Learning from the past, planning for the future: twenty years of regulatory reform in health and care professional regulation

1. Why look back?

1.1 In a year when the Paterson and Cumberlege Inquiries have highlighted weaknesses in the current patient safety framework, we have taken the opportunity to look back on the evolution of professional regulation in health and care across the UK over the last two decades. During this time, through successive cycles of reform generally prompted by failings in healthcare, regulation in our sector has been transformed.

1.2 Professional regulators seek to ensure the safe practice of health and care professionals through:

- setting standards of competence and conduct that professionals must meet to practise
- ensuring that education and training courses give students the skills and knowledge to practise safely and competently
- maintaining a register of professionals that everyone can search
- investigating complaints about people on the register and deciding if they should be allowed to continue to practise or should be struck off the register – either because of problems with their conduct or their competence.

1.3 There is a still a largely UK-wide approach to the regulation of health professionals, under a four-country working agreement. Responsibility for regulation of social care professionals has been devolved, with the creation of separate social care workforce regulators across each country. The Professional Standards Authority's remit covers all the UK health professional regulators, and the regulator for social workers in England – this amounts to 10 of the 13 statutory professional regulators in health and care. All regulators operate under different legislation and with different powers and processes.

1.4 Despite delays arising from Brexit and the impact of Covid-19 pandemic, we are on the cusp of further reform following a 2017-18 consultation and Government proposals outlined in July 2019. It is helpful to look back on the learnings of the past to inform future change. The timeline we have laid out is not intended to be exhaustive, but charts some of the key developments over the last 20 years that have led to the system that we have in place today.

1.5 Key themes arising from the timeline of reforms below include:

- In the second half of the timeline, the post-Shipman push for regulation to be more focused on the public interest starts to give way to calls for a system of regulation that is less adversarial, more compassionate, more understanding, and even more supportive of professionals. This reaches a peak after Bawa-Garba and raises interesting and challenging questions that have been brought to the fore by the Covid crisis about where the balance should lie between professional interests and public protection.
- This swing of the pendulum is exemplified in the evolution of fitness to practise, which has become, in the eyes of many including the Authority, too rigid in its post-Shipman quasi-judicial form. The Social Work England model seeks to reintroduce flexibility and reduce costs, as well as the impact on the professionals involved. However, there is a balance to be struck between the move to more flexible ways of working, and the need to retain a robust process that delivers fair and safe decisions.
- Lack of candour with patients and families, and the cultural issues that underpin it, are a recurring theme through 20 years of inquiries. It is not clear what impact the actions taken by Government, NHS bodies and regulators to address these have had.
- In *Enabling Excellence* in 2011, Government starts to show a greater interest in the rising costs of regulation, and this features throughout the second decade of the timeline.
- The question of whether there are the right number of regulators, and the extent to which they should, do, or can work together and share functions features several times in the timeline; no government yet has been willing to address this point head-on.
- Who should be regulated? There are repeated calls, not all of which are featured here, for the statutory regulation of different groups including NHS managers and directors, social care workers (many of whom are regulated in the other UK countries), advanced practitioners in nursing, and talking therapists (many of whom appear on accredited registers).
- Public and government trust in regulation appeared to hit a low point after Kennedy and Shipman, however, the most recent reform proposals suggest that this Government places significant levels of trust in them to operate autonomously in the public interest, with no additional independent oversight.
- The Williams Review highlights the issue of a perception of inconsistency in the professional regulators' decision-making. Lack of consistency and coherence of the regulatory system overall, and observations about the risks arising from its fragmented nature, are a common theme arising as far back as Bristol and Francis but most recently in the Paterson and Cumberlege Reviews.

2. The modern era of regulatory reform[1]

2.1 The following timeline aims to chart the key reports and developments relevant to the regulation of health professionals and social workers from 1998 to 2020.[2]

1998-2004 – into the modern era with the Kennedy reforms

- Under the **Scotland Act 1998**, any powers to regulate new groups (since the passing of the Act) or amend legislation relating to those new groups must pass through the Scottish Parliament because they fall under devolved matters. Regulation of existing professions remains reserved to the UK Parliament, and the four countries commit to a UK-wide approach to professional regulation – a commitment that stands to this day.
- The **Health Act 1999** – sets out the legislative framework for any future reforms to professional regulators under s.60 of the Act. It enables amendments to be made to the founding legislation of the health professional regulators through Orders in Council (secondary legislation), under the affirmative Parliamentary process.
- The **Care Standards Act 2000** sets up the General Social Care Council, the first ever regulatory body for social workers in England. This is primarily a response to widespread criticism of social services throughout the 1990s, but is also a timely development in the light of the tragic death of Victoria Climbié in 2000. Equivalent regulators are created in the other UK countries.
- **The Kennedy Report (July 2001)** into the failings in children's heart surgery at Bristol Royal Infirmary identifies concerns about the lack of independence of regulators from the professions they regulate, the absence of a coordinated approach to professional regulation, and the need for regular competence checks for professionals. He proposes the establishment of a council for the regulation of healthcare professionals to coordinate the activities of the disparate bodies involved in professional regulation and ensure a greater focus on the interests of patients and the public. He also recommends a duty of candour for professionals.
- The Government, responds with **Modernising regulation in the health professions (August 2001)**. *It proposes the creation of a new Council for the Regulation of Healthcare Professionals* (CRHP, now the PSA) to carry out the following functions – yellow highlights show the functions that the PSA has active powers to undertake, grey highlights

[1] The interactive timeline on the history of healthcare regulatory produced by the Health Foundation is a valuable resource. It is available here: https://navigator.health.org.uk/theme/762/timeline

[2] This timeline is intended as an overview of key developments, but there are undoubtedly others not referenced here which are also relevant to health and care professional regulation.

those powers that are in the PSA's legislation but have not been activated, the remaining proposals did not make it into the legislation:

- protect the interests of the public and patients in the field of the regulation of health professionals
- manage a framework for regulation, including oversight of regulators' rules and practices
- publish an annual report on the regulators' performance
- compare the performance of the regulatory bodies in order to promote continuous improvement, by reference to each other and to other organisations
- setting performance improvement targets with the regulatory bodies where necessary and monitoring progress
- require the regulatory bodies to conform to the principles of good regulation
- ensure that the regulatory bodies act in a consistent manner
- promote greater integration and co-ordination between the regulatory bodies and the sharing of good practice and information
- provide an ombudsman service for complainants alleging maladministration against a regulatory body in the performance of its regulatory functions
- with the Health Professions Council, advising the Secretary of State and the devolved health ministers on the extension of health professional registration to currently unregulated professions
- make public interest appeals in extreme cases against individual decisions of the regulatory bodies.

- The **Nursing and Midwifery Council** and **Health Professions Council**[3] are created under two section 60 Orders, the **Nursing and Midwifery Order 2001**, and the **Health Professions Order 2001**.The former is intended to be a modern regulator for nurses and midwives, taking over from the United Kingdom Central Council for Nursing, Midwifery and Health Visiting; the latter is a new regulator for allied health professions, formerly regulated by the Council for Professions Supplementary to Medicine.
- Social care regulators are set up in each of the four countries of the UK. The Scottish Social Services Council (SSSC) is created by the **Regulation of Care (Scotland) Act 2001**, the Northern Ireland Social Care Council (NISCC) by the **Health and Personal Social Services Act (Northern Ireland) 2001**. The General Social Care Council (GSCC) and the

[3] Becomes the Health and Care Professions Council in 2012.

Care Council for Wales (later to become Social Care Wales) are set up to regulate social care workers in England and Wales respectively by the **Care Standards Act 2000**.

- **The National Health Service Reform and Healthcare Professions Act 2002** sets out the legislative framework for the CRHP, which is established on **1 April 2003**. During the passage of the legislation, Ministers describe the organisation as the 'guardian of the public interest', which operates independently of government in its task of modernising regulation.
- **NHS Quality Improvement Scotland (NHS QIS)** is established under article 3 of the **NHS QIS Scotland Order 2002** on **1 January 2003** as a special health board with a responsibility for improving the quality of healthcare in Scotland.
- In **September 2004**, CRHP changes its name to the *Council for Healthcare Regulatory Excellence* (CHRE)

2004-2010 – moving away from self-regulation with the post-Shipman reforms

- The National Assembly for Wales established **Healthcare Inspectorate Wales (HIW)** on **1 April 2004**, with the purpose of promoting continuous improvement in the quality and safety of patient care within NHS Wales operating under delegated powers provided by the **Health and Social Care (Community Health and Standards) Act 2003**.
- The GMC introduces new **fitness to practise rules** **in November 2004** that bring structure and transparency to their processes. In doing so, it creates the role of case examiners to act as gatekeepers at the end of the investigation and determine whether a case should proceed to a hearing, but also to dispose of less serious cases through undertakings agreed with registrants. The CHRE is not given any powers to challenge undertakings that do not protect the public.
- Dame Janet Smith publishes the **Fifth Shipman Report** **in December 2004**, focusing on the role of regulation in failing to identify Harold Shipman as the serial killer he was, and possibly prevent the deaths of many. The GMC comes under intense scrutiny in the report, and although some of Dame Janet's recommendations for reform are pre-empted by the GMC's 2004 fitness to practise rules (she describes these rules as 'a curate's egg'), the report's extensive and forensic analysis of the GMC's failings in fitness to practise becomes a reference point for fitness to practise policy. It makes important recommendations relating to the separation of investigation and adjudication, and the need for greater lay involvement in fitness to practise decision-making. It also highlights the need for ongoing competence checks in the form of revalidation for doctors.
- In April 2005, the **Regulation and Quality Improvement Authority (RQIA)** was established as a non-departmental public body of the Department of Health, Social Services and Public Safety (DHSSPS) under the legal framework

created by the **Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003**, for raising the quality of health and social care services in Northern Ireland.

- In **February 2007**, Health Secretary Patricia Hewitt publishes the **White Paper, Trust Assurance and Safety**, setting out a modernised framework for the regulation of healthcare professions, based primarily on **a departmental review** carried out in 2006. The proposals include:
  - significant governance reforms to ensure greater independence and accountability of both the regulators and CHRE: reduction in the size of regulator councils, parity of lay and professional members (except for CHRE, which moved to all lay members), independent appointments, and reporting of regulators annually to Parliament and Devolved legislatures
  - a series of proposals relating to revalidation, in particular for doctors – which ultimately led to the introduction of the GMC's current revalidation model
  - setting up what would become the Office of the Health Professions Adjudicator (OHPA), which was intended to become in due course the independent adjudicator for all the regulators following the recommendation of Dame Janet Smith, but was abolished in 2012
  - the creation of the General Pharmaceutical Council to separate the regulatory functions of the Royal Pharmaceutical Society of Great Britain from its representative function.
- The **Health and Social Care Act 2008** sets up the Care Quality Commission (CQC), which became operational on **1 April 2009**, and takes over from the Healthcare Commission, the Commission for Social Care Inspection, and the Mental Health Act Commission. Section 115 of the Act also provides the CHRE with new powers to carry out audits at the investigation stage of FtP proceedings.

2010-2015 – the NHS is redesigned while radical regulatory reform remains elusive

- The General Pharmaceutical Council is established under the **Pharmacy Order 2010** as the regulator for the pharmacy professions. For pharmacy this marks the separation of professional representation, a role which the Royal Pharmaceutical Society of Great Britain retains, from professional regulation. The Pharmaceutical Society of Northern Ireland continues to have responsibility for both functions.

- In **August 2010**, CHRE publishes **Right-touch regulation**,[4] which describes a framework for developing regulatory policy, and goes on to become hugely influential **both in the UK, and internationally**.
- The **Public Services Reform (Scotland) Act 2010** dissolves NHS Quality Improvement Scotland as at 31 March 2011, and sets up **Healthcare Improvement Scotland**.
- The Coalition Government publishes the Command Paper, **Enabling excellence in February 2011**, that will endure as the Government's position on regulatory reform for nearly 10 years, and bases some of its key proposals on the principles of *Right-touch regulation*. The paper:
  - Describes the Government's risk-based approach to regulating new groups, and sets out proposals for a framework for accredited voluntary registers of those groups providing health and care (now Accredited Registers)
  - Acknowledges the mounting costs of regulation, and announces a cost-effectiveness and efficiency review of the regulators to consider the financial benefits of mergers – to be carried out by CHRE. The CHRE completes this **review** in 2012, identifying some areas where the use of shared services could help to reduce costs, but stopping short of recommending mergers.
  - Announces the simplification review of the nine regulators under CHRE to be undertaken jointly by the Law Commissions, to recommend greater flexibility for regulators to amend their processes, balanced with greater accountability including a possibly enhanced role for CHRE
  - Highlights the need for greater independence of appointments to regulator and CHRE Councils, in the context of the planned abolition of the Appointments Commission. This eventually leads to the Privy Council being granted appointment powers, under which decisions rely on a recommendation from CHRE
  - Applies right-touch thinking to the question of continuing fitness to practise, acknowledging that different approaches may be justified by different levels of risk presented by each profession, and asking each regulator to develop an evidence-base for a continuing fitness to practise model
  - Announces the transfer of social worker regulation from the GSCC to the Health Professions Council (now the Health and Care Professions Council)
- The **Health and Social Care Act 2012** brings about huge structural change in the NHS, replacing Primary Care Trusts with Clinical Commissioning Groups to give GPs responsibility for commissioning services in their area, and formalising

[4] We revised *Right-touch regulation* in 2015 to take into account feedback on its application and develop some of the concepts on which it is based. The principles, and substance remain unchanged.

the commissioner/provider split to drive competition and improvement. It aims to depoliticise the running of the health service by creating NHS England, an independent body to run the NHS. The Act also makes a number of significant changes to CHRE, by:

  - changing its name to the Professional Standards Authority for Health and Social Care
  - giving it financial independence from government, in the form of a statutory levy on the regulators it oversees, and
  - granting powers in relation to regulator council appointments and accredited registers.

- In **August 2012**, the HCPC takes on responsibility for regulating social workers, and the GSCC closes although its sister social care regulators in the other three countries of the UK remain
- In **December 2012**, the GMC introduces revalidation for doctors
- In **February 2013**, Robert Francis QC publishes his **report of the Inquiry into the failings at Mid-Staffordshire NHS Foundation Trust**, where over the course of five years, many patients died as a result of poor standards of care[5] while patients and families were kept in the dark, in spite of the many layers of scrutiny, regulatory or otherwise, under which the hospital was operating. The Inquiry finds the failings to have been mainly systemic and governance-related, and only a handful of healthcare professionals are reprimanded by their regulator. However, the report identifies significant failings in candour with patients and families, and this is arguably where it has had its biggest impact in our sector. It also criticises the lack of joined-up working among professional regulators and between professional and system regulation, and recommends either the regulation of NHS managers, or the introduction of a fit and proper person test. The latter option was introduced by the Government in England in 2014, under the CQC regulations.
- In the context of a number of instances of ineffective governance that resulted in internal conflict and loss of confidence in regulation, the Authority publishes **Fit and Proper – Governance in the Public Interest, in March 2013**. The paper makes the case for a better approach to governance in professional regulation, looking at appointments, conflicts of interest, and the proper role of an effective board, among other things.
- **In August 2013, A Promise to Learn – a Commitment to Act**, a review by Sir Don Berwick of patient safety in the NHS, recommends the move away from a blame, target-driven culture, to one where staff are supported to learn about

[5] No official number has been given. At the time it was reported that between 400 and 1,200 patients died as a result of the poor care at the hospital, however, this was not officially endorsed.

quality. He also called for greater clarity in the respective roles of the different regulators responsible for quality and safety.

- The Law Commissions publish the **findings of their simplification review in April 2014**. The report includes a draft Bill to put all regulators on a shared statutory footing, bring greater consistency in key areas, and award them greater powers to design and amend their own processes. It does not recommend any mergers. The Authority sees it as a missed opportunity and is publicly critical of the lack of accountability to balance the greater autonomy for regulators, describing it as a '*backward step*' for regulation. The Government considers the Bill in detail, but eventually decides not to take the work forward in this form.
- **May 2014** sees the publication of **Trusted to Care - An independent Review of the Princess of Wales Hospital and Neath Port Talbot Hospital at Abertawe Bro Morgannwg University Health Board**, a report commissioned by the Welsh Government over concerns about standards of care at two hospitals run by the health board. This report highlights the need for openness and honesty about where things have gone wrong, and also the problems of staff colluding to cover up poor practice.
- **In October 2014**, a **joint statement on the professional duty of candour** is published by eight of the regulators the Authority oversees,[6] who commit to a shared approach to tackle candour issues. This was the culmination of two commissions undertaken by the Authority on candour for the then Department of Health, in response to the Francis recommendations in this area. This year also sees the introduction of a statutory, organisational duty of candour on providers in England, under the CQC regulations. This duty has been mirrored in Scotland, and there are commitments to do the same in Northern Ireland, where legislation has yet to be passed, and in Wales where the primary legislation is currently going through the Assembly.
- The NMC and GDC are granted powers to use case examiners with the ability to agree undertakings for less serious cases that meet the seriousness threshold for referral to a panel, **in 2014 and 2015** respectively. The Authority is not given powers to challenge undertakings that do not protect the public.

2015-2020 – time to rethink regulation

- A Private Member's Bill brought by Jeremy Lefroy MP, and sponsored by the Department of Health, receives Royal Assent on 26 March 2015. **The Health and Social Care (Safety and Quality) Act 2015** gives all the regulators (with

[6] The HCPC did not participate.

the exception of the PSNI) and the Authority the same over-arching objective, which reflects the well-established purpose of fitness to practise as per the case law:

> "*The over-arching objective of the […] in exercising its functions […] is the protection of the public.*
>
> *The pursuit by the […] of its over-arching objective involves the pursuit of the following objectives—*
>
> *(a) to protect, promote and maintain the health, safety and well-being of the public;*
>
> *(b) to promote and maintain public confidence in the professions regulated by the regulatory bodies;*
>
> *(c) to promote and maintain proper professional standards and conduct for members of those professions."*[7]

- With work on the Law Commissions reforms stalled, the Professional Standards Authority calls for radical reform of professional regulation in ***Rethinking regulation*** in November 2015. The paper highlights the lack of coherence of the regulatory landscape, the expense and human impact of the fitness to practise framework, and the need for regulation to adapt to keep up with the changes in the healthcare system and calls for:
  - a shared theory of regulation, based on right-touch thinking
  - shared objectives for system and professional regulators, and greater clarity on respective roles and duties
  - a rebuilding of trust between professionals, the public and regulators
  - a reduced scope of regulation so it focuses on what works (evidence-based regulation)
  - a proper risk assessment model for who and what should be regulated put into practice through a continuum of assurance
  - to break down boundaries between statutory professions and accredited occupations
  - to make it easier to create new roles and occupations within a continuum of assurance
  - a drive for efficiency and reduced cost which may lead to mergers and deregulation
  - to place real responsibility where it lies with the people who manage and deliver care.

[7] The Authority is also given new objectives relating to the regulation of businesses by the GPhC and GOC.

- In **December 2015**, the then Health Minister **Ben Gummer announces plans to reform health and care professional regulation** building on the work of the Law Commissions, and the Authority's calls for reform in *Rethinking regulation*.
- Under **legislation passed in** **December 2015**, the Authority's threshold for appealing s.29 decisions is amended from a test of undue leniency to one of insufficiency for public protection, to match the over-arching objective. In the same section 60 Order, the GMC's legislation is amended to put its adjudication arm, the Medical Practitioners' Tribunal Service (MPTS) on a statutory footing by making it a committee of the GMC. At the same time, it is awarded powers to challenge decisions of the MPTS on a similar basis to the Authority's s.29 powers; the Authority retains its powers to challenge MPTS decisions, and unlike the GMC it can challenge cases on grounds of under-prosecution.
- The Education Secretary Nicky Morgan announces **plans to set up a new, dedicated regulator for social workers in England** (**January 2016)**.
- In **October 2016**, the Professional Standards Authority builds on *Rethinking regulation* with a further thought piece, ***Regulation rethought*****,** that sets out ways in which the challenges previously identified could be addressed. It proposes that all parts of the regulatory system should have a shared purpose of protecting patients and reducing harms, promoting professional standards, and securing public trust in professionals. Detailed proposals include:
  - a single assurance body with a shared public register, a system of licensing, a common code of conduct for all professions, and shared delivery of investigation, prosecution and adjudication in fitness to practise
  - greater emphasis on local resolution, and the adoption of an inquiring instead of a confrontational approach to dealing with concerns about professional
  - a methodology for assessing and assuring occupational risk should be adopted as part of reformed arrangements, developed and published as *Right-touch assurance*.
- **Jeremy Hunt announces plans to regulate a new group of nursing support staff, nursing associates, in England only, in November 2016**.
- The **Healthcare Safety Investigation Branch** is set up under Jeremy Hunt **in April 2017**, to identify and investigate system-wide failings. It remains a branch of NHS England and NHS Improvement, although the intention is for it to become an independent body enshrined in statute. Aspects of its work have been controversial among professional regulators and **the Authority** – in particular the 'safe space' approach appears to contradict the Government's commitment to transparency and accountability, as expressed though the legal and professional duty of candour, and could conflict with existing regulatory processes and the ability of regulators to protect the public. The Government

publishes a Bill to put HSIB on a statutory footing in October 2019, but the Bill falls after the Prime Minister, Boris Johnson, calls a general election.

- The Authority publishes ***Right-touch reform*** **in November 2017**. This report looks in detail at all the regulatory functions in the context of the recommendations from *Regulation rethought*. It details ways in which regulation could make better use of data to prevent harm, and proposes that quality assurance of education should be reviewed to reduce duplication and variation; it considers the role of the professional registers, and makes recommendations for ways in which they could be more accessible and consistent. It also makes detailed recommendations for the reform of fitness to practise:
  - To move to a less adversarial model with a greater focus on early resolution and remediation
  - In any case where there is no dispute about the facts, following a thorough investigation, the registrant should be asked to accept or reject the regulator's case on facts, impairment, and sanction. Any rejected case would be sent to a hearing; all decisions would be published.
  - Transparency and accountability would be maintained through a s.29-type power of independent scrutiny, and challenge of decisions that did not protect the public.
- The publication of *Right-touch reform* coincides with a long-awaited **UK-wide consultation on reforming professional regulation**. The consultation topics are broad, with open questions about mergers of regulators, sharing of functions, fitness to practise and governance reform, and how to determine which groups should be regulated, among others – drawing on much of the Authority's thinking in *Rethinking regulation* and *Regulation rethought*. The findings and Government response will not be published until July 2019 (see below for more information).
- In **January 2018**, the **Inquiry into Hyponatraemia-related Deaths in Northern Ireland reports its findings**, nearly 25 years after the first child death it covers. It exposes, among a range of other concerns, a lack of candour with the families.
- **The GMC successfully appeals at the High Court to have Dr Hadiza Bawa-Garba removed from the register (January 2018).**[8] Dr Bawa-Garba was involved in the tragic death of a six year-old boy, whose fatal sepsis condition was not diagnosed by hospital staff. The MPTS had previously suspended her registration for 12 months, following a

[8] A timeline of the case is available on Pulse, a publication for general practitioners: http://www.pulsetoday.co.uk/news/gp-topics/gmc/bawa-garba-timeline-of-a-case-that-has-rocked-medicine/20036044.article

conviction for gross negligence manslaughter (GNM) in the criminal courts.[9] The case is complex, primarily because of the challenging conditions under which Dr Bawa-Garba was working on that particular shift.

The medical profession responds with anger at what it considers to be scapegoating for wider systemic failings, and unreasonable expectations on professionals working in an underfunded and over-subscribed NHS. The then Health Secretary Jeremy Hunt launches a rapid **review of how professional regulation deals with GNM cases, chaired by Sir Norman Williams**, which reports in June of the same year. The report's recommendations are all accepted by Government. Those most pertinent to this timeline are that:

- The GMC should lose its right of appeal against MPTS decisions (not yet implemented)
- Systemic issues and human factors should be considered alongside the individual actions of healthcare professionals where errors are made that lead to a death.

The review also highlights a perception of inconsistency in the professional regulators' decision-making, with a sense that decisions made on similar facts by different regulators result in different sanctions. Dr Bawa-Garba goes on to successfully appeal the decision to have her struck off, and the original suspension decision is reinstated.

- A **May 2018** review commissioned by Betsy Cadwaladr University Health Board, **Independent Investigation into the Care and Treatment Provided on Tawel Fan Ward: a Lessons for Learning Report** reports on the failures of care on the dementia unit in Colwyn Bay in north Wales. It identifies a number of issues including in the understanding and application of the duty of candour, lack of clarity around leadership and registration requirements amongst staff, and resistance amongst staff to the clinical decision-making process being overseen by formal governance and management structures.
- **November 2018** sees the publication of the **Kark Review into the Fit and Proper Person Test**, which forms part of the CQC's regulatory regime, and is intended as a means of ensuring that directors of NHS providers are vetted before they are appointed. There is a consensus that the test is not effective, and Kark makes seven recommendations, including developing competencies for directors, making a central database of directors' qualifications, training and appraisals, and expanding the definition of serious misconduct.
- The Secretary of State for Health and Social Care announces **plans to regulate physician associates (PAs) and anaesthesia associates (AAs)** **across the UK in October 2018**. It is decided in July 2019 that the GMC will take this forward.

[9] The Authority reviews the MPTS decisions, and does not consider it to be insufficient for protection of the public.

- The **NMC opens its register of nursing associates in England in January 2019**.
- The Authority publishes its **review of the regulatory response to the professional duty of candour in January 2019**. It highlights the challenges of measurement of any change in practice, and shows some perceived improvements but overall finds that regulators could do more.
- The **Sturrock Review** into allegations of bullying and intimidation at NHS Highland reports **in May 2019**. The report identifies major cultural issues within the organisation. A working group is set up by the Cabinet Secretary for Health and Sport, Jeane Freeman, to consider how to address these cultural issues across the NHS in Scotland.
- The Government **response to its consultation *Reforming regulation, promoting professionalism*** is published **in July 2019**. It sets out a plan for reform, focused principally on fitness to practise and governance, announcing that:
  - all regulators would be granted new fitness to practise powers based on the Social Work England model;
  - they would be granted extensive powers to make their own rules, and
  - their Councils would move to a smaller Board structure with appointments based on competency rather than representation.

  The response endorses the use of **Right-touch assurance** as a means of determining which groups should be regulated, but no commitments are made in relation to the Authority's oversight of case examiner decisions. *The proposals are still under development and negotiation, with plans to consult on a section 60 Order to amend the GMC's legislation as a template for reforms to the other professional regulators in early 2021*.
- **Social Work England** opens its doors on **2 December 2019**. It embodies some of the key elements of the Authority's fitness to practise proposals from *Right-touch reform*, with case examiners able to dispose of even serious cases consensually with the registrant.[10] However, the Government stops short of granting the Authority powers to appeal case examiner accepted outcomes, meaning that decisions that do not protect the public can go unchallenged.
- The **Report of the Independent Inquiry into the Issues raised by Paterson** is published on **4 February 2020** outlining the failures of the regulatory system that allowed breast surgeon Ian Paterson to be able to cause harm to hundreds of patients under his care. Amongst other findings, the inquiry comments on the fragmented nature of the regulatory system with a 'jigsaw of organisations' involved in patient safety and recommended that: 'the Government

[10] Case examiners have powers to impose all the same sanctions as a panel, with the exception of striking off.

should ensure that the current system of regulation and the collaboration of the regulators serves patient safety as the top priority, given the ineffectiveness of the system identified in this Inquiry.'

- The rising number of cases of Covid-19 lead to Government announcing a national lock-down including enforced closures of many businesses and the public advised not to go into work or mix with anyone outside of their immediate household on **23 March 2020**. The Department of Health and Social Care works with the professional regulators to supplement the NHS workforce by creating temporary registers of frontline professionals allowing students and retired professionals to return to practice for a time-limited basis, to support efforts to tackle coronavirus and maintain essential healthcare delivery.
- **First Do No Harm – The Independent Medicines and Medical Devices Safety Inquiry** ('the Cumberlege Review') is published on **8 July 2020.** The report outlines the serious harm caused to many female patients and echoes both the findings of the Paterson Report about the challenges for patients in making their voice heard as well as the fragmented nature of the system with the risk of patient safety concerns falling through the gaps between organisations. There were a number of significant recommendations from the report including the proposals to create a 'Patient Safety Commissioner' to act as a voice for patients within the system in relation to medicines and medical devices.
- Secretary of State for Health and Social, Matt Hancock announces a call for evidence on **Reducing bureaucracy in the health and social care system** in **July 2020**. The exercise invites those working in health or social care, or those who have recently left, to share their views on overly burdensome or dysfunctional bureaucracy in the health and social care system. The Government response **Busting bureaucracy** is published in **November 2020** and amongst other proposals re-states the commitment to 'simplify, streamline and modernise' the legal framework of the nine health and care professional regulators, starting with the GMC as well as bring physician associates and anaesthesia associates into statutory regulation.