation? Please give a reason for your answer.

38.1 We are not clear why the decision not to grant a person voluntary removal from a register has been included in this list, owing to its close ties to the fitness to practise process. While we would not say that this decision should not be appealed, practically, regulators may want to ensure that any such appeals do not hold up the fitness to practise process.

39. Do you agree or disagree that regulators should set out their registration appeals procedures in rules or should these be set out in their governing legislation? Please give a reason for your answer.

39.1 We agree with this proposal. We believe that the statute should set out the regulators' duty to establish an appeals process, under which we would expect regulators to continue to meet our standards in this area.

39.2 We reiterate our previous comments about the need to balance flexibility and consistency, which similarly apply here. It may be helpful to review whether flexibility is desirable in this area as divergence in approach between regulators may have implications for patient safety and fairness towards registrants.

40. Do you agree or disagree with our proposal that the regulators should not have discretionary powers to establish student registers? Please give a reason for your answer.

40.1 We agree with this proposal. In our view, student registration is probably unnecessary as any risk can be managed by pre-registration²³. Maintaining a student register may mean use of excess regulatory force by a regulator, as well as unnecessary administrative burden.

41. Do you agree or disagree with our proposal that the regulators should not have discretionary powers to establish non-practising registers? Please give a reason for your answer.

41.1 We agree with this proposal. We have previously set out our view that non-practising registers are a relic of self-regulation and serve no public protection function.²⁴ The reasons for which regulators have previously used non-practising registers are better addressed in other ways including by other organisations.

41.2 We recognise that historically the GMC has been exceptional because its licensing structure made the use of non-practising status necessary. Given the proposal for the licence to practise to become an annotation, we are unclear whether the proposal for regulators not to have non-practising registers would have implications for the reformed GMC.

²³ Professional Standards Authority (2017) *Right-touch reform* (5.59)

²⁴ Professional Standards Authority (2017) *Right-touch reform*.

42. Do you agree or disagree that the prescriptive detail on international registration requirements should be removed from legislation? Please give a reason for your answer.

42.1 We agree with this proposal. We are aware that, for some of the regulators, the prescriptive nature of their legislation acts as a barrier to the expedient registration of overseas applicants.

42.2 We note the proposed changes to the international registration processes operated by the GDC and NMC in section 7 of the document. We welcome the forthcoming consultation on these proposals. We are also aware of the ongoing work by the Department for Business, Energy, and Industrial Strategy to develop a coherent UK-wide framework for the recognition of professional qualifications, as well as the Professional Qualifications Bill currently before Parliament. We hope to see alignment between the work that DHSC is taking forward around international registration of healthcare professionals and broader Government objectives in this area.

43. Do you agree or disagree with our proposal that regulators should be given powers to operate a three-step fitness to practise process, covering: 1: initial assessment; 2: case examiner stage; 3: fitness to practise panel stage? Please give a reason for your answer.

43.1 We neither agree nor disagree.

43.2 We welcome the desire to develop elements of the process that could be less adversarial, but each element must deliver public protection, noting that speed does not always equate to public protection, which must be paramount. The emphasis on reflection and learning is helpful but this must be meaningful, and we would expect there to be evidence that this has been embedded in the registrant's practice.

43.3 However, there is insufficient detail in the consultation document for us to provide a fully considered response to this question. In particular, the initial assessment stage requires clarification:

- 1) Where in the process will the decision-making take place, at which point cases can either be closed or moved on to the next stage?
- 2) Where in the process will the meaningful investigation take place?
- 3) What thresholds will be applied?

43.4 With regards to 1) and 2), currently, the regulators generally have two decision-making or sifting stages before a case is considered for adjudication. Taking the GMC as an example, it has a triage stage at which it can make preliminary enquiries, in order to establish whether the case meets the criteria for full investigation. Cases that pass triage are then investigated. At the end of investigation comes a further sift, carried out by case examiners. They apply the 'real prospect test' to determine whether it is likely that a panel would find impairment based on the seriousness of the allegations, and the evidence available to support them. Cases that meet the real prospect test are either

referred to a panel, or dealt with through undertakings agreed with the registrant, without referral to a hearing.

- 43.5 This two-stage decision-making enables the regulator:
- to close down at the earliest points cases that have no prospect of calling into question the registrant's fitness to practise, and
 - to reconsider those that have been subject to a full investigation, to establish whether with more information available the seriousness and evidential thresholds are met.
- 43.6 The consultation document on the other hand describes the 'initial assessment stage' as though it were a single sifting stage. It gives no consideration to where the investigation would take place. It is important for the public to have clarity about when and how a concern is investigated, so that there is confidence in decisions to close cases down before they reach the adjudication.
- 43.7 In our 2017 report *Right-touch reform*²⁵ we considered the different models in operation across the regulators for the early stages of fitness to practise. We found a lack of transparency as a result of these stages largely not being captured by the legislation. We also found problematic variation across the regulators in how these stages worked, where differences in process could lead to unjustifiable disparities in outcome.
- 43.8 In addition, the consultation largely avoids the question of thresholds for action in fitness to practise and how they should be framed and tested at different stages of the process. This is another area we considered needed greater clarity and consistency in our 2017 report, with reference to the thinking that the Law Commissions had put into this question. Echoing that point made in paragraph 264 of the consultation document, clear thresholds are essential to ensure that the right sorts of concerns are brought to the regulator's attention, and provide clarity and transparency to complainants and registrants.
- 43.9 The proposals in the consultation document would exacerbate all these issues. They would remove what little detail there is currently in legislation, and create the conditions ripe for opacity, along with significant unjustifiable disparity.
- 43.10 The question of whether a sift would occur at the end of the investigation stage is significant, because this sift is the cut-off point beyond which the Authority's powers of appeal are intended to take effect, as well as the corresponding registrant rights of appeal to the higher courts. Broadly speaking, it is also the cut-off point for publication of fitness to practise decisions, noting that most regulators publish decisions made by panels even when impairment is not found.
- 43.11 We cover these points in more detail later in our response.

²⁵ https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-reform-2017-fitness-to-practise.pdf?sfvrsn=49517320_8

44. Do you agree or disagree that:

- All regulators should be provided with two grounds for action – lack of competence, and misconduct?
- Lack of competence and misconduct are the most appropriate terminology for these grounds for action?
- Any separate grounds for action relating to health and English language should be removed from the legislation, and concerns of this kind investigated under the ground of lack of competence?
- This proposal provides sufficient scope for regulators to investigate concerns about registrants and ensure public protection? Please give a reason for your answers.

44.1 We disagree.

44.2 We are unfortunately not in a position to support this move to two grounds for action, because it appears to us that the risks of this approach are high, while the benefits have yet to be clearly articulated. We also note from conversations with patient and registrant representative bodies that there appears to be very little understanding of and support for this proposal among these key groups.

44.3 Our position is underpinned by the following factors:

- That regulators will not be able to take proactive action to protect the public where no harm has yet occurred
- The lack of information about the policy itself, the purpose of this change, and evidence or analysis to support it
- The fact that there do not appear to us to be any matters excluded by the existing grounds that should be covered, or matters captured by the current grounds that are not fitness to practise issues
- The potential for this change to redefine the meaning and purpose of key fitness to practise concepts either as an unintended consequence, or as an intended consequence, which would have significant public protection implications that do not appear not to be reflected or supported in the overarching objective
- The potential for this change to make the process more adversarial by introducing new opportunities to challenge whether a particular allegation might be capable of impairing fitness to practise, where currently there are none
- The potential cumulative effects of changes across all aspects of fitness to practise policy and process making the implications of individual changes harder if not impossible to assess
- The lack of consensus among regulators on this policy change.

44.4 We support the move to a more consistent approach, if that is what is driving this policy, but do not consider that reducing the number of grounds is likely to be the right solution.

- 44.5 The most obvious alternative, consisting of retaining the current list of grounds for action, to be applied consistently across all regulators, would address the problems of inconsistency without risking undermining the current fitness to practise framework.²⁶
- 44.6 The consultation states that health issues would fall under the competence ground. While this is likely to be the case for most concerns, some may more appropriately be classified as misconduct. If the Government does go ahead with this proposal, or something similar, this should be allowed for in the legislation.

The benefits of the current approach

- 44.7 It seems to us on initial review that the current approach has a number of benefits that could be lost through the proposed changes.
- 44.8 Our primary concerns relate to the removal of specific grounds relating to health, and to a lesser extent English language, bearing in mind the latter is only available to the GMC, NMC, GDC, GPhC, and PSNI.

Being able to take preventative action before harm occurs

- 44.9 The change would require regulators to demonstrate that allegations relating to either of these two concerns constituted either misconduct or a lack of competence. Currently the simple demonstration that the registrant fails to meet the requirements relating to language competence or health in a way that puts the public at risk is enough to justify and enable a finding of impaired fitness to practise, and appropriate action on registration.
- 44.10 What this means is that regulators can take remedial action through fitness to practise on the basis of health or, for the relevant regulators, English language issues, before any harmful incident has occurred. We know that this is a power that some of the regulators value. We ourselves consider this to be a beneficial and appropriate use of regulatory force to protect the public from an unwarranted risk of harm, compared to the alternative of having to wait for a patient to have been harmed.
- 44.11 This point was made strongly by the Department of Health in relation to the ability to bring English language competence cases, in its report on the 2014 consultation on this topic:

'The Department does not consider that the NMC, GDC, GPhC or PSNI currently have power to take fitness to practise action where there are serious complaints that a registered professional working in the UK lacks the necessary knowledge of the English language to provide safe care to patients, but where this has not yet given rise to deficient performance in practice. We therefore propose to take a similar approach to that taken in relation to doctors, and add this as an additional ground to enable the regulatory bodies to take pre-emptive action to prevent harm to patients. There is no evidence that this power would lead to vexatious complaints and we are of the view that without it regulatory bodies are not able to

²⁶ Noting that some regulators (GOsC, GCC) do not currently separate impairment from grounds.

*take the necessary action needed where language competence is a cause for concern but there is no deficient performance in practice.*²⁷

Evidential thresholds and decision-maker discretion

- 44.12 In order to prove lack of competence, the case law in this area provides that a 'fair sample of work' should be put before decision-makers.²⁸ The grounds relating to health and language on the other hand bypass this, by using the relevant test or assessment as the basic benchmark.
- 44.13 The results of any such assessments provide a direct and explicit link between a failure to meet minimum requirements and impairment. Asking regulators to prove that there is link between a specific assessment outcome and lack of competence adds an extra hurdle, and creates opportunities for inconsistency.
- 44.14 While it is of course fair that registrants should have a right to challenge the case made by the regulators, we are concerned that having to present a charge as a lack of competence, or more rarely, misconduct, would create a new barrier to successful prosecution of these cases, because of the greater stigma attracted by either of the two grounds – and in the case of misconduct, more severe sanctions available. This change could make the process more adversarial than at present, which would run counter to what we understand to be the aims of these reforms.
- 44.15 We fully accept that the current powers relating to both health and language need to be used cautiously, with consideration of the potential for discrimination. But unless the Department has evidence that the current framework is risking non-compliance with human rights or equalities legislation, we do not see the argument for introducing a barrier to public protection and effectively raising the bar for regulatory action on health or English language competence concerns.

Clarity about sanctions

- 44.16 For the most part, regulators cannot remove registrants on health, competence (or in some cases performance) or English language grounds.
- 44.17 These proposals would potentially break this link between the grounds for impairment and the sanctions available to a panel. This issue could be resolved through rules or sanctions guidance but it would seem to be a step in the wrong direction and raises the possibility of inconsistencies.

A potentially discriminatory approach

- 44.18 We query whether what is being proposed would be desirable from the point of view of dealing sensitively with health and English language concerns. We are

²⁷ The Authority, along with a number of the regulators concerned, were opposed to the introduction of the new ground for English language in their responses to consultations in 2013-14. We argued that there was insufficient evidence of a problem needing to be solved, and that English language competence, like health, should only be of interest to the regulator insofar as it related either to competence or conduct and therefore captured by the existing grounds. We now have a better understanding of the practical benefits of the regulators having separate grounds, that go beyond the more theoretical position that fitness to practise can be broken down into the two categories of conduct and competence.

²⁸ See *Calhaem v GMC*, para 39. [\[2007\] EWHC 2606 \(Admin\)](#)

aware of many cases that have been dealt with sensitively and appropriately by the regulator, and where the registrant has been provided with the support they needed to address concerns. This has meant that a valuable member of the workforce has been retained.

- 44.19 We suggest that to have to characterise either issue, but particularly health, as incompetence could be seen as unnecessarily stigmatising, and represent a backward step in the approach to dealing sensitively and appropriately with health matters.

Some distinctions between health and English language competence

- 44.20 Overall, while there are many parallels between health and English language competence, we regard the *prima facie* case for a standalone ground relating to the former more compelling than the latter. That said, we do not have the data to hand regarding the number of cases brought on each of the two grounds, so this view may evolve.
- 44.21 Our reasoning is as follows. At the point of registration, the regulator must have assurances on the applicant's health as well as her or his English language skills. It would seem that the latter is less likely to deteriorate over time than the former, so we would expect more cases relating to health than language to arise – which means that the arguments for a health ground are stronger.
- 44.22 In addition, should it become apparent that registrants with insufficient knowledge of English are being admitted to the register, the regulator can amend its requirements for future applicants. No such mitigations are available for health requirements.

Grounds relating to convictions, findings by other bodies etc

- 44.23 Removing the grounds relating to convictions and findings by other bodies might have some similar effects to those described above, in particular with the introduction of an additional step to establish whether a particular conviction or determination constitutes misconduct.
- 44.24 As above, this could raise the bar for impairment, make the process more adversarial, and introduce greater scope for inconsistency of outcomes, which would be in sharp contrast to the proposed policy to allow automatic erasure for serious criminal offences.

Making these changes in the context of a move to case examiner accepted outcomes

- 44.25 Officials may wish to consider the impacts of making such a shift in the context of the introduction of accepted outcomes. The points made above about the increased scope for challenge by the registrant may be of interest when considering the likelihood of a registrant accepting the case put to her or him by a case examiner.
- 44.26 Making it harder for the regulator to prove impairment in pure health or language cases, and having to present these cases as conduct or competence failings, would undermine one of the key aims of introducing greater powers for

consensual disposal — to make the process less, rather than more, adversarial.

Thresholds for action in health and English language cases

- 44.27 The consultation document mentions that ‘addressing concerns that do not meet the fitness to practise threshold through the fitness to practise process is disproportionate and unfair.’ (para 264 of the consultation document). What is not clear is what the Government intends for the fitness to practise threshold for these cases. One reading of this proposal is that the current threshold is considered too low, which would at least explain why the grounds for action were being amended. However, no evidence is presented to support this view, and we have none of our own to present. This approach would also be lacking in transparency, as this argument is not made clear.
- 44.28 Alternatively, if the intention is to keep the same threshold as currently, we question the purpose of the change at all.
- 44.29 As we have no concerns about the regulators being able to take action based on the grounds for impairment, we would be extremely concerned if the effect, whether intentional or not, was to limit regulators’ ability to successfully prosecute health cases in particular, and English language to a lesser extent.
- 44.30 Linked to this is the proposal under question 37 that regulators should have power to take action outside the fitness to practise process where there are health or English language concerns. We question what the justification for action would be in such circumstances, as presumably the threshold for fitness to practise, described at paragraph 265 of the consultation document as ‘where conduct or competence fell below the standards set by the regulator’, would not have been met. We have responded to this proposal in more detail under the relevant question.

45. Do you agree or disagree that:

- **all measures (warnings, conditions, suspension orders and removal orders) should be made available to both Case Examiners and Fitness to Practise panels?**

- 45.1 We agree that all measures should be available to both case examiners and panels, but the proposed measures are not complete.
- 45.2 We support the ambition to bring consistency to the sanctions/measures available to regulators. We called for this in our publication *Right-touch reform*.²⁹ We also believe that the full range of sanctions should be made available to both panels and case examiners so that they can ‘address the range of scenarios in which a registrant’s fitness to practise is found to be impaired, or is below the expected standard’. However, this does not seem to be what is proposed.

²⁹ https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-reform-2017-fitness-to-practise.pdf?sfvrsn=49517320_8

- 45.3 Most of the regulators' panels currently have powers to impose a warning, or equivalent,³⁰ when the registrant has been found to be impaired. This is not proposed under the new scheme and it is unclear why not.
- 45.4 Post-impairment warnings are useful where the misconduct is sufficiently serious to warrant regulatory action for the purposes of maintaining public confidence, or declaring and upholding professional standards – but there is insufficient risk to the public to justify a restrictive sanction. This might be the case, for example, where the registrant is considered to have remediated, but the behaviour is of a sufficiently serious nature to need to be marked publicly. Such a sanction may be considered particularly useful in an emergency like the current pandemic, where greater leniency may be granted to registrants who were working under very challenging conditions, but it is nonetheless important to mark the seriousness of the misconduct. Only a finding of impairment combined with a published warning can achieve this.
- 45.5 It is impossible to predict the precise consequences of the approach. It seems likely though that some cases that would appropriately be dealt with through an impairment finding with a warning under the current framework, would be disposed of through a warning without impairment; we could also see a rise in the proportion of impairment findings without sanction (if this option is available), or even the use of more restrictive sanctions. Such workarounds would inevitably lead to inconsistencies.
- 45.6 More broadly, limiting the range of sanctions available at this stage would seem to run counter to the stated aim of giving the regulators a full suite of powers for handling fitness to practise cases. We have seen examples in MPTS cases (where there is no equivalent of a caution after impairment) where panels have provided very tortuous arguments as to why an individual is not impaired because a suspension or conditions would be inappropriate. They have then imposed a warning, but this leads to a watering down of the concept of impairment. Alternatively, they have imposed a very short suspension, which sends the wrong signal.
- 45.7 This shift could also send a signal that certain unprofessional behaviours not directly connected with patient care may be less important or worthy of action by regulators. Panels and case examiners should have all the tools they need, and this includes a low-level non-restrictive sanction when impairment is found.
- 45.8 Our second query relates to the maximum length of conditions orders. Under current legislation, it is standard for regulators to be able to impose conditions for up to three years. Some behaviour may warrant a longer period, as longstanding issues can take time to resolve, in particular where there are challenges obtaining employment. Rather than clogging up the system with review hearings, it would seem fairer, as well as more transparent and efficient to allow panels to impose from the start the length of conditions they think is appropriate.

³⁰ Currently the terminology varies between regulators.

45.9 Finally, we suggest that to build on the case law,³¹ regulators should be under a duty to publish indicative sanctions guidance, applicable to both case examiner and panel decisions, to ensure transparency, fairness, public protection, and consistency.

- **automatic removal orders should be made available to a regulator following conviction for a listed offence?**

45.10 We agree.

45.11 We welcome measures to enable serious cases to be resolved quickly, but suggest that greater clarity is required in relation to section 3 of the Sexual Offences Act. This section encompasses a range of actions, some of which may come to the regulator as a complaint without a conviction if at the lower end of the seriousness scale. In such circumstances, it would be possible for two registrants having displayed similar behaviour to be treated very differently. It might be helpful to allow for some discretion for low-level section 3 offences, so they can be considered on a case-by-case basis.

45.12 Finally, we welcome the proposal that all decisions and measures will be published along with the reasons. We would also welcome a further stipulation that the decision should clearly set out all the stages of the decision – facts found, grounds for action/impairment decision, and sanction, along with the reasoning. This would aid transparency, encourage thorough decision-making, and support public and professional confidence in both process and outcomes, particularly for accepted outcomes which by their very nature are less transparent than hearings.

46. Do you agree or disagree with the proposed powers for reviewing measures? Please give a reason for your answer.

46.1 We neither agree nor disagree.

46.2 It would be helpful to understand how the review process would work. Currently, this is a formal process with decisions made by panels,³² and as such, these decisions fall under our section 29 powers. We review, and have appealed decisions not to renew conditions or a suspension. It would be concerning to us if these decisions were removed from our jurisdiction as they can have significant public protection implications.

46.3 It is not a given that these will be straightforward cases. Some will involve continuing issues of insight, and our experience is that not all clinical or professional issues are easy to resolve. In some cases the paper exercise may miss out on the nuances of the case.

³¹ R (on the application of Bevan) v General Medical Council [2005] EWHC 174 (Admin) – Collins J stated that good quality sanctions guidance is sensible and helpful. In R (on the application of) Abrahams v General Medical Council [2004] EWHC 279 Admin, Newham J observed “Those are very useful guidelines and they form a framework which enables any tribunal, including this court, to focus its attention on the relevant issues”

³² With the exception of Social Work England, which has the option of using SWE staff, case examiners or adjudicators.

- 46.4 It would also be helpful to understand how it is intended that regulators should decide whether a review decision should be made by a panel, case examiner, or officer.
- 47. Do you agree or disagree with our proposal on notification provisions, including the duty to keep the person(s) who raised the concern informed at key points during the fitness to practise process? Please give a reason for your answer.**
- 47.1 We agree.
- 47.2 We welcome the requirement to keep the complainant informed at key points. We would also welcome a duty to notify employers (in the widest sense), which is currently described as optional at paragraph 289 of the consultation document. If there is no express requirement to share this information with employers, this can create a public protection risk, as for the regulator as there is no statutory basis for sharing this otherwise confidential information.
- 47.3 It might also be helpful to include a requirement for the regulator to inform the registrants and complainants of options for review and appeal of decisions to close or proceed/take action.
- 47.4 We would welcome greater clarity on the point at which parties would first be informed that a complaint had been received and was being progressed through the system.
- 48. Do you agree or disagree with our proposal that regulators should have discretion to decide whether to investigate, and if so, how best to investigate a fitness to practise concern? Please give a reason for your answer.**
- 48.1 We agree in principle but would need more clarification about how this will work in practice. This is because, as we explained in our response to question 43, the consultation document provides insufficient information for us to firmly support what is proposed.
- 48.2 We would welcome clarity on:
- 1) Where in the process the decision-making stages would take place, at which point cases can either be closed or moved on to the next stage?
 - 2) Where in the process the meaningful investigation would take place?
 - 3) What thresholds would be applied?
- 48.3 We agree in principle that regulators should not have to investigate every complaint they receive, and should be required only to progress those that raise a fitness to practise concern. However, a thorough and robust investigation stage is central to an effective fitness to practise process. There are significant risks to the public associated with cases being closed too soon, before it has been possible fully to establish the extent and seriousness of a possible concern. Over-reliance on third party investigations that are either inadequate or

unsuitable is another possible flaw in investigation processes, that we have identified in the past.³³

48.4 These are not matters that can easily be translated into legislation, but we believe it is important to stress the significance of getting this part of the process right, as the quality of any decision is only as good as the information on which it relies.

48.5 We query whether the power to close a case at initial assessment would be new, as stated in the final bullet of paragraph 292 of the consultation document. We understand that the power to close cases at what is often referred to as the triage stage, that is, the first sift of concerns, is available to most of the regulators.

49. Do you agree or disagree that the current restrictions on regulators being able to consider concerns more than five years after they came to light should be removed? Please give a reason for your answer.

49.1 We agree.

49.2 We have been calling for this restriction to be removed for a number of years. We consider that regulators have adequate means of closing cases at the early stages where there is insufficient evidence or the concerns do not appear serious enough. The five-year rule, as it is sometimes referred to, has led to contentious decisions. If we look at recent public inquiries in healthcare, such as Mid-Staffs, Paterson, or Cumberlege, it is plain to see that the truth about what happened when care has gone wrong and lives are lost or irreparably damaged, can take years to emerge. The tragic case of Robbie Powell is another clear example of this.³⁴ This arbitrary time limit appears to ignore the reality of how long these processes take, and is not consistent with a regulator's fundamental duty to protect the public. It also provides a perverse incentive for professionals to delay being candid about harmful mistakes.

50. Do you think that regulators should be provided with a separate power to address non-compliance, or should non-compliance be managed using existing powers such as "adverse inferences"? Please give a reason for your answer.

50.1 We think that regulators should be provided with a separate power to address non-compliance.

50.2 We understand that the GMC finds this power useful in dealing with cases where the lack of engagement of the registrant means that it is not possible even to establish impairment. In the interests of giving regulators all the tools they need to protect the public effectively, it seems sensible for this power to be maintained for the GMC and extended to other regulators in due course.

³³ See for example our Lessons Learned Review of the NMC's handling of the Morecambe Bay cases, available at: <https://www.professionalstandards.org.uk/publications/detail/nmc---lessons-learned-review-may-2018>

³⁴ <https://www.walesonline.co.uk/news/wales-news/charity-wins-cover-up-battle-2125722>

51. Do you agree or disagree with our proposed approach for onward referral of a case at the end of the initial assessment stage? Please give a reason for your answer.

51.1 We neither agree nor disagree.

51.2 We agree that such a mechanism needs to exist, but there is insufficient information in the consultation document about how this would work in practice. As we explained in our response to question 43, we would welcome more information about the decision-making stages and the thresholds to be applied.

51.3 It is unclear whether what is described in paragraph 298 of the consultation document would constitute such a decision-making stage, and if so, whether it would effectively replicate the real prospect test. This would seem logical, given that the next stage for a case that is referred is adjudication by a case examiner, in the shape of a determination on impairment.

51.4 If that is the case, it would have been helpful to make that explicit. If not, we find the process extremely unclear.

51.5 There is a linked question of whether no-impairment warnings might need to be made available at such a sifting stage at the end of the investigation. This is the case now for many regulators, and without it, officers conducting this sift could find themselves referring a case to a case examiner fully expecting impairment not to be found, but seeing a need for a warning to be imposed. This would seem both inefficient and unfair to the registrant.

52. Do you agree or disagree with our proposal that regulators should be given a new power to automatically remove a registrant from the Register, if they have been convicted of a listed offence, in line with the powers set out in the Social Workers Regulations? Please give a reason for your answer.

52.1 See our response to question 45 above.

53. Do you agree or disagree with our proposals that case examiners should:
Make the full suite of measures available to them, including removal from the register;

53.1 We agree, but with the caveats set out below.

Make final decisions on impairment if they have sufficient written evidence and the registrant has had the opportunity to make representations?

53.2 We agree, but with the caveats set out below.

Be able to conclude such a case through an accepted outcome, where the registrant must accept both the finding of impairment and the proposed measure?

- 53.3 We agree, but with the caveats set out below.
- 53.4 We welcome the introduction of a less adversarial alternative to panel hearings. We called for this in *Right-touch reform*³⁵ in 2017, arguing that it was needed to avoid unnecessary harmful impacts on registrants and witnesses, for whom the hearing process can be extremely stressful.
- 53.5 We did however stipulate that the decisions made through this process should be subject to independent oversight in the form of public protection appeal powers, in the same way as panel decisions are. In the absence of this safety net, a public protection gap would be created. We elaborate on this point in our response to questions 61 and 62.
- 53.6 The consultation document does not clarify what decisions would be available to the case examiners. We understand these to be:
- no impairment, close case, with or without a warning
 - impairment, accepted outcome (conditions, suspension or erasure)
 - impairment, non-consensual outcome as registrant not engaging
 - referral to panel on basis of facts, impairment, or sanction not being accepted by registrant
 - referral to panel because case examiner unable to make determination on impairment.
- 53.7 The consultation document does not explain the status of a case examiner's determination that the registrant's fitness to practise is impaired, in the event of a subsequent referral to a panel, which would presumably be expected to make a further decision on impairment.
- 53.8 It will be important for any accepted outcome decisions to include the facts, as well as impairment and sanction, to ensure there is clarity in the event of future review hearings or restoration decisions, and transparency for the public and employers.
- 53.9 We see from paragraph 310 that *all* case examiner decisions should be made publicly available. On the assumption that case examiner decisions would be equivalent to panel decisions, we consider this entirely appropriate. However some clarity on what is meant by 'publicly available' would be helpful, as would some firm assurance that decisions should be published online, rather than just, say, available on request. In addition, some definition of the exceptions to this rule would give us greater confidence in the policy, and help to maintain a consistent approach across the regulators. We consider these points in more detail in relation to our proposed section 29 oversight of accepted outcomes in our response to questions 61 and 62.

³⁵ Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-reform-2017-fitness-to-practise.pdf?sfvrsn=49517320_8

- 53.10 We would welcome clarity on what would be referred to the case examiner – particularised charges or summary regulatory concerns? It is important for non-represented registrants to understand the case that they are being charged with, for the decision makers to understand the case that they are deciding on, and to remove any room for misunderstanding.
- 53.11 While we support the aim that the accepted outcomes process should not be a negotiation, we note that the possibility of this occurring in practice cannot be excluded, and it would be unrealistic to expect otherwise. We also appreciate that where conditions are being offered, some discussion may be needed to ensure that they are workable. For example, case examiners might propose conditions which were impractical for the registrant but which could be amended to achieve a similar level of public protection. It would be better in this case for there to be a discussion than for it to be referred to a panel.
- 53.12 Finally on this point, we are beginning to see some evidence that accepted outcomes may not be the most effective means of dealing with certain types of cases. We carried out a systematic review of accepted disposals during Social Work England’s first year of operation. These decisions are similar to what is being proposed here, with the notable difference that SWE case examiners cannot impose a striking off order. Overall, we found that accepted disposals, which are made by pairs of case examiners working on the papers, that is, without the opportunity for face-to-face questioning, had limitations. We found that cases less likely to be appropriate for such methods of disposal were where:
- There are disputes about the material facts
 - There is uncertainty around the background to and seriousness of the conduct – for example, if the registrant interprets the facts in a way which contradicts the impression of other witnesses or where there may be concerns about the evidence of those witnesses
 - There are doubts about the extent of the social worker’s insight, for example because they are blaming others.
- 53.13 This echoes the advice we received from Leslie Cuthbert,³⁶ a lawyer with expertise in cognitive bias and fitness to practise decision-making. He looked at the different biases that would come into play in the accepted outcomes and panel models. What he found was that case examiner adjudication carried out in private, on the papers, with a consensual element was likely to be more suited to:
- Cases where a decision needs to be made urgently
 - Cases where there is very little missing information and very little ambiguity, and
 - Cases which are likely to require limited amounts of engagement with the registrant.

³⁶ Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/research-paper/advice-on-biases-in-fitness-to-practise-decision-making.pdf?sfvrsn=b0154920_8

53.14 On the other hand, cases potentially more appropriate for the Panel route would be:

- Paper heavy cases as there would be less likelihood of a number of the biases which would impact on an individual decision maker considering matters on the papers having a significant effect e.g. the absent-mindedness bias
- Cases which may involve different cultural considerations (providing the panel itself is diverse) as individual decision makers may be more prone to blind spot bias and to stereotyping, whether intentionally or not
- Cases with significant 'gaps' in the information and/or with substantial ambiguity as to what occurred.

53.15 We make these points independently of our arguments about oversight. Regulators should, regardless of whether we are granted powers to appeal case examiner decisions, give careful consideration to the strengths and weaknesses of each disposal method, to ensure that it is using each one to best effect both for public protection and fairness to the registrant.

Be able to impose a decision if a registrant does not respond to an accepted outcomes proposal within 28 days?

53.16 We agree with the principle.

53.17 We suggest however that 28 days may not be long enough for a registrant to seek advice and make a decision about whether or not to accept what is offered. It would also be helpful to explain that at this point regulators would be expected to notify the employers, however defined.

54. Do you agree or disagree with our proposed powers for Interim Measures, set out above? Please give a reason for your answer.

54.1 We agree, with the following caveat.

54.2 We suggest that introducing the consensual route for interim measures might lead to delays which could put the public at risk. In those cases where the registrant does accept the interim measure proposed, this would add an extra stage, as the decision would then need to be referred to an interim measures panel. We suggest that strict timelines will be needed to avoid delays in restricting the practice of a potentially dangerous registrant.

54.3 Interim measures are used only when the registrant is considered to pose an immediate risk to the public, so it is essential that swift action can be taken.

55. Do you agree or disagree that regulators should be able to determine in rules the details of how the Fitness to Practise panel stage operates? Please give a reason for your answer.

55.1 We agree but only subject to a number of caveats, as follows.

55.2 We have set out elsewhere in this response our concerns about allowing regulators to develop rules without any checks or balances, and our views about where the inconsistencies that might result would be of concern.

55.3 In addition, we have the following comments:

- Para 342 bullet 1: What is meant by reasonable request here? We suggest the language be that of a duty to inquire, to mirror the case law around the role of a panel.³⁷ It might also be appropriate for this power/duty to be available to case examiners.
- Para 342 bullet 4: Is this the process for closing a case once it has been referred for a hearing? It would be helpful to distinguish this from other powers to close cases with no further action referred to in the consultation (see para 292).
- Para 346: As at question 53 above, we would have welcomed greater clarity about the meaning of ‘publicly available’ and ‘exceptional reasons’, with concerns about transparency, public protection, and consistency.
- We note the absence of any high-level expectations around interactions with complainant.
- We are concerned about the absence of any basic requirements for the procedure to be followed by panels, to ensure that proceedings are fair, open, transparent, compliant with Human Rights law, and will protect the public effectively.
- We welcome the requirement to publicly consult on the rules.

56. Do you agree or disagree that a registrant should have a right of appeal against a decision by a case examiner, Fitness to Practise panel or Interim Measures panel? Please give a reason for your answer.

56.1 We agree, with the following caveats.

56.2 We question the purpose of a right of appeal for a registrant who has accepted an outcome proposed by a case examiner, when there is also an option for registrants to request a registrar review on the basis of prevention of injustice to the registrant. It is unclear why the two options are being proposed and how they would interact. We also cover this point in our response to questions 61 and 62.

56.3 Secondly, if registrants are to have a right of appeal over accepted outcomes, the same should also apply to interim measures agreed by case examiners.

³⁷ Council for the Regulation of Health Care Professionals v General Medical Council and Ruscillo [2005] 1 WLR 717; Professional Standards Authority for Health and Social Care v Nursing and Midwifery Council and Jozi [2015] EWHC 764 (Admin))

57. Should this be a right of appeal to the High Court in England and Wales, the Court of Session in Scotland, or the High Court in Northern Ireland? Please give a reason for your answer.

57.1 It is usual in cases involving serious questions of professional misconduct affecting the registrant's livelihood for the appeals to be heard in the High Courts (for England, Wales and Northern Ireland), or Court of Session in Scotland. Since such appeals also frequently create new law in respect of fitness to practise we consider that these courts are the right level for such disposals.

58. Do you agree or disagree that regulators should be able to set out in Rules their own restoration to the register processes in relation to fitness to practise cases? Please give a reason for your answer.

58.1 We disagree.

58.2 The change in approach here is unexplained and concerning. There does not appear to be a requirement for a restoration panel hearing following a fitness to practise erasure. This raises questions about cases where the panel would need to assess insight in person, to understand whether the registrant still poses a risk to the public. From reviewing these cases under our section 29 powers, which we can do under the current regime as these decisions are made by panels, we are aware that such in-person assessments are often essential. We successfully appealed a General Dental Council restoration decision that turned on such a question of the registrant's insight, and the fact that the panel had not been presented with all the information needed to make a fully informed assessment.³⁸ There is also the case of the General Medical Council v Chandra, in which the Court clarified that all three limbs of the overarching objective applied to restorations decisions, and stressed the importance of establishing insight and remorse in these cases.³⁹

58.3 These are different to registration applications because the registrant is not of good standing when s/he applies. These are not run-of-the mill administrative decisions – registrants will usually have committed egregious misconduct to have justified their removal from the register. The risk of harm to the public of a poorly judged restoration decision is high. Public confidence could also be damaged given the serious nature of the cases at hand, and particularly if these decisions are taken behind closed doors. We therefore suggest that panels must be required to consider these in person and not on the papers.

58.4 Furthermore, if restoration decisions are made by anyone other than a fitness to practise panel, as the proposals stand, the Authority would lose the ability to appeal a restoration decision that fails to keep the public safe, and no alternative public protection mechanism is offered. This has not been made

³⁸ Professional Standards Authority for Health And Social Care v General Dental Council & Hussain [2019] EWHC 2640 (Admin) (18 October 2019). Available at: <https://www.bailii.org/ew/cases/EWHC/Admin/2019/2640.html>

³⁹ General Medical Council v Chandra [2018] EWCA 1898

clear in the consultation document. We recommend that restoration decisions should remain under our section 29 appeal jurisdiction.

58.5 We are also concerned about the flexibility that will be granted to regulators to determine the timeframe in which an application for restoration can be made. Currently, there is some consistency in this area, with five years the standard across the biggest regulators. It is unclear why the Government is not taking this opportunity to mandate consistency, as this aspect has a major impact on the meaning of a removal order, and how it is understood by the public, professionals, employers and others. Given the welcome intention to bring consistency to the measures available to regulators, we do not understand why this aspect is not considered part and parcel of the measures policy.

59. Do you agree or disagree that a registrant should have a further onward right of appeal against a decision not to permit restoration to the register? Please give a reason for your answer.

59.1 As above, it is our view that restoration decisions following erasure by a case examiner or a panel should be made by panels. Where an application for restoration is rejected by a panel, there should be a statutory appeal right to the High Court for a registrant and where an application is granted, there should be a power to appeal that decision (again by way of statutory appeal) by the Authority.

59.2 We are concerned however to see the proposal that restoration appeals should be modelled on registration, with an internal appeal route, followed by a further appeal to a higher authority. As we have explained, these are not simple registration decisions: at the point of applying, the registrant is not of good standing because s/he will have been previously struck off for egregious conduct. To have the registrar decision reviewed through an internal mechanism, which we note could be the registrar reviewing her/his own decisions, runs counter to the principle of separation of powers, which we say more about below. It would also sit outside the Authority's remit, meaning that there would be no means of challenging an appeal decision in the registrant's favour that failed to protect the public. We therefore do not support the proposal for an internal appeal process for these decisions, as the risks resulting from a poor decision would be high, and there would be no counter-balancing public protection appeal mechanism

60. Should this be a right of appeal to the High Court in England and Wales, the Court of Session in Scotland, or the High Court in Northern Ireland? Please give a reason for your answer.

60.1 See above.

61. Do you agree or disagree that the proposed Registrar Review power provides sufficient oversight of decisions made by case examiners

(including accepted outcome decisions) to protect the public? Please provide any reasons for your answer.

61.1 We disagree.

61.2 We agree that accepted outcomes would be beneficial, with the caveats detailed in our responses to the earlier questions. However in our view it is essential that they are underpinned by an effective public protection safety net. The opening paragraph of this section states that ‘greater autonomy must be accompanied by greater accountability’. We do not believe that the proposals set out here would achieve this.

61.3 In summary:

- Like panels, case examiners will make mistakes. The cases they would be looking at and could resolve through accepted outcomes are serious and give rise to serious public protection concerns. Errors may be rare, but panels are still making them as our current successful appeal rate shows.⁴⁰ We have also identified Social Work England (SWE) cases decided under a similar process, that we would most likely have appealed had we had the powers to do so. A public protection safety net is therefore needed.
- It is unfair and unrealistic to expect patients to take on the role of challenging a decision that does not protect the public. This power should sit with a statutory body with the powers to do so.
- Regulators are not well placed to identify these errors because (a) they themselves make mistakes in their own investigations so that panels or case examiners may not have the right information in front of them and (b) they are close to the cases and may not look at decisions critically. While regulators occasionally refer cases of concern to us, this has not to date involved them identifying their own mistakes, and those they do refer to us represent less than 10% of the cases we refer.
- The Authority exercises a right of appeal over panel decisions, some of which would in future be disposed of through accepted outcomes with no upper limits on their seriousness. We propose that in order for the public to remain protected, this power should continue to apply to those cases, by allowing our jurisdiction to cover case examiner disposals.

Why effective public protection oversight is needed

61.4 Public protection in our sector means having in place the necessary regulatory mechanisms to protect the public from risk of harm. Right-touch regulation⁴¹ stipulates that the regulatory response should be proportionate to the risk – neither too much, nor too little regulatory force to achieve the desired result.

61.5 Currently the Professional Standards Authority has a statutory power, provided by section 29 of the NHS Reform and Healthcare Act 2002, to challenge in the courts a decision made by a panel of any of the regulators we oversee. These powers were introduced following on from the findings of Sir Ian Kennedy’s

⁴⁰ Approximately 9 in 10 of our appeals are successful.

⁴¹ <https://www.professionalstandards.org.uk/what-we-do/improving-regulation/right-touch-regulation>

Inquiry into child deaths at Bristol Royal Infirmary,⁴² that highlighted the need for greater separation of professional regulators from the professions they regulate. This was referred to in an early judgment on an appeal brought by a previous incarnation of the Authority:

‘Professor Kennedy referred to a public perception that a system of regulation of health care professionals which involves the determination of disciplinary allegations by a panel or committee largely comprising members of the profession in question was not necessarily in the best interests of patients. He recommended an overreaching body for the regulation of health care professionals.’⁴³

- 61.6 Section 29 enables the Authority to challenge a final fitness to practise decision by a panel where it considers that the decision is not sufficient for the protection of the public. Whilst the process the Authority has established means that it will in effect consider every final panel decision, it has a discretion whether to refer the decision to Court.
- 61.7 The value of this power is reinforced in the consultation document at paragraph 356 (‘The PSA’s ability to review fitness to practise cases is an important element of public protection, and its right to refer cases resolved by a panel to court will remain.’), and we welcome this endorsement. This power was also endorsed by the Williams review in 2018.⁴⁴
- 61.8 It is proposed in the consultation document that this power should not apply to accepted outcomes, despite these being the same range of final fitness to practise decisions as those currently made by panels, with the same legal status. From the statement in the consultation document that oversight of accepted outcomes should be ‘proportionate’ (para 357), we conclude that our powers are considered to be disproportionate – we assume this means proportionate to risk.
- 61.9 There are two risk factors to consider in the model set out: the risks presented by the cases that will be disposed of through accepted outcomes, and those presented by the fitness to practise decision-making itself.
- 61.10 On the former, there is no way of knowing what proportion of cases will continue to be decided by panels. What we do know is that the proposals put no constraints on what will be dealt with by case examiners, aside from the basic requirement that the registrant should accept the finding of impairment and the proposed measure. This means that the most serious of cases could be disposed of in this way. We therefore expect the risk profile of the cases resolved through accepted outcomes to be similar to that of panel cases. Or put more plainly, the same sorts of cases will be dealt with through accepted

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https://webarchive.nationalarchives.gov.uk/20100407202128/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005620

⁴³ *Ruscillo v Council for the Regulation of Health Care Professionals & Anor* [2004] EWCA Civ 1356 (20 October 2004). Available at: <https://www.bailii.org/ew/cases/EWCA/Civ/2004/1356.html>

⁴⁴ Available at: <https://www.gov.uk/government/publications/williams-review-into-gross-negligence-manslaughter-in-healthcare>

outcomes as are currently dealt with by panels and subject to our section 29 scrutiny and challenge.

61.11 We do have some evidence to turn to for the second point, despite the fact that what is being proposed would be a new model. For its first year of operation, we systematically reviewed Social Work England's accepted outcome decisions, over which we have no appeal powers, and have now published our report on this.⁴⁵ These decisions are close to what the Government is proposing for the other regulators, with the notable exception that case examiners cannot strike off.

61.12 The findings of our review were that decisions were not obviously of a higher quality than those of panels. With the caveats noted in our report (small number of cases, first months of a new process, the cases had not been through all of our normal stages of consideration), we had concerns about a higher proportion of cases than for other regulators' panel decisions. A major concern was that case examiners were offering these outcomes in cases for which they were not suitable because the facts were not agreed or there were doubts about insight. While law or guidance can address this to an extent there is little, in practice, that will stop case examiners making, in good faith, wrong decisions.

61.13 The second source of evidence is the exercise of our section 29 powers over panel decisions.⁴⁶ We are not aware of any evidence that shows case examiners will be better at making decisions than panels at hearings; in fact the consensual nature of accepted outcomes could make lenient outcomes more likely. Furthermore, the automatic reduction in transparency in moving more cases from public to private settings may create risks in itself.

61.14 We have legal advice to illustrate these points:

'I do not consider that the fact a registrant has agreed a particular sanction can justify a lesser level of scrutiny. Under current FTP procedures it is always open to a registrant to indicate that he or she agrees that a particular sanction should be imposed (and it is not uncommon for conditions to be agreed in principle with the regulator). The fact that a registrant has agreed a particular sanction does not, logically, mean it is less likely to be insufficient. If anything, it makes it more likely in that a registrant is unlikely to agree a sanction that is not favourable to him or her. The procedure is also less transparent and there is a risk that decision makers may take the "easy option" of agreed disposal in some more difficult cases. This is not to suggest bad faith on the part of any decision makers, but anecdotal evidence from cases of regulators where similar procedures have been adopted [...] suggests that such procedure may, perhaps unconsciously, be used to dispose of more complex cases without adequate analysis or scrutiny.'

⁴⁵ Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/performance-reviews/review-of-social-work-england-process-for-accepted-outcomes-in-fitness-to-practise-cases.pdf?sfvrsn=1dec4920_6

⁴⁶ Information about the cases we appeal can be found here: <https://www.professionalstandards.org.uk/what-we-do/our-work-with-regulators/decisions-about-practitioners/cases-appealed>

61.15 It is our view therefore that accepted outcomes should be subject to oversight that provides the same level of public protection as that which currently exists for panel decisions.

Why the registrar review power would not represent ‘sufficient oversight’ to protect the public

Is it fair or realistic to ask patient to challenge unsafe fitness to practise decision?

61.16 ‘To oversee’ suggests an active accountability mechanism by a body or person with official responsibility for carrying it out. The registrar review power would not provide oversight in any recognisable form. It would be more akin to a complaints process open to anyone to use but operated by the regulator, the outcome of which, if successful, would be a referral of the case to a panel.

61.17 Unlike the section 29 power, there would be no expert public body with a responsibility for identifying decisions that fail to protect the public and challenging them. Instead, what is being proposed is that someone (‘anyone’) should have to request a registrar review, that the registrar could at her/his discretion accept or reject, using the criteria set out in legislation. This shift would do away with a legal responsibility vested in a statutory body, the Authority, to protect the public. It would replace it with an expectation that members of the public – and in reality this would be primarily wronged or harmed patients – should do this for themselves.⁴⁷

61.18 Whether members of the public would have the information to hand to mount a successful challenge is a question that is not addressed in the consultation. In the best-case scenario, a patient would be relying on the information they had had access to as a witness in the proceedings. In the worst case, they might not even have the determination to refer to, if for a range of legitimate reasons, the decision was not published. It is not at all clear how patients would be expected to mount a successful challenge without having access to key documents.

61.19 Not only would this proposed transfer of responsibility compound the distress and grief for many harmed patients, it also entails a fundamental misunderstanding of the purpose of fitness to practise. It confuses the public interest with the interests of a particular member of the public. The courts have established that the purpose of fitness to practise proceedings is to establish whether a registrant is impaired at the time of the fitness to practise decision, based on a forward-looking assessment of risk of repetition. Once it has been found that the registrant committed misconduct at a defined point in the past, the fundamental question with regard to public protection in its narrowest sense is: will the registrant pose a risk to others in the future? We know that regulators have been at pains for many years to explain that they are not complaints bodies, they do not provide redress or compensation, nor are they there to punish for past wrongdoing. Fitness to practise is about preventing the public from future harm, and where appropriate marking that conduct or competence

⁴⁷ We will cover this in more detail below, but the Authority would not be granted any special powers or status in relation to requesting registrar reviews. If we were to request one, we would be doing so on the same basis as a member of the public, and going beyond our statutory remit.

has fallen below acceptable standards in order to maintain public confidence or uphold professional standards.

- 61.20 What is expected therefore under the registrar review is that harmed individuals should put themselves through a complex – see below – and potentially painful process of challenging the regulator’s decision, for little or no personal gain. To expect this to function as an ‘oversight’ mechanism seems both unfair and unrealistic. It may well be discriminatory, as those with greater means are more likely to have the time and money to go through this process; more vulnerable people may not be in a position even to contemplate it. In our view, the responsibility for ensuring that the decisions of regulators protect the public should remain with a statutory body with the powers to do so effectively.
- 61.21 The proposed registrar review power is limited by strictly defined criteria – either a material flaw, or new information coming to light, *and* a public protection risk (or injustice to the registrant, though this is not relevant here). This test has been modelled on the GMC’s Rule 12, or similar for the GDC and NMC, which applies not to final adjudication decisions, but to decisions about whether to refer a case to a hearing at the end of the investigation or to close it, with or without a warning or undertakings.
- 61.22 The scope of the existing registrar review powers is therefore narrowly defined and was never intended to address the sufficiency of the outcome overall. In particular, the public protection issues engaged when imposing a sanction in serious cases that will now be available for determination by case examiners will not be captured by the scope of the proposed power.
- 61.23 Advice sought from Eleanor Grey QC on the use of a Rule 12-type registrar review power states the following:

*‘The provisions governing the role of the Registrar are time-consuming and complex. There is a three-stage process, effectively. The Registrar must first have reason to believe that the conditions in Rule 12(2) and (3) are fulfilled; s/he then must write to the various interested parties to invite representations, before considering the representations and reaching a final decision. **This is not a simple and straightforward review process.***

*Second, the conditions which must be fulfilled to enable the Registrar to overturn the CE’s decision are relatively complex. There has to be both (i) either a ‘material flaw’ or new information not available to the original decision-maker, and (ii) a judgment that a fresh decision is “necessary” to protect the public. **This is not an automatic right to a review of the merits.** Deciding what is “new information” can be complex (e.g. if fresh perspectives are presented by complainants that fall short amounting to fresh evidence of defined “events”), and the question of what a “material flaw” is may be contested. [...]*

***Questions about the existence of flaws and their materiality, are issues of judgment.**⁴⁸*

- 61.24 We recognise that the proposed test for the Registrar review sets a lower bar than Rule 12, by allowing the second part of the test to rest on a ‘may’ rather

⁴⁸ Our emphasis.

than on 'is necessary to'. This might mean that the power could be more readily exercised than current registrar review powers. However, unless the scope of the power is defined in a similar way to section 29, it will not be able to identify and change the outcomes agreed between registrants and case examiners for the same reasons that the courts can currently change the decisions made by independent panels.

61.25 Therefore we do not consider the proposed power will provide the same or similar public protection as section 29 oversight. We strongly recommend that if the Registrar Review is to be the only public protection safety net for case examiner decisions, it should at least be framed as such, taking the Authority's section 29 threshold as the model.

Registrar discretion and concentration of powers

61.26 The proposals would effectively put the Registrar in the role currently fulfilled by the courts of determining whether a challenge against an adjudication decision made by case examiners should be reconsidered and sent to a panel. This registrar discretion is made clear in the wording of the test itself – '*in the judgement of the registrar...*', '*the registrar considers that...*' (para 359).

61.27 We have noted above the similarities with the existing registrar review powers, such as the GMC Rule 12. Notwithstanding the fact that they apply to a different kind of decision, we hear from many dissatisfied patients who have requested such a review, and been turned down for reasons that are not immediately apparent. While this is anecdotal, it illustrates that this way of working lacks transparency, and can disempower patients. In seeking to challenge a regulatory decision, they are faced with a huge power imbalance and information and skills asymmetry. This is detrimental to public confidence, as well as representing a potential public protection risk.

61.28 The accepted outcomes framework already removes a layer of independence, as panel hearings are currently at arm's length from the regulators, and in the case of the GMC, run by a part of the organisation that is operationally separate.⁴⁹ Case examiners on the other hand do not benefit from this kind of Chinese wall arrangement; they are embedded within the same fitness to practise directorates that are responsible for all other stages of the process.

61.29 The combined effect of introducing accepted outcomes, which do away with the semi-independence of adjudication, and the registrar review power, which does away with the independent final review, is a concerning concentration of powers. It ultimately makes the Registrar responsible for investigation, prosecution, adjudication, and appeals.

61.30 Creating closed systems that look inwards is poor public sector governance generally: external scrutiny and accountability are key to ensuring that public services are being delivered properly and providing value for money.⁵⁰ On a

⁴⁹ The MPTS is a statutory committee of the GMC.

⁵⁰ See for example, the *Good Governance in the Public Sector* framework published by the International Federation of Accountants (IFAC) and the Chartered Institute of Public Finance and Accountancy (CIPFA), available here: <https://www.cipfa.org/policy-and-guidance/standards/international-framework-good-governance-in-the-public-sector>

basic level, there are obvious and unavoidable disincentives for a public body publicly to question, challenge, or criticise its own work. In regulatory systems, external scrutiny and challenge are necessary to keep the public safe. The Fifth Shipman report of the Inquiry led by Dame Janet Smith called for greater separation of the different parts of the fitness to practise process, a recommendation that ultimately led to the creation of the Medical Practitioners' Tribunal Service (MPTS), the semi-independent adjudication arm of the GMC.⁵¹

- 61.31 Dame Janet's concerns were driven by the observation that the existing model allowed the interests of professionals to have undue influence in decision-making. We are less concerned about this as the changes to regulator governance that have taken place over the past decade or so have largely moved regulators away from self-regulation. That said we should always be alert to the risks of a step backwards in this area. Of greater concern currently however is the risk of operational pressures driving regulators to prefer cheaper, quicker options, such as of accepted outcomes, over more expensive options like panel hearings, even when the latter option would be more effective to protect the public.
- 61.32 As was recognised by the High Court in a recent case involving the GMC regarding costs, the regulator has other competing priorities that are likely to affect its willingness to challenge a decision of its own.⁵² The Authority has no such competing priorities, and regularly brings appeals on the basis that the regulator has under prosecuted the case. By this, we mean that the regulator has not brought charges that adequately reflect the nature of the misconduct, or has failed to bring the full gravity of the situation and relevant evidence to the attention of the panel. In basic terms this means that the panel has considered a case of reduced seriousness where the regulator had the relevant evidence and, through failings in its process, did not take the most serious case forward.⁵³
- 61.33 These cases are only identified through scrutiny of the evidence and analysis of the decision-making of the regulator at the investigation stage. It is not clear to us that the regulator would be undertaking any systematic review of cases to assess whether there had been under prosecution and address this error in their prosecution of the case. We also query whether a member of the public would be able to identify under-prosecution as a concern when the only documents they have to hand is the decision of the case examiners and possibly their witness statement.
- 61.34 To disregard the need for some basic separation of function, and in particular for an external public protection appeal mechanism, would enable a return to previously discredited models of fitness to practise. Such criticisms have

⁵¹ Available at: <https://webarchive.nationalarchives.gov.uk/20090808160144/http://www.the-shipman-inquiry.org.uk/fifthreport.asp>

⁵² *Professional Standards Authority for Health and Social Care v (1) General Medical Council (2) Christian Hanson* [2021] EWHC 1288 (Admin) Chamberlain J

⁵³ In these cases it is often not possible to say whether or not a decision as to sanction (or absence of sanction) was sufficient for the protection of the public, but what can be said is that if the panel had made findings based on that evidence/charges then the outcome in place does not protect the public. These cases are successfully appealed even where the decision of the panel was not "wrong" on the charges actually brought and the case actually advanced by the regulator.

emerged as recently as 2018, when the Williams review into the handling of gross negligence manslaughter cases by regulators recommended that the General Medical Council should be stripped of its appeal powers:

*'The review heard concerns that the GMC's power to appeal MPTS decisions is inconsistent with other healthcare professional regulators. While the MPTS is a statutory subcommittee of the GMC rather than a panel within the organisation like the other healthcare regulators, it is still part of the GMC. This has led to the perception that the GMC is in effect appealing against itself and having two opportunities to make its case – first in putting its case for a sanction to the MPTS and then appealing the MPTS decision if it doesn't 'agree' with the GMC's view. The panel heard evidence that this perception has led to fear in the medical community and a lack of confidence in the GMC.'*⁵⁴

Why the Authority making use of registrar reviews would not provide the same assurance as section 29

- 61.35 We are left, upon reading the proposals, with a fundamental question about what could legitimately be expected of the Authority, if the registrar review power were introduced.
- 61.36 It is clearly the intention for the Authority to be able to use the registrar review power by requesting a registrar review on the same basis as a member of the public. We note that the Authority's own legislation⁵⁵ would need to be amended in order for this to be possible, as we are currently prohibited from interfering in any prospective, live or closed fitness to practise cases aside from through section 29. Assuming that this aspect would be dealt with alongside the legislative changes planned for each regulator, we nonetheless question the basis of this expectation.
- 61.37 The Authority is an independent statutory body that carries out the functions dictated by the powers and duties in its legislation. A broadly expressed ministerial desire that we might carry out a public protection function in relation to challenging accepted outcomes is unlikely to provide a sufficient legitimate basis for us to expend significant resources on this endeavour – in the absence of an explicit power or duty to do so.
- 61.38 At the moment, we systematically review decisions made by panels⁵⁶ to identify the small number that meet our threshold for appeal. This use of resources is justified by our statutory role in this area, and indeed we could be challenged for deciding not to use this power in any significant way, as it would be seen as fettering our discretion. We would have no such mandate or duty in relation to the registrar review power, and therefore may find it difficult to justify this level of activity.

⁵⁴ Available at: <https://www.gov.uk/government/publications/williams-review-into-gross-negligence-manslaughter-in-healthcare>

⁵⁵ Section 26(3) of the NHS Reform and Healthcare Professions Act 2002.

⁵⁶ With the exception of certain types of decision that present no or little risk – removals and renewals of conditions or suspensions.

- 61.39 Secondly, we query how effectively we could protect the public using these means – not least because, as explained above, the test for a successful registrar review is not a public protection test. There is also the question of what information would be available to the Authority on which to base a request for a registrar review. Our section 29 powers give us a strong basis on which to ask for confidential information from the regulators in order to conduct a full review of a decision. Without this clear mandate, it is unclear whether we could or indeed should have access to any data that is not in the public domain, and therefore not also available to others who are eligible to request such a review.
- 61.40 A more obvious and appropriate use of our powers might be to focus more of our performance review work on these decisions, carrying out regular audits to identify areas for improvement, particularly in the early stages of implementation. We know from our experiences of using this sort of oversight that it can be highly effective, however improvements are neither instantaneous, nor guaranteed. They depend on the regulator’s overall capacity to respond and react to this sort of feedback, which is variable. We also stress that this approach would only enable improvement for future decisions, and would not provide a route for rectifying unsafe decisions.
- 61.41 Though not mentioned in the consultation document, we are aware that it would be open to the Authority to challenge a registrar review decision through Judicial Review. Unfortunately, this would not represent an effective public protection mechanism either. Judicial Review is a test of the way in which a decision was reached, rather than the merits, public protection or otherwise, of the decision itself. It is also lengthy and expensive, raising questions about legitimate and effective use of resources.

How our section 29 powers would work with accepted outcomes

- 61.42 We propose that our existing section 29 power should be extended to accepted outcomes. Our powers have a range of benefits. Each successful appeal can protect hundreds if not thousands of patients; they also create important precedents in caselaw that lead to improvements in fitness to practise, and clarify the purpose and role of regulation. In scrutinising decisions, we develop a picture of the quality of decision-making across the regulators, and report back to each one with recommendations for improvement. Our scrutiny ensures a minimum level of transparency and accountability of decisions and decision-makers. We also operate in the public interest, and shoulder the burden that might otherwise sit with the ‘victims’ of harm, to challenge a decision that fails to protect the public.⁵⁷
- 61.43 What our proposal would mean in practice is that we would put in place a process to identify those decisions that met our threshold for appeal, and as we do now, launch an appeal in the courts. If we were successful, the courts could send the case back to the regulator for a panel hearing, or substitute its own decision. If the registrant and the regulator did not want to contest our

⁵⁷ We have recently published a blog that illustrates this point, using testimonial from a person who was the victim of a fellow social worker’s sexual misconduct. Available at: <https://www.professionalstandards.org.uk/news-and-blog/blog/detail/blog/2021/06/09/does-our-power-of-appeal-matter>

challenge, a satisfactory outcome could be agreed by all three parties and approved by the court. This proposal is cost-neutral, in the sense that it would replicate the current processes and jurisdiction. For the regulators, little would change. This is in sharp contrast to the Registrar review proposals that could lead to high numbers of requests, and would require new teams to be set up across the regulatory bodies to manage these requests.

- 61.44 It is worth returning to the proportionality question. As we explained above, our section 29 power is broad, but the threshold for action, as determined by our legal test and by the case law, is high. Within those parameters we can choose how to use it. We operate a highly efficient and effective sifting mechanism to whittle thousands of cases down to the 10-20 or so (numbers vary year on year) where we believe it is necessary to act.
- 61.45 We can, as a matter of policy, decide that we do not need to look at particular categories of cases on the basis that there is minimal risk in our deciding not to review them. We have done this with erasures, refusals of restoration, and panel decisions to renew suspensions and conditions, around a third of the notional case load. We could similarly decide that not all accepted outcomes decisions required systematic scrutiny. We can therefore ensure that our own processes are proportionate and targeted to the areas of greatest risk.

Which decisions would we have power to challenge?

- 61.46 The jurisdiction of our section 29 powers is currently defined in the legislation by listing the decision-making bodies whose decisions we can appeal – that is, fitness to practise panels. This would need amending to cover equivalent decisions made by case examiners.
- 61.47 Case examiners will no longer be sifting cases as they do now, and will instead be making adjudication decisions starting with the determination on impairment. With the caveat that the absence of detail about the initial assessment process makes it difficult to be fully confident (see our response to question 43 above), we would expect our redefined jurisdiction to cover all case examiner adjudication decisions. This would include no impairment decisions (currently covered by section 29 when made by panels, and the subject of appeals in the past), as well as impairment + sanction. It would likely exclude any referrals to panel, which would not represent adjudication decisions, and for which, therefore, our appeal threshold would not be suitable. This approach would enable the jurisdiction we have now to be replicated.

Interaction with other review mechanisms

- 61.48 We note that the consultation document does not include questions on whether the Registrar Review power should be introduced:
- for cases closed at the initial assessment stage, or
 - for the purposes of preventing injustice to the registrant (para 359 fourth bullet).
- 61.49 We would like to address these points while considering whether and how the Registrar Review power might coexist with our proposal for section 29 oversight of accepted outcomes.

61.50 Firstly, we support the introduction of a review power for cases closed at stages prior to adjudication, referred to generally here as initial assessment. We have considerable sympathy with the position of Action against Medical Accidents (AvMA) that has long called for a public body with powers to challenge these decisions on behalf of patients. We are not of the view that the Authority should have such a power, as our powers explicitly prevent us from interfering in live regulatory decisions. Section 29 allows us to get involved, exceptionally, and even then only at the end of the process.

61.51 Secondly, it is necessary, and good regulatory practice, for registrants to have appeal rights over any final fitness to practise decisions, including accepted outcomes. We note that the consultation proposes giving them two possible routes, with an appeal possible to the courts, alongside the registrar review power. This seems overly complex, and it is far from clear how the two would work together. It also suggests a greater focus on the rights of the registrant than on public protection, because, as we have explained at length in these paragraphs, there would be no equivalent public protection appeal to the courts for these decisions.

61.52 We have no particular view on which of the two routes proposed would be more appropriate for the registrant's appeal. What would be important would be to ensure that the registrant's right of appeal could coexist with our section 29 powers, as is currently the case for panel decisions.

61.53 There is a further outstanding question about whether it would be appropriate for there to be a right for patients to request a review of an accepted outcome, to sit alongside our section 29 power. We question the need for this, particularly given the arguments we put forward above about the confusing the role of fitness to practice with that of a complaints or redress route.

61.54 Currently, the Authority hears from patients who are dissatisfied with the outcome of a final fitness to practise decision. We take into account their views when exercising our judgement about whether or not the statutory appeal threshold is met. We would fully expect this to be the case for accepted outcomes too.

62. Under our proposals, the PSA will not have a right to refer decisions made by case examiners (including accepted outcome decisions) to court, but they will have the right to request a registrar review as detailed above. Do you agree or disagree with this proposed mechanism? Please provide any reasons for your answer.

62.1 We disagree for the reasons given under question 61.

63. Do you have any further comments on our proposed model for fitness to practise?

63.1 See our general comments in Part I of our response to the consultation.

64. Do you agree or disagree with the proposed approach to the regulation of PAs and AAs? Please give a reason for your answer.

- 64.1 We agree with the proposed approach to the regulation of PAs and AAs as outlined in paragraphs 375-378 of the consultation document. This appears to outline in high-level terms the main considerations required when bringing these groups into statutory regulation.
- 64.2 We welcome the reference at paragraph 376 to the need for regulation of PAs and AAs to be tailored to the specific context of practice and risks posed by each role.

65. In relation to PAs and AAs, do you agree or disagree that the GMC should be given a power to approve high level curricula and set and administer exams? Please give a reason for your answer.

- 65.1 We agree that the GMC should be given the power to approve high level curricula and to set and administer exams. It may be helpful to distinguish between 'high level curricula' and learning outcomes as a way of describing what graduates need to achieve in order to join the register.

66. Do you agree or disagree with the transitional arrangements for PAs and AAs set out above? Please give a reason for your answer.

- 66.1 We agree with the transitional arrangements for PAs and AAs set out at paragraphs 389-397 of the consultation document. The existence of the voluntary registers held by the Faculty of Physician Associates and Royal College of Anaesthetists is likely to make the transition more straightforward as those on these registers will have to have gained a relevant qualification and passed the specified assessment.
- 66.2 The period for those who are not on the voluntary register to enter into statutory regulation appears reasonable and as the consultation document states, in line with processes for other roles brought into statutory regulation recently.
- 66.3 We would expect the requirements for self-declaration of fitness to practise to be the same as for doctors entering the register.
- 66.4 We note that there are additional complexities to this transition process due to the fact that the GMC will be taking on new powers for regulation of medical professionals. It would be helpful to have further clarity on when PAs and AAs will be subject to the new powers, in particular those relating to fitness to practise where there will be a new system for dealing with concerns about professionals.
- 66.5 We will be monitoring any additional risks arising from this process via the Authority's performance review. Please also see our comments in response to question 35.

67. Do you agree or disagree that PAs and AAs should be required to demonstrate that they remain fit to practise to maintain their registration? Please give a reason for your answer.

67.1 We agree that PAs and AAs should be required to demonstrate that they remain fit to practise to maintain their registration. It is important that professionals remain up to date with their practice to ensure they continue to meet the regulators' standards and can practise safely and effectively.

67.2 As outlined in our policy advice on this issue, continuing fitness to practise requirements should be proportionate to the risks arising from the profession.⁵⁸ We agree with the consultation document that the GMC are best placed to develop a system appropriate to the context in which the different groups are practising but would expect there to be appropriate consultation and engagement with stakeholders when developing these requirements.

68. Do you agree or disagree with the benefits identified in the table above? Please set out why you've selected your answer and any alternative benefits you consider to be relevant and any evidence to support your views.

68.1 We disagree with the assertion that there will be an opportunity for cost savings for the Professional Standards Authority arising from 'a more economic use of resources e.g. moving away from focusing on Fitness to Practise and moving towards preventative regulation.'

68.2 We have not provided any data to support this assessment, so we are unsure what this is based on. However, if Government do proceed with the proposal to effectively reduce the number of cases subject to section 29 scrutiny then we would almost certainly seek to divert any resource savings to enhance or scrutiny of the accepted outcome process through the performance review, and to drawing case examiner decisions to the attention of the registrar, which we understood to be the Government's intention. This would probably use at least the same resources as currently.

68.3 The reforms and the resulting transition period are also likely to result in a period of higher risk, particularly whilst new processes bed in therefore there seems little evidence for listing cost savings for the Authority as a likely benefit.

68.4 Under current proposals we would also disagree with the benefit identified of increased patient safety arising from the reforms. As highlighted in our comments in the fitness to practise section the effective removal of our independent power of appeal over a large proportion of cases will objectively reduce public protection. In our view the reduction in grounds for action could also have this effect.

69. Do you agree or disagree with the costs identified in the table above? Please set out why you've chosen your answer and any alternative

⁵⁸ https://www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/continuing-fitness-to-practise-based-on-right-touch-regulation-2012.pdf?sfvrsn=68c67f20_6

impacts you consider to be relevant and any evidence to support your views.

69.1 We suggest that there may also be transitional costs for the Professional Standards Authority associated with the implementation of changes and any corresponding changes required in our oversight.

70. Do you think any of the proposals in this consultation could impact (positively or negatively) on any persons with protected characteristics covered by the general equality duty that is set out in the Equality Act 2010, or by section 75 of the Northern Ireland Act 1998? Yes – positively; Yes - negatively; No; Don't know. Please provide further information to support your answer.

70.1 There is the potential for elements of the reforms to have a negative impact on those with protected characteristics.

70.2 While proposals for a less adversarial approach to fitness to practise are intended to reduce the impact of the process on those involved there may be a risk of unrepresented registrants particularly those with protected characteristics being disadvantaged by the process. They may feel less able to challenge an outcome proposed by the regulator and be more likely to accept it to avoid a panel hearing at all costs.

70.3 This may also apply to utilisation of the proposed Registrar review process for challenging accepted outcome decisions. Those with protected characteristics may feel less able to request a review and may find it more difficult to utilise the process effectively.

70.4 The proposals to reduce the grounds for action may disadvantage or discriminate against those with protected characteristics if regulators end up having to label an unmanaged health condition as misconduct in order to be able to take regulatory action.

71. Further information

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

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