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# **Regulation of health care professionals Regulation of social care professionals in England Consultation Analysis**

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**Joint Consultation Paper LCCP 202 / SLCDP 153 / NILC 12 (2012)  
(Consultation Analysis)**

**20 February 2013**

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LAW COMMISSION  
SCOTTISH LAW COMMISSION  
NORTHERN IRELAND LAW COMMISSION

# **REGULATION OF HEALTH CARE PROFESSIONALS**

# **REGULATION OF SOCIAL CARE PROFESSIONALS IN ENGLAND**

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# **PART 1**

## **INTRODUCTION**

- 1.1 This document sets out the responses to the Law Commissions' consultation paper, Regulation of Health Care Professionals; Regulation of Social Care Professionals in England.<sup>1</sup> It describes the views of consultees in relation to each of the 111 provisional proposals and 66 consultation questions put forward.

### **The consultation process**

- 1.2 The consultation paper was published on 1 March 2012. The public consultation process ran from publication until 31 May 2012, and we received 192 submissions. These were received from a wide range of consultees which included:

- (1) the relevant Government departments for England, Wales, Scotland, and Northern Ireland;
- (2) the regulators, the Professional Standards Authority, the Northern Ireland Social Care Council, the Scottish Care Council and the Care Council for Wales;
- (3) non-departmental public bodies, including the Equality and Human Rights Commission and the Care Quality Commission;
- (4) 26 professional representative bodies;
- (5) defence organisations and unions;
- (6) patient representative groups and charities, including the Patients Association, Action Against Medical Accidents and the NSPCC;
- (7) 4 local authorities;
- (8) 7 NHS Trusts;
- (9) academics and legal practitioners; and
- (10) individual health and social care practitioners and patients.

- 1.3 A full list of formal written responses is provided in Appendix A. In addition, the Law Commission attended 42 events across England, Wales, Scotland and Northern Ireland. These events covered a wide audience, including regulators, professional bodies, academics, legal practitioners and defence organisations. A full list of events attended is provided in Appendix B.

<sup>1</sup> Regulation of Health Care Professionals, Regulation of Social Care Professionals in England (2012) Law Commission Consultation Paper No 202; Northern Ireland Law Commission Consultation Paper No 12; Scottish Law Commission Discussion Paper No 153.

- 1.4 We are very grateful to all those who took part in consultation events and submitted formal responses.

**Next steps**

- 1.5 Nothing in this document should be read as indicating that the Law Commissions have come to any conclusions about our final recommendations. All of our provisional proposals will be reviewed in the light of the evidence received at the consultation events and the formal responses to our consultation paper from individuals and organisations. Our final report and draft Bill will be published in early 2014.

## **PART 2**

# **THE STRUCTURE OF REFORM AND ACCOUNTABILITY**

**Provisional Proposal 2-1: All the existing governing legislation should be repealed and a single Act of Parliament introduced which would provide the legal framework for all the professional regulators.**

- 2.1 A large majority of consultees who expressed a view agreed with this proposal.<sup>1</sup> For example, the General Medical Council argued that:

A single, overarching Act focused on high level principles will support overall consistency across health care regulation while releasing individual regulators to develop policies and operational approaches appropriate to the circumstances of the professions they regulate.

- 2.2 Similarly, the Professional Standards Authority argued that:

based on our experience of reviewing the performance of the health professional regulators, such a move would provide greater consistency of approach and outcome, enable the legislation pertinent to all regulatory bodies to be changed at the same time and provide the prospect of better understanding of regulation by registrants and the public.

- 2.3 The Chartered Society of Physiotherapy thought that the proposal:

should streamline arrangements, thereby increasing effectiveness and efficiency, and achieve greater transparency, commonality of approach and public understanding. All this should enhance both patient safety and clarity for registrants.

- 2.4 The General Pharmaceutical Council felt that a single Act presented “opportunities for regulators to learn and adapt from best practice more quickly”. Others argued that the existing legislative structure encourages the regulators to work in silos and inhibits joint working and the sharing of functions and facilities.

- 2.5 A small number of consultees expressed qualified support for the proposal. For example, the British Medical Association felt that unless there is “sufficient flexibility to ensure each regulator can reflect its profession”, the single Act could prevent innovation. The Academy of Royal Medical Colleges noted that “the different circumstances in which the regulators operate may mean that differences are justifiable and sometimes vital to their work”.

- 2.6 The proposal was opposed outright by the Royal College of Midwives which argued that a single statute would entail dismantling essential regulatory frameworks. The Royal College supported a system which recognises

<sup>1</sup> Of the 192 submissions which were received, 35 expressed a view on this proposal: 31 agreed, 1 disagreed, whilst 3 held equivocal positions.

professional differences and where nursing is not combined with midwifery. Moreover, at consultation events, a small number of attendees felt that separate statutes for each profession recognised the status and uniqueness of each profession, and therefore ensured professional buy-in and support.

**Provisional Proposal 2-2: The new legal framework should impose consistency across the regulators where it is necessary in order to establish the same core functions, guarantee certain minimum procedural requirements and establish certain core requirements in the public interest. But otherwise the regulators should be given greater autonomy in the exercise of their statutory responsibilities and to adopt their own approach to regulation in the light of their circumstances and resources.**

- 2.7 An overwhelming majority supported this proposal.<sup>2</sup> However, in general terms, consultation responses were divided between those who supported greater autonomy and those who wanted greater consistency imposed across the regulators.

***Support for greater autonomy***

- 2.8 Most of the regulators supported the need for enhanced autonomy. For example, the General Optical Council argued that consistency should not be imposed “for its own sake at a high level”, but limited to certain “core principles”:

The areas in which consistency is sought across regulators through the overarching legislation will need to be carefully chosen, and appropriate safeguards and opportunities for collaboration put in place to ensure an appropriate balance is maintained in respect of consistency and regulator flexibility.

- 2.9 The General Medical Council also felt that consistency should be limited to certain “core principles”:

It would be wrong for the statute to impose a “one size fits all approach” and regulators must have the policy and operational autonomy to develop regulation in the way that is most appropriate to the sector.

- 2.10 The General Osteopathic Council also emphasised that:

Consistency should not imply uniformity. Each regulated profession operates in different circumstances and at different stages of development that determine the most appropriate way for them to be regulated. It is also important to recognise that innovation in the field of regulation comes from regulators doing things differently, not working to a single set formula.

- 2.11 The General Dental Council argued that the compulsory elements of the legal framework should be “carefully chosen” and that:

<sup>2</sup> Of the 192 submissions which were received, 54 expressed a view on this proposal: 52 agreed, whilst 2 held equivocal positions.



Simplicity and consistency should not be at the expense of an individual regulator's ability to deliver its functions in a way that is suited to the profession concerned and which promotes confidence in its regulation.

- 2.12 The General Social Care Council suggested economic reasons for flexibility:

The increase in referrals which many professional regulators have experienced over recent years, as well as the expectation from Government (and the professions) that the cost of regulation should not be increased, makes this ability to react to changed circumstances imperative.

- 2.13 A number of professional bodies also supported increased autonomy. For example, the Royal College of Physicians in Edinburgh felt that "regulators must have autonomy to adapt their own approach in light of their circumstances and resources".

***Support for consistency***

- 2.14 Many consultees expressed concern that our proposal failed to impose greater consistency across the regulators. For example, the Allied Health Professions Federation argued that increased autonomy could lead to individual regulators "enacting their roles and functions quite differently" and thus "undermining transparency, consistency, public understanding and fairness".

- 2.15 The Council of Deans of Health said that our proposal presupposes that all of the regulators are equally well prepared "to take on and apply the principles of right touch regulation" and that the regulators will wield their increased powers "sparingly and successfully". The Council felt that, in reality, only some of the regulators will be capable of operating successfully in the new context. Many pointed to the recent difficulties at the Nursing and Midwifery Council as illustrating precisely why the regulators should not be given greater autonomy.

- 2.16 The Professional Standards Authority argued for "a consistent approach directed to producing the same outcomes". It said that:

We do not propose a consistency of approach from the regulators for the sake of it; we encourage it because we have seen first-hand the negative outcomes for people that can arise from core functions being undertaken in different ways. Differences in the content of public registers and the sanctions that regulators have available, for instance, have affected confidence in regulation. In addition, such differences will potentially make it more difficult for employers to navigate the different systems.

- 2.17 Specifically, the Authority argued that fitness to practise adjudication – being the most high profile and public facing of all the regulatory functions – requires greater consistency in order to maintain public confidence. It considered that:

There should be an expectation that, if different health professionals each erred in their actions over the same issue, for example in the

prescribing of drugs, the actions taken against them and the sanctions imposed should be similar in similar circumstances.

2.18 Several consultees, such as UNISON, also felt that a consistent approach would be of particular use in dealing with issues arising from the actions of multi-disciplinary teams, which is likely to become a greater regulatory challenge in the future.

2.19 The Scottish Government recognised that “the regulators work in different areas and contexts and need to have the freedom to adopt different procedures” but nonetheless argued that:

An appropriate balance needs to be struck between the consistency referred to and the degree of discretion/freedom afforded to the regulators. In the event that the new framework offers too great a level of autonomy, this could lead to inconsistency and serve to complicate rather than simplify the regulatory landscape.

2.20 The Department of Health, Social Services and Public Safety for Northern Ireland supported “the concept of legislative consistency” and cautioned that “the freedom proposed does not become licence”.

**Provisional Proposal 2-3: The regulators should be given broad powers to make or amend rules concerning the exercise of their functions and governance without any direct oversight, including Privy Council approval and Government scrutiny (subject to certain safeguards).**

2.21 A significant majority agreed that the regulators should be given broad rule-making powers without Privy Council or Government oversight.<sup>3</sup>

2.22 Both the General Osteopathic Council and the General Social Care Council argued that the difficulties in securing Department of Health resources or Parliamentary time in order to amend rules had prevented their evolution.

2.23 The General Osteopathic Council argued that removing Privy Council or Government scrutiny should not automatically imply that regulators “couldn’t or shouldn’t work with the Government to ensure that new rules are compatible with European or public law requirements”.

2.24 The Department of Health agreed that the regulators should be given rule-making powers, but also suggested that, in order to address any risks in relation to the capability of the Councils:

It may therefore be necessary to include provision so that existing rule-making processes continue, subject to any necessary modifications, until such time as the regulators have the capacity to operate without the Department of Health’s scrutiny. We would suggest that there should be an assessment (a “test of readiness”) of a regulator’s ability to take on its new powers before they would be commenced, and that consideration be given to other safeguards,

<sup>3</sup> Of the 192 submissions which were received, 51 expressed a view on this proposal: 42 agreed, 5 disagreed, whilst 4 held equivocal positions.

such as whether the Professional Standards Authority may be given a greater role in oversight of the regulators' rules.

- 2.25 The Scottish Government agreed that the regulators should have broad rule-making powers but was concerned about the legal capacity of the regulators to do this and suggested that “cross subsidisation of public monies should also be considered”.
- 2.26 The Department of Health, Social Services and Public Safety for Northern Ireland argued that “some form of scrutiny is required” and “it cannot be a ‘free for all’”. The Welsh Government stated that it “will want to be assured that processes in the regulatory bodies will take account of devolved differences” and that “working arrangements are in place with the Department of Health for a UK approach to any changes”. It also suggested that it may be more cost effective for the smaller regulators “to commission the Professional Standards Authority to provide services on their behalf”.
- 2.27 Further risks identified by the General Optical Council included poorly drafted rules being put in place by regulators, frequent amendment of these rules and additional legal challenges, all of which would create additional expense and uncertainty. Similarly, the Nursing and Midwifery Council argued that “the current system helps to ensure that rules are fit for purpose, thereby reducing [that] risk and maximising public safety” and that the removal of the Government’s role would have resource implications for each regulator.
- 2.28 Some expressed concern that our proposals will only work for the larger and better resourced regulators, whereas the smaller regulators will struggle. Once again, several consultees pointed to the current difficulties at the Nursing and Midwifery Council as illustrating why the regulators should not be given greater autonomy and why enhanced oversight is essential.
- 2.29 The Institute of Medical Illustrators argued that our proposed approach would undermine the ability of members of the public to challenge the regulators’ rules, as the only available option would be judicial review.
- 2.30 Some felt that the proposal would lead to a disparate approach to the development of rules. For example, Action Against Medical Accidents argued that “simply giving regulators broad powers is a recipe for even more inconsistency” and that “all the regulators should be bound by overarching regulations which guarantee a consistent approach”. The Professional Standards Authority argued that our proposal would work against “the drive for greater consistency in outcomes across the regulators”.

**Question 2-4: Would the perceived status of legal rules be less clear or certain without Parliamentary approval? Should the Professional Standards Authority be given an active role in scrutinising new rules, or should a limited number of the rules be subject to Secretary of State approval and contained in a statutory instrument?**

- 2.31 A slim majority felt that the status of rules would be less clear.<sup>4</sup>
- 2.32 The Department of Health felt that there was no reason why the status of rules should be less clear without Parliamentary approval, but suggested requiring the regulators to be explicit about the version of the rules they apply and to publish “the latest, consolidated version of their rules in a specific place to ensure ease of access for registrants and the public”. It also expressed some concerns about the resource implications of an enhanced role for the Professional Standards Authority.
- 2.33 Opinion was divided over whether the Professional Standards Authority should be given an active role in scrutinising new rules.<sup>5</sup>
- 2.34 The Professional Standards Authority accepted that it could perform an oversight or rule-approval role to “ensure that any proposed rule changes take into account the wider context and do not lead to unintended consequences on others”. However, this would require “additional legal resources and extended Parliamentary accountability”. The Authority also called for clarity on whether it would have the power to stop a regulatory body from proceeding or merely to issue advice – or whether it could refer such matters to the Secretary of State.
- 2.35 The Council of Deans of Health argued that formal oversight by the Authority was necessary to mitigate against the risk of the regulators implementing new rules which are “over-burdensome, unnecessary or are duplicated elsewhere”. The Association of Regulatory and Disciplinary Lawyers suggested the Authority’s role should include formal approval of rules in key areas (such as fitness to practise). In the event of any dispute between a regulator and the Authority, the matter could be reported to the Health Select Committee or, as a last resort, dealt with by way of judicial review proceedings.
- 2.36 Many of the regulators opposed giving the Authority an active role in scrutinising new rules. The General Medical Council argued this would turn the Authority into a “regulator of regulators” and would compromise its ability to comment upon performance because “it would be implicated in the approval of the policies and procedures it was being asked to judge”. The General Optical Council shared this concern.
- 2.37 The General Pharmaceutical Council argued that:

Accountability and transparency are enhanced by clarity and certainty on the question of who is responsible for what. The more the

<sup>4</sup> Of the 192 submissions which were received, 21 expressed a view on this question: 11 said the status of rules would be less clear, whilst 10 said it would not be less clear.

<sup>5</sup> Of the 192 submissions which were received, 34 expressed a view on this question: 18 said the PSA should be given such a role, 13 disagreed, whilst 3 held equivocal positions.

regulators (which are the bodies with responsibility for regulation) are explicitly, or in effect, subject to direction by the Professional Standards Authority the less accountable and transparent regulation as a whole will become, with (almost inevitably) more and more control being exercised, less transparently and with less accountability, by a body which is not legally responsible for regulation.

- 2.38 The Health and Care Professions Council supported a role for the Authority in scrutinising new rules, but argued this did not require any change in role because the Authority can report on this area as part of its annual performance review of the regulators. It argued that oversight should take the form of “ensuring that each regulator undertakes a transparent consultation process and is able to justify the rules it is proposing or has implemented”.
- 2.39 The General Osteopathic Council argued that the Authority has “no greater expertise in this area than the regulators and, in the case of larger regulators, arguably less” but accepted it may have a role in setting standards for new rules “to underpin quality and transparency”.
- 2.40 The Scottish Government also felt that the Professional Standards Authority “does not currently have sufficient legal, policy or human resource capacity/capability/expertise” to perform an enhanced oversight role, and that a system would need to be put in place to monitor its performance. The Department of Health, Social Services and Public Safety for Northern Ireland also pointed to the need to ensure the accountability of the Professional Standards Authority if its role were enhanced.
- 2.41 A majority agreed that a limited number of rules should be subject to Secretary of State approval and contained in a statutory instrument.<sup>6</sup> For example, the General Dental Council suggested that such approval should be required for constitutional orders and matters relating to public protection. The Nursing and Midwifery Council suggested that approval should be limited to fitness to practise and registration rules. The General Osteopathic Council argued that a limited number of rules could be approved by the Secretary of State but the regime “should be one where the approval process is about granting authority rather than exercising a veto”. UNISON suggested that only specific matters, such as “entrance, maintenance and removal from the register” should be subject to Secretary of State approval.
- 2.42 The General Medical Council argued that the key distinction is between operational concerns which should be left to the regulators to determine and matters which relate to the nature of the regulator (such as the composition of the Council) which need additional Parliamentary oversight.
- 2.43 The Scottish Social Services Council pointed out that it has powers to make its own rules with the consent of Scottish Ministers and felt this allows “flexibility” and ensures the draft rules are considered by “skilled Government lawyers” who can offer “helpful comments to us on applicable drafting conventions”.

<sup>6</sup> Of the 192 submissions which were received, 21 expressed a view on this question: 13 agreed with Secretary of State approval, 4 disagreed, whilst 4 held equivocal positions.

**Provisional Proposal 2-5: The power of the regulators to issue standing orders should be abolished.**

2.44 The vast majority agreed that the express power to issue standing orders should be removed.<sup>7</sup>

2.45 The Professional Standards Authority was confident that:

The procedural standing orders that currently address matters of delegation could be undertaken through internal governance procedures such as corporate standing orders, delegated authorities or schemes of delegation. Transparency of such decisions could be achieved through the publication of the individual arrangements on the regulatory bodies' websites.

2.46 However, the General Dental Council wanted "an explicit power for the regulators to make rules governing their internal procedures ... this then leaves no room for dispute about implicit powers". Similarly, the Nursing and Midwifery Council argued that the maintenance of standing orders "demonstrates a commitment to good governance" since they would help to prevent governance processes and procedures being by-passed.

**Provisional Proposal 2-6: The regulators should have the ability to implement their statutory powers by making rules, instead of a mixture of rules and regulations.**

2.47 The vast majority of consultees who expressed a view on this proposal agreed that the regulators should use rules to implement their statutory powers.<sup>8</sup>

2.48 The Patients Association and the British Association for Counselling and Psychotherapy were amongst several consultees who thought the proposal would make the system less confusing.

2.49 The UK-wide Nursing and Midwifery Council Lead Midwives for Education Group opposed the proposal, on the basis that it did not offer sufficient protection against potential bias between professional groups.

<sup>7</sup> Of the 192 submissions which were received, 31 expressed a view on this proposal: 28 agreed, 1 disagreed, whilst 2 held equivocal positions.

<sup>8</sup> Of the 192 submissions which were received, 36 expressed a view on this proposal: 34 agreed, 1 disagreed, whilst 1 held an equivocal position.

**Provisional Proposal 2-7: The statute should require the regulators to consult whenever issuing or varying anything which is binding, anything which sets a benchmark or standard, and a competency. The regulators should be required to consult such persons it considers appropriate, including:**

**(1) members of the public, patients and service users;**

**(2) registrants (including business registrants);**

**(3) employers of registrants;**

**(4) the other health and social care professional regulators, the Professional Standards Authority, the health and social care inspectorates, the independent safeguarding authorities and any other regulatory bodies;**

**(5) the Department of Health, Northern Ireland Executive, Scottish Government and Welsh Government;**

**(6) professional bodies that represent registrants; and**

**(7) persons or bodies commissioning or funding the services provided by registrants or at a registered premises/business.**

2.50 An overwhelming majority supported the proposed duty to consult.<sup>9</sup>

2.51 However, there was some concern about how this duty had been formulated. Some of the regulators argued that it was overly prescriptive and inflexible in places. For instance, the General Pharmaceutical Council had concerns “about what is meant by ‘anything which is binding’.” The General Medical Council agreed that the formulation is too rigid, and stated that:

A statutory requirement to consult on “anything that is binding” ... risks forcing regulators to consult in a tokenistic manner when there is no genuine opportunity for respondents to affect the outcome. For example, a change to rules necessary to achieve compliance with aspects of European Union law may require outcomes which are binding on registrants who are subject to those rules. Even if respondents oppose the change, the regulator would be obliged to make it anyway.

2.52 The Council argued that regulators should be expected to use their judgment on “when it is appropriate to consult and when it is not” in the knowledge that if they fail to do so, judicial review proceedings may follow.

2.53 Similarly, the General Optical Council argued that the proposal would “take away the ability of regulators to use their own knowledge of their sectors to gauge whether a consultation is necessary for the issue and audience”. The Association of Regulatory and Disciplinary Lawyers also questioned whether consultation on every rule change would be practicable or proportionate, and argued it could undermine the regulators’ ability to respond quickly where there was a need for

<sup>9</sup> Of the 192 submissions which were received, 60 expressed a view on this proposal: 59 agreed, whilst 1 held an equivocal position.

urgency. The Nursing and Midwifery Council suggested there should be no requirement to consult if the change relates to providing clarification, correcting a mistake or bringing a document in line with other legislation. The Royal College of Obstetricians and Gynaecologists supported consultation on legally binding measures, and competencies, but also favoured “a consultation process that is not bureaucratic and time consuming”.

2.54 However, this view was not accepted by all consultees. For example, the Institute of Biomedical Science felt that there should still be a requirement to consult on all changes to rules, guidance and competence standards “as even minor changes can have profound or unanticipated consequences”. The General Chiropractic Council supported a “mandatory requirement to consult”. The Department of Health also considered that “it would be realistic to expect the regulatory bodies to consult on every substantial variation of a rule etc”.

2.55 Many felt that the proposed duty to consult needed to be strengthened in order to prevent the regulators only paying lip service to this requirement. The Department of Health, Social Services and Public Safety for Northern Ireland queried how the objectivity of the consultation will be preserved in the statute and pointed out that “leading questions would bias the responses”.

2.56 Some responses provided specific examples of where a regulator had consulted inadequately or ignored the views expressed at consultation. For example, UNISON was particularly critical of online consultations which only allow for predetermined answers. Some of the proposed solutions included that:

- (1) the regulators should be required to publish a summary of the views expressed at consultation and “their justification of how they have acted on them” (Committee of Contact Lenses Educators);
- (2) the regulators should be required to give weight to the responses and recommendations of the relevant professional associations (British Association of Dental Nurses);
- (3) there should be a new duty which “prevents cynical or cursory consultation exercises and ensures that the voice of legitimate consultees is heard and taken into account” (Institute of Health Visiting);
- (4) there should be a requirement to produce documentation in a variety of formats and media and a “minimum response rate” for responses from patients and service users (Patients Association); and
- (5) the legal standards for consultation imposed by the *Coughlan* judgment should be stated in the statute (Medical Defence Union).<sup>10</sup>

2.57 The Professional Standards Authority argued that there should be a framework imposed similar to the Government Code of Practice on Consultation, in places. It pointed out that the Authority is required to develop such a framework in relation to the accreditation of voluntary registers.

<sup>10</sup> *R v North and East Devon Health Authority ex p Coughlan* [2001] QB 213. See discussion in Joint CP, para 2.41.



2.58 Some consultees made drafting suggestions. It was suggested that phrases such as “that which is binding” or “that which sets a benchmark” are unclear and would lead to argument about their meaning. The Health and Care Professions Council felt it was unhelpful to differentiate between standards, such as a code of conduct, and standards such as standards of proficiency. Instead, it felt that consultation should be required “before making and amending rules; setting or amending standards; and setting or amending guidance”. The General Pharmaceutical Council pointed out that some binding requirements will not always be set out in rules. For example, it requires international pharmacist applicants to demonstrate they have achieved level 7 of the International English Language Testing System on language competence, which is not set in rules but is binding.

***The list of consultees***

2.59 Some consultees contended that the statute should not be overly prescriptive about which organisations or individuals are consulted. For example, the General Medical Council argued that “blanket coverage of every issue risks devaluing attempts to engage with key interests on other occasions where their input will add real value”. The General Pharmaceutical Council also cautioned against too much specificity and argued that “good consultation should be tailored to the issue and the format for each consultation will often vary”.

2.60 However, others disagreed and suggested that the list needed to be expanded to ensure it is sufficiently comprehensive. Suggested additions included:

- (1) education and training providers (Council of Deans of Health);
- (2) other key workforce stakeholders (Skills for Care);
- (3) organisations that contract with professionals, for example in primary care (National Clinical Assessment Service);
- (4) providers of healthcare, whether in public or private sectors (Association of Clinical Biochemistry);
- (5) trade associations – such as those who represent the collective interests of the owners of pharmacies (Pharmacy Voice);
- (6) trade unions (Unite);
- (7) European regulatory bodies (Pharmaceutical Society of Northern Ireland);
- (8) Parliament and the devolved assemblies (consultation event participant);
- (9) charities and support groups (Patients Association); and
- (10) carers (Professional Standards Authority);

2.61 In addition, the Nursing and Midwifery Council argued that the reference to “members of the public” could be problematic and potentially ineffective. Instead, a more robust approach could be achieved by including reference to “groups or organisations representing the views of members of the public”. An individual

consultee (Don Brand) argued that, unlike social work, most health services and professional functions are available to the public on a universal basis. Therefore “simply lumping in service users with patients and members of the public as a category of people to be consulted is inadequate”. The General Dental Council suggested it should be made clear that the duty only applies to UK bodies.

- 2.62 The Department of Health suggested that the list of consultees should include representatives of patients, registrants and employers. Furthermore:

Currently the regulators have different practices regarding consultations before making rules. Our view is that there should be statutory obligations on them to consult before making rules (including any amendments in future) and expectations about the period for consultation. For example, in line with cabinet office guidance on public sector consultation, which we consider reflects good practice, there should be an expectation that consultations should be for 12 weeks unless there are compelling public interest reasons for a shorter consultation period.

- 2.63 The Scottish Government suggested that consultation should be across the four countries and “include appropriate representation from the devolved administrations”. Some concern was expressed that the list of consultees might be seen as definitive which could have the effect of “precluding from the consultation essential groups, persons or bodies whom, in certain circumstances, it would be appropriate to consult”. The Welsh Government stated “it should be acknowledged that these wider contacts will be different in each part of the UK”.

**Provisional Proposal 2-8: The formal role of the Privy Council in relation to health and social care professional regulation should be removed entirely.**

- 2.64 A majority agreed that the formal role of the Privy Council in relation to health and social care professional regulation should be removed entirely.<sup>11</sup> For example, the Royal College of Radiologists agreed “with this proposal in view of the complex and lengthy procedure required for Privy Council approval”.
- 2.65 The General Medical Council agreed, and further argued that the Privy Council role “does not ensure distance between the regulators and the Government, it merely masks the relationship”. The Council also pointed out that in several areas it can already make regulations that do not require Privy Council approval, such as setting fees, and this does not affect the perceived status of these regulations.
- 2.66 The Scottish Government felt that the Privy Council role “is something of a formality” and in practice “matters fall to the Department of Health to perform”, which was described as contrary to the need for independence from Government.
- 2.67 The Association of Regulatory and Disciplinary Lawyers argued that:

The current system is overly bureaucratic and, critically, very slow. This inhibits the ability of regulators to make changes quickly that are

<sup>11</sup> Of the 192 submissions which were received, 47 expressed a view on this proposal: 33 agreed, 12 disagreed, whilst 2 held equivocal positions.

necessary and urgent. The current process of approval is weighted very much in favour of safeguards and oversight of the regulators and does not support the regulators' need to make changes that they are best placed to identify as necessary changes.

2.68 However, several consultees – including those who agreed with the proposal – expressed concerns. A small number disagreed that the Privy Council role was largely symbolic and instead argued that it added real value. For example, Optometry Scotland felt that the Privy Council provides an “appeal process for concerned professions with a grievance regarding any aspect of regulation” and resolves disputes through “a fair and balanced approach based on what would be in the best interest of the public”.

2.69 This view was supported by the Optical Confederation which stated that:

The strength of the Privy Council system was that it generally liked to receive joint proposals both from the regulator and the regulated so that it was not forced to arbitrate on controversial issues. This invariably forced the parties to seek reasonable accommodations which were in the public interest.

2.70 Some consultees claimed that the Privy Council guards against political interference. The Royal College of Midwives felt that the Privy Council provides a “counterbalance to the administration of the day” which prevents undue political influence. The Institute of Biomedical Science argued that the role of the Privy Council ensures the separation and independence of the regulators from Government, builds in wider cross-Government participation and is an important part of “joined-up Government”.

2.71 The Department of Health disagreed with the removal of the Privy Council role. It felt that:

The statutory role of the Privy Council indicates a clear intention for there to be distance between these bodies and the Government. Current policy is that professional regulation should be seen as independent from day-to-day political pressures to ensure professional and public confidence in regulation is maintained. Removing the role of the Privy Council could call into question the independence of the regulatory bodies from Government and the Secretary of State for Health. We also have concerns about the impact on the classification of the regulatory bodies as a result of removing the role of the Privy Council.

2.72 The General Pharmaceutical Council argued that one of the benefits of the Privy Council role is that – as a UK-wide body – it can ensure all rules are consistent with legislation in Scotland, Wales and Northern Ireland, and take account of divergent health service delivery and management arrangements.

2.73 Some consultees accepted that, in practical terms, the role of the Privy Council is insignificant but argued that its real significance lay in expediting valuable input from the Government. For example, the General Optical Council contended that:

We are not certain that the input and expertise that is currently provided by Department of Health lawyers in the process of drafting new rules can easily be obtained elsewhere. Even if that expertise is available privately, there will be substantial additional costs on regulators, and losing the Department as a central resource may create overall inefficiencies among the regulators relative to the current system.

- 2.74 Some consultees argued that if the role of the Privy Council is removed, greater joint working amongst the regulators would be required. The General Optical Council argued that it would “explore initiatives to share expertise and resources among regulators to help ensure the robustness of future rules”. The Professional Standards Authority suggested that greater co-operation could be facilitated through the introduction of “oversight committees” to work on developing the core requirements and the development of template documents and methodologies.

**Provisional Proposal 2-9: The House of Commons Health Committee should consider holding annual accountability hearings with the regulators which should be coordinated with the Professional Standards Authority’s performance reviews. The Scottish Parliament, National Assembly for Wales and Northern Ireland Assembly should also consider instituting similar forms of accountability.**

- 2.75 A large majority agreed with this proposal.<sup>12</sup>
- 2.76 Some consultees argued that our proposal should go further. The Royal College of Midwives argued that all regulators should have to attend annual accountability hearings, not just the larger regulators. The College also said that the Health Committee should be mandated to enquire “how the public safety and care quality of those receiving care from registrants is assured by the regulator”.
- 2.77 However, some consultees queried the expertise of the Health Committee. It was suggested that the first accountability hearings, undertaken earlier in 2012 with the General Medical Council and the Nursing and Midwifery Council, had exposed the Committee’s lack of resources and knowledge. Specifically, it was felt that the Committee had not asked probing questions and appeared to misunderstand the role of professional regulation. However, some accepted that the Committee’s expertise and effectiveness may improve if accountability hearings become a regular occurrence.
- 2.78 However, the Optical Confederation remained unconvinced that accountability hearings could ever be effective, describing them as “post hoc, largely self-congratulatory PR exercises and seldom hard-hitting or genuinely effective in holding regulators to account”. The Royal College of Radiologists suggested that the Health Committee does not have the appropriate level of independence since it can too easily become “a party political tool”. The General Dental Council argued that the Health Committee “has too wide a brief to be able to satisfactorily take on the systematic holding to account of the health and social care

<sup>12</sup> Of the 192 submissions which were received, 49 expressed a view on this proposal: 43 agreed, 4 disagreed, whilst 2 held equivocal positions.

regulators”. Optometry Scotland also drew attention to the cost implications of such hearings which it felt would be passed on to registrants.

- 2.79 Several consultees expressed support for the establishment of a specialist Joint Committee to oversee the regulators. For example, the Institute of Medical Illustrators argued this would reassure practitioners “that a political agenda would not be followed if there were a strong representation from experts from the upper House rather than only from professional politicians”. The Professional Standards Authority argued that a Joint Committee would “facilitate a more overarching coordinated approach”, but also recognised that the effectiveness of Parliamentary scrutiny through any committee will depend in part on the quality of the evidence submitted.
- 2.80 Some consultees also commented on the devolution aspects of this proposal. The General Medical Council argued that if accountability hearings were put in place for all four legislatures it would be important that “there was an agreement for managing this to avoid potentially competing and conflicting demands on regulators and to minimise the duplication of regulatory effort”. The Nursing and Midwifery Council stated that:

Under our current legislation, we are only legally accountable to the UK Parliament. Our concern is that, if we were legally accountable to the legislative bodies of Northern Ireland, Scotland and Wales, there would be a strong risk of being pulled in different directions by divergent policy concerns, undermining the four nations approach to nursing and midwifery regulation. We would be pleased to consider ways of addressing the interest of the devolved administrations, while avoiding the risk of fragmentation.

**Provisional Proposal 2-10: The Secretary of State should be given formal powers to make decisions on matters that require a political policy decision to be made, including matters where there is a sufficient public interest and matters that give rise to questions about the allocation of public resources.**

- 2.81 A majority agreed that the Secretary of State should be given formal powers on matters that require a political policy decision to be made.<sup>13</sup> The Department of Health agreed generally with our approach to conferring powers of this nature (including default powers) but argued they should be vested in the Privy Council.
- 2.82 The Scottish Government agreed that the Secretary of State should retain responsibility for public policy decisions but emphasised that any change in this regard “must take into account devolved interests and allow for Scottish Government input into any decisions which are within devolved competence”.
- 2.83 The Department of Health, Social Services and Public Safety for Northern Ireland agreed with our proposals for Government regulation-making powers but noted that “there is still a need for Government to administratively support”.
- 2.84 Several consultees qualified their support by pointing to the dangers of unnecessary Government interference in professional regulation. The National

<sup>13</sup> Of the 192 submissions which were received, 42 expressed a view on this proposal: 27 agreed, 4 disagreed, whilst 11 held equivocal positions.

Clinical Assessment Service argued that while the policy of the present Government is a more hands-off approach, future Government interventions based on “knee jerk reactions to emerging issues which have high public interest eg child protection issues or rogue doctor issues” are possible. The Royal College of General Practitioners argued that the Secretary of State’s intervention powers need to be “very carefully delineated” in order to prevent unnecessary intervention on the basis of short-term political expediency.

- 2.85 Some, including the Association of Clinical Biochemistry and the Patients Association, were concerned about the impact of the proposal on the independence of the regulators. The General Osteopathic Council stated that:

Part of the *raison d’être* of independent regulation is to separate it from the dominant supplier of health care (ie the Government) and this proposal could undermine that principle if regulation simply becomes part of the health service funding/policy mix.

- 2.86 The Royal Pharmaceutical Society of Great Britain suggested that the Government’s role should be “more overarching” and the Professional Standards Authority should be given formal powers over political policy decisions.

- 2.87 The General Dental Council argued that, in some areas, we had not drawn the line in the correct place between political policy decisions and matters that should be left to the regulators. For example, it considered that the constitution of the Councils should fall within the former since it is properly a matter for the Government, while financial penalties and costs awards should fall within the latter and left to the regulators to decide. Coventry and Warwickshire Partnership Trust also thought that the proposal required further clarification.

- 2.88 The Nursing and Midwifery Council was cautious about our overall approach and sought clarification over whether the Secretary of State would be required to consult on all decisions and whether the exercise of Government powers would be subject to Parliamentary approval, as is the case with section 60 orders. Some consultees wanted clarification on how the Government would decide to exercise its powers and argued that there needed to be statutory criteria.

**Provisional Proposal 2-11: The statute should place a duty on each regulator to provide information to the public and registrants about its work.**

- 2.89 The vast majority agreed that the regulators should be required to provide information to the public and registrants about its work.<sup>14</sup> For example, the Chartered Society of Physiotherapy thought the requirements “essential to ensure transparency”, whilst West Sussex County Council supported an “expectation of transparency and honesty in the work the regulators do”.

- 2.90 Some felt that this duty needed to be strengthened. The Patients Association for example supported “a duty to publish such information in a public place, in a variety of formats and media”. The Medical Defence Union argued there should be a requirement for consistency in terms of the information that is made

<sup>14</sup> Of the 192 submissions which were received, 53 expressed a view on this proposal: 51 agreed, whilst 2 held equivocal positions.

available by each regulator. It claimed that at least one regulator always requires registrants or their representatives to make a request under the Freedom of Information Act 2000 in order to gain access to information that other regulators provide freely.

- 2.91 The General Dental Council was concerned that the duty does not replicate or overlap with other statutory duties and does not extend the application of the Freedom of Information Act 2000 by introducing an additional class of information which individuals can request. The Council further argued that the Professional Standards Authority should identify and promulgate best practice.
- 2.92 An individual consultee (Anonymous) felt an express duty was unnecessary and could force the regulators to take their eye off “the central objective of protecting the public” and lead to higher fees because “the regulator feels they need to produce lots of information”. The Association of Regulatory and Disciplinary Lawyers argued that while a duty to provide information would do no harm, it does not need to be provided for by statute since each regulator currently maintains a website with such information. Furthermore, any requirement to publish information should “recognise the role and experience of individual regulators on how much information it chooses to publish”. The Royal College of Radiologists agreed that any requirements must respect the regulators’ independence.

**Provisional Proposal 2-12: Each regulator and the Professional Standards Authority should be required to lay copies of their annual reports, statistical reports, strategic plans and accounts before Parliament and also in all cases the Scottish Parliament, the National Assembly for Wales and the Northern Ireland Assembly.**

- 2.93 An overwhelming majority agreed that the statute should require the regulators to lay copies of their annual reports, statistical reports, strategic plans and accounts before Parliament, the Scottish Parliament, the National Assembly for Wales and the Northern Ireland Assembly.<sup>15</sup>
- 2.94 The Pharmaceutical Society for Northern Ireland said, in addition, that:
- It would be helpful if there were formal arrangements for the relevant administration to review, comment upon or seek further detail from the regulators or Professional Standards Authority.
- 2.95 While the Nursing and Midwifery Council had no objection to laying its reports formally in all four legislatures, it suggested that this would involve “considerable administrative work” and did not want this to affect the timing of its reporting.
- 2.96 An individual consultee (Anonymous) described the requirement of laying copies of reports in Parliament as “old fashioned” and “a relatively expensive exercise”, and was not convinced that “anything more than a duty to produce and make these reports available is necessary”. The Professional Standards Authority also described the laying requirements as being largely symbolic, and questioned

<sup>15</sup> Of the 192 submissions which were received, 50 expressed a view on this proposal: 48 agreed, whilst 2 held an equivocal position.

whether there should be a general requirement for all the regulators to “make available to the public all publications that report on its performance”.

**Provisional Proposal 2-13: The statute should not require the regulators to send a copy of their accounts to the Comptroller and Auditor General or to the Auditor General for Scotland.**

- 2.97 A significant majority agreed that the duty to send accounts to the Comptroller and Auditor General or to the Auditor General for Scotland should be removed.<sup>16</sup>
- 2.98 The Nursing and Midwifery Council argued that this proposal would remove “an unnecessary layer of bureaucracy and additional expense”. The Pharmaceutical Society of Northern Ireland pointed out that it is not required to send a copy of accounts to the Comptroller and Auditor General. The General Dental Council suggested that the National Audit Office should instead be responsible for the guidance as to the content of the report and accounts.
- 2.99 However, the National Audit Office argued that it should continue to be responsible for auditing the accounts of the regulators because although the regulators do not receive public funds, they have powers that derive from legislation and therefore remain accountable to Parliament for how they use those powers and how they spend their funds. The analogy was made with Ofcom which does not directly receive public funds but the Comptroller and Auditor General audits through Parliamentary authority. In its view, the regulators would in any event meet the criteria under the Government Resources and Accounts Act 2000, which would enable the Treasury to provide by order for their accounts to be audited by the Comptroller and Auditor General. This would be a decision for the Treasury.

**Provisional Proposal 2-14: The order making power in section 60 of the Health Act 1999 should be repealed and instead the Government should be given regulation-making powers on certain issues.**

- 2.100 A significant majority agreed with this proposal.<sup>17</sup>
- 2.101 Many noted that under our proposal the Government would be given regulation-making powers on most matters currently dealt with by section 60 orders (such as powers to establish, merge or abolish regulators). Some support was conditional on Government powers being delineated clearly in the new statute. The Scottish Government supported this proposal “on the assumption that Governments are given similar regulation-making powers which reflect the devolution settlement”.
- 2.102 The Local Supervising Authority Midwifery Officers Forum UK thought that section 60 orders should be retained on the basis that they allow “amendment of legislation without the need to pass primary legislation and are subject to

<sup>16</sup> Of the 192 submissions which were received, 39 expressed a view on this proposal: 33 agreed, 4 disagreed, whilst 2 held an equivocal position.

<sup>17</sup> Of the 192 submissions which were received, 49 expressed a view on this proposal: 43 agreed, 5 disagreed, whilst 1 held equivocal positions.



parliamentary approval". UNISON also supported the retention of the power as it "allows all parties including the Secretary of State to consider proposals in a clear and transparent way."

- 2.103 The Nursing and Midwifery Council opposed the abolition of section 60 orders. It argued that "however carefully the new statute is drafted, it will not be possible to include provision for every possible change that may be required in the future". The Council felt that the regulators will need some provision to request a change if, for example, some aspect of the new statute proves to be unworkable. Similarly, the General Optical Council suggested that a section 60 mechanism should be retained as a safeguard against "unforeseen difficulties".

**Provisional Proposal 2-15: The Government should be given a regulation-making power to abolish or merge any existing regulator, or to establish a new regulatory body. This power would also enable the Government to add new professional groups to, or remove professional groups from, statutory regulation.**

- 2.104 A significant majority agreed with the proposal.<sup>18</sup> The Department of Health agreed, but argued that the power should be vested in the Privy Council.
- 2.105 Several consultees argued that safeguards were needed to protect the position of registrants. The Osteopathic Alliance felt that any proposal to alter the number of regulators should be subject to consultation and the full agreement of the members of the professions concerned. The Royal College of Midwives argued, in respect of the power to remove a professional group from statutory regulation, that there must be "a clear process to show that public protection was not compromised" and that the employment prospects of current registrants would not be adversely affected.
- 2.106 Some suggested a role for the regulators before these powers are exercised. The Institute of Biomedical Science argued that "the addition or removal of a profession to or from statutory regulation should only take place with the full support of the regulator in question". The British Pharmaceutical Students' Association was concerned that our proposal may enable the Government to force proposals through and argued that the regulators should be "able to make recommendations on which professional groups should be registered and whether their regulatory function needs to be merged or abolished".
- 2.107 Many consultees suggested additional procedural safeguards before the proposed powers could be exercised. For example, the General Dental Council argued that before any proposal to abolish or merge regulators, the statute should "specify prior steps to be gone through such as the giving of directions and the taking over by the Government of particular functions". The British Association and College of Occupational Therapists argued that any decision should be subject to a full day's debate on the floor of the House of Commons and subject to a vote of the whole House. The Association for Regulatory and Disciplinary Lawyers argued that the Secretary of State should be required to demonstrate that the use of this power does not undermine "the health, safety

<sup>18</sup> Of the 192 submissions which were received, 53 expressed a view on this proposal: 42 agreed, 6 disagreed, whilst 5 held equivocal positions.

and well-being of the public” or “public confidence in the independent regulation of the health care or social care professions and the lowering of professional standards”.

- 2.108 A small number categorically opposed the proposal. The Association of Clinical Biochemistry argued that the ability to abolish a regulator “would only be relevant where a whole sphere of health care activity was deemed obsolete – a situation we cannot easily envisage occurring”. The General Chiropractic Council argued there is no need for such powers because the Government already can regulate, abolish or merge regulators and establish a new regulatory body.

**Question 2-16: Should the Professional Standards Authority be given a power to recommend a profession for statutory regulation, or the removal of a profession from statutory regulation? If the Government decided not to comply, it would be required to issue a report setting out its reasons.**

- 2.109 A large majority of consultees agreed that the Professional Standards Authority should be given a power to recommend a profession for statutory regulation, or the removal of a profession from statutory regulation.<sup>19</sup> Rescare and the British Dental Association were amongst those who answered the question in the affirmative.
- 2.110 The Professional Standards Authority itself argued that this power could be linked to its existing statutory power to provide advice to the Secretary of State and Ministers in the devolved administrations. In effect, the Government could request that the Authority undertakes an investigation – for example on whether a specific profession should be brought under statutory regulation – and the Authority could provide advice on the basis of a risk assessment.
- 2.111 The Health and Care Professions Council agreed that this role could rest with the Authority. Currently, the Council itself has a power to make recommendations on statutory regulation but it accepted that the Authority’s:
- oversight role independent of the regulators and of Government means that it is in a better position than the individual regulators to make such a recommendation. Further, its forthcoming role in quality assuring voluntary registers means that it may be able to draw on this experience to identify where voluntary registration may be insufficient and statutory regulation may be merited.
- 2.112 Some consultees felt it was inappropriate for this power to be given to individual regulators – such as the Health and Care Professions Council – which has a vested interest in extending its remit.
- 2.113 However, the General Dental Council and General Osteopathic Council queried whether an express power for the Authority was necessary, since it is an independent authority in its own right and would be at liberty to make such recommendations in any event (as would any of the regulators).

<sup>19</sup> Of the 192 submissions which were received, 55 expressed a view on this question: 42 said the Professional Standards Authority should be given such a power, 9 disagreed, whilst 4 held equivocal positions.

- 2.114 The Nursing and Midwifery Council opposed giving the Authority any formal powers of recommendation, arguing that:

Since it is soon to be funded by the regulators, there is a clear question of whether the Authority can be perceived by the Government, regulators and the public to act as a disinterested party in making such recommendation.

- 2.115 The Association for Regulatory and Disciplinary Lawyers argued there was no reason to extend the role of the Authority from overseeing the regulators to an area that is more to do with political policy. The Department of Health also disagreed with the proposal since the decision has “political elements”.
- 2.116 The Scottish Government felt there were a number of important considerations that needed to be addressed before it could decide whether the Professional Standards Authority should be given powers in this area. It sought further information about the criteria that would be used to make such a determination, the sequence of events if one or more of the four countries did not support a recommendation and the extent to which these deliberations would be made public.
- 2.117 The Welsh Government commented on the role of the Professional Standards Authority and stated “there would need to be clarity how each part of the UK could influence the Authority to recommend a profession for statutory regulation”. It continued that “issues of transferability will need to be considered if the requirement is for a new profession in only one part of the UK”.
- 2.118 Several consultees, including the Registration Council for Clinical Physiologists and UNISON, commented on the importance of the Government being required to provide reasons for any decision not to implement a recommendation made by the Professional Standards Authority.

**Provisional Proposal 2-17: The Government should be given powers to issue a direction in circumstances where a regulator has failed to perform any of its functions, and if the regulator fails to comply with the direction, the Government may itself give effect to the direction (see also provisional proposal 13-2).**

- 2.119 A large majority agreed with the proposals.<sup>20</sup> For example, the Dental Schools Council and Optometry Scotland welcomed the proposal on the grounds of safety.
- 2.120 The Health and Care Professions Council and Coventry and Warwickshire Partnership Trust were among several consultees who stressed that their support for the proposals was on the basis that they should only be used as a “last resort”.
- 2.121 While agreeing in principle with our proposal, the General Medical Council expressed concern that default powers might extend to failures to implement the Qualifications Directive. The Council argued that while it was legitimate that the

<sup>20</sup> Of the 192 submissions which were received, 47 expressed a view on this proposal: 38 agreed, 5 disagreed, whilst 4 held equivocal positions.

Government would wish to “avoid costly infraction proceedings and a fine if a regulator’s actions are in conflict with European Union law”, it has “powers under the Localism Act 2011 to pass such fines onto the regulator concerned”. Furthermore, the Council said that:

It may be far from clear whether a regulator is failing to perform its functions or, more specifically, failing to implement [European Union law] appropriately. Some issues may be interpreted differently by the regulator and the Government and may need to be tested in the courts. It is important that regulators pursuing their prime purpose of protecting the public are not subject to undue political pressure for Government.

- 2.122 Many consultees expressed concern about the potential abuse of Government default powers, and the impact on the independence of the regulators. The General Optical Council argued that:

While these powers are currently held by the Privy Council, they are somewhat limited in scope and have never been used. We believe that if such broad powers are to be held by the Secretary of State there would again be the potential for the political independence of regulators to be compromised without appropriate safeguards.

- 2.123 The Nursing and Midwifery Council argued that the introduction of Government default powers has the “potential to erode the independence of the regulators”. It felt that:

Formalising such a transferral of powers to the Government does raise the question of when regulators cease to be independent and become non-departmental public bodies ... we would like clarification on when and how such powers would be used and, in particular, what the role of the Professional Standards Authority would be in these situations. As the scrutiny and oversight body for regulators, it would seem necessary for it to have a role in identifying when a regulator is failing to perform its functions and whether it has subsequently failed to comply with directions.

- 2.124 The College of Social Work reported:

serious reservations about the broad nature of this power. The independence of the regulator may be compromised unless the circumstances in which the Government may act are defined and limited. The circumstances in which Government is entitled to declare that a regulator has “failed to perform” must be clearly set out in regulations.

- 2.125 The General Pharmaceutical Council felt that Government default powers – unless they are tightly prescribed – have the potential to undermine the independence of the regulators. Moreover, the Council argued that:

It is not in the best interests of patients and the public, nor likely to support consistent and proportionate regulation if regulators look “up”

to Government for “direction” about what is expected, rather than looking “out” to patients and the public.

- 2.126 The Association of Regulatory and Disciplinary Lawyers argued that the Government should be required to consult the Professional Standards Authority and appoint a nominee who should be accountable to and report to the Health Select Committee.
- 2.127 Others suggested that the Government should be required to submit a report to the Health Committee if such powers are used and that Parliament should be required to authorise the use of default powers and nominate a body to implement these powers on its behalf.
- 2.128 Several consultees pointed to the existing problems being experienced by the Nursing and Midwifery Council and argued that intervention had been achieved without the use of default powers through the Government requesting the Professional Standards Authority to step in and investigate. It was therefore suggested that default powers are unnecessary.

**Provisional Proposal 2-18: The Government should be given powers to take over a regulator which is failing to carry out its functions.**

- 2.129 A significant majority also agreed that the Government should be given powers to take over a regulator which is failing to carry out its functions.<sup>21</sup> The majority of the reasons given in support reflected those provided in response to the previous proposal.
- 2.130 The General Dental Council supported the proposal, but believed that it should be “explicitly circumscribed”. It felt that:
- The Secretary of State should be obliged to set out in regulations the process to be followed in such an eventuality (directions, timescale, consultation and time for submissions, time for compliance, alternative proposals, justification.)
- 2.131 The Department of Health agreed there should be a power to take over a failing body, but this power should be vested in the Privy Council. It thought the power should be extended to provide for “the Privy Council to make arrangements with another regulatory body to provide assistance to, or to exercise the functions of, the failing body” (and regulators could be merged if necessary).
- 2.132 The Royal College of General Practitioners did not consider that the Government would have the “expertise required to directly take over the regulator”, and suggested instead that Parliament should be given power in this area, for example, to transfer the authority of the regulator to an alternative body.
- 2.133 The General Pharmaceutical Council did not support the proposal. The Council rejected our analogy of Government powers to take over a local authority, since local authorities are funded by taxpayers whereas the regulators are independent bodies funded by fees charged to registrant groups.

<sup>21</sup> Of the 192 submissions which were received, 44 expressed a view on this proposal: 33 agreed, 5 disagreed, whilst 6 held equivocal positions.

**Provisional Proposal 2-19: The Government should not have express powers in the statute to initiate a public inquiry. This would continue to be provided for under other existing Government powers.**

- 2.134 The vast majority agreed that Government should not have express powers in the statute to initiate a public inquiry.<sup>22</sup>
- 2.135 However, the South Staffordshire and Shropshire Healthcare NHS Foundation Trust (Social Care) considered that the powers should be retained to ensure consistency.
- 2.136 The Scottish Government sought reassurance that it had suitable powers to initiate a public inquiry and that “such legislation is clearly stated/referred to within the statute”.

**Provisional Proposal 2-20: If the Scotland Bill 2010 does not become law, any use of the proposed regulation-making power set out in provisional proposal 2-13 in respect of a profession for which the Scottish Parliament has legislative competence, must be consulted on by Scottish Ministers and laid before the Scottish Parliament as well as the UK Parliament.**

- 2.137 A large majority agreed with this proposal.<sup>23</sup>
- 2.138 The Scottish Government supported the proposal and stated that:
- We would want the use of any new regulation-making powers to be consulted on by Scottish Ministers and laid in the Scottish Parliament. We would also want the current arrangements for making section 60 powers to remain whereby any consultation by UK Government and Scottish Ministers has been run as a joint exercise, with the Department of Health leading.
- 2.139 Some consultees made general comments about the importance of UK-wide regulation of health and care professionals. For example, the Professional Standards Authority pointed out that the public has “shared expectations” about health and social care professionals across the UK and that “UK-wide regulation also supports the free movement of labour and we anticipate that regulation will need to support greater flexibility in the workforce in the future”. Coventry and Warwickshire Partnership Trust also argued that:

There are high levels of movement from different parts of the UK within professional groups and changes to regulation in different parts of the country could hinder people transferring employment.

<sup>22</sup> Of the 192 submissions which were received, 35 expressed a view on this proposal: 34 agreed, whilst 1 disagreed.

<sup>23</sup> Of the 192 submissions which were received, 27 expressed a view on this proposal: 24 agreed, whilst 3 held equivocal positions.

**Question 2-21: Should the Pharmacy (Northern Ireland) Order 1976 be reconstituted and retained as a separate part of the new statute?**

- 2.140 A large majority felt that the Pharmacy (Northern Ireland) Order 1976 should be reconstituted and retained as a separate part of the new statute.<sup>24</sup> Most consultees covered this question and the next in the same response.

**Question 2-22: Should the proposed regulation-making power set out in provisional proposal 2-15 include a general provision to incorporate the Pharmaceutical Society of Northern Ireland into the main legal framework of the new statute (following approval by the Northern Ireland Assembly)?**

- 2.141 A majority agreed that the Government regulation-making powers should include a general provision to incorporate the Pharmaceutical Society of Northern Ireland into the main legal framework of the new statute.<sup>25</sup>
- 2.142 Many argued that professional regulation should be consistent across the UK. For example, the Professional Standards Authority stated that our review:

presents a unique opportunity to establish consistency across the four countries in the regulation of all health and care professions, wherever possible. While respecting the devolved powers in Northern Ireland, the position of the Pharmaceutical Society of Northern Ireland should wherever possible be brought into greater consistency with the other UK professional regulators.

- 2.143 The Northern Ireland Practice and Education Council for Nursing and Midwifery also argued that the powers of all the regulators should be harmonised. UNISON went a step further and argued that the Society should be merged with the General Pharmaceutical Council to form a single UK-wide body.

- 2.144 The Pharmaceutical Society of Northern Ireland supported inclusion in the single statute only on the basis that:

- (1) the use of Government default powers in relation to the Society must be approved by the Northern Ireland Assembly or exercised by the Northern Ireland Executive; and
- (2) the Society's dual role of regulation and professional leadership is retained.

- 2.145 The Professional Forum of the Pharmaceutical Society of Northern Ireland supported the incorporation of the Society into the statute only on the basis of certain safeguards being introduced such as:

the provision of similar protections as afforded to Scotland in section 62 of the Health Act 1999 ... and a recognition that the Northern Ireland Assembly remains the primary legislature for health care regulation in Northern Ireland.

<sup>24</sup> Of the 192 submissions which were received, 13 expressed a view on this question: 10 said the Order should be retained, 2 disagreed, whilst 1 held an equivocal position.

<sup>25</sup> Of the 192 submissions which were received, 10 expressed a view on this question: 7 said a general provision should be included, 1 disagreed, whilst 2 held equivocal positions.

- 2.146 The Forum also stated that the Westminster Government should not be empowered to abolish or merge the Society or to merge it without the explicit support of the Northern Ireland Assembly and any such proposal should be subject to full consultation.

**Question 2-23: Which, if any, of the specific proposals which follow in this consultation paper should be applied to the Pharmaceutical Society of Northern Ireland?**

- 2.147 All those who expressed a view argued that the proposals should be applied to the Society, generally on the basis that it would promote consistency.<sup>26</sup>
- 2.148 UNISON also thought the proposals would “allow for equality across differing professional groups”. It said that registration fees were a key issue, and noted that “pharmacy technicians are having to pay a registration fee which is disproportionate to their earnings and those imposed by comparative regulators”.

**Question 2-24: How should the new legal framework deal with cases left over from the previous legal regimes? What practical difficulties are likely to arise from the repeal of existing legislation and rules?**

- 2.149 Of the consultees who responded to this question, a small majority thought that transitional provisions would be required to deal with cases left over from the previous legal regimes.<sup>27</sup>
- 2.150 The Scottish Government supported giving Government transitional provision-making powers. It anticipated an increased number of appeals, and considered that measures would be required to deal with that situation.
- 2.151 The Medical Defence Union stated that when the General Medical Council and the General Dental Council changed their fitness to practise procedures substantially they produced transitional rules that ensured cases were dealt with appropriately. Therefore, the Union felt that as long as “the legislation specifies that regulators will need to make and agree with stakeholders clear transitional arrangements for legal cases arising under a previous legal regime”, there should not be any significant difficulties.
- 2.152 However, the British Psychological Society reported a different experience when the Health and Care Professions Council took over the statutory regulation for psychologists from the Society in 2009, resulting in some members having been subject to the disciplinary procedures of both bodies. The Society suggested “a transition period to be agreed during which all active cases could be completed under the old system”. The Professional Standards Authority agreed that existing cases “should be dealt with under the old rules”.

<sup>26</sup> Of the 192 submissions which were received, 8 expressed a view on this question: all said that all of the proposals should apply to the Pharmaceutical Society of Northern Ireland.

<sup>27</sup> Of the 192 submissions received, 37 expressed a view; 8 said that the cases should be dealt with under the old regime, 8 said that the method used by the General Pharmaceutical Council should be adopted, whilst 21 said that some form of transitional provisions should be provided.



- 2.153 The Nursing and Midwifery Council stated, based on its experience of managing the changeover from the United Kingdom Central Council for Nursing, Midwifery and Health Visiting, the “challenges of maintaining the current framework, while preparing for the implementation of a new one, should not be underestimated”. The Council stated that considerable resources are required, both in terms of costs and staff time and that there was a particular need to ensure that the regulatory framework to support the supervision of midwives across the UK should not suddenly cease to exist.
- 2.154 The British Association for Counselling and Psychotherapy suggested that the timetable for change should be consistent for all the regulators. The General Osteopathic Council argued that there will need to be a “considerable period of transition between Royal Assent and the switching on of new powers”. In particular it highlighted that regulators will need time to:
- (1) draft new rules and associated consultation documents,
  - (2) seek approval from their Council;
  - (3) consult;
  - (4) analyse consultations, redraft rules and undertake legal scrutiny;
  - (5) seek final approval from their Council and make rules;
  - (6) adapt information technology and other administrative systems; and
  - (7) train staff and panellists (where appropriate).
- 2.155 The Professional Forum of the Pharmaceutical Society of Northern Ireland, together with several other respondents, suggested that the approach used previously by the General Pharmaceutical Council should be adopted; namely a general provision should be made in legislation to allow the new structures to deal with legacy cases in a manner they consider just.

## **PART 3**

# **MAIN DUTY AND GENERAL FUNCTIONS OF THE REGULATORS**

**Question 3-1: Should the statute specify the paramount duty of the regulators and the Professional Standards Authority is to: (1) protect, promote and maintain the health, safety and well-being of the public by ensuring proper standards for safe and effective practice; or (2) protect, promote and maintain the health, safety and well-being of the public and maintain confidence in the profession, by ensuring proper standards for safe and effective practice?**

- 3.1 This issue provoked the biggest response at consultation. A significant majority argued that the paramount duty should contain express reference to maintaining confidence in the profession.<sup>28</sup>

### ***Support for maintaining confidence in the profession***

- 3.2 Many supported this option on the basis that ensuring confidence in the profession was seen as an important aspect of professional regulation. For example, the British Chiropractic Association described the maintenance of confidence as “an essential component of statutory regulation”, and an individual consultee (Dr Anton E A Joseph) agreed that it was a “high priority”. A common concern was that the lack of an express reference to maintaining confidence might narrow the ability of the regulators to intervene.
- 3.3 Some took this point further and argued that confidence in the profession is a legitimate and separate basis for regulatory intervention. The General Medical Council argued that it is not appropriate for regulators to intervene in essentially private matters but “there are undoubtedly behaviours unconnected with a doctor’s professional conduct which would undermine public confidence in the profession”. The following examples were provided:
- (1) a doctor found guilty of certain offences – for example, rape, using child pornography, dangerous driving causing death or committing fraud against a vulnerable person – seeking to resume medical practice once their criminal sentence had been served; and
  - (2) a doctor involved in non-criminal activities such as publishing homophobic materials.
- 3.4 The Council drew a distinction between direct issues of “patient protection” and issues of “public protection insofar as the behaviour, if it appears to be condoned by the regulator, undermines public confidence in the profession as a whole”. Therefore, it argued that:

<sup>28</sup> Of the 192 submissions which were received, 100 expressed a view on this question: 18 supported a public protection focused duty, 77 agreed with an express reference to maintaining confidence, whilst 5 held equivocal positions

While we recognise that the notion of public confidence is neither fixed nor binary, regulators should be able to act in a way which protects the public by enabling them to have confidence in the profession.

- 3.5 The Nursing and Midwifery Council used the example of a professional who has downloaded child abuse images. It argued that, in itself, this behaviour does not impede safe and effective practice. Without the requirement to maintain confidence in the profession, it could be difficult to stop the registrant practising.
- 3.6 A small number of responses linked the issue of maintaining confidence in the profession with a representational and development role for the regulators. For example, the General Osteopathic Council argued that:

There remain considerable developmental needs within some of the more recently regulated professions to ensure that practice is of a uniformly high standard and that there is confidence in these professions not just from the public but also other professions and the commissioners of health care.

- 3.7 Newcastle City Council argued that the reference to maintaining confidence in the profession would enable the regulators to work in partnership with professional bodies and other organisations that represent the profession to promote a positive image of the profession. An individual consultee (Jane C Hern) went further and argued that since registrants fund the regulatory bodies:

it is important that the regulators do all they can to maintain the confidence of the profession, particularly if appointment is to replace election of Council members from the profession, as there will in effect be taxation without representation.

- 3.8 However, the Patients Association took a different approach and argued that the lack of an express reference to maintaining confidence has contributed:

to the perception in some patients' and service users' minds that regulators "look out for their own" rather than working to improve the standard of the profession as a whole.

- 3.9 Similarly, the Optical Confederation felt that reference to maintaining confidence in the profession would:

act as a rein on any regulator which pursued egregious ideas about promoting, protecting and maintaining the health of the public which would undermine confidence in the profession.

- 3.10 An individual consultee (Andrew Colman) argued that:

The retention of maintenance of public confidence in the profession as part of the paramount duty is [therefore] not about protecting an outmoded code of professional conduct but forms an integral part of protecting, promoting and maintaining the health, safety and well-being of the public.

- 3.11 The Royal College of Nursing supported the inclusion of maintaining confidence in the profession but only “reluctantly”. Its position was based on the fact that public protection and maintaining confidence have become so “interlinked in the minds of the regulators, courts and the public that it can be very difficult for these concepts to now be looked at entirely separately”. The College suggested that concerns about regulatory intervention based on maintaining confidence should be addressed by alterations to the concept of impaired fitness to practise and the criteria for interim orders in the statute.

***Support for a public protection focused duty***

- 3.12 Most who supported this option argued that a public protection focused duty would provide clarity about the purpose of health and social care professional regulation. For example, the Medical Defence Union argued that this option:

best encapsulates the primary role of the regulators and maintaining confidence in the profession may not be consistent with ensuring proper standards for safe and effective practice.

- 3.13 Bupa recognised that maintaining confidence is an “important standard”, but it should be a regulatory aim only in relation to public protection. It was critical of the Nursing and Midwifery Council for frequently pursuing professionals on the basis of non-public protection related conduct.

- 3.14 Several consultees drew a distinction between public protection which was the proper role of the regulators and maintaining confidence which was viewed as a matter for professional and other representative bodies and the profession itself. The British Society of Hearing Aid Audiologists felt that “it is the responsibility of the profession, through its professional body, to maintain confidence in the profession”.

- 3.15 The Royal Pharmaceutical Society of Great Britain stated that:

Regulation is effectively a shared responsibility between professional leadership bodies setting standards for professional activity and the enforcement role of the regulator. This approach ensures that the regulator maintains public confidence in the regulatory process and achieves a safe environment for the public to access their pharmaceutical care. The professional leadership body has the role of demonstrating to the public that pharmacy is a trusted profession whose members deliver safe pharmaceutical care.

- 3.16 Many who supported a public protection focused duty did so on the basis that maintaining confidence in the profession was implicit. RadcliffesLeBrasseur argued that confidence in the profession was a “natural consequence” of ensuring proper standards and there is no need for its maintenance as a separate element. The Royal College of General Practitioners suggested that a public protection focused duty might be preferable in terms of public perception and the need to avoid any suggestion of the profession looking after its own interests.

- 3.17 The Department of Health and the Scottish Government supported a public protection focused duty. The Scottish Government also recognised “that the

perception that the professions are self-interested could potentially arise” and therefore commented:

It would be useful to identify which external objectives would be used, if any, to determine how level(s) of public confidence in the professions would be assessed, and by whom any such analysis would be carried out.

- 3.18 Others were critical of the extent of “regulation-creep” into the private affairs of individuals. For example, an individual consultee (Trevor Williams) argued that the regulators’ primary purpose is public protection and maintaining confidence in the profession is a secondary “public policy” responsibility. He thought that this secondary purpose is:

often used as a guise to basically punish professional people who actually pose no threat whatsoever to the public but who have done something which incurs general opprobrium. People are being deprived of their careers in order to protect the reputation of the profession when there is no real substance to the idea of a profession's reputation being damaged.

- 3.19 Mr Williams also questioned the assumptions behind the links made between public protection and maintaining confidence. He suggested that people are not put off seeking help from a profession because certain individuals have been struck off but if they have been treated badly by a professional they will avoid that individual. He was critical of panel decisions which “frequently” justify erasure on the basis that a strong message needs to be sent to the profession that such behaviour will not be tolerated, when such decisions are not reported widely or publicised, and most professionals are not interested in disciplinary matters.

- 3.20 Some responses provided specific examples of what they saw as inappropriate attempts by regulators to police private matters. UNISON pointed to a case involving a nurse who was investigated after participating in the Greenham Common protests. An individual consultee at a consultation event referred to a doctor being investigated by the General Medical Council following a complaint about their behaviour at a Parent-Teacher Association meeting. In addition, the Royal College of Nursing provided the following examples:

the striking off of a registrant with an impeccable background as a nurse, who has inadvertently allowed video footage of herself having sexual relations at a party to appear on the internet, or a registrant who admitted engaging in her own time in prostitution being removed from the register. We are currently defending a case for a nurse who had formerly treated a family, who then many years later strikes up a friendship with family members outside a school gate (where both parties’ children attend). She now faces charges of forming an inappropriate friendship even though there is no sexual element to it.

- 3.21 The Guild of Healthcare Pharmacists reflected on its previous experience when the regulatory body for pharmacy also represented the profession. It said that:

In practice regulation became over-zealous with an excessive focus on maintaining confidence in the profession due in part to the

commercial nature of the majority of the profession rather than the need for public safety.

- 3.22 The British Association for Music Therapy felt that the inclusion of maintaining confidence in the profession may encourage the regulators to impose more severe sanctions on individual registrants, risking “unfairness to individual registrants in unusual or highly publicised fitness to practise cases”.
- 3.23 The Society of Chiropractors and Podiatrists argued that in order to prevent inappropriate investigations by the regulators, the duty should be “to maintain confidence in the profession in addition to the duty to protect the public, but with a specific exception for matters of private conduct and belief”.
- 3.24 Many responses felt that the concept of maintaining confidence in the profession was too vague to form the basis of a statutory duty. The Royal College of Surgeons of Edinburgh argued that maintaining confidence is a subjective concept and very difficult to quantify, and is affected by events outside the control of the regulator. Thus, it was “difficult to see how the regulators’ performance in this respect could be adequately ascertained and monitored”. Similarly, an individual consultee (Trevor Williams) argued that:

The “reputation of a profession” is an abstract concept which cannot be measured, cannot even be known, so if it is damaged in some way nobody knows and frankly nobody outside the Royal Colleges cares about, yet it is being used daily to deprive people of their right to work.

- 3.25 RadcliffesLeBrasseur expressed concern that in practice “the yardstick of a public confidence standard will be the most recent tabloid headline which would be entirely inappropriate”.
- 3.26 The Department of Health, Social Services and Public Safety for Northern Ireland supported a public protection focused duty and suggested that the duty should include “a discipline dimension ‘by ensuring compliance with and intervening where practice behaviour falls short of expected standards””.

#### ***Ensuring proper standards for safe and effective practice***

- 3.27 Some consultees commented on the inclusion of the wording “by ensuring proper standards for safe and effective practice” in the duty. For example, the Department of Health expressed concerns that the inclusion of “by ensuring proper standards for safe and effective practice” would narrow the current duty:

We would prefer if it provided that this was to be done “*primarily* by ensuring proper standards for safe and effective practice” but allowed for other methods too, to avoid any possibility that the new definition might inadvertently narrow the regulators’ scope for application of their powers. The legislation needs to be clear that the main duty does not include promoting the professions an organisation regulates.<sup>29</sup>

<sup>29</sup> Emphasis in the original.

- 3.28 The Scottish Government agreed with the proposed amendment.
- 3.29 The Nursing and Midwifery Council was concerned that this additional wording was unnecessary because it could be misinterpreted as limiting the current functions of the regulators. In other words, the reference to “standards” would be interpreted as meaning the specific tasks of issuing codes of conduct or standards of proficiency. The Professional Standards Authority also warned that the proposed wording might lead people to think that regulators are primarily concerned with setting standards and have little role in taking action when people fail to adhere to them.
- 3.30 Some said that the wording required amendment to cover the full functions of the regulators, such as establishing a register and setting standards for education.
- 3.31 The General Medical Council argued there will be cases where public confidence is not strictly a matter of safe and effective practice for individual patients, (such as convictions for fraud). It felt, therefore, that it may be better to use a broader formulation such as “ensuring proper standards in the practice of the profession”. The Patients Association suggested that “ensuring proper standards” did not go far enough and preferred “guarantees proper standards”. The Royal Pharmaceutical Society of Great Britain also felt that the wording needed strengthening and suggested “maintenance of accepted standards of behaviour”.

***Alternative formulations of the main duty***

- 3.32 A number of consultees suggested amendments to the proposed wording of the public protection element of the paramount duty. Some felt that a requirement that the regulators must “maintain” the health, safety and well-being of the public was not achievable. The British Dental Association suggested that instead the duty should be to “promote” these matters, while the Nursing and Midwifery Council felt the duty should be to “safeguard” these matters. Other responses expressed concern that the term “well-being” is imprecise, and the General Dental Council suggested that the term was more relevant to the context of social care. At a consultation event organised by 39 Essex Street, a participant suggested that “welfare” was more appropriate.
- 3.33 Some consultees suggested amendments to the proposed wording of the maintaining confidence element of the paramount duty. For example:
- (1) the duty should apply to the “public’s confidence in the professions” rather than the confidence of the professions in the work of the regulators (General Optical Council);
  - (2) the duty needed to refer to maintaining confidence in the “professions” in order to take into account multi-professional regulators (Health and Care Professions Council);
  - (3) the duty should be to “develop and maintain high confidence in the profession” because maintaining confidence suggests that “confidence is there in the first place and that there is no room for improvement, thus risking complacency” (NSPCC);

- (4) it would be impossible for a regulator alone to maintain confidence in the profession since this will depend on a range of factors and therefore the duty should be to “take account of its responsibility to uphold public confidence in the profession as far as is in its power” (Care Council for Wales); and
  - (5) the maintaining confidence in the profession element should not apply to the Professional Standards Authority (Medical Protection Society).
- 3.34 An individual consultee (Don Brand) suggested that “the public” would need to be carefully defined, and recognised that there will be occasions where the interests of service users conflict with those of the wider public.
- 3.35 Some put forward alternative main duties. While the precise wording varied, most sought to require the regulators to maintain confidence in the *system* of regulation. A participant at a consultation event with the General Social Care Council pointed out that there is a precedent for this approach: the Police Complaints Commission is required to secure public confidence in the complaints system.<sup>30</sup> The Professional Standards Authority suggested the duty should be “to protect, promote and maintain the health, safety and wellbeing of the public and maintain confidence in the profession and its regulation.”

**Provisional Proposal 3-2: The statute should not include a statement setting out the general or principal function(s) of the regulators.**

- 3.36 A majority agreed that the statute should not include a statement setting out the general or principal functions of the regulators.<sup>31</sup>
- 3.37 Many thought that such a statement would simply be repetitious. For example, the Health and Care Professions Council said that “such statements are unnecessary and duplicate the functions of the regulators set out elsewhere in statute”. The Institute of Health Visiting felt that the paramount duty was sufficient.
- 3.38 However, the General Medical Council disagreed and felt it was important to include such a statement in order to set parameters within which the regulators operate and for public expectation. The Department of Health, Social Services and Public Safety for Northern Ireland supported a statement setting out general or principal functions on the basis that they “need to be communicated/transparent to the public”.
- 3.39 The Patients Association accepted that general functions were “superfluous” from a legal perspective, but felt they performed an important policy role by emphasising the regulators’ duties and functions. It pointed to the example of the Care Quality Commission where general or principle functions were not in place and argued that, consequently, the Commission’s inspection function has been underused.

<sup>30</sup> Police Reform Act 2002, s 10(1) (d).

<sup>31</sup> Of the 192 submissions which were received, 44 expressed a view on this proposal: 30 agreed and 14 disagreed.



- 3.40 The Association of Clinical Biochemistry felt that the inclusion of a statement of general functions would improve “clarity and general understanding by the public”. UNISON’s opposition to the proposal was based on its belief that “a statement could help to ensure a level of consistency across the regulators”.

**Question 3-3: Should the statute include guiding principles which would apply to all decisions made by the regulators, and if so what should they be?**

- 3.41 A majority felt that the statute should include guiding principles.<sup>32</sup> For example, the Equality and Human Rights Commission said that it “would welcome a set of general principles for decision-making”, and suggested that the public sector equality duty could be a useful starting point. The General Osteopathic Council, British Psychological Society and a number of individual consultees (Lucy Reid and Jacqueline A Wier) were amongst others who supported the proposal.
- 3.42 The Scottish Government supported the inclusion of guiding principles based on timescales for communicating with third parties and responding to allegations of impairment.
- 3.43 The Department of Health, Social Services and Public Safety also supported the inclusion of a statement of principles which it suggested should include “proportionality, gravity, equity and fairness”.
- 3.44 However, the General Chiropractic Council argued that guiding principles would make the Act unwieldy and are, in any event, legal principles which would apply anyway. The General Medical Council argued that such principles easily slip into vacuous statements of the obvious. The Nursing and Midwifery Council felt that guiding principles are unnecessary since the regulators are already subject to the Equality Act 2010 and Human Rights Act 1998. The Professional Standards Authority considered that given the existing work in this area, including its paper on right-touch regulation, there is no need to create anything new.
- 3.45 The Medical Defence Union, Optometry Scotland and the Department of Health were amongst the consultees who opposed the inclusion of guiding principles in the statute.

**Question 3-4: Should the statute include a general power for the regulators to do anything which facilitates the proper discharge of their functions?**

- 3.46 A majority agreed that the statute should provide a general power for the regulators to do anything which facilitates the proper discharge of their functions.<sup>33</sup> The General Osteopathic Council argued that this kind of power enables regulators to adapt their operations to the individual professions they regulate.

<sup>32</sup> Of the 192 submissions which were received, 50 expressed a view on this question: 36 agreed that the statute should include guiding principles, whilst 14 disagreed.

<sup>33</sup> Of the 192 submissions which were received, 48 expressed a view on this question: 33 said there should be such a power, whilst 15 disagreed.

- 3.47 The Department of Health supported a general power for the regulators, whilst the Scottish Government felt that the inclusion of a general duty would assist the regulators in carrying out their functions. It suggested that the use of this power should be monitored by the Professional Standards Authority.
- 3.48 The Department of Health, Social Services and Public Safety also supported the inclusion of a general duty and felt it should be expanded “to include the need to follow due process and that any action that is taken under this power must be listed and reported in annual accountability reviews”.
- 3.49 However, several consultees were concerned about the breadth of such a power. The Professional Standards Authority reported that in the past, it has been concerned that regulators have strayed beyond their remit, and so was uneasy about this proposal.
- 3.50 The Association of Directors of Adult Social Services thought that the wording in the question was “too vague”, and the Medical Protection Society agreed that a general power would be “too broad and has the potential to lead to inconsistency”.

## PART 4

# GOVERNANCE

**Question 4-1: Should the statute: (1) reform the existing structure to encourage Councils to become more board-like; *and/or* (2) reform the existing structure by establishing a statutory executive board consisting of the chief executive and senior directors; *and/or* (3) establish a unitary board structure which would move away from a two-tier approach based on a Council and officials?**

- 4.1 This question divided opinion at consultation. Most consultees expressed equivocal positions. For example, the Department of Health remained open as to the most appropriate structure but was “initially inclined” towards option two. The Scottish Government was also “undecided” but was inclined towards option two followed by option three. Whichever option is agreed, It argued there should be consistency across the regulators, whichever option is adopted.
- 4.2 Both the Department of Health and the Scottish Government argued that a Council’s purpose should be to:
- (1) provide strategic direction;
  - (2) provide a point of public accountability; and
  - (3) exercise scrutiny over the exercise of powers by officials of the organisation, in particular by providing a first point of appeal in certain circumstances (for example, in relation to decisions not to accept an application for restoration to the register).
- 4.3 The Department of Health, Social Services and Public Safety for Northern Ireland suggested that the structures “need to reflect the size of the organisation to some extent”. It expressed a preference for “some separation of Council from executive allied to accountability”.
- 4.4 Of those who did express a preference, most favoured options one and three.<sup>1</sup>

### ***Option one: reform of the existing structure***

- 4.5 Many preferred this option as it reflected the existing arrangements. For example, the General Pharmaceutical Council felt that the current system is “well established, understood well by our stakeholders with a transparent separation between Council members and the executive”. It was also reluctant to undertake any “significant structural change so soon after establishment”.<sup>2</sup> The Association of Regulatory and Disciplinary Lawyers agreed that these features weighed in favour of option one. The General Dental Council described option one as

<sup>1</sup> Of the 192 submissions which were received, 55 expressed a view on this question: 18 supported option one, 5 supported option two, 11 supported option three, whilst 21 held equivocal positions.

<sup>2</sup> The General Pharmaceutical Council was created in 2010, replacing the Royal Pharmaceutical Society of Great Britain as the regulator.

“viable” and one which “could be made to work even better with smaller Council sizes”.

4.6 The Professional Standards Authority was attracted to option one because it:

- (1) allows for separation of operational and strategic perspectives;
- (2) makes explicit the role and responsibility of the board to be strategic and hold the executive to account;
- (3) allows for board sizes that deliver optimal performance; and
- (4) allows for the interests of key stakeholders to be included, but also respects the increasing professionalism of regulatory staff.

4.7 The Pharmaceutical Society of Northern Ireland supported this option because the alternatives “blend strategy and delivery and the accountability is less clear between the parties”.

4.8 Some consultees thought that option one provided the necessary flexibility. The Royal College of Surgeons of Edinburgh and the Medical Defence Union both felt that regulators should be able to adapt the governance framework to their individual circumstances.

***Option two: a statutory executive board***

4.9 The Medical Protection Society argued that option two would provide “an appropriate separation of functions and powers”, and pointed out that this model had been implemented informally by the General Dental Council “with the executive creating a tightly knit team of directors and a policy advisory committee consisting of the executive and some Council members”. This committee develops policy and the Council is expected to act “essentially as non-executive directors commenting upon and approving policy”. Others favoured this option on the basis that it would provide a governance structure in line with other corporate organisations and health bodies.

4.10 However, several consultees were critical of option two. The General Pharmaceutical Council felt it would not command the confidence of the professions and provided a “reduced level of public accountability and fewer checks and balances in the system”. The Nursing and Midwifery Council discounted this option on the grounds that it would not provide sufficient safeguards “in the event of an ineffective relationship between the chair and the chief executive”. The General Dental Council felt that a scrutiny role for the Council could be “unrewarding” and might attract fewer applicants. The Professional Standards Authority described this as the “least attractive option” since it “defines how the executive should organise itself and would be inappropriate in smaller regulators”.

***Option three: a unitary structure***

4.11 The support for option three was often based on its perceived efficiency. For example, the British Association for Counselling and Psychotherapy felt that it would “maximise efficiency, ensure faster decision making and cooperation”. The Professional Standards Authority argued that the unitary board structure “has

been found to deliver well” and that unitary boards “would also establish that it is the organisation that is the regulator not the Council”. The Institute of Biomedical Science argued that the use of non-executive directors would provide “a more representative breadth of expertise”.

- 4.12 However, an individual consultee (Jane C Hern) argued that it is vital to maintain the Council/staff separation so that the staff are able to offer:

wholly impartial advice so that the strengths and weaknesses of any proposal can be fully considered and once the policy is determined, to implement it to the best of their ability.

- 4.13 A number of consultees felt that the unitary model provides insufficient oversight since board members are naturally closer to the executive as the management is sitting on the board alongside non-executives.

#### ***Other comments***

- 4.14 Many argued for flexibility. For example, the General Medical Council supported option one on the understanding that “the legislative structure should allow Councils or governing boards the scope to consider other options at a later date”. The Nursing and Midwifery Council also suggested that each regulator should be able to “establish a model that suits its particular situation and have the flexibility, if necessary, for that to evolve over the years to meet any changing needs”. The General Osteopathic Council also wanted the freedom to determine which model would be most suitable, following the outcome of its current governance review. An individual consultee (Anonymous) was “concerned that putting anything in statute on governance arrangements would inhibit modernisation”.
- 4.15 Several responses suggested that the consultation paper had over emphasised structural issues. For example, the General Pharmaceutical Council stated that:

The competence, values and behaviours of those involved (whatever the structure) are likely to have a much greater impact on the effectiveness, efficiency and accountability of the regulators than the seemingly endless quest for some ideal governance structure.

- 4.16 Similarly, the Health and Care Professions Council argued that good governance depends less on “the form a governing body takes” and more on “having a strong, values driven Board, recruited against competencies with strong allegiance to the Nolan principles of public life”. The Professional Standards Authority argued that even under a common approach to governance structures, the performance of different regulators “var[ies] substantially”. It said that:

While structure is important it is unrealistic to rely on this as the major determinant of good organisational performance and delivery of regulatory obligations for wider society. Competent and skilled Council members and executives are essential.

**Provisional Proposal 4-2: The statute should establish each Council as a body corporate. The regulators should continue to be able to apply to become registered with the Charity Commission if they wish to do so.**

- 4.17 The vast majority agreed with this proposal.<sup>3</sup>
- 4.18 Most consultees did not elaborate on their reasons for supporting the proposal that Councils should be established as body corporates.
- 4.19 The General Optical Council suggested that:

rules around the constitution of Councils is one of the areas in which the Government may have a legitimate oversight interest, as currently provided by means of Privy Council approval. There may be risks that public confidence in the regulators could be damaged if there is a perception that Councils are able to change their key constitutional arrangements to suit the interests of their current members without checks and balances.

- 4.20 A number of responses pointed out that the statute also needed to cover registration with the Office of the Scottish Charity Regulator and the Charity Commission for Northern Ireland.

- 4.21 Several regulators commented on the issue of registration with the Charity Commission. The Nursing and Midwifery Council said:

We support the proposal that each Council should be a body corporate. The Nursing and Midwifery Council is already registered as a charity but we have no views in relation to the other regulators. However, it should be noted that the Charity Commission may have a view on this. It should also be noted that the Unitary Trust Board model might have an impact on charitable status, as a charity's employees cannot usually serve as management board members or governors.

- 4.22 The Health and Care Professions Council commented:

We have previously considered the possibility of seeking charitable status but, after some preliminary investigation, decided not to explore this further as we consider that we do not perform any charitable functions.

- 4.23 The British Association for Counselling and Psychotherapy queried whether "this could lead to a conflict of interest and treble accountability to the Professional Standards Authority, the Government and the Charity Commission".

**Provisional Proposal 4-3: The statute should require that each Council must be constituted by rules issued by the regulators.**

- 4.24 An overwhelming majority agreed that the statute should require that each Council must be constituted by rules issued by the regulators.<sup>4</sup> For example, the

<sup>3</sup> Of the 192 submissions which were received, 34 expressed a view on this proposal: 33 agreed, whilst 1 held an equivocal position.

Wales National Joint Professional Advisory Committee said that it was “sensible to have the make up of the body stipulated by regulators”.

4.25 However, many consultees expressed concerns. The Professional Standards Authority argued that the statute must direct the nature and content of the rules and there must be limits to the flexibility given to the regulators in their governance structures.

4.26 Similarly, the Health and Care Professions Council argued that the constitution of a Council is “fundamental in underpinning good corporate governance” and therefore should not be left entirely to the discretion of the regulator. In particular, it pointed to the potential risk of inconsistency and pressure from stakeholder groups such as professional bodies to amend the constitution. The Council argued that the regulators should only have powers to issue rules on the following:

- (1) the appointment of Council members and chairs;
- (2) terms of office;
- (3) duration of membership;
- (4) quorum for meetings;
- (5) education and training of Council members; and
- (6) attendance requirements.

4.27 In contrast, the following should be provided for in legislation:

- (1) the size of the Council;
- (2) the requirement for parity between registrant and lay members;
- (3) a requirement for Council members to be appointed from the four countries of the UK; and
- (4) provisions for the disqualification, suspension and removal of members.

4.28 The General Optical Council stated that:

There may be risks that public confidence in the regulators could be damaged if there is a perception that Councils are able to change their key constitutional arrangements to suit the interests of their current members without checks and balances. Some form of oversight of regulators’ constitutions would also help ensure that an appropriate degree of consistency in constitutional arrangements is in place across the regulators, while flexibility in the details is also maintained.

<sup>4</sup> Of the 192 submissions which were received, 31 expressed a view on this proposal: 28 agreed, whilst 3 disagreed.

4.29 Others felt that Government should have an enhanced oversight role. The General Social Care Council argued that the Secretary of State should be required to approve the rules governing the constitution of the Council or have powers to issue binding guidance on these rules. The General Dental Council agreed that all constitutional arrangements should be subject to Government approval. Some consultees argued that there should be also be a mechanism to require input by the devolved administrations.

4.30 The Department of Health, Social Services and Public Safety for Northern Ireland did not comment specifically on this proposal but made a general comment that:

There is a need for Government to act on behalf of the people; while more and more power is ceded to a regulator it feels more and more like self-regulation and that would be a retrograde step.

**Provisional Proposal 4-4: Each regulator should be required to issue rules on the appointment of Council members and chairs, terms of office, duration of membership, grounds for disqualification, quorum for meetings, circumstances in which members (including chairs) cease to hold office, are removed or are suspended, education and training of Council members, and attendance requirements of Council members.**

4.31 A large majority agreed with our proposal on which matters must be addressed by the rules.<sup>5</sup> For example, the Royal College of Surgeons of Edinburgh considered that the proposal represented “good governance”.

4.32 The General Medical Council also argued that the rules should avoid detail and prescription in some areas, such as the content of training programmes for Council members. The General Social Care Council thought that the rules should not cover the quorum for meetings.

4.33 The Department of Health supported the proposals but “within certain parameters, for example parity between lay and registrant membership”.

4.34 UNISON argued that certain core elements – appointments, term of office, remuneration and disqualification – must have a level of consistency across the regulators. The Scottish Government agreed that “this is an area where there is likely to be a degree of commonality across the regulators and one in which consistency of approach would be warranted”.

4.35 Several consultees were uncomfortable about the regulators determining their own appointment processes. The British Dental Association supported a single appointments mechanism for all the regulators, “independent of, but administered by, the Professional Standards Authority”.

4.36 Several consultees agreed that the statute should require that at least one Council member must work or live in each of Northern Ireland, Scotland and Wales. However, it was also recognised that this might be difficult in the context

<sup>5</sup> Of the 192 submissions which were received, 42 expressed a view on this proposal: 34 agreed, 4 disagreed, whilst 4 held equivocal positions.



of smaller regulators. The General Osteopathic Council felt that while appointments from each country in the UK would be difficult to justify in a smaller regulator, it would be important for the larger regulators “particularly where national health services may differ considerably”. The Scottish Government supported “the continued approach that at least one member of each Council should live or work in Scotland, England and Wales” but beyond this, the regulators should have discretion to “set requirements for national/regional based appointments to their Councils if they so wished”.

**Question 4-5: Is an additional form of oversight required over the appointment of the General Council members? For example, should the Government have powers to remove members in certain circumstances?**

- 4.37 A small majority agreed that additional oversight was required.<sup>6</sup> For example, the Scottish Government argued that “the Government and, where applicable, the Scottish Government” should have powers to remove Council members in order to ensure effective leadership or prevent organisational failure.
- 4.38 Some felt that Government had a role to play. For example, the Patients Association suggested that the Secretary of State should have powers to intervene and to remove members of Councils where there has been a failure of effective leadership. The Association pointed to recent events at the Nursing and Midwifery Council where “problems with strategic leadership have hampered the regulator’s ability to perform its duties”. Rescare argued that the Government should have the power to remove Council members in “grave or extreme circumstances”.
- 4.39 The Department of Health argued there should be an order-making power vested in the Privy Council to remove members if, for example, “they are failing to meet their duties to a standard that the public and professionals have the right to expect”.
- 4.40 However, several consultees were concerned that additional Government oversight would allow for political interference in the way regulators are run. An individual consultee (Lucy Reid) stated that:

Government powers and oversight may not necessarily enhance the public confidence and there is a risk that the Councils will then be seen to be political bodies and/or may be vulnerable to political influence or policy.

- 4.41 The General Optical Council felt that a Government power to directly remove individual members was unnecessary as other safeguards would be in place, including Government intervention powers where a regulator is failing to deliver its statutory functions. However, the Council felt that Government oversight would be beneficial in respect of the “rules around the constitution of Councils”.

<sup>6</sup> Of the 192 submissions which were received, 55 expressed a view on this question: 32 said that additional oversight was required; 20 consultees disagreed; whilst 3 held equivocal positions.

- 4.42 Some consultees felt that oversight should be provided by the Professional Standards Authority. For example, Coventry and Warwickshire Partnership Trust argued that the Authority should be tasked with “ensuring a consistent approach to these rules and regulations to ensure a fair approach and a role to overview the application of the rules”.
- 4.43 However, the General Pharmaceutical Council argued that it would not be appropriate for the Authority to be given a role since it does not have the necessary independence. The General Medical Council and the Health and Care Professionals Council felt that the Authority’s role should be limited to setting standards.
- 4.44 Several consultees argued that, rather than establishing greater oversight, the new system should ensure that appointments are made independently or at arms-length from the Council. Many responses contained strong statements of support for the role of the Appointments Commission and argued it would be deleterious if these benefits were lost. For example, the General Pharmaceutical Council argued that the current system provides “effective scrutiny, independence, transparency as well as quality of process”. It suggested that the Commissioner for Public Appointments or the Civil Service Commissioner, or an independent body set up by the regulators themselves, could be used in the place of the Appointments Commission. Furthermore, it noted that there remains an argument for retaining a role for the Privy Council in affirming appointments.
- 4.45 The Professional Standards Authority felt that additional oversight could be provided by the Commissioner for Public Appointments. The Patients Association argued that, at the very least, the chairs should be independently appointed under “recognised public appointments norms”. The Scottish Government argued that the “good practice exemplars that have emerged from the involvement of the Appointments Commission [should be] retained” and the Professional Standards Authority should continue to have responsibility for guidance and standards setting.
- 4.46 The Department of Health wanted to explore the need for further oversight with the Professional Standards Authority and the regulators.
- 4.47 Some consultees argued that no additional oversight is needed over the appointment of Council members. For example, the Nursing and Midwifery Council felt that “as long as the standards set by the Professional Standards Authority are adhered to” and “there is a path for concerned individuals to question the appropriateness of members remaining in post”, additional Government powers are unnecessary. This position was also supported by many of the regulators including the General Medical Council, the General Chiropractic Council and the General Osteopathic Council.

**Question 4-6: Should: (1) the statute specify a ceiling for the size of the Councils of and the proportion of lay/registrant members; or (2) the Government be required to specify in regulations the size of Councils and the proportion of lay/registrant members; or (3) the regulators be given general powers to set the size and composition of their Councils and the Government be given default powers to intervene if this is necessary in the public interest?**

4.48 Opinion was divided on this question. Most supported option three.<sup>7</sup>

***Option one: upper ceiling and composition set in statute***

4.49 The Royal College of Surgeons of Edinburgh supported this option, arguing that:

The use of a ceiling would seem to be the correct approach and one that chimes with the overall aims of imposing increased consistency whilst also allowing flexibility to allow regulators to respond to changing circumstances.

4.50 The Professional Standards Authority also supported this option but on the basis that “Councils are kept small and lay members have a majority”. The Medical Schools Council argued that if this option is adopted, the ceiling for Council membership should be closer to 16 than eight. The Northern Ireland Practice and Education Council for Nursing and Midwifery argued that the statute should not only specify a ceiling but also a minimum number of Council members.

4.51 Several professional bodies argued that registrants should be in the majority on Councils and membership should comprise of at least one professional from each of the professions regulated by the Council. Moreover, the Medical Schools Council argued that the statute should also recognise the importance of clinical academic input in terms of composition.

4.52 Most consultees who opposed this option felt it was too inflexible and argued that the statute should allow the development of future policy – which may not be in favour of smaller Councils and equal lay and registrant membership.

4.53 The Nursing and Midwifery Council argued that rather than specifying the proportion of lay and registrant members, the statute should be expressed in terms of principles, such as “the number of registrant members should not outnumber the number of lay members”. It was felt this would allow more flexibility to ensure that where there is a specific skills gap (such as financial expertise) a lay person could be appointed over a registrant.

***Option two: size and composition set in Government regulations***

4.54 Many supported this option on the basis that it provided for consistency and certainty. For example, the Health and Care Professions Council felt that the legal framework should be prescriptive about the size of Councils and equal lay and registrant membership. It thought this was necessary in order to maintain

<sup>7</sup> Of the 192 submissions which were received, 63 expressed a view on this question: 14 supported option one, 13 supported option two, 31 supported option three, whilst 5 held equivocal positions.

public confidence and “avoid any possible perception that regulators make decisions in the interests of the professions as opposed to upholding the public interest”. This view was shared by the British Association for Counselling and Psychotherapy, which argued that “Councils should decide the ends not the means and hold the executive to account and ensure that public protection is central to all decisions”.

- 4.55 Some also felt that the use of regulations would allow for the future proofing of the legal framework. For example, the Institute of Medical Illustrators argued that regulations give “a certain flexibility for unforeseen circumstances whilst ensuring that the size and composition is not unduly rigid”.
- 4.56 Most who opposed this option were concerned to limit the powers of Government. For example, the British Dental Association argued that if this option was adopted, and Government were given powers to approve constitution orders, then “the executive would have complete control over the regulator”.

### ***Option three: general powers for the regulators***

- 4.57 Many supported this option because they felt it would give the regulators maximum flexibility. For example, Coventry and Warwickshire Partnership Trust argued that the variation in size of the different regulated professions makes it difficult to have a consistent Council size. UNISON also argued that “it is important that boards do take a proportionate account of the numbers of individuals they regulate”. The General Osteopathic Council felt that this option recognised the differences between the size and turnover in the regulators, as well as being the “least resource intensive” for the Government.
- 4.58 Some consultees – particularly professional bodies – favoured this option because they felt it could secure an increased number of registrant members. For example, the British Association of Music Therapy argued that it is important that individual professions are adequately represented at Council level in the context of a multi-professional regulator such as the Health and Care Professions Council. On the other side, the British Association of Dental Nurses did not agree with this option because it would lead to the General Dental Council “continuing to sideline its members and to reflect primarily the views and interests of dentists”.
- 4.59 Most who opposed this option were concerned about giving the regulators too much discretion on such important matters. The Professional Standards Authority argued that it “provides too much latitude and would create instability and distraction” and “it may also provoke ongoing Government involvement in the regulators”.

### ***Other comments***

- 4.60 Some consultees favoured a combination of the options set out above. For example, the General Medical Council argued that the proportion of lay and registrant members on the Council is a matter of overriding public interest that should be specified in statute (option one). However, it felt that the Council size should be left to regulations (option three) because “it is not a matter of such overriding public interest as to need to be fixed in statute” and “perceptions of the ideal size may, in any event, change over time”. Furthermore, it argued that the

issue of size relates to the nature of the regulator (rather than how it regulates) and therefore should not be left to the Councils themselves to determine but should be specified by Government in regulations. The General Optical Council argued that the size should be left to the regulators to determine (option two), but that “the principle of an equal split between lay and registrant members ... is important enough to warrant inclusion in the statute” (option one).

4.61 An alternative approach was suggested by the Centre for the Advancement of Interprofessional Education. It argued that the Professional Standards Authority should set the Councils size and consider the mix of lay, profession-specific and other professional members.

4.62 The Department of Health argued that the Privy Council should have an order-making power to set the parameters within which the regulators may constitute their Councils “for example by setting maximum and minimum number of council members, the proportion of lay and registrant members”.

4.63 Similarly, the Scottish Government supported an approach whereby:

The Government and, where applicable, the Scottish Government, should set parameters within which the regulators can establish their Councils, including the proportion of lay/registrant members.

4.64 Some responses argued for greater professional representation on the Councils. For example, the Royal Pharmaceutical Society of Great Britain stated that:

Professional input at a strategic level is essential. Members of a profession have a unique body of knowledge and expertise, and, as professionals, will act in the best interest of their patients.

4.65 Many representative bodies argued that the moves by Government to reduce the size of Councils would mean that the ability of the regulators to secure the expertise and support from the regulated professions would be reduced. Concerns were also raised about the ability of a small Council to be representative of all four countries of the UK.

4.66 Some responses queried the position of the Council chair in our proposed scheme. The General Optical Council felt that – as well as establishing an equal split between lay and registrant members – the statute should make allowance “for an additional lay chair”. The General Social Care Council argued that the chair of each Council should be lay “in order to maintain the independence of the regulator and to enhance public confidence in the profession”.

**Provisional Proposal 4-7: The statute should define a lay member of the Council as any person who is not and has not been entered in the register of that particular regulatory body, and a registrant member as any person who is entered in the register of that particular regulatory body.**

4.67 A large majority agreed with this proposal.<sup>8</sup>

<sup>8</sup> Of the 192 submissions which were received, 39 expressed a view on this proposal: 30 agreed, 7 disagreed, whilst 2 held equivocal positions.

4.68 However, several consultees suggested a more restrictive definition of a lay member. For example, the General Medical Council pointed out that our proposed definition of a lay member could include doctors who hold professional qualifications but who had not been granted registration. Instead, it proposed defining lay member as:

someone who is not and has never been entered in the register of that particular regulatory body and *does not hold a qualification which would render that person eligible to be entered in the register.*<sup>9</sup>

4.69 The Pharmaceutical Society of Northern Ireland pointed out that, under our proposed definition of a lay member, a pharmacist previously registered with either the Pharmaceutical Society of Ireland or the General Pharmaceutical Council could become a lay member of its Council. It therefore proposed that those eligible to join the relevant register should be precluded from being a lay member.

4.70 The Health and Care Professions Council argued that the definition of a lay member should exclude any person who was included on the register of a predecessor organisation. The General Social Care Council also argued that the definition should exclude people who have been practising the profession during a period where there was no registration requirement. It pointed out that it considers social workers who were in practise before the introduction of statutory regulation in 2005 to be registrant members.

4.71 The Health and Care Professions Council also argued that the definition of a lay member should exclude any professional who is registered with another health or social care regulatory body. It felt that a more stringent definition would reflect “the reasonable expectations that most members of the public would have of a lay member”. The Guild of Healthcare Pharmacists also supported that approach. The Patients Association also argued that the definition of lay member should be limited to those who have never been registered with any health related regulator. It stated that:

For example, nurses and doctors will often work in very close quarters, sharing working environments, stresses and concerns. It would seem inappropriate for a nurse to be described as a “lay member” at the General Medical Council when they in all likelihood have been working amongst doctors as a healthcare professional throughout their entire professional career.

4.72 However, the General Osteopathic Council supported the definition of lay incorporating other health professionals because “for a small, developing profession their input – particularly in areas such as education and training – can be extremely valuable”. Similarly, the General Optical Council considered that a blanket exclusion for all health professions would be too broad.

<sup>9</sup> Emphasis added.

4.73 The General Optical Council also pointed out that its definition of lay members excludes current and former directors of registered bodies corporate and anyone holding a qualification that would make them eligible for registration.

4.74 Some consultees argued for a broader definition of a registrant member. For example, the Professional Forum of the Pharmaceutical Society of Northern Ireland felt the definition should include those eligible to be on the register – including those who have withdrawn as matter of personal choice or having moved away from active practice. Nevertheless, the Forum warned that a Council populated by non-practising professionals should be avoided.

4.75 Similarly, the Professional Standards Authority argued that the definition of a registrant member should be expanded to include “those individuals who have been but are not currently registered”. It felt that:

This provides clarity for all stakeholders and may be of practical benefit to those regulators where there is a relatively small pool of registrants to appoint from (subject to meeting the criteria for a good appointment and they had not lapsed because of serious fitness to practise concerns).

4.76 However, the Scottish Government suggested that “a registrant member should be registered with that body during the period of their appointment to the Council”.

4.77 The Nursing and Midwifery Council queried whether voluntary registrants should qualify as registrant members or lay members. An individual consultee (James Kellock) also queried whether a registrant of a foreign professional body practising in the same area is eligible to be appointed as a lay member.

**Question 4-8: Should Council members be prohibited from concurrent membership of another Council?**

4.78 A slim majority felt that Council members should be prohibited from concurrent membership of another Council.<sup>10</sup>

4.79 The Health and Care Professions Council argued that concurrent Council membership reflects negatively on the image of the regulators. It said:

We consider that concurrent council membership concentrates the power of regulators in the hands of a few and could also lead to potential conflicts of interest in relation to certain policies that may be adopted by councils. We have never experienced difficulties in attracting a high calibre of Council members such that it would precipitate concurrent membership.

4.80 The Scottish Government stated:

<sup>10</sup> Of the 192 submissions which were received, 39 expressed a view on this question: 20 said that concurrent membership should be prohibited, 16 said that it should not, whilst 3 held equivocal positions.

In the interests of transparency and fairness, ensuring faith, trust and confidence in the professions and the regulatory process, and to avoid the perception of bias we recommend that Council members should be prohibited from concurrent membership of another Council. This would also reduce the potential for any “cross-contamination” and recognises that the relevant expertise can be found in a range of individuals rather than vested only in a small number. This would also afford considerably more transparency.

4.81 The Pharmaceutical Society of Northern Ireland stated:

Whilst the potential for experienced and concurrent members of other regulatory Councils to bring knowledge to other Councils is recognised, there is concern that such individuals will be disproportionately successful in securing appointments to the detriment of other individuals. The risk of limiting the pool of potential candidates brings with it the loss of fresh thinking and innovation which could be gained from other sectors.

4.82 The Medical Protection Society agreed that concurrent membership would have the effect of “limiting the positions open to new people who may bring fresh views and insight”. The British Association for Counselling and Psychotherapy felt that a prohibition was necessary to prevent the development of a “pseudo profession” and subsequent loss of the “distance and alternative view” brought by lay members. The British Medical Association did not accept that an individual would be able to devote sufficient time to undertake each role effectively.

4.83 The Patients Association argued that cross membership reflected poorly on the regulators. It felt that:

The “old school tie” image of self regulation does nothing to improve public confidence in their operation, and every effort should be made to ensure that not only is this not the case, but that there is not even the possibility of such a perception.

4.84 The McTimoney Chiropractic Association agreed “that ‘the old boys’ network’ undermines confidence both by registrants and the public”,

4.85 The Professional Standards Authority anticipated that there will be a smaller total number of board places in the future and that a prohibition on concurrent membership would allow “an individual to focus on a single role and avoids any conflicts of interest arising”. It suggested that conflicts of interest “may be more frequent and consequential if there are additional instances and opportunity for joint working and collaboration”.

4.86 However, the General Medical Council felt there were advantages in concurrent membership, such as facilitating “shared learning and experience, the cross-fertilisation of ideas and harmonisation of regulatory approaches”. The Scottish Social Services Council agreed that the sharing of ideas was a positive benefit of concurrent membership.



- 4.87 The Department of Health expressed concerns “about the capacity of an individual to serve on more than one regulatory body” but felt there was no reason for a prohibition. It thought that:

In practice any appointing body would give due consideration to the capacity of the individual to take on multiple roles and of any potential conflicts of interest which may arise.

- 4.88 The Nursing and Midwifery Council also felt that rather than prohibiting concurrent membership, the key issue is to ensure that each Council member “has the right skill set and the ability to give the necessary time commitment to enable them to carry out their duties and make an effective contribution”.

- 4.89 The Medical Defence Union argued that concurrent membership should be allowed “in the interests of fostering consistency and co-operation among regulators and sharing of best practice”. However, this would need to be “subject to approval from the ‘first’ regulator” and undertaken in circumstances “where membership of the ‘second’ regulator did not prevent the Council member from properly fulfilling his or her duties in respect of the ‘first’”. The Medical and Dental Defence Union of Scotland argued that a prohibition would reduce the pool of qualified participants in professional regulation and governance.

- 4.90 Some consultees argued that Council members should be prohibited from being a member of more than two Councils at the same time. Coventry and Warwickshire Partnership Trust felt this would “encourage exchange of ideas between councils, but stop ‘career’ committee members from holding multiple posts”. This approach was also supported by the British Psychological Society.

- 4.91 The General Osteopathic Council argued that, while there should be no absolute prohibition:

It is important that regulators are clear why it is in their interests to appoint such members, rather than expand the pool of external expertise supporting the regulators.

- 4.92 The Council also felt that the regulators should draw the net widely when seeking Council members. While recognising the importance of being able to draw on expertise and experience from other regulators, it argued that the selection processes “must not overly favour those with pre-existing knowledge and experience of health care professional regulation”.

**Provisional Proposal 4-9: The regulators should be given broad rule-making powers to determine their own governance arrangements, including the ability to establish committees if they wish to do so.**

- 4.93 An overwhelming majority supported this proposal.<sup>11</sup> For example, the General Chiropractic Council agreed that the decision “whether to have committees and how they should be composed” are matters for the regulator. Similarly, the British Chiropractic Association and Allied Health Professions Federation welcomed the

<sup>11</sup> Of the 192 submissions which were received, 43 expressed a view on this proposal: 40 agreed, whilst 3 expressed equivocal positions.

proposal. The Academy of Medical Royal Colleges supported the proposal “as it allows for flexibility”.

- 4.94 Several consultees supported the proposal, but stressed that there would need to be some external scrutiny. For example, NHS Greater Glasgow and Clyde thought that any governance arrangements would need to be “open to scrutiny and involve stakeholder involvement in evaluating function/transparency”.
- 4.95 The General Optical Council argued that if regulators are to be required to reduce the size of their Councils, they should “be given the ability to change their other governance arrangements as necessary, to make best use of their members and committees”.
- 4.96 The General Medical Council agreed with this proposal but felt the governance arrangements for committees did not need to be in rules but could be achieved through standing orders. It also argued that detailed rules should not be required for “ad-hoc working groups and other similar fora that may need to be established from time to time”.
- 4.97 Some consultees representing midwives expressed concern that the proposal could lead to the abolition of the Midwifery Committee by the Nursing and Midwifery Council.
- 4.98 The Scottish Government agreed with the proposal, however it also stated that:

An exception to this would be in relation to groups such as midwives who currently have a separate committee established under the Nursing and Midwifery Council. We would propose that a clause is added in the new statute which reflects the requirement for regulators to consult and seek Government/Department of Health and, where relevant, devolved administration approval where the establishment or removal of committees would impact significantly on such professions.

- 4.99 A small number of responses supported a uniform system of statutory committees across all the regulators. For instance, the Optical Confederation supported preserving certain core committees, in any new legislation, namely the Fitness to Practise Committee, Investigation Committee and Registration Appeals Committee.

**Provisional Proposal 4-10: The regulators should be able to make rules for committees or any other internal groups it establishes, including their size and membership.**

- 4.100 All the consultees who responded to this proposal agreed that regulators should have the power to make rules for committees or any other internal groups.<sup>12</sup>
- 4.101 NHS Greater Glasgow and Clyde agreed, subject to:

<sup>12</sup> Of the 192 submissions which were received, 33 expressed a view on this proposal: all agreed.

the overriding caveat that governance arrangements must clearly and unambiguously account for regulatory function, be open to scrutiny and involve stakeholder involvement in evaluating function/transparency.

- 4.102 The Chartered Society of Physiotherapy felt that regulators should “subject their structures to periodic review to ensure that they remain fit for purpose”.

**Provisional Proposal 4-11: Each Council should be given powers to delegate any of its functions to any Council member, officer or internal body. Any delegations must be recorded in publicly available scheme of delegation. There should continue to be a prohibition on delegating any power to make rules.**

- 4.103 The vast majority agreed with our proposed powers of delegation.<sup>13</sup>
- 4.104 The General Osteopathic Council supported the proposal. However, it felt that there was potential for “conflict and loss of effective accountability” if the Councils delegate their functions to individuals outside of the line management structure, rather than to the Chief Executive to delegate to others “under normal managerial arrangements”.
- 4.105 The Professional Standards Authority considered that this proposal was too broad and argued it would not be appropriate for the Council to delegate, in the interests of “good decision making”. For example, “it would be inappropriate for Council to delegate to a Council member any adjudication on fitness to practise”. The General Social Care Council shared this view.

<sup>13</sup> Of the 192 submissions which were received, 37 expressed a view on this proposal: 36 agreed, whilst 1 held an equivocal position.

## PART 5

# REGISTERS

### **Provisional Proposal 5-1: The statute should set out a core duty on all the regulators to establish and maintain a professional register.**

- 5.1 All consultees who expressed a view supported the proposal that the statute should set out a core on duty on all the regulators.<sup>1</sup> For example, the Chartered Society of Physiotherapy stated that:

Establishing and maintaining registers is the primary statutory function of regulators and the fundamental way in which they fulfil their public protection role. It is from holding and maintaining a register that all other regulatory activities stem (including managing admission to the register, the renewal and review of registration, and the management of fitness to practise cases that may remove an individual's eligibility to remain on a register).

- 5.2 Similarly, the Association of Regulatory and Disciplinary Lawyers described professional registers as the “centrepiece of statutory regulation”. The Patients Association felt that, for the public, the register is “a stamp of accreditation of the abilities, skills and qualifications of a professional” and that “registration inspires a certain amount of trust and confidence in individual registrants”.
- 5.3 The Professional Standards Authority suggested changing the term “professional register” to “register of professionals” since the former could be interpreted as describing a register that is run “for the benefit of professionals”.
- 5.4 Some consultees argued for greater consistency over how this duty is implemented. For example, both the Association of Regulatory and Disciplinary Lawyers and the Patients Association called for certain core features of professional registers to be enshrined in legislation, such as qualifications, registration status, specialism, name, title, gender and sanctions.

### **Provisional Proposal 5-2: The regulators should have the ability but not a duty to appoint a Registrar.**

- 5.5 A significant majority agreed that it should be left to the regulators to decide whether or not to appoint a Registrar.<sup>2</sup> For example, an individual consultee (Jane C Hern) said that:

The appointment of a Registrar is not essential; much of what is required can be undertaken by suitably qualified members of staff, supported by committees setting policy, determining unusual cases and for hearing appeals.

<sup>1</sup> Of the 192 submissions which were received, 51 expressed a view on this proposal: all agreed with the proposal.

<sup>2</sup> Of the 192 submissions which were received, 41 expressed a view on this proposal: 32 agreed, 8 disagreed, whilst 1 held an equivocal position.

- 5.6 Some supported the proposal on the condition that it is made clear who has responsibility for the task of registration. The Patients Association stated that:

While we agree with the proposal to vest official registration authority in the Council, which may be delegated to a Registrar or other appropriate official, there must be a clear line of accountability for the Council who must be able to be held responsible for errors in the Registers.

- 5.7 The General Osteopathic Council supported the proposal, but believed that “it is important that the statute recognises the notion of an accountable officer within each regulator”.

- 5.8 The General Medical Council also expressed concern that if the responsibilities currently allocated to the Registrar were distributed among a number of staff members, it could undermine confidence in the regulators. However, it had no strong preference about whether there should be a duty to appoint a Registrar.

- 5.9 Those who opposed the proposal argued that a Registrar is essential to the regulatory task of registration. The Dental Schools Council stated that:

It would be impossible and ineffective to set up a register without a Registrar; we would strongly recommend that the legal requirement for the appointment of a registrar is continued. This provides the transparency and accountability for maintaining the register.

- 5.10 Some made suggestions about the eligibility requirements for appointment as Registrar. The Professional Standards Authority felt that the statute should prohibit the appointment of a registrant Registrar because:

The powers that are awarded to the Registrar in relation to registration decisions may be considerable; therefore their integrity and independence from the profession should be beyond question.

- 5.11 The Department of Health, Social Services and Public Safety for Northern Ireland thought that “there would be merit in redefining the role of a Registrar but the concept is essentially good”.

- 5.12 However, the Royal College of Nursing argued that it is appropriate for this role to be carried out by a registrant “in order to maintain public and professional confidence”. UNISON argued that the Registrar should not be a dual role for the chief executive.

- 5.13 The British Society of Hearing Aid Audiologists went further and argued that regulators should not be able to appoint a Registrar, as the “Chief Executive should be directly responsible and accountable for this role”.

**Provisional Proposal 5-3: The statute should specify which registers must be established by the regulators, including any different parts and specialist lists. The Government would be given a regulation-making power to add, remove or alter the parts of the register and specialist lists.**

- 5.14 A majority of consultees agreed that the statute should specify how the registers must be structured.<sup>3</sup> A large majority agreed with Government regulation-making powers.<sup>4</sup>
- 5.15 In respect of Government regulation-making powers, the Professional Standards Authority argued that “given the socio-economic impact of regulation” it would not be appropriate to give such powers to the regulators themselves. It stated:

We believe that in the context of statutory regulation, any decisions to register or specialise a professional group should be based on an assessment of the risk that the group poses to the public, and whether registration or specialist registration is the most appropriate and effective response to this risk. It is therefore important to consider the other means of mitigating these risks that are already available to the regulator, or in place elsewhere.

- 5.16 The Department of Health argued that:

The further division of a register or the introduction of a specialist register/list is a decision to restrict the practice of a profession, or a certain level of practice, to a certain group of people. To restrict practice in such a way can have significant political and economic repercussions and therefore it is right that such decisions should be the subject of a formal [Privy Council] power.

- 5.17 The Scottish Government also supported the proposals. It agreed that changes to the types of registers could potentially “lead to the establishment of new specialities/subspecialties, new protected titles and functions, and the amendment of existing groups”. It felt, therefore, that it would be appropriate for the Department of Health and, “within devolved competence”, the Scottish Government to make decisions about such changes.

- 5.18 However, some consultees did not support the proposal. The British Dental Association disagreed that specialist lists should be set in statute, as it did “not see how they are so different from other, even more fundamental, aspects, that will be subject to regulations or rules”. The British Pharmaceutical Students’ Association also opposed the proposals. It said that:

<sup>3</sup> Of the 192 submissions which were received, 31 submissions expressed a view on this proposal: 22 agreed, 7 disagreed, whilst 2 held equivocal positions.

<sup>4</sup> Of the 192 submissions which were received, 38 submissions expressed a view on this proposal: 29 agreed, 8 disagreed, whilst 1 held an equivocal position.

Each healthcare profession is different and therefore a one-size-fits-all approach introduced by the Government may not work. Government may also not understand the finer intricacies of each healthcare profession and giving it the ability to add, remove, or alter parts of the register could introduce problems.

- 5.19 The Nursing and Midwifery Council supported Government regulation-making powers in this area as long as the use of such powers is based on:

A clearly articulated regulatory rationale for establishing a part of the register or a specialist list, against which proposals to add, remove or alter could be evaluated. This rationale would need to be explicit about why public protection demanded a level of assurance for a specific role above that provided by registration.

- 5.20 The General Medical Council agreed generally with the proposals. However, it suggested that a distinction should be drawn between specialist registers, which have a clear legal effect, and “specialist lists or credentials which are indicative of a regulatory standard having been attained but which have no direct legal effect”. The Council felt that the latter should be left to the regulators to decide “as part of their duty to ensure the utility of the registers they maintain” and the former should be in the statute and subject to Government regulation-making powers.

- 5.21 The General Dental Council agreed that the statute should specify the different parts of the register and specialist lists. The Council felt that the establishment of new “specialist lists or advance registers” should be for the regulators to decide, subject to consultation rather than “Government approval or veto”. This was because:

Regulators are arguably in a better position to discern whether, in the interests of patient protection, additional specialisms should be recognised and made the subject of additional regulation. Regulators can form this view on the basis of an assessment of its fitness to practise data and other sources which reveal the need for additional regulation in complex areas of the discipline.

- 5.22 A small number of consultees disagreed with both proposals. The Registration Council for Clinical Physiologists argued that the regulators are best placed to make decisions about the need for specialist lists and that any changes would be more difficult to achieve and take too long if they were left to Government. Similarly, the British Society of Hearing Aid Audiologists argued that a regulator “can consult and act more quickly, will be more in touch with what might be required and bureaucracy will be kept to a minimum”.

- 5.23 The General Osteopathic Council described the proposals as “overly prescriptive”. It argued that registers provide useful information for members of the public seeking professional support. The Council also thought it should be possible for regulators “to annotate a register with ‘additional information’, should the regulator consider it appropriate, rather than necessarily giving it the status of a specialist register”.

- 5.24 The British Association for Counselling and Psychotherapy queried “under what circumstances and with what level of specialist knowledge any government”

would seek to amend the register or specialist lists. The Association feared an increase in legislation.

5.25 Some suggested that new specialist lists should be established. For example, West Sussex County Council referred to Approved Mental Health Professionals under the Mental Health Act 1983 and Best Interests Assessors under the Mental Capacity Act 2005. The Council felt that the important statutory functions of these roles, particularly in relation to powers of detention, should be recognised separately by the Health and Care Professions Council.

5.26 A number of consultees argued that a specialist list should be established for health visitors. For example, the Institute of Health Visiting felt that:

Treating health visiting as a sub-part of nursing is unhelpful and potentially harmful to the public, because it hampers recruitment and the development of appropriate standards for qualification.

5.27 The Royal College of Nursing argued for “a specialist list of advanced practitioners/nurses working to advanced practice” since “it is important that patients are able to understand and verify that the nurse caring for them is competent to practise at an advanced level”.

**Provisional Proposal 5-4: The Government should be given a regulation-making power to introduce compulsory student registration in relation to any of the regulated professions.**

5.28 A small majority agreed that the Government should be given a regulation-making power to introduce compulsory student registers.<sup>5</sup>

5.29 The Department of Health argued that the power to introduce student registration should be vested in the Privy Council. It also stated:

Whilst recognising that there are existing student registers, we are not convinced that there is a need to introduce compulsory registration of students. There is an argument that it runs contrary to the purpose of registration to register persons who have not yet successfully completed their degree (ie who by definition are not yet “fit to practise” without supervision), although we can see merits in provisional registration ... to allow graduates to complete a year of practical training under the supervision of a university before being registered.

5.30 The Scottish Government agreed with proposal on Government regulation-making powers on the basis that “this is a decision for the Government and, within devolved competence, for the Scottish Government to make”.

5.31 Most of those who supported the proposed power did so because they supported the introduction of student registers. Conversely, those who disagreed with the proposal did so because they did not support student registration. Consultees’

<sup>5</sup> Of the 192 submissions which were received, 50 expressed a view on this proposal: 27 agreed, 19 disagreed, whilst 4 held equivocal positions.



views on student registration are covered in the following section, in response to the consultation question whether student registration should be retained.

- 5.32 The General Optical Council – which is the only regulator that has a compulsory student register – supported the proposal on Government regulation-making powers. However, it expressed concerns about the costs of student registration to students and training providers, and the administrative difficulties of ensuring that the register is accurate. It concluded:

This is an area that we intend to explore further. However, we would note at this point that it is possible that the General Optical Council may not seek to have compulsory student registration powers activated by the Government under a new statutory framework.

- 5.33 The Institute of Biomedical Science argued that:

A more proportionate approach would be for the regulators to only approve education providers whose courses leading to registration teach the principles and practices of professionalism and the expectations of a healthcare professional.

- 5.34 A small number opposed the proposal on the basis that decisions relating to the introduction of student registers should not be a matter for Government. For example, the Nursing and Midwifery Council argued that the regulators should be left to decide whether or not to introduce a student register or whether an alternative is proportionate and effective.

- 5.35 The Department of Health, Social Services and Public Safety for Northern Ireland felt that the proposal needed “further consideration in the context that the universities/colleges have responsibilities for vetting students”.

**Question 5-5: Should student registration be retained in the new legal framework, and/or how can the legal framework help to ensure that the principles and practices of professionalism are embedded in pre-registration training?**

- 5.36 A majority felt that student registration should be retained in the new legal framework.<sup>6</sup> For example, the Academy of Medical Royal Colleges stated that:

Students should be encouraged to develop a professional ethic from the start of their studies. A student register could be introduced by the regulators and guidelines produced on the criteria for admission or removal from this register.

- 5.37 The Professional Leads for Allied Health Professions, Medics, Pharmacy and Psychological Therapies at South Staffordshire and Shropshire Health Care NHS Foundation Trust reported that “resolving issues through working with the University and the Trust to deal with fitness to practise issues can sometimes be difficult”. It was thought that student registration would provide “an additional sanction tool”.

<sup>6</sup> Of the 192 submissions which were received, 57 expressed a view on this question: 35 said student registration should be retained, 19 disagreed and 3 held equivocal positions.

- 5.38 Several consultees supported the registration of social work students. The British Association of Social Workers argued that social work students need to be registered for reasons of public protection because they often work “without direct supervision with some of the most vulnerable people”. The College of Social Work argued that the arguments for registration of student social workers were much stronger than for health professionals “where there is limited contact with patients and service users”. An individual consultee (Don Brand) suggested that the Health and Care Professions Council’s decision not to register student social workers was “a worrying instance where the regulator has not taken account of the different learning processes of the different professions it regulates, and has chosen uniformity over effectiveness”.
- 5.39 The Care Council for Wales and the Northern Ireland Social Care Council suggested there is evidence that, in relation to student social workers, “the requirement to meet the registration thresholds has sharpened the recruitment and selection of the universities”. It has also been found that students are “much more conscious of their professional role through being registered with the regulatory body from the point of entering professional training”. They also argued there is an economic benefit to “weeding out, as far as possible, those who are unsuitable at the start of the training rather than the cost to the public purse of training people who are not suitable”.
- 5.40 The Medical Protection Society argued that “where students have contact with the public as part of their training, registration would be appropriate” but student fitness to practise hearings should remain under the remit of the educational establishments. It also suggested that the regulators could have “advisory oversight” of the processes and the possibility of a representative member of a fitness to practise panel on student panels.
- 5.41 However, a number of consultees were opposed to student registers. For example, the Medical Defence Union stated that:
- It would not simply be a matter of registering students. The regulator would need to set up new procedures to deal with matters such as application and approval processes and removal from the register etc. There would be numerous other considerations, for example, whether students should be subject to the regulator’s “fitness to practise” proceedings and how this would fit in with their school and university’s own procedures. All this additional activity would incur considerable expense which would presumably be funded principally, if not entirely, by registrants because students do not have sufficient financial means.
- 5.42 Similarly, the Optometry Course Team at the University of Ulster argued that student registration should not be retained because it is “disproportionate, unnecessarily bureaucratic and hinders dealing with issues in a timely fashion”. The Committee of Contact Lens Educators agreed that student registration “is unnecessary and burdensome”.
- 5.43 The British Association and College of Occupational Therapists thought that the introduction of student registration would “duplicate activity and detract from the

greater priority of developing students' understanding of professional responsibilities".

- 5.44 The Professional Standards Authority argued that risks associated with "poor performance, harm to service users, fraudulent re-enrolment and programme hopping" should be managed through:

the design and delivery of courses, including robust recruitment practices, clear admission criteria, embedding professionalism and standards of conduct throughout the course, and effective supervision. The regulator has a role supporting education providers, through advice and guidance on standards to be met and the management of fitness to practise issues among students.

- 5.45 Some opposed student registration because students are at a different stage of their development compared to registrants. For example, the Society of Chiropodists and Podiatrists stated that:

Students must have the freedom to learn, both how to be a competent clinician and how to behave professionally. It would be tragic if a student's future career were destroyed as the result of a youthful mistake or misjudgement.

#### ***Embedding professionalism in pre-registration training***

- 5.46 A number of consultees expressed a view on how the legal framework could help to ensure that the principles and practices of professionalism are embedded in pre-registration training. Of those, a small majority said that professionalism should be promoted through curricula.<sup>7</sup>
- 5.47 The British Medical Association pointed out that, in order to strengthen engagement with students, the General Medical Council plans to issue its reference numbers at the beginning of the final year of student courses, rather than towards the end of their final year.
- 5.48 The Medical Schools Council felt that the statute should "encourage regulators to work with education providers to develop mechanisms for identifying, reporting and sharing information relating to fitness to practise incidents".

#### ***Other comments***

- 5.49 The Northern Ireland Practice and Education Council for Nursing and Midwifery supported compulsory student indexing as there is no mechanism in Northern Ireland to enable higher education institutions to alert the regulatory body "should there be an issue in relation to a student's fitness to practice". Thus, a student may be removed from a course but then "embark on another course at a different higher education institution or get a job in a caring role without disclosure of their

<sup>7</sup> Of the 192 submissions which were received, 31 expressed a view on this question: 18 said that professionalism should be promoted through curricula, 7 said that the regulators should work with the educational institutions, 4 said that student registration would itself lead to professionalism being embedded and 2 said that there was no need to alter legal framework in this context.

fitness to practice issues". It was argued that indexing "would enable that tracking of students and thus enhance public protection". The Royal College of Midwives suggested that the Professional Standards Authority could be required to maintain "a register of all students to prevent individuals disciplined and removed from one health professional training programme, joining another".

- 5.50 The College of Optometrists argued that a distinction must be made between undergraduate registration and the provisional registration of pre-registration professionals. In the case of pre-registration optometrists, the College argued that provisional registration is essential since "although they practise under supervision, and the supervisor must be in the same building, pre-registration optometrists often work alone with patients". The General Optical Council also considered that regulators should retain the power to register students on a provisional registration basis, as well as a system of registration of all students. It also pointed to differences in the way that training is structured for the professions that it regulates and the levels of unsupervised practice.

**Question 5-6: Should the regulators be given powers to introduce voluntary registers?**

- 5.51 Opinion was divided on this question. Exactly fifty per cent of consultees agreed that the regulators should be given powers to introduce voluntary registers, but a significant number disagreed.<sup>8</sup>
- 5.52 The UK Public Health Register, which maintains a voluntary register for public health practitioners, put forward the case for voluntary registers. It felt that:

The benefits of a voluntary register ... are that it establishes a clear boundary around a defined professional group where an assessment of public risk has shown insufficient reason to move directly to statutory registration; provides a readily accessible statement of the values and ethics to which members of that group subscribe; constitutes a powerful means of exerting effective peer pressure on professionals both to demonstrate current competence and to answer formal complaints; and furnishes employers and the public with a means of handling questions about the fitness of an individual to retain the quality mark of registration.

- 5.53 The Department of Health strongly supported voluntary registers. It stated that:

Voluntary registers of professionals have existed for many years and have successfully helped to set standards and expectations for a range of professions and occupational groups. For some groups of workers no involvement of an external organisation is needed to establish a voluntary register, as effective professional and occupational networks already exist within which it is possible for the conditions to support the establishment of a voluntary register to develop organically. However, this is not the case for all groups of

<sup>8</sup> Of the 192 submissions which were received, 76 expressed a view on this question: 38 said that the regulators should be given such a power, 30 disagreed, whilst 8 held equivocal positions.

workers and in some cases, particularly for lower paid workers in supporting roles, voluntary arrangements are less likely to be fostered by the workers themselves. In these circumstances it is our view that the skills and expertise of existing regulatory bodies could be used to help establish voluntary registers and standards for those groups. The use of the existing infrastructure within the regulatory bodies, coupled with the higher numbers of statutory and voluntary registrants will allow the regulators to operate a voluntary register at reduced costs, compared with some other bodies.

5.54 The Association for Nutrition, which maintains a voluntary register for nutritionists, argued that the effects of its register “are equal to that of a statutory register; although without the consequent protection of title or function”. This is partly due to the fact that registered nutritionists are subject to a Code of Ethics and Professional Conduct.

5.55 The Health and Care Professions Council was also in favour of retaining the powers to establish voluntary registers, arguing that such registers:

have the potential to contribute to public protection, particularly where for a given group a voluntary register does not already exist and where arrangements can be put in place to encourage or compel registration.

5.56 Many of those who supported voluntary registers did so because they were seen as an interim measure leading to statutory registration. For example, the Pharmaceutical Society of Northern Ireland regarded voluntary registers as a “valuable precursor to statutory registers” and supported the notion that “voluntary registers should be a matter for regulators to decide based upon their assessment of risk”. Similarly, Unite only supported voluntary registers where “this is part of the preparation for a profession to become registered”. The Department of Health, Social Services and Public Safety for Northern Ireland’s support for the proposal was also on the condition that the establishment of voluntary registers was limited to cases where there was a “clear intention to form a statutory register”.

5.57 The Optical Confederation supported a power for the regulators to introduce voluntary registers provided “there was a right of appeal to the Health Departments against this by the professions already regulated” in order to:

prevent the risks of regulation creep, of regulators seeking to bring new groups into regulation to boost funding and of the potential undermining of the professional status of existing registered professionals.

5.58 It also argued for further limits on the powers granted to the regulators, in particular a stipulation that “voluntary registers should operate on a full cost recovery basis” to ensure that registrants are not funding the voluntary register.

5.59 However, the Professional Standards Authority disagreed that the regulators should have powers to introduce voluntary registers. It felt that voluntary registration should be clearly distinguished from statutory regulation “to avoid

confusing the public and undermining the validity of either model". It further argued that:

The personal behaviours that drive a professional group to self-organise – a commitment to achieve higher standards – are unlikely to exist amongst groups that are “hosted” by a statutory regulator ... This need not preclude statutory regulators from offering services to voluntary registers on a commercial basis, for instance managing a register on their behalf, but the two systems must remain visibly and distinctly separate.

5.60 The General Optical Council, along with several other consultees, was also wary of the potential for confusion. The Council suggested that alternative wording might be helpful in that regard, and suggested that “lists” would be more appropriate.

5.61 The Institute of Physics and Engineering in Medicine was opposed to voluntary registers, which it described as “divisive and confusing”. It felt that a workforce “either required regulation or not”, a view shared by the Association of Clinical Biochemistry.

5.62 The General Medical Council was also opposed to voluntary registers. It said:

We do not see the value of voluntary registers being held by professional regulators. A professional group either merits formal regulation or it does not. By undertaking both statutory and voluntary regulation a regulator risks confusing the public and undermining the credibility of both models. Furthermore, if the paramount objective of regulators is to protect the public and ensure public confidence it is difficult to see how this can be achieved when those who may pose the greatest risk to the public would have the choice over whether or not they wished to be regulated.

5.63 The Patients Association expressed “deep and grave concerns” about the use of voluntary registers and argued “that their use is a danger to patients where the status of the list and indeed the registrants on said list is in doubt”. The Royal Pharmaceutical Society of Great Britain felt that there was “little value in a register that is non-mandatory and fails to offer a safeguard to the profession that mandatory regulation applies”. The Society, therefore, considered the introduction of voluntary registers to be a “retrograde [step] in the modernisation of professional regulation”.

5.64 Pharmacy Voice thought that voluntary registers could create a two tier system as it would leave “the most vulnerable people likely to use the staff not on the register and the staff who know they are not up to standard would not be likely to register”.

5.65 The Nursing and Midwifery Council argued that there is “not yet a body of evidence to inform opinion on the public protection benefit of voluntary registers”. It suggested “there is now an urgent need to begin development of an evidence base around this approach to public safeguarding”. UNISON also called for the further testing of the new powers under the Health and Social Care Act 2012 before any conclusions are reached about voluntary registers. The Scottish

Government suggested that the question of voluntary registers should be “revisited at regular intervals” to ensure that any learning from the Professional Standards Authority’s implementation work is reflected in the review.

- 5.66 The Rehabilitation Engineering Services Management Group said that the consultation paper made:

no attempt to explain the relative merits or fundamental differences between mandatory and voluntary systems of registration save that it reminds us that protected titles and functions relating to mandatory registration may be enforced under the criminal law.

**Question 5-7: If the regulators are given powers to introduce voluntary registers, should the Professional Standards Authority be given a formal power to recommend to the regulator in question that a group should become or cease to be voluntarily registered? If the regulator decided not to comply, it would be required to issue a report setting out its reasons.**

- 5.67 Opinion was divided on this question. Fifty percent of consultees agreed that the Authority should be given such powers but a significant number disagreed.<sup>9</sup>

- 5.68 The British Psychological Society supported a formal power since this “would provide an accountable framework and safeguard the public”. An individual consultee (Jacqueline A. Wier) agreed that oversight was necessary to “ensure that regulation is robust.” The Joint Committee on Genetic Counselling Regulation also supported a role for the Professional Standards Authority.

- 5.69 The Health and Care Professions Council suggested that such a power was unnecessary because it would conflict with the Authority’s function of quality assuring and accrediting voluntary registers. It was also argued that the Authority already has powers to make recommendations for actions and improvements in its annual performance review which could cover voluntary registers. The General Dental Council also felt that such a power was unnecessary because the Authority would automatically be consulted on any proposals to establish or remove a voluntary register. The General Chiropractic Council expected that the Authority would be likely to issue recommendations, and so the Council agreed that there was no need for a formal power.

- 5.70 The Nursing and Midwifery Council was “cautious” about giving the Professional Standards Authority this power because:

It appears to compromise the independence of the regulator and the right of decision-making bodies to set strategy in accordance with their statutory purpose. This renders regulators independent in letter but not in spirit, and we believe the public interest is best served by independence, coupled with effective governance and accountability.

<sup>9</sup> Of the 192 submissions which were received, 40 submissions expressed a view on this question: 20 agreed that the Professional Standards Authority should be given such a power, 17 disagreed, whilst 3 held equivocal positions.

- 5.71 The Professional Standards Authority itself also disagreed that it should be given a formal power because “this would cut across the powers vested in us by the Health and Social Care Act 2012 to independently accredit organisations to open voluntary registers”. The Department of Health also thought the proposed power was unnecessary “as this can be dealt with under other powers and duties in relation to monitoring performance of regulators and voluntary registers”. Similarly, the Scottish Government disagreed that the Authority should be given powers to make recommendations “as powers/duties already exist in this regard under the existing monitoring arrangements of the regulators”.

**Question 5-8: Should non-practising registers be retained or abolished?**

- 5.72 A slim majority felt that non-practising registers should be abolished.<sup>10</sup> For example, the Health and Care Professions Council argued that:

Registration exists to protect the public and it is important that registers are a reflection of those professionals who continue to meet the regulators’ standards. An individual who remains registered with any of the regulators should continue to meet the relevant standards for practice including meeting any continuing professional development requirements.

- 5.73 The Dental Schools Council argued that non-practising registers “add to confusion” and “do not reflect an individual’s appropriate competence, fitness to practise or ongoing continuing professional development”, and therefore, they do not “enhance or add to public safety”. Similarly, the Chartered Society of Physiotherapy argued that non-practising registers “undermine clarity and public/employer understanding and [are] cumbersome to administer”.
- 5.74 The Department of Health considered that “there is scope for considerable confusion about the purpose of non-practising registers” but added that “removing the non-registered (or unlicensed) part of the register may cause a number of operational difficulties for the General Medical Council”.
- 5.75 The Scottish Government argued that there was “much confusion” regarding non-practising registers and that the statute should clarify what is meant by the term “non-practising”. On balance, it felt that such registers should only be retained for those “who perform management, education or advisory roles which directly or indirectly impact upon patient care”. Such individuals need to be up to date “in their knowledge-base and demonstrate that they have satisfactorily met their ongoing professional requirements”.
- 5.76 The Patients Association argued that:

The function of non-practising registers in keeping professionals in touch with their profession is well enough served by the professional bodies and Royal Colleges which will attract more prestige and recognition than registration with a regulator. Naturally, if non-

<sup>10</sup> Of the 192 submissions which were received, 62 expressed a view on this question: 19 said that non-practising registers should be retained, 35 said that non-practising registers should be abolished, whilst 8 held equivocal positions.



practising professionals wish to return to practise, they may do so but they must be able to show that they are fit to practise before being re-entered onto the register.

5.77 The Professional Standards Authority described non-practising registers as “a relic of professional self-regulation” and “only benefiting registrants who wish to retain their ‘status’ as professionals beyond their practising careers”. The British Association for Counselling and Psychotherapy agreed that non-practising registers should be abolished as “the main purpose of a register is to protect the public, not enhance the status of individual registrants”.

5.78 The General Medical Council retains a system whereby a doctor can be registered but not licensed to practise. The Council felt that the system only has value in particular circumstances. These include where doctors practise overseas in jurisdictions which look to the Council “for assurance of the individual’s adherence to the values of the profession”, or when a doctor is performing “non clinical roles which nevertheless draw on their training and experience as a doctor”. It concluded:

We see no value in registering and regulating individuals who no longer have any involvement in activities, whether clinical or non-clinical, connected with the practise of the profession.

5.79 The Department of Health, Social Services and Public Safety for Northern Ireland argued that non-practising registers should be abolished since “a non-practising register seems self contradictory”.

5.80 However, a number of consultees supported the retention of non-practising registers. The Academy of Medical Royal Colleges suggested that such registers “serve an important purpose for doctors in particular who may need to re-enter practice later”. The Royal College of General Practitioners suggested that non-practising registers provide a public benefit by allowing doctors return to practice “without additional impediment”.

5.81 The Society of Chiropractors and Podiatrists argued that:

Registrants spend many years building up their status as professionals and define themselves according to their chosen profession. It seems callous and unnecessary to take away this status and pride, providing that regulators demarcate clearly between practising and non-practising.

5.82 Optometry Scotland supported the retention of non-practising registers “as this ensures all professionals are bound by the codes of conduct and less likely to bring the profession into disrepute”.

5.83 The Institute of Health Visiting Professionals pointed out that:

The list held by the Nursing and Midwifery Council of formerly qualified health visitors who are no longer practicing was recently used by Department of Health as part of the recruitment exercise – to invite such individuals to consider applying for return to practice

programmes and revalidate their qualification. So, this is potentially useful – and should be retained.

5.84 The Medical Defence Union rejected the argument that non-practising registers undermine public safety because, in the case of doctors, such registrants do not hold themselves out as licensed practitioners.

5.85 The Association of Regulatory and Disciplinary Lawyers considered that a non-practising register:

bestows an acceptable status on former practitioners, but more importantly provides a clear delineation in the public's mind between non-practising practitioners and those whose name has been erased or removed from the register following fitness to practise proceedings.

5.86 The General Osteopathic Council – which maintains a category of non-practising status on its register – wished to maintain this system, along with “the ability to make rules to test competence before restoration to the ‘practising register’”. It also felt that the definition of non-practising was unclear.

**Provisional Proposal 5-9: The regulators will be required to register applicants on a full, conditional or temporary basis. In addition, the regulators will be given powers to introduce provisional registration if they wish to do so.**

5.87 An overwhelming majority agreed that the regulators should be required to register applicants on a full, conditional or temporary basis.<sup>11</sup> For example, the Professional Standards Authority felt that this proposal would ensure greater consistency across the regulators in relation to the types of registration that are available to all the regulators. An individual consultee (Jane C Hern) felt that “full, conditional and temporary classifications are similarly helpful to accommodate a variety of circumstances, including emergency needs”.

5.88 The Nursing and Midwifery Council agreed that regulators should be able to establish different types of registration, but only if to do satisfied “a public protection and proportionality test”.

5.89 However, some consultees raised concerns about conditional registration. The General Medical Council pointed out that its general system of conditional registration (in non fitness to practise cases) – which imposed certain conditions on the practice of international medical graduates – was abolished in 2007. The Council considered that any move towards restoring it would be a “retrograde step”. It argued that when registration is granted “it is in the public interest that the new registrant should be fit to practise, not partially fit to practise”. The Council also felt there may be major implications for education and training leading to registration, since some applicants will not need to have completed the full programme of education and training normally required.

<sup>11</sup> Of the 192 submissions which were received, 36 submissions expressed a view on this proposal: 33 agreed, whilst 3 disagreed.

- 5.90 The Association of Regulatory and Disciplinary Lawyers was also concerned about conditional registration outside of fitness to practise cases. It pointed out that both the General Chiropractic Council and the General Osteopathic Council retain powers to grant conditional registration. These were only used when the registers were initially set up to allow experienced practitioners who did not hold a recognised qualification to be "grandfathered" onto the new statutory registers. This power has since remained dormant.
- 5.91 The General Osteopathic Council did not support conditional registration. It felt that "it is important for transparency and public protection that all registrants are fit to practise at the point of registration". The Council also argued that "conditions of practice should be a matter to be determined by a Fitness to Practise Panel rather than as a function of the registration process". However, the General Optical Council considered that there are circumstances in which it would be "valuable" to impose conditions at the point of registration, although it did not envisage this power being used regularly.
- 5.92 A small number of consultees opposed this proposal. For example, UNISON disagreed with different registration levels and argued that it must be "clear and unambiguous" that registrants are "registered and fit to practise or they are not".

#### ***Provisional registration***

- 5.93 A majority agreed that the regulators should be given powers to introduce provisional registration if they wish to do so.<sup>12</sup>
- 5.94 The Health and Care Professions Council agreed with the proposal but stated it would be unlikely to use any such powers due to the financial and other costs. The British Association for Counselling and Psychotherapy felt that provisional registration should be "the exception where newly qualified professionals require further experience to become full registrants" rather than being used to "provisionally register those who do not meet standards".
- 5.95 The Department of Health's view on the use of provisional registration was:

We consider that for some professions it makes sense for provisional registration to apply where a professional has completed an undergraduate degree, but is then required to complete a year of practical training under the supervision of a university before being registered. We would distinguish the situation, where a person has the necessary knowledge and theory to practise their profession, but needs to gain experience of applying that theory before they can be deemed "fit to practise" without supervision, from student registration where a person has not yet acquired the knowledge and skills to practise their profession.

- 5.96 The Association of Regulatory and Disciplinary Lawyers argued that provisional registration was "confusing to the public" and that, generally, "registration should indicate that the registrant is fully fit to practise without restriction" (except in fitness to practise cases). The Society and College of Radiographers believed

<sup>12</sup> Of the 192 submissions which were received, 39 expressed a view on this proposal: 27 agreed, 10 disagreed, whilst 2 held equivocal positions.

that provisional registration would be “ambiguous and unhelpful” from the perspective of the public and registrants.

5.97 Several consultees linked provisional registration with student registration. For example, the General Optical Council saw provisional registration as a possible alternative to a full, compulsory student registration scheme.

5.98 The Department of Health, Social Services and Public Safety for Northern Ireland disagreed “with the principle of provisional regulation [for nurses] beyond what is identified for doctors”.

**Provisional Proposal 5-10: The statute will provide that if the Secretary of State advises that an emergency has occurred, a regulator can make certain temporary changes to the register.**

5.99 An overwhelming majority agreed that the statute should provide that if the Secretary of State advises that an emergency has occurred, a regulator can make certain temporary changes to the register.<sup>13</sup>

5.100 The Medical Defence Union felt that the potential benefits of this proposal were demonstrated by “the arrangements that were made by the General Medical Council in anticipation of the flu pandemic”. The Association of Clinical Biochemistry suggested that there should be a requirement that any such changes to the register should be regularly reviewed. Other consultees, such as the General Dental Council, pointed to the need to consider devolution issues especially since emergencies, such as a pandemic, may be limited to one of the devolved countries.

5.101 The National Clinical Assessment Service was amongst several consultees who sought greater clarity about the definition and timescales for registration. The Nursing and Midwifery Council suggested that the statute should define the changes that can be made and the meaning of emergency. The Council suggested the latter should be “an event or situation which threatens serious damage to human welfare in the UK”, as provided for in its governing legislation. The Professional Forum of the Pharmaceutical Society of Northern Ireland suggested that “temporary” should be defined as being “six months but renewable thereafter”.

5.102 The Department of Health pointed out that the emergency powers were introduced to cover emergencies “such as pandemics and were designed to ensure supply of drugs, medicines and appliances”. It therefore argued that emergency registration does not need to apply to all professions, “for example, psychologists, chiropodists [and] podiatrists”. Therefore, the Secretary of State should be able to “state the regulatory bodies to which the emergency powers would apply” and “restrict the application of emergency powers by a regulator to only some of the professions they oversee”.

5.103 The Scottish Government argued that:

<sup>13</sup> Of the 192 submissions which were received, 39 expressed a view on this proposal: 38 agreed, whilst 1 held an equivocal position.

The Secretary of State should also specify the regulatory bodies and professional/healthcare groups to which the emergency powers would apply, the intended duration of these powers, and the particular circumstances in which they apply.

- 5.104 It also stated that such powers “pertained to some professional groups more than others” and that “powers could apply in a wider range of situations than pandemics and that the statute needs to provide for these”.

**Provisional Proposal 5-11: The statute should specify that in order to be registered on a full or temporary basis the applicant must be appropriately qualified, be fit to practise, have adequate insurance or indemnity arrangements (except for social workers), and have paid a prescribed fee. The regulators should have broad rule-making powers to specify the precise detail under each of these requirements.**

- 5.105 An overwhelming majority agreed that in order to be registered on a full or temporary basis an applicant must be appropriately qualified, be fit to practise, have adequate indemnity/insurance and have paid a prescribed fee (and that the regulators should have broad powers to make rules under each of these headings).<sup>14</sup>
- 5.106 The Department of Health supported the proposed criteria for full and temporary registration. It felt that “the regulators should also be specifically required to ensure that any such rules are compliant with EU Directive 2005/36/EC in this area”.
- 5.107 Many also argued that the detail of the rules should be consistent across the regulators. The Association of Regulatory and Disciplinary Lawyers suggested that such consistency was particularly important in relation to any health and character requirements, and requiring appropriate insurance or indemnity arrangements. The Scottish Government argued that the statute should seek to ensure “the requisite degree of transparency and accountability ... and that a consistent approach is taken across all the regulators”. However, the Professional Standards Authority felt that the detail is “likely to need to vary legitimately across the professions”.
- 5.108 The General Medical Council agreed with the proposal on the understanding that “appropriately qualified” and “fit to practise” encompass:

the possession of any necessary formal qualifications and appropriate knowledge, skills (including language proficiency) and experience, as well as the absence of any matters which might lead to a referral into our fitness to practise procedures. Care will also be needed in the drafting of the legislation to clarify that applicants must demonstrate fitness to practise at the point of registration as distinct from the absence of a finding that their fitness to practise is impaired.

- 5.109 The Professional Standards Authority welcomed the inclusion of a generic fitness to practise requirement that encompasses both health and character. It said that:

<sup>14</sup> Of the 192 submissions which were received, 46 expressed a view on this proposal: 45 agreed, whilst 1 held an equivocal position.

The regulators' current requirements in relation to health in particular are relatively blunt and can lead to discrimination. The principles of right-touch regulation suggest that at the point of registration and renewal, a self-declaration approach to health or character issues that could impair fitness to practise (followed by enquiries where there appears to be a risk) is a targeted and proportionate regulatory measure; and that employers are better equipped than the regulator to make decisions relating to health or character *in situ*.<sup>15</sup>

- 5.110 The Nursing and Midwifery Council and Royal College of Midwives suggested that being “fit to practise” should be defined to include “the concept of the applicant being of good standing, as well as having the capability to be a safe and effective practitioner”.

### ***Indemnity and insurance***

- 5.111 A number of consultees commented expressly on the proposed criterion relating to indemnity and insurance. A majority agreed with the criterion.<sup>16</sup> For example, Pharmacy Voice felt that “patients should have the reassurance of knowing that, in the event of something going wrong, professionals are appropriately insured”.

- 5.112 However, the British Association of Dental Nurses argued that “adequate” should be clearly defined. It said that “registrants should be required to have their own indemnity cover – preferably insurance as that is regulated in contrast to other forms of indemnity cover”.

- 5.113 The Nursing and Midwifery Council felt that the regulators are limited in their ability to determine the adequacy of insurance arrangements. It suggested – in line with the recommendations of the *Scott report* – that the applicant must have “insurance or indemnity in respect of liabilities which may be incurred in carrying out work as a registered health care professional” rather than “must have adequate insurance”.<sup>17</sup>

- 5.114 The Medical Protection Society suggested the following definition of indemnity arrangements:

- (1) a policy of insurance;
- (2) an arrangement made for the purposes of indemnifying a person; or
- (3) a combination of a policy of insurance and an arrangement made for the purposes of indemnifying a person.<sup>18</sup>

- 5.115 Some consultees also suggested that our proposal could go further. For example, Action Against Medical Accidents argued that:

<sup>15</sup> Emphasis in the original.

<sup>16</sup> Of the 192 submissions which were received, 17 specifically addressed the criterion: 12 agreed with the criterion, whilst 5 disagreed.

<sup>17</sup> F Scott, *Independent Review of the Requirement to have Insurance or Indemnity as a Condition of Registration as a Healthcare Professional* (2010).

<sup>18</sup> Reflecting section 44C of the Medical Act 1983 (Amendment) and Miscellaneous Amendments Order 2006.

If a registered health professional causes harm to a patient and is found not to have sufficient indemnity, the regulator should be required to compensate the patient. It is unacceptable that a patient injured by a registered health professional should not be able to receive redress. Regulators should take responsibility for ensuring this does not happen.

- 5.116 Bridge the Gap suggested that the statute should impose additional duties in respect of insurance and indemnity arrangements, as it identified several problems with the regulators being responsible for setting and monitoring such arrangements. It said:

We submit, therefore, that the duty to inform a patient of insurance or indemnity cover, like the duty to inform of treatment options and safety, is that of the individual healthcare professional, and not that of the regulators, and this should be enshrined in statute as an individual healthcare provider's duty.

- 5.117 It also suggested:

The Commissions should propose a requirement within the proposed legal framework that all healthcare professional liability insurers and indemnity providers have an overriding duty to cooperate with patients and patient representatives in enabling remedies to harm sustained.

- 5.118 The Nursing and Midwifery Council and the Medical Protection Society expressed support for the final recommendations of the *Scott report*. These were that the regulators should have powers to:

- (1) require information in relation to cover;
- (2) require registrants to inform the regulator if cover ceases;
- (3) refuse registration if sufficient information about cover is not provided; and
- (4) refer cases concerning inadequate or inappropriate cover to a Fitness to Practise Panel.<sup>19</sup>

- 5.119 The Medical Protection Society further proposed that the following reforms should be introduced in relation to personal cover required for self-employed practitioners:

- (1) a duty on registrants to provide full disclosure of relevant facts to their insurer or indemnifier;
- (2) registrants can rely on the defence that they have acted in accordance with the proposals of their insurer or indemnifier;

<sup>19</sup> F Scott, *Independent Review of the Requirement to have Insurance or Indemnity as a Condition of Registration as a Healthcare Professional* (2010) p 4.

- (3) if registrants wish to change the scope of their practice, they should first have, or acquire, adequate and appropriate insurance or indemnity; and
  - (4) regulators should consider their requirements for run-off cover and how to deal with past periods when the statutory condition of registration had been breached.<sup>20</sup>
- 5.120 Several groups – including the UK-wide Nursing and Midwifery Council Lead Midwives for Education Group and the Association for Improvements in the Maternity Services – pointed to difficulties that the indemnity requirement could create for independent midwives who are not covered by existing professional indemnity schemes. Similarly, the Professional Standards Authority argued that the Government must “support the development of schemes to enable independent midwives to meet this requirement, if it were introduced”. An individual consultee (Andrew Cottington) cautioned against a situation whereby the cost of insurance and other registration fees could mean that individuals were forced to stop practising.
- 5.121 West Sussex County Council felt that social workers should also be required to provide details of insurance or indemnity arrangements given the specialist roles that some undertake, and for which evidence of insurance and indemnity arrangements is a pre-requisite for practice.

**Provisional Proposal 5-12: The regulators should be given powers to establish separate criteria for the renewal of registration and for registrants proceeding from provisional to full registration.**

- 5.122 An overwhelming majority supported the proposal that the regulators should be given powers to establish separate criteria for the renewal of registration and for registrants proceeding from provisional to full registration.<sup>21</sup>
- 5.123 The British Pharmaceutical Students’ Association thought that “formal public consultation” would be necessary in the regulators’ exercise of the power to establish separate criteria.
- 5.124 The Professional Standards Authority argued that the statute must enable the regulators “to develop their renewal procedures to provide greater assurances than at present about a registrant’s continuing fitness to practise”. The Local Supervising Authority Midwifery Officers Forum UK also agreed with this proposal “assuming ‘provisional to full’ means moving from student to registrant”.

**Question 5-13: Should the statute provide that in order to be registered an applicant must demonstrate that they are a “fit and proper person” to exercise the responsibilities of their profession?**

- 5.125 A slim majority agreed that the statute should provide that in order to be registered an applicant must demonstrate that they are a “fit and proper person”

<sup>20</sup> F Scott, *Independent Review of the Requirement to have Insurance or Indemnity as a Condition of Registration as a Healthcare Professional* (2010).

<sup>21</sup> Of the 192 submissions which were received, 41 expressed a view: 40 agreed, whilst 1 disagreed.



to exercise the responsibilities of their profession.<sup>22</sup> For example, the British Psychological Society supported the proposal, which it considered “a positive criterion that puts the onus on the individual to demonstrate the qualities required”.

5.126 The Nursing and Midwifery Council said that it would welcome the ability for regulators “to set their own requirements below that of ‘fit and proper person’ and define what constitutes a fit and proper person, in the context of their own professions”. The Royal College of Midwives argued that “the public has the right to assurances that those in whom they place their trust are ‘fit and proper’”. The Northern Ireland Practice and Education Council for Nursing and Midwifery also supported this criterion, arguing that “fitness to practice alone does not automatically imply good character, something which is at the heart of the caring profession and should apply to all regulators”.

5.127 The Scottish Government argued that a general requirement to be a “fit and proper person” and to demonstrate good character should be contained in the statute “as these directly relate to a professional’s fitness to practise”. However, it opposed any suggestion that the regulators should establish in rules any additional criteria to determine whether professionals are “fit and proper” as this could have the effect of “creating double standards and suggests that the public require a greater degree of ‘protection’ from some groups rather than others”.

5.128 Some consultees, for example the Local Supervising Authority Midwifery Officers Forum UK and the Medical Protection Society, were of the view that the proposal would only be effective if the concept of “fit and proper person” was clearly defined.

5.129 However, some were concerned that the term “fit and proper” was too subjective and would lead to inconsistency. For example, the Medical Defence Union stated:

While it is reasonable to expect a regulator to assess measurable and relevant competencies which can be easily defined, we do not think it reasonable to expect a regulator to determine if a person is “fit and proper”. Further, with no clear objective measures, it would be more difficult to achieve consistency in decision-making which may make assessments more vulnerable to challenge.

5.130 The Association of Clinical Biochemistry anticipated “considerable difficulties in applying an appropriate legal test to establish whether an individual is a ‘fit and proper person’”. The South Staffordshire and Shropshire Healthcare NHS Foundation Trust (Social Care) agreed that the concept appeared “somewhat meaningless and open to numerous interpretations”.

5.131 The General Social Care Council and UNISON argued that the term might be interpreted by some regulators as excluding anyone with a conviction from the profession, or in a way that is incompatible with the Equality Act 2010.

<sup>22</sup> Of the 192 submissions which were received, 56 expressed a view on this question: 31 said that the statute should so provide, 18 disagreed, whilst 7 held equivocal positions.

- 5.132 Several consultees argued that this criterion is unnecessary given that applicants would be required to be fit to practise. For example, the Professional Standards Authority felt that the regulators should only have the “freedom to require that registrants be of good character to the extent that it relates to their fitness to practise”. Similarly, the General Medical Council felt that “the terminology also seems to refer back to the anachronistic concept ‘good character’ which we have discarded in favour of ‘fitness to practise’”.
- 5.133 The Department of Health argued that the statute should require that, in order to be registered, a person must be fit to practise their profession and that “regulators should be free to determine whether the applicant should demonstrate that they are a fit and proper person”.
- 5.134 A number of consultees, such as the General Dental Council, pointed out that “fit and proper” is widely used in the context of company law and regulation and, therefore, might be a suitable requirement in the context of entity regulation.

**Question 5-14: Should the legislation state that applicants are entitled to be registered provided that they satisfy the relevant criteria or that the regulator must register the applicant provided that they satisfy the relevant criteria? Does either formulation make any difference in practice?**

- 5.135 Opinion was divided over whether the legislation should state that applicants are “entitled” to be registered or that the regulator “must register” the applicant provided that they satisfy the relevant criteria.<sup>23</sup>
- 5.136 The General Dental Council felt “that the current formulation ‘entitled’ works satisfactorily, and there is no compelling case to change it”. In contrast, the Professional Standards Authority felt the second formulation “embodies the spirit of modern professional regulation”. The Institute of Health Visiting agreed that the requirement to register was “more consistent with the paramount duty to protect the public”.
- 5.137 The General Osteopathic Council argued that this issue went beyond symbolism. It said that the important point is that the regulator must be “satisfied that the applicant meets the criteria at the point of first registration”. The regulator must have “the ability to explore and test the applicant’s fitness to practise at the point of registration and may refuse an application” (whereas in contrast renewal can be on an administrative basis).
- 5.138 Pharmacy Voice also supported the first formulation, on the basis that it was necessary to ensure that the regulator has “the option of refusing to register an applicant if, for example, an applicant has a character failing which would make them unsuitable to work as a pharmacist”.
- 5.139 The Scottish Government also suggested that the word “entitled” should be dropped given that registration “is dependent on a number of relevant criteria being satisfied”, particularly good character, “rather than an entitlement (for

<sup>23</sup> Of the 192 submissions which were received, 40 expressed a view on this question: 11 preferred the first formulation, 15 preferred the second formulation, whilst 14 said that there was no difference in practice between the two formulations.

example, following the acquisition of a professional qualification)". It also pointed out that EU Directive 2005/36/EC is relevant in terms of automatic recognition of qualifications and it is important that any change to the wording is compliant with this Directive.

- 5.140 The Department of Health was amongst several consultees who considered that there was no practical difference between the formulations. The General Social Care Council could not discern a "significant amount of difference".

**Provisional Proposal 5-15: The statute should require the regulators to communicate expeditiously with registrants and potential registrants. The regulators would be given broad rule-making powers concerning the processing of registration applications.**

- 5.141 The vast majority agreed that the statute should require the regulators to communicate expeditiously.<sup>24</sup> All consultees who responded agreed that the regulators should be given broad rule-making powers concerning the processing of registration applications.<sup>25</sup>

- 5.142 The Department of Health agreed with both proposals. It also suggested that EU (European) law may "prescribe specific timeframes for processing certain types of applications and therefore the regulators should be under a general duty to observe these requirements".

- 5.143 The Professional Standards Authority argued that:

The statute should allow regulators to extend their deadlines when processing an application if there is evidence of a risk to public protection. We would guard against any provisions for automatic registration or renewal where regulators fail to meet a deadline for application processing.

- 5.144 However, the General Chiropractic Council and the General Dental Council expressed concern about endless possibilities of legal action over the meaning of the word "expeditious". To address this, the General Dental Council suggested that the Professional Standards Authority could issue guidance and monitor compliance as part of its annual performance review.

- 5.145 A small number of consultees suggested that the statute should specify timescales for communications. The Scottish Government supported these proposals. It did recommend that the statute should set down "minimum procedural requirements in terms of the *broad* timescales in which regulators are required to respond" which take into account "modern methods of communication such as email and DX".<sup>26</sup>

<sup>24</sup> Of the 192 submissions which were received, 41 expressed a view on this proposal: 38 agreed, 2 disagreed, whilst 1 held an equivocal position.

<sup>25</sup> Of the 192 submissions which were received, 26 submissions expressed a view on this proposal: 26 agreed.

<sup>26</sup> Emphasis in the original.

**Provisional Proposal 5-16: The statute should require each regulator to establish an appeals process for when registration applications are refused. The regulators would have broad powers to decide the precise process it wants to introduce.**

- 5.146 An overwhelming majority agreed that the statute should require each regulator to establish a registration appeals process.<sup>27</sup> For example, the Professional Standards Authority pointed out that its *Standards of Good Regulation* stipulate that the “management of appeals, is fair, based on the regulators’ standards, efficient, transparent, secure, and continuously improving”.<sup>28</sup> In line with this, it argued:

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.

- 5.147 However, some argued that the systems established by the regulators should be as consistent as possible. For example, the Association of Regulatory and Disciplinary Lawyers felt that “a registration appeals committee is a sensible and helpful way of dealing with appeals against refusal of registration and also provides transparency”. NHS Education for Scotland agreed that a “consistent approach” was required.
- 5.148 An individual consultation response (Dr Waghorn and Dr Jooste) also suggested that the right of appeal should extend to cases where the regulator decides to register the applicant in a type of registration other than that applied for, or subject to a condition. The General Medical Council felt that the right to appeal should be circumscribed and should not exist “where the reason for refusal of the application is because the applicant did not possess an acceptable qualification”.
- 5.149 Others argued that the statute should require the regulators to give reasons for the decision, supply the applicant with any documentation that had been used in order to reach the decision (such as medical reports), and provide details of how to lodge an appeal.
- 5.150 The General Osteopathic Council suggested that, in the same way that Council members are prohibited from fitness to practise panels, “so too is it inappropriate for them to hear registration appeals and that these processes also require a degree of independence”. The Professional Standards Authority argued that the statute may need to stipulate that “appeals decisions should not be made by committees on which members of the regulator’s Council may sit, nor by a registrant Registrar”.
- 5.151 The Administrative Appeals Chamber of the Upper Tribunal argued there should be a right of appeal to the First-tier Tribunal “which would make it unnecessary to set up internal appeal panels for registration cases”.

<sup>27</sup> Of the 192 submissions which were received, 41 expressed a view on this proposal: 40 agreed, whilst 1 held an equivocal position.

<sup>28</sup> Council for Healthcare and Regulatory Excellence, *The Performance Review Standards – Standards of good regulation* (2010), para 5.1, .

**Provisional Proposal 5-17: The statute should provide a right of appeal when registration applications are refused, to the High Court in England and Wales, the Court of Session in Scotland, and the High Court in Northern Ireland.**

5.152 A significant majority agreed that the statute should provide a right to appeal to the higher courts.<sup>29</sup> For example, the College of Social Work argued that “there must be an appeal process independent of the regulator so that an aggrieved applicant can be confident that appeal decisions are impartial and fair”.

5.153 The Scottish Government supported the proposals and agreed that the appropriate court in Scotland would be the Court of Session. However, it also considered that:

There is a strong need for transparency and accountability in the process adopted to ensure fairness and consistency and to maintain confidence in the professions. We suggest that this is an area where the Professional Standards Authority could have a useful role to play in monitoring and scrutinising performance.

5.154 However, some expressed concern that this would be much more expensive than the current system (for some regulators) which allows for a right to appeal to the county court.

5.155 The Scottish Court Service also felt that the sheriff court would be the most appropriate level for a right of appeal, rather than the Court of Session:

The sheriff courts have a wide ranging experience of appeals from Statutory Bodies and, as stated in the report, currently have jurisdiction for appeals under some of the existing legislation. In reaching this view, we have considered Lord Gill’s Scottish Civil Courts Review, which recommends the effective and efficient use of the civil court’s own resources, allocating them to cases in proportion to the importance and value of the issues at stake

**Provisional Proposal 5-18: The regulators should have broad powers to establish rules concerning the upkeep and publication of the register.**

5.156 All those who expressed a view agreed that the regulators should have broad powers to establish rules concerning the upkeep and publication of the register.<sup>30</sup>

5.157 The Nursing and Midwifery Council felt it was particularly important that each regulator should be given powers “to publish its register in such a manner as it considers appropriate”. It said that “with [its] register having in excess of 650,000 registrants, electronic publication is the only viable option”.

5.158 The Professional Standards Authority also argued that the public protection function of a register is such that “a duty (rather than a power) to *publish* it should

<sup>29</sup> Of the 192 submissions which were received, 40 expressed a view on this proposal: 34 agreed, 3 disagreed, whilst 3 held equivocal positions.

<sup>30</sup> Of the 192 submissions which were received, 41 expressed a view on this proposal: 41 agreed.

be included in the statute, along with a duty to keep it up-to-date”.<sup>31</sup> The Association of Clinical Biochemistry agreed that “it should be clear that this is a duty of the regulators”.

- 5.159 UNISON argued in support of consistency between the regulators “to ensure a level playing field”. The Scottish Government felt that “there should be consistency in the content of the registers across the various regulators” and that they “should also be made available for inspection by members of the public at all reasonable times”.

**Provisional Proposal 5-19: The statute should require each regulator to establish a process for dealing with fraudulently procured or incorrectly made entries. The regulators would have broad powers to decide the precise process it wishes to introduce.**

- 5.160 All those who expressed a view on the issue agreed that the regulators should be required to establish a process for dealing with fraudulently procured or incorrectly made entries, and be given broad discretion to decide which process to introduce.<sup>32</sup>

- 5.161 The Professional Standards Authority felt that the statute should permit the amendment of incorrect entries to the register without referral to a committee, where the mistake was the result of an administrative error. The General Medical Council felt it might be desirable “to be absolutely clear that [fraudulently procured] covers failure to disclose pertinent information”. Many argued that the processes established by the regulators should be as consistent as possible.

- 5.162 The Administrative Appeals Chamber of the Upper Tribunal argued that regulators should be required to have processes for dealing with incorrectly made entries (based on the grounds of ignorance of, or a mistake as to, a material fact or legal or administrative error). However, it felt that this should not apply to fraudulently procured entries because such entries:

will necessarily have been based on ignorance of, or a mistake as to, a material fact and the question whether there was fraud will, if it is necessary to go into it at all, be relevant to the question whether the would-be registrant is fit to practise and therefore as to what decision should be made on the review.

- 5.163 The Patients Association felt that, in the case of fraud or mistake:

The result of an investigation into how this had occurred should also be made available to the public including any changes that may be introduced to internal procedures to prevent it from happening again.

- 5.164 The Nursing and Midwifery Council welcomed this opportunity to deal with these issues “as part of [its] registration function rather than within [its] fitness to practise procedures”.

<sup>31</sup> Emphasis in the original.

<sup>32</sup> Of the 192 submissions which were received, 39 submissions expressed a view on this proposal: all agreed.

- 5.165 The Scottish Government argued that there should be a consistent approach to dealing with fraudulently procured entries “such as requiring all decisions to remove entries to be made by fitness to practise panels or the Registrar”. It said that:

Whilst we recognise that this could have resource implications, particularly for some of the smaller regulators, we consider that this would be in the public interest, would promote transparency and is in line with the overall aim of the review ie to simplify and make the legal framework more consistent (and maintain confidence in the professions).

**Provisional Proposal 5-20: The statute should provide a right to appeal against registration decisions relating to fraudulently procured or incorrectly made entries, to the High Court in England and Wales, the Court of Session in Scotland, and the High Court in Northern Ireland.**

- 5.166 The vast majority agreed that there should be a right to appeal to the higher courts.<sup>33</sup> For example, the Nursing and Midwifery Council thought that it would be “beneficial for all appeals to go to the same level of Court jurisdiction”.
- 5.167 However, some expressed concern about the costs of appeals to these courts. For example, the Administrative Appeals Chamber of the Upper Tribunal felt that this route was “disproportionate in terms of both cost and complication” and suggested an appeal to the First-tier Tribunal in the first instance. The Scottish Law Service also felt that the sheriff court would be the most appropriate level for a right of appeal, rather than the Court of Session.

**Provisional Proposal 5-21: The statute should provide that applications for restoration in cases where a registrant’s entry has been erased following fitness to practise proceedings must be referred to a Fitness to Practise Panel or similar committee.**

- 5.168 An overwhelming majority agreed that applications for restoration from people who have been erased must be referred to a Fitness to Practise Panel.<sup>34</sup>
- 5.169 The Association of Regulatory and Disciplinary Lawyers suggested that “most if not all the regulators now follow this approach” and argued that:

A robust process for consideration of applications for restoration is a critical element of the overall public protection ensured by the regulatory process and is one which has sometimes been a weak area in the past.

- 5.170 The Patients Association sought clarity on whether this process will apply “where a professional voluntarily erased themselves from the register, for example the doctor at the centre of the Baby P scandal”. The Professional Forum of the

<sup>33</sup> Of the 192 submissions which were received, 39 submissions expressed a view on this proposal: 37 agreed, whilst 2 held equivocal positions.

<sup>34</sup> Of the 192 submissions which were received, 44 expressed a view on this proposal: 42 agreed, whilst 2 disagreed.

Pharmaceutical Society of Northern Ireland argued that if a registrant has been erased for failure to “complete or comply with continuing professional development requirements, then restoration must be via a continuing professional development committee”. The National Clinical Assessment Service also thought there should be a practical element, and suggested “a performance assessment process”.

5.171 Bupa Care Services argued for a requirement that the panel reviewing the application “must be one which has experience of the specific sector involved”.

5.172 However, the General Dental Council disagreed with the proposal. It argued that “the regulators should be able to make their own decisions regarding the process for agreeing restoration” and did not accept “that it is necessary to provide for a particular process in the statute”.

5.173 The Administrative Appeals Chamber of the Upper Tribunal argued that:

An application for restoration to a register should be treated procedurally in the same way as an initial application for registration, albeit possibly by a different committee, and that this should be the same even if it follows erasure ... There should be a right of appeal to the First-tier Tribunal against a refusal to restore to the register.

**Provisional Proposal 5-22: The statute should provide a right to appeal against restoration decisions by a Fitness to Practise Panel to the High Court in England and Wales, the Court of Session in Scotland, and the High Court in Northern Ireland.**

5.174 An overwhelming majority of consultees supported this proposal.<sup>35</sup> For example, the General Pharmaceutical Council agreed with “the proposal to move away from appeals to be made to the county courts or sheriff in Scotland”.

5.175 The British Society of Hearing Aid Audiologists supported a right of appeal, but said that “it should not be to such a high authority ... because most registrants could not afford the costs”.

**Question 5-23: Should the statute set a consistent time period before which applications for restoration cannot be made (in cases where a registrant’s entry has been erased following fitness to practise proceedings), or should this matter be left to the regulators to determine?**

5.176 A majority of respondents agreed that the statute should set a consistent time limit before which applications for restoration cannot be made.<sup>36</sup> For example, the Health and Care Professions Council felt that consistency was “crucially important for public protection and for public faith and confidence in the

<sup>35</sup> Of the 192 submissions which were received, 39 expressed a view on this proposal: 38 agreed, whilst 1 held an equivocal position.

<sup>36</sup> Of the 192 submissions which were received, 48 expressed a view on this question: 29 said that the statute set a consistent time period, 18 felt this matter should be left to the regulators to determine, whilst 1 held an equivocal position.



regulatory process". Similarly, the Society of Chiropractors and Podiatrists agreed that a set time period would benefit the public, as well as registrants.

5.177 The Association of Regulatory and Disciplinary Lawyers argued that there was no "logical justification for a different period to apply to different professions". The General Medical Council reported difficulties before it had introduced a five year time limit with people seeking restoration in inappropriate circumstances.

5.178 The Health and Care Professions Council and Nursing and Midwifery Council argued that restoration applications should not be made until a period of five years has lapsed since removal from the register, and that there must be a gap of 12 months between applications. The General Dental Council felt the period should be at least three years and preferably five years. The General Osteopathic Council considered that its current ten months limit is inadequate, although had no fixed view on the appropriate period.

5.179 The Department of Health considered that the statute should set a minimum length of time before an application for restoration can be made. The Department said that:

We are unclear why a situation where there is significant variation between different bodies would be desirable, or necessary. This would also set a clear differential between erasure from the register and suspension.

5.180 The Department also suggested that the regulators should have the ability to stop someone from repeatedly making applications for restoration within a short space of time. The Scottish Government also argued that the regulators should be given powers to limit the number of times an application for restoration can be made, or at least time-limit such applications.

5.181 The Institute of Medical Illustrators recognised the need for increased consistency, but cautioned that a "one size fits all approach' cannot work here".

5.182 However, the Medical Defence Union argued that the regulators should be able to determine the time limit "as this will be dependent on the type of health care professional and the risk that he or she is considered to pose to the public". The British Medical Association also argued this "should be left to individual regulators to determine, who may in fact wish to vary this from case to case". The General Chiropractic Council warned that:

There is a danger of setting time limits without providing for exceptional cases. There are some cases where applications for restoration could reasonably be made falling outside the time period.

5.183 The Royal Pharmaceutical Society of Great Britain argued that:

When a regulator erases someone from a Register they are in possession of the facts as to why that erasure is a proper and just sanction. They should then decide the timeframe required to resolve the issue, or provide a timeframe that would impose a sufficient sanction on the individual. This cannot be determined by overarching legislation.

- 5.184 An individual consultee (Lucy Reid) went further and suggested that “the statute should actually include circumstances in which it is entirely inappropriate for applications for restoration”. She queried whether regulators should have to “reconsider the case at great expense and time to all involved” where a registrant had been erased for a serious, dishonest act.

**Provisional Proposal 5-24: The statute should require each regulator to establish in rules a process for considering applications for restoration in cases which are not related to fitness to practise proceedings. The regulators would be given broad discretion to determine the precise process it wishes to adopt.**

- 5.185 All those who expressed a view on the issue agreed that for restoration cases not related to fitness to practise, regulators should be able to develop their own processes.<sup>37</sup> For example, the Association of Regulatory and Disciplinary Lawyers did not consider that the argument in favour of consistency “is of the same significance in relation to this type of restoration application” and accepted “that there may be different factors affecting the different professions”.
- 5.186 The Royal College of Surgeons of Edinburgh and the General Optical Council supported the proposal on the basis that it allows the regulators flexibility when delivering their functions.
- 5.187 The Health and Care Professions Council pointed out that it uses the term “readmission” to differentiate registrants having previously lapsed or voluntarily removed themselves from the register, from those struck-off through fitness to practise proceedings. The Nursing and Midwifery Council suggested that the terminology regarding such cases should be standardised in the statute.
- 5.188 The Professional Standards Authority recommended that the regulators should have a means of identifying those restoration applicants who “came off the register because of a fitness to practise concern, or while concerns about their fitness to practise were being investigated but had not concluded”.
- 5.189 However, as set out above, the Administrative Appeals Chamber of the Upper Tribunal suggested that all restoration applications should be treated procedurally in the same way as an initial registration application and there should be a right of appeal to the First-tier Tribunal.

**Provisional Proposal 5-25: The regulators should have broad powers to make rules concerning the content of the registers. The only exception to this approach would be that set out in provisional proposal 5-27.**

- 5.190 A significant majority agreed that the regulators should have broad powers to make rules concerning the content of the registers.<sup>38</sup> For example, the British Pharmaceutical Students’ Association was in favour of the General Pharmaceutical Council retaining discretion over the content of its register.

<sup>37</sup> Of the 192 submissions which were received, 35 expressed a view on this proposal: all agreed.

<sup>38</sup> Of the 192 submissions which were received, 37 expressed a view on this proposal: 32 agreed, whilst 5 disagreed.

- 5.191 The Scottish Government supported giving the regulators broad powers regarding the content of the registers but suggested there is already a “significant degree of commonality” in the information that is recorded and differences normally arise in relation to post-registration qualifications.
- 5.192 Those who disagreed with the proposal argued in favour of greater consistency. For example, the Nursing and Midwifery Council stated that:
- We believe there is merit in “the register” having a common meaning across the health care regulators. A common approach to what is in the public domain would help to clarify and manage public expectations. Beyond this basic dataset, it should be possible to reach agreement about the underpinning data that supports regulatory activity.
- 5.193 This view was supported by the General Osteopathic Council and the Royal College of Midwives, although the latter cautioned against publication of registrants’ home addresses. UNISON argued for consistency since the data collected by the regulators “can be invaluable to workforce planning, therefore its significance should be recognised and data published on a regular basis”.
- 5.194 The Patients Association felt that the register should only include those details pertinent to the practice of the registrant, namely “qualifications, registration status, specialism, name, title, gender and sanctions (both fitness to practise and non fitness to practise)”. The Nightingale Collaboration agreed that the content of the public register should be limited.
- 5.195 Pharmacy Voice argued that the register should include the name and contact details of a company’s superintendent pharmacist, and argued that this information is not easily accessible on the General Pharmaceutical Council’s register unless the superintendent’s name is known.

**Question 5-26: Should the regulators be given broad powers to annotate their registers to indicate additional qualifications or should this power be subject to certain restrictions?**

- 5.196 A majority agreed that the regulators should be given broad powers to annotate their registers to indicate additional qualifications.<sup>39</sup> For example, the British Medical Association argued that:

The changing healthcare environment in the NHS, together with the proliferation of new titles both medical and non-medical has, we believe, made it more difficult for patients to make an informed choice about their treatment and their treatment providers. To this end, we believe that the regulators should be given powers to annotate their registers more fully in order to ensure clarity for patients.

<sup>39</sup> Of the 192 submissions which were received, 45 expressed a view on this question: 28 said that the regulators should have broad powers to annotate, whilst 17 said that this power be subject to certain restrictions.

- 5.197 The Department of Health agreed with annotation provided it “is in keeping with the principle of patient safety and is therefore meaningful to the public and employers”. Similarly, the Scottish Government argued that:

Any annotation should be relevant to patient care, patient safety and risk management, indicate a level of practice substantially beyond the requirements for basic registration, and be meaningful to the public rather than merely a reflection of qualifications.

- 5.198 The College of Social Work said that annotation would “go some way to meeting one of the recommendations of the Social Work Task Force report”.

- 5.199 A significant number argued that there should be some restrictions. The UK-wide Nursing and Midwifery Council Lead Midwives for Education Group felt that the regulators “should only annotate qualifications for which they have set standards”. The General Dental Council noted that it only includes post-graduate qualifications which it has “directly quality assured” and preferred that “there are no powers to recognise additional qualifications beyond those inherent in the membership of specialist lists”.

- 5.200 The Nursing and Midwifery Council suggested that “only those qualifications required for practice should form part of the register”. It pointed out that the law may require the inclusion of additional qualifications. For example, it is required to record nurse prescribing qualifications as a result of the Medicines Act 1968.

- 5.201 Some consultees felt that the deciding factors should be the scope of professional practice and public protection. The Registration Council for Clinical Physiologists argued that annotations should be limited to qualifications and experience which could result “in the practitioner undertaking a different level of function that could impact upon a member of the public’s wellbeing, for instance the prescribing of medication”. The Society of Chiropodists and Podiatrists argued that registers should only be annotated in the public interest, and that:

The public interest criterion would be met if, by virtue of an additional qualification, a registrant is carrying out procedures or therapies that are significantly different from the new graduate standards of proficiency, and not simply extended scope.

- 5.202 Similarly, the Association of Clinical Biochemistry suggested that registers should only be annotated where “additional qualifications materially affect the functions which a registrant can fulfil or the professional level at which a registrant can safely practise”.

- 5.203 The Chartered Society of Physiotherapy argued that:

The purpose of additional annotations on a register should only be used in exceptional circumstances. This should be to identify those areas of professional activity that require a specific type of competence, achieved through post-registration professional development (ie that are clearly outside the remit of pre-registration education), the application of which carries specific patient safety risks such that only registrants who can demonstrate their successful completion of a relevant programme of learning and development can

be enabled to practise it. This might apply to areas of practice in which there is a legislative need to identify certain practitioners who can safely engage in it (eg non-medical prescribing), and where there is a higher risk of patient harm even if performed correctly (eg surgical and/or other invasive techniques).

5.204 The Health and Care Professions Council felt that there needed to be clarity about the purpose and meaning of any annotation. It pointed to its own approach whereby it will only annotate in exceptional circumstances where:

- (1) there is a clear risk to the public if the register is not annotated and the risk could not be mitigated through other systems;
- (2) annotation is a proportionate and cost-effective response to the risks posed;
- (3) the qualification annotated on the register is necessary in order to carry out a particular role or function safely and effectively; and
- (4) where there is a link between the qualification and a particular title or function which is protected by law.

5.205 The Professional Standards Authority also supported a limited power:

This is on condition that the power is used only in situations where a risk has been identified that is best addressed by the regulator, and there is a clear benefit in terms of public protection in publishing information about specialist practice. It must not be used simply as tool for career development or a means for the regulator to charge additional fees.

**Provisional Proposal 5-27: The statute should require all current fitness to practise sanctions to appear in the public register.**

5.206 A significant majority agreed that the statute should require all current sanctions, including interim orders, to appear on the public register.<sup>40</sup> For example, the Parliamentary and Health Service Ombudsman agreed that current sanctions should appear on the register “for the sake of clarity and consistency”.

5.207 The Scottish Government agreed that all sanctions should appear in the public register but in health cases “a bracketed entry” should be made indicating “health reasons”.

5.208 Charles Russell LLP agreed that there was a need for consistency in this area, but thought that further clarification was required as to the meaning of “current”.

5.209 However, a small number disagreed. For example, the Registration Council for Clinical Physiologists argued that this information should not appear in the public register but “should be kept by the regulator to ensure that no patterns of behaviour persist”. UNISON also felt that “in a minority of cases registrants’ own

<sup>40</sup> Of the 192 submissions which were received, 46 expressed a view on this proposal: 40 agreed, 4 disagreed, whilst 2 held equivocal positions.

safety could be put at risk by the publication of such information” and suggested that the regulators should take this into consideration and “hear evidence from either the registrant or their representative if they believe this is a risk”.

- 5.210 The Department of Health, Social Services and Public Safety for Northern Ireland stated that “regulators need to be careful in publishing information that they do not add further, through publication, to the impact of any sanction they have imposed”.

**Provisional Proposal 5-28: The regulators should have discretion to include details of undertakings, warnings and interim orders in the public register (subject to the main duty of the regulators to protect the public by ensuring proper standards).**

- 5.211 A majority agreed that the regulators should have discretion to include details of current undertakings, warnings and interim orders in the public register.<sup>41</sup> For example, Optometry Scotland said the proposal “will provide the regulator with the ability to make whatever decision is most appropriate and in the public’s best interest”.
- 5.212 Many supported this proposal provided that there were clear procedures in place governing retention and removal of information that is no longer current. For example, the Medical Defence Union argued:

The purpose of fitness to practise procedures is not to punish registrants and they must be able to make representations to the regulators about their publication procedures if they are perceived to have this effect, especially if the original “sanction” is no longer current.

- 5.213 However, many of the regulators – including the General Medical Council, Health and Care Professions Council and General Optical Council – opposed this proposal because they argued that the publication of these sanctions should be mandatory. The Professional Standards Authority argued that “any regulatory action taken in response to a finding *or admission* of impairment should be visible on the register while it is in force”. It also felt that it should be mandatory to publish details of all current interim orders “because of the severity of the alleged risk and ensuing regulatory action”.<sup>42</sup>
- 5.214 The Scottish Government also argued that all warnings, undertakings and interim orders should be included in the public register, and that “consistency is required in the public interest”.
- 5.215 However, Charles Russell LLP expressed concerns that details of interim sanctions may be published when the evidence relied on in support of the allegation has not been tested by a Fitness to Practise Panel. It felt that:

In these circumstances it is our view that it would be unfair for interim sanctions to be published as the publication could be very damaging

<sup>41</sup> Of the 192 submissions which were received, 36 expressed a view on this proposal: 24 agreed, 11 disagreed, whilst 1 held an equivocal position.

<sup>42</sup> Emphasis in the original.

to a registrant's reputation and the allegations could, ultimately, be proved to be unfounded at the subsequent fitness to practise hearing.

- 5.216 Several consultees pointed out that interim orders will be replaced by a substantive order which will appear on the register if there is a fitness to practise finding and therefore argued they do not need to be recorded.

**Question 5-29: Should the regulators be required to publish information about professionals who have been struck off, for at least five years after they have been struck off?**

- 5.217 A significant majority felt that the regulators should be required to publish information about professionals who have been struck off for at least five years after the decision.<sup>43</sup>

- 5.218 The General Dental Council argued that a requirement in the statute would ensure consistency between the regulators and help to avoid disputes in relation to the Data Protection Act 1998 and Freedom of Information Act 2000. The Scottish Social Services Council also felt that "express statutory authority would mean there is less likely to be a legal challenge".

- 5.219 The Department of Health stated:

We would have concerns about information relating to struck off practitioners being removed from registers after a period of time. The health care workforce is a highly mobile workforce and there is the potential for many struck off workers to seek work abroad. For this reason, our view is that information about struck off practitioners needs to remain as long as there is a possibility that the individual could seek work in a professional capacity.

- 5.220 The British Dental Association argued that "simply removing the name might not give the clarity required for public protection". Bupa stated that publishing this information would be of "great value" to future employers and "a useful tool in tracking specific cases".

- 5.221 The Professional Standards Authority reported instances "where individuals who have been struck off continue to practise under a different but related job title, thereby posing a clear risk to the public". The General Osteopathic Council agreed that the proposal could provide "an important public safeguard" where a practitioner chooses to "undertake similar practice using a non-protected title".

- 5.222 The Scottish Government argued that the regulators should publish information about all professionals who have been struck off and that timescales should not be applied because they "would effectively enable practitioners to seek registration with alternative regulators or in alternative countries/jurisdictions". It added that the regulators (and those who run voluntary registers accredited by

<sup>43</sup> Of the 192 submissions which were received, 48 expressed a view on this question: 39 said that the regulators should be so required, 6 disagreed, whilst 3 held equivocal positions.

the Professional Standards Authority) should be required to notify other relevant bodies in this regard.

5.223 The Pharmaceutical Society of Northern Ireland felt that further consideration should be given “around cases where health professionals have been restored to the register” and where a relative of a deceased registrant asks for their sanctions to be removed from the register. The Professional Forum of the Pharmaceutical Society of Northern Ireland argued that erasure in health cases should not be included in the register.

5.224 The General Optical Council agreed that this information should be public but argued that it should not be located in the register but “should be clearly separated from the list of currently registered professionals, to avoid confusion”. Similarly, the Nursing and Midwifery Council argued that regulators “should be free to decide in what form this information is made public”.

5.225 However, a small number of consultees disagreed that the registers should include such information. The Health and Care Professions Council argued that:

Someone who is struck off is no longer registered and is therefore no longer entitled to practise using the relevant protected title. Including the names of such former registrants in the regulators’ public facing registers would be contrary to the purpose of those registers and increase the likelihood of confusion for members of the public.

5.226 The Society and College of Radiographers also stated:

We believe it is unhelpful to the public understanding of registration to have this view potentially clouded by details of past sanctions. It is also unnecessarily punitive to the registrant to retain details of sanctions that are “spent”.

5.227 The Institute of Medical Illustrators thought that the fact that an individual was not on the register “should be sufficient”.

5.228 Some consultees argued that the regulators should have discretion over the publication of such information. The General Social Care Council felt there should not be any time limit on the publication of information in relation to individuals who have been struck off where “there are good public protection reasons why information about an individual who has been removed from or struck off a register should be made public”:

This is particularly the case in social care where an individual who has been removed from working as a social worker may nonetheless seek employment elsewhere in the social care sector. It is important that if an employer or service user wishes to find out about any possible sanctions against that individual that they are able to check the relevant professional register.

5.229 The Chartered Society of Physiotherapy argued that regulators should have discretion to, for example, record more serious sanctions for a longer time, but remove more minor sanctions – particularly if they do not relate directly to patient safety –after a set period of time.



**Question 5-30: Should the regulators be required to include in their registers details of all previous sanctions?**

- 5.230 A small majority disagreed that the regulators should be required to include details of all previous sanctions in their registers.<sup>44</sup>
- 5.231 The Health and Care Professions Council argued that publication would send “confusing messages about the fitness to practise of a registrant who is no longer subject to sanction” and “would be punitive and contrary to the public protection purpose of fitness to practise proceedings”. The Society and College of Radiographers agreed that it would be “unnecessarily punitive to the registrant to retain details of sanctions that are ‘spent’”.
- 5.232 The General Osteopathic Council felt that where the registrant has been found to be fit to practise following a time limited sanction, “it would be inappropriate for a register to indicate in this way that perhaps some practitioners were more fit to practise than others”.
- 5.233 The Department of Health felt that the register should only include sanctions which are still in force, although regulators “should retain details of previous sanctions and these should be made available to prospective employers on request”.
- 5.234 The General Medical Council pointed out that in its register previous sanctions can be viewed by selecting “a fitness to practise history tab”, but that this information is not published on the register itself. It argued that this system “provides transparency about a doctor’s fitness to practise history while making the important distinction between current and historical sanctions”. The Nursing and Midwifery Council considered that information about previous sanctions should be retained by the regulator but, in order to avoid confusion and prejudice, “only current sanctions should be visible on the public register”. The Royal College of Midwives suggested there should be a symbol in the register against the entry signifying that the regulator should be contacted for more information. Similarly, the General Pharmaceutical Council felt that previous “sanctions should, as a minimum, remain a matter of public record and be available on request”.
- 5.235 Several consultees favoured discretionary powers in this area. The Association of Regulatory and Disciplinary Lawyers suggested that “previous sanctions should be included for different periods according to the gravity of the sanction”. Similarly, Optometry Scotland said that inclusion of previous sanctions “would be dependent on the severity of the misconduct, duration since last offence and the overall risk to the public”.
- 5.236 The Professional Standards Authority stated that it may not be appropriate to introduce a blanket duty to publish this information, but that regulators should nevertheless ensure that “where it is clearly in the interests of public protection, fitness to practise histories are made accessible”.

<sup>44</sup> Of the 192 submissions which were received, 42 submissions expressed a view on this question: 11 said that the regulators should be so required, 25 disagreed, whilst 7 held equivocal positions.

5.237 The General Social Care Council distinguished public facing registers (where regulators should have discretion over the inclusion of previous sanctions) and the data held in relation to each registrant on the register which may not be publicly available (which should include all previous sanctions). It argued that “any sanction which has restricted the practice of a registrant should be made publicly available without any time restriction”. For other lower level misdemeanours, the rules should stipulate how long sanctions appear in the register.

5.238 The Scottish Government also argued that only current sanctions should be on the registers but there should be “an exception clause” relating to:

those situations where older sanctions may potentially impact on the ability of individuals to perform their current job (but where their fitness to practise has not been found to be impaired). Details of such sanctions could remain on individuals’ files but would only appear in the public register where they potentially impact on their ability and fitness to practices.

#### ***Other comments***

5.239 Several consultees – including the Parliamentary and Health Services Ombudsman – felt that sanctions in cases which related solely to a professional’s ill-health should not be included in the register. The Medical Protection Society also suggested that sanctions which related indirectly to health should not be made public (for example, reference to a requirement for medical supervision).

5.240 The Royal Pharmaceutical Society of Great Britain argued that “where a case is pending, this should not be in the public domain”. The Optical Confederation argued that “any decision taken by case screeners/examiners/Investigation Committees” should be excluded from the register.

#### **Provisional Proposal 5-31: All the existing protected titles and functions that are contained currently in the governing legislation should be specified in the new statute.**

5.241 An overwhelming majority agreed that all existing protected titles and functions should be specified in the new statute.<sup>45</sup> For example, West Sussex County Council said it would “welcome the inclusion of all the current protected titles being specified in the proposed new governing legislation”. Similarly, the McTimoney Chiropractic Association felt “strongly that all protected titles/functions should be included in the new statute”.

5.242 The Professional Standards Authority stated that:

protected titles are important because patients and the public recognise them as indicators of competence and fitness to practise. Protection of title legislation gives regulators the power to ensure that the titles are not abused and the public put at risk as a result.

<sup>45</sup> Of the 192 submissions which were received, 49 expressed a view on this proposal: 47 agreed, 1 disagreed, whilst 1 held an equivocal position.

- 5.243 The Scottish Government supported the proposal to include all the existing protected titles and functions in the new statute on the understanding that it will need to “reflect devolved competence”.
- 5.244 Several consultees argued that the current levels of fines are out of date, insufficient and do not provide an effective deterrent.
- 5.245 The Optical Confederation also pointed to the need to include in the statute a catch all provision to create an offence where a title is used to falsely imply that someone is registered.<sup>46</sup>

**Provisional Proposal 5-32: Government should be given a regulation-making power to add to or remove any of the protected titles and functions.**

- 5.246 An overwhelming majority supported the proposal that the Government should be given a regulation-making power to add to or remove any of the protected titles and functions.<sup>47</sup> For example, the Association for Nutrition agreed that the “government should be given a regulation-making power to add to or remove any of the protected titles of functions”.
- 5.247 The Optical Confederation agreed that the regulators should not have powers to add to or remove any protected titles as this requires “a political policy decision to be made” about public protection, the introduction of criminal offences and the allocation of public resources. The General Optical Council supported a role for the Government due to the “impact of changes to protected titles and functions”.
- 5.248 The Department of Health argued the powers to alter the protected titles should remain with the Privy Council.
- 5.249 The Allied Health Professions Federation agreed with the proposal, but with the caveat that any changes by Government must always follow:

a thorough evaluation of need and impact, including the implications of any specific change on public understanding and on professions that already hold protection of title.

- 5.250 The Scottish Government supported the proposal, subject to it properly reflecting devolved competence. It believed that the proposed approach to protected titles would clarify their legal status, and also that:

This approach would provide structure and a sense of control over the plethora of titles that have emerged and been adopted by healthcare professionals, particularly in recent decades. Whilst many working in healthcare environments understand the roles and responsibilities associated with new titles, patients/service users are often left confused regarding their meaning and resulting in the potential for them to be misled, thereby undermining their faith, trust and confidence in the professions.

<sup>46</sup> See, section 28 (1) (d) of the Opticians Act 1989.

<sup>47</sup> Of the 192 submissions which were received, 40 submissions expressed a view on this proposal: 36 agreed, 2 disagreed, whilst 2 held equivocal positions.

5.251 The Professional Standards Authority argued that:

Any decisions taken in this area should also be in full cognisance of the restrictions that protection of title and function can introduce into workforce dynamics, and the impact this can have on the labour market.

5.252 The Association of Clinical Biochemistry felt that the Government should have powers to add to protected titles and functions but that “removal should require a more stringent level of scrutiny”.

5.253 A small number disagreed with Government regulation-making powers in this area. The Royal Pharmaceutical Society of Great Britain argued that the decision to add or remove protected titles or functions should rest with the Professional Standards Authority and “should be subject to scrutiny through reports and hearings by the House of Commons Health Committee”. UNISON argued that our proposal could be seen as “political interference with a regulatory matter and undermine the independence of the regulators”.

**Question 5-33: How appropriate are the existing protected titles and functions?**

5.254 A majority felt that the existing titles and functions were appropriate.<sup>48</sup>

5.255 Several consultees argued that the use of the titles “doctor”, “surgeon” and “consultant” in a health care setting other than by a medically qualified practitioner is confusing to the public and open to misuse. For example, the Patients Association argued that patients are often led to believe that “podiatric surgeons” are medically qualified. The British Medical Association argued that non-medically qualified individuals should not be permitted to extend their titles in this way “as there is a clear overlap between such terminology and that used by medically qualified practitioners”.

5.256 The Department of Health was also concerned about the use of titles by non medical professionals which imply that they might be medically qualified. For example, “use of the term ‘surgeon’ in job titles” and people avoiding the protected title regime by using another title which is not protected “for example ‘foot care specialist’ instead of ‘chiroprapist””. It wished to explore further the possibility of a power to enable specific titles to be banned in a health care context, other than by certain regulated professionals.

5.257 The Scottish Government also expressed concern over the use of titles which convey the impression that the person is suitably qualified and registered (such as the “widespread use of the term ‘nurse’, and increasing use of the terms ‘surgeon’ and ‘foot specialist’”).

<sup>48</sup> Of the 192 submissions which were received, 50 expressed a view on this question: 30 said that the existing protected titles and functions were appropriate, 8 said that there were issues regarding the scope of different titles and functions, 6 noted the complexity in this area, 2 argued for a general overhaul, whilst 4 argued that new titles should be included.

5.258 However, the General Medical Council cautioned against extending the range of protected titles to terms such as “consultant” and “doctor” because of the high risk of unintended consequences. It thought that:

It is of little regulatory significance if a person simply claims the academic title of doctor. It is of considerable significance if a person claims falsely to be a registered and licensed doctor. The public protection lies in the fact of the regulation and the fact that posing as a registered medical practitioner is a criminal offence.

5.259 Unite expressed concern that the titles “nurse” and “health visitor” are not protected (although “registered nurse” is) and suggested that registered nurses are sometimes “passed off” as health visitors despite not holding the relevant qualification. The Institute of Health Visiting also argued that the title “health visitor” should also be “protected in law once more”, on the basis that:

The term “health visitor” has been in use for nearly 150 years and it is a known and trusted brand, so it is meaningful to the public. The absence of a formal, legal definition of the title “health visitor” has led to confusion for professionals, employers and public alike.<sup>49</sup>

5.260 Several consultees felt that the title “specialist community public health nurse” should not be protected since it is not in common usage, causes confusion amongst professionals and the public, and is unnecessary since all practitioners must be a registered nurse or midwife.

5.261 The Nursing and Midwifery Council noted there is potential for confusion among members of the public where “nurse” is used “in relation to other, unrelated roles, such as veterinary nurse and nursery nurse”. The Council recognised the concerns relating to “specialist community public health nurse” and suggested there may already be developments in the Government to address these issues.

5.262 The Society of Chiropodists and Podiatrists expressed concern about the use of the title “foot health practitioners” by unregulated professionals. The Society said that there was a need for some “creative thinking”, in order that there can be “reasonable protection of function, whilst not stifling clinical innovation and development”.

5.263 The Nightingale Collaboration also pointed to titles used such as “osteomyologist”, “neuroosteomyologist”, “spine/spinal specialist”, “spinologist” and “bonesetter” in order to undertake tasks similar to chiropractic or osteopathy.

5.264 Similarly, the Association of Regulatory and Disciplinary Lawyers felt that:

The protection rendered to the public where there is purely protection of a title, for example in the cases of “chiropractor” and “osteopath”, rather than of actual function, is weak, given that a practitioner who is erased following a finding of unacceptable professional conduct may continue exactly the same form of practice upon the same patients

<sup>49</sup> Health Visitor was a protected title up until 2001.

immediately afterwards, provided s/he does so under a different title, for example "spinal therapist" or "manipulative therapist".

- 5.265 The Optical Confederation and Optometry Scotland argued that existing protected titles should be extended to include “ophthalmic”, “optical”, “eye health” and “eye care”.
- 5.266 The College of Optometrists supported the existing legislative requirement that the optometrist or medical practitioner who carries out the eye test must also carry out the examination for the purpose of detecting injury, disease or abnormality. An individual consultee (Richard Calver) argued that “sight testing” by dispensing opticians is not and should not be permitted, and that refraction does not lie within a dispensing optician’s core competencies.
- 5.267 An individual consultee (Dr Susan Blakeney) argued that “because of the limited experience in ophthalmology and contact lens fitting that most doctors receive during their training”, “only medical practitioners who have appropriate expertise in the protected functions should be allowed to provide them”.
- 5.268 In relation to pharmacy, Charles Russell LLP argued:
- Currently, the Medicines Act 1968 gives greater protection to the outdated title “chemist” than to the modern title “pharmacist”. In addition, there is some overlap between the provisions of the Medicines Act 1968 and the Pharmacy Order 2010, in that both create an offence of using the title “pharmacist” without being registered.
- 5.269 The Society and College of Radiographers argued there is an “urgent need for protection of titles pertaining to the practice of diagnostic ultrasound, specifically ‘sonographer’ and ‘ultrasonographer’”. The McTimoney Chiropractic Association argued that the titles “animal chiropractor” and “veterinary chiropractor” should be protected. The British Pharmaceutical Students' Association suggested that “pre-registration pharmacist” should be a protected title. The Professional Leads for Allied Health Professions, Medics, Pharmacy and Psychological Therapies, South Staffordshire and Shropshire Healthcare NHS Foundation Trust, felt that the range of psychologist titles needed “clarification and harmonising”.
- 5.270 The British Association of Social Workers felt that qualified social workers, who are working in a role that has another title but where there is a significant social work element, should be required to be registered with the regulator. Skills for Care said that it is “essential that social work remains a protected title and that social work functions can only be undertaken lawfully by registrants or certain registrants”.
- 5.271 The Institute of Health Visiting argued that the term “protected title” is “widely misunderstood to refer to protecting the profession/professional, so perhaps reference to ‘formal’ or ‘legally defined professional titles’ might be clearer”.

5.272 The General Osteopathic Council argued that the statute should ensure that the offence captures those who do not use a protected title but cause or permit another person to make any representation about him or her to the effect that they are registered.<sup>50</sup>

5.273 However, the General Optical Council felt that the “scope and criteria of these broad provisions are not certain, and are expensive to test”. It did recognise that they do provide some ability for it to act “when the spirit of the law is being breached by a misuse of title”.

5.274 The Department of Health was also concerned about the widespread use of protection of function:

To define a profession by reference to its functions could limit the flexibility of that profession to adapt to change and also reduce workforce flexibility, as other professionals undertaking similar functions might be prohibited from doing so. It is also rarely the case that a particular function is the sole preserve of a single profession and therefore attempting to protect the functions of a particular profession as a general approach to professional regulation could be cumbersome and unworkable.

5.275 The Scottish Government did not consider that the protection of functions is an area that should be regulated “as this would serve to restrict rather than enable the development of practice and practitioners that has featured strongly in health care delivery in recent years”.

5.276 It pointed to a number of new roles which have emerged as a result of “new ways of working initiatives” – for example “Surgical Care Practitioner”, “Physician Assistant”, “Anaesthetic Practitioner” and “Emergency Care Practitioner.” It said that these roles, “although unprotected, are associated with a heightened skill set (eg in relation to prescribing) and...the potential for an increased risk to patients”.

5.277 The Scottish Government also stated that:

We consider that the existing protected titles and functions are limited in their impact and do not take account of the array of new titles that have emerged in recent years. We would like to further explore the possibility of Governments being given the power to prohibit the use of titles which are not protected where there is evidence that they are being misused and therefore causing confusion.

**Provisional Proposal 5-34: The regulators will have powers to bring prosecutions and will be required to set out in a publicly available document their policy on bringing prosecutions (except in Scotland).**

5.278 The vast majority agreed that the regulators should have powers to bring prosecutions, and be required to set out in a publicly available document their

<sup>50</sup> This formulation is used in the Health Profession and Care Professions Order 2001.

policy on bringing prosecutions (except in Scotland).<sup>51</sup> For example, the Professional Standards Authority stated that:

It is important that protected titles retain meaning and integrity in the eyes of the public. If the misuse of title persists unchecked, the public is at risk of harm and regulation is at risk of losing public confidence.

5.279 The Scottish Government supported giving the regulators powers to bring prosecutions but suggested a single mechanism could be created whereby:

all such investigations (and, indeed, those relating to fitness to practise) are considered and undertaken by one central body with representation from individual regulators as required (ie a ‘hub and spoke’ type of model).

5.280 An individual consultee (Stephen King) supported the proposal on the basis that “titles can only be protected if offenders are prosecuted if they fail to desist from using a protected title”.

5.281 The College of Chiropractors and the Royal Pharmaceutical Society of Great Britain argued that our proposal should go further and require the regulators to uphold the protected titles of its registrants. The General Osteopathic Council also pointed out that it brought a private case in Scotland in respect of the misuse of a protected title.<sup>52</sup>

5.282 However, the Medical Defence Union questioned more generally whether prosecution of illegal practitioners is an activity that should be undertaken at all by the regulators since they “have powers in respect of their registrants but those who are practising illegally are by definition not registrants”. It suggested that prosecutions should be publically funded. It explained:

We make this point because there is a substantial cost attached to prosecuting illegal practitioners, in terms of the regulator’s time and staff and of course financially and this cost is borne by registrants through their annual retention fees. We expect that very many registrants are not even aware they are funding prosecutions of illegal practitioners and that, even if they agree wholeheartedly that illegal practitioners must be prosecuted, in the current economic climate they may be dismayed to find they are expected to meet a cost that should arguably be funded from the public purse.

5.283 It pointed to precedents where the police have brought successful prosecutions against practitioners “notably most recently of a ‘dentist’ for fraud and in such instances this is funded by the public purse”.

<sup>51</sup> Of the 192 submissions which were received, 40 expressed a view on this proposal: 36 agreed proposal, whilst 4 disagreed.

<sup>52</sup> *General Osteopathic Council v Sobande* [2011] CSOH 39.



5.284 Similarly, the Nursing and Midwifery Council disagreed that “it is the place of the regulator to bring prosecutions” and suggested the statute should make clear that prosecutions should be brought “by other legal agencies such as the police and Crown Prosecution Service”.

## **PART 6**

# **EDUCATION, CONDUCT AND PRACTICE**

**Question 6-1: Should our proposals go further in encouraging a more streamlined and coordinated approach to regulation in the areas of education, conduct and practice? If so, how could this be achieved?**

- 6.1 A large majority argued that our proposals should go further in encouraging a more streamlined and coordinated approach.<sup>1</sup> For example, UNISON said that it “would strongly welcome greater collaboration across regulators”.
- 6.2 The General Medical Council acknowledged that greater joint working between regulators can “add value to the regulatory process” and ensure “better sharing of intelligence, better co-ordination of activity and reduced regulatory burden”.
- 6.3 Several consultees pointed to the problems caused by a lack of cooperation and coordination. The Professional Standards Authority argued that:
- the combined, and often cumulative, activity of the regulators in these areas demonstrates considerable duplication, which we are aware causes puzzlement and occasionally frustration at the apparent inconsistencies in delivery of very similar regulatory functions.
- 6.4 The Medical Defence Union pointed out that “in some specialties clinicians take out dual registration with the General Dental Council and the General Medical Council”. It warned that problems can arise if there is no joint working between these regulators. It provided an example of when the General Dental Council issued rules requiring the dual registration of maxillo-facial surgeons, which resulted in the “potential for prosecution of medical doctors in training (anaesthetists as well as maxillo-facial surgeons) and in theory their trainers”.
- 6.5 An individual consultee (Lucy Reid) felt there was a lack of a coordination between the regulators and the Performers’ List maintained by Primary Care Trusts; for example, if an “inexperienced practitioner” applies to a Performers’ List, the Trust can apply conditions to allow them to practise, however “this minimum standard is not currently set by the regulators appropriately, partly as a result of overseas training and qualifications”.
- 6.6 Several consultees argued that the statute should promote joint working. For example, the Centre for the Advancement of Interprofessional Education felt that each of the regulators should “be required explicitly to promote interprofessional collaboration” and that “each committee, board and panel within a regulatory body [should include] a proportion of members from other professions”.
- 6.7 However, some consultees did not think that our proposals needed to go further. For example, Optometry Scotland thought that the “current arrangements are satisfactory” as they allow “a reasonable level of flexibility”. The Medical Protection Society agreed that the “current level of oversight of the regulators is appropriate in the educational context”.

- 6.8 The General Optical Council and General Dental Council were willing to consider ways of streamlining the current system, but stressed that regulators must retain the flexibility to regulate their sectors appropriately.
- 6.9 The Department of Health emphasised the importance of “ensuring compliance by the regulatory bodies with EU legislation, in particular EU Directive 2005/36/EC on the recognition of qualifications”. It suggested that all rule-making powers should specify this.
- 6.10 The Department also supported “a broad power for the regulators to work together (and with other bodies) on education and training matters” in order to support a “more coherent approach towards engaging with education providers” for example, “in relation to the various data returns they have to provide to the different regulators”.
- 6.11 The Scottish Government called for the establishment of a new body to ensure a more coordinated and streamlined approach:

The new statute could provide further clarity and consistency by co-ordinating their activities through one central body with representation from individual regulators as required (ie a ‘hub and spoke’ model). This would provide greater consistency in standards and a more co-ordinated approach to quality assurance and inspections, and provide opportunities for shared learning and decision-making including, for example, in relation to multi-disciplinary/multi-professional education and training. Any decision to reduce or withdraw involvement in any of these areas would be subject to the agreement of all the regulators and the overarching duty to protect the public and maintain confidence in the professions.

- 6.12 The Scottish Government also wanted to explore whether the new statute should ensure “a combined code of conduct, performance and ethics that would apply across all the regulators” and “whether similar consistency could be provided in the approach to continuous professional development”.
- 6.13 The Department of Health, Social Services and Public Safety for Northern Ireland pointed to the need to develop:

a more corporate approach to regulation that would involve, for example, employers and educational providers. Regulation is not the exclusive province of a regulator – it needs to embrace other stakeholders. Also the development of core principles across all regulators would establish some consistency.

### ***Education***

- 6.14 Many commented specifically on education issues. The Professional Standards Authority felt that greater cooperation will demand certain consistencies to be established “in terms of quality assurance of education [such as] the subject of

<sup>1</sup> Of the 192 submissions which were received, 47 expressed a view on this question: 37 said that our proposals should go further, whilst 10 said they should not.

the approval – institution or programme or environment or course”. The Committee of Postgraduate Dental Deans and Directors expressed concern that unlike the General Medical Council, the General Dental Council does not quality assure foundation training and education/training throughout a registrant’s career.

- 6.15 The Chartered Society of Physiotherapy argued that the Professional Standards Authority had a key role in ensuring a “light touch” and “outcomes based” approach to the regulation of education and training. The General Medical Council felt that because “education is a complex field with many interdependencies” the regulators should have “statutory levers (for example, to require information, undertake inspections and withdraw recognition of training)” in order to “support the delivery of their functions”.
- 6.16 Several consultees argued the statute should ensure the involvement of professional bodies in education and training. For example, the British Society of Hearing Aid Audiologists argued that the regulators should be required to “enter into partnerships with professional bodies” in undertaking the approval of pre-registration and post-registration courses. However, an individual consultee (Jane C Hern) cautioned that where education providers and regulators do work together, the latter should be aware of the “need to minimise the burdens on universities etc, which may have to satisfy the differing requirements of a number of regulators”.
- 6.17 However, the Royal College of Radiologists argued for greater demarcation of responsibilities and that doctors in postgraduate training should be “primarily the responsibility of the postgraduate deaneries” and “doctors who have completed training should be in the first instance the responsibility of the responsible officer”.

### ***Conduct and practice***

- 6.18 In relation to conduct and practice, the Nursing and Midwifery Council commented that our proposals could go further by providing for:
- a generic core code of conduct for all health professionals, covering issues such as the centrality of the patient interest, involving patients in decisions, confidentiality, keeping up to date and raising concerns all at an appropriately high level.
- 6.19 The Royal College of Radiologists argued for:
- a uniform standard of care whoever is providing it, so lower standards of care for a procedure or investigation should not be acceptable when it is routinely provided by a nurse, for example rather than by a doctor. A uniform standard for that activity should be upheld, preferably with advice, and preferably consensus from organisations like Royal Colleges or professional organisations. If the same standard cannot be achieved then the activity should be restricted to those who can attain that standard.
- 6.20 However, some consultees urged caution in developing a coordinated and streamlined approach. An individual consultee (Jacqueline A. Wier) felt that “specific issues that relate to individual professions need specific knowledge and expertise” and “it is important that these are not lost in the drive for improved

efficiency”. The Professional Forum of the Pharmaceutical Society of Northern Ireland supported the principle of a coordinated approach to education but stated “this cannot become a one size fits all dogma”.

6.21 The Royal Pharmaceutical Society of Great Britain argued that:

Multidisciplinary working is only successful if based on sound individual professional development. Each profession must bring its own expertise to the team and education, conduct and practice standards can have overarching elements, such as confidentiality, but must also be specifically developed for the individual profession.

6.22 The General Osteopathic Council argued that while a multitude of organisations are involved in education, conduct and practice, this position is not consistent across all professions and in osteopathy there is no other body than the General Osteopathic Council that “has a remit for these issues”. It further argued that:

Given the diversity of the professions under regulation, the history of their development and the variety of institutions involved, it is not obvious that this statute would be the place to seek to introduce a more streamlined approach beyond the general duty of cooperation ... It is also important to ensure that accountability for the quality of clinical education which involves direct patient care is clear. This must remain with the regulator.

**Provisional Proposal 6-2: The statute should require the regulators to make rules on:**

**(1) which qualifications are approved qualifications for the purposes of pre-registration and post-registration qualifications;**

**(2) the approval of education institutions, courses, programmes and/or environments leading to an award of approved qualifications and the withdrawal of approval;**

**(3) rights of appeals to an individual or a panel against the decision of the regulator to refuse or withdraw approval from an institution, course or programme;**

**(4) the quality assurance, monitoring and review of institutions, courses, programmes and/or environments; and**

**(5) the appointment of visitors and establishment of a system of inspection of all relevant education institutions.**

6.23 All of those who expressed a view agreed with the proposal.<sup>2</sup> For example, the National Clinical Assessment Service was in favour of the regulators having rule-making powers in this area, as it would “support the improvement of education standards”. Many consultees provided comments on the specific elements of this proposal.

<sup>2</sup> Of the 192 submissions which were received, 43 expressed a view on this proposal: all agreed.

- 6.24 The Department of Health felt that the regulators should have a power to approve post-registration courses, rather than an obligation to do so, as some use continuing professional development for this purpose.
- 6.25 The Association of Clinical Biochemistry argued that the statute should enable the “recognition of prior experience and education other than formal approved education schemes and qualifications” (as currently provided for in the Clinical Scientists part of the Health and Care Professions Council’s register). It argued this provides a “career route mechanism for experienced scientists from academia, industry and elsewhere”. Similarly, the General Dental Council suggested the wording of the statute should be “sufficiently wide to encompass a requirement for vocational training as well as academic training”.
- 6.26 Several responses noted the importance of securing effective practice settings. NHS Education for Scotland pointed out that:
- Whilst the majority of the preparation of health care professionals is within higher education these programmes are delivered in partnership with clinical practice areas predominately but not exclusively the NHS.
- 6.27 The General Optical Council argued that “not all regulators have an existing internal appeals process regarding decisions on approval of training providers” and any duty to introduce this process might impose additional financial burdens.
- 6.28 The Professional Standards Authority argued that the new legal framework “should be more flexible around quality assurance” since:
- It may not be necessary for regulators to quality assure programmes themselves to confirm that those individuals completing courses are fit to join the register, especially if other agencies share the regulator’s interest in the course. The statute may not need to require all regulators to make rules around quality assurance, providing they have provision for monitoring and reviewing institutions.
- 6.29 It also argued that the statute should define who can act as a visitor, the options available for an appeal and the purpose of approval and monitoring reviews.
- 6.30 The Nursing and Midwifery Council suggested that the appointment of visitors should be “a permissive power and left to the discretion of the regulators” because “their use might be just one approach to assuring the quality of provision, there may be others”. The General Dental Council also argued that “inspection is not the only model of quality assurance” and the statute should refer to “mechanisms for quality assurance of education, which may include the appointment of visitors and the establishment of a system of inspection”.
- 6.31 The Scottish Government supported our proposal but again felt that it may be appropriate to explore further a centralised “hub and spoke” approach to the appointment of visitors. It also argued that visiting schemes should be extended to include practice placements and the regulators should be able to choose from “an agreed suite of sanctions (such as formal warnings and conditions) when addressing quality assurance problems”.

- 6.32 The General Osteopathic Council suggested the following additional powers:
- (1) to set and enforce conditions and require action to remediate (something similar to Ofsted’s “special measures”);
  - (2) to charge for inspection activity – particularly because most osteopathic education is delivered in the independent sector and not in the traditional university sector; and
  - (3) to restrict the extent of the approval to education and training delivered in the UK should the regulator so wish.

- 6.33 The Health and Care Professions Council questioned whether the regulators should be given powers to use “special measures for struggling institutions” and argued that “the use of formal warnings and conditions for approval should be sufficient”. It also argued that:

The regulators should not be able to introduce “excellence schemes”. The primary purpose of regulation is public protection and not the promotion or development of the professions. The suggestion that the regulators might operate such schemes appears to stray into the role of professional bodies in developing, as opposed to regulating, the professions.

- 6.34 Some consultees pointed to the key role of professional bodies in education and training. For example, the Academy of Medical Royal Colleges argued that while the regulators should set standards for education:

it is for professional bodies like Royal Colleges (postgraduate) and universities (undergraduate) to determine the content and standards of curricula, assessments and qualifications ... Royal Colleges and professional bodies, as independent experts, are in an ideal position to contribute to quality assurance through playing a role in visiting and inspection arrangements.

- 6.35 The Osteopathic Alliance warned that “the more that the regulator is involved in postgraduate education the more this could stifle development, innovation and on-going patient care”. The Royal College of Physicians of Edinburgh felt that specialist Royal Colleges “require resourcing to support the regulator in this way”.

- 6.36 The Department of Health argued that the regulators should be required to comply with EU requirements in making rules. Similarly, the Scottish Government argued that the statute should make explicit reference to compliance with EU legislation.

**Provisional Proposal 6-3: The statute should require the regulators to establish and maintain a published list of approved institutions and/or courses and programmes, and publish information on any decisions regarding approvals.**

- 6.37 All those who expressed a view agreed that the statute should require the regulators to publish a list of approved institutions and/or courses and

programmes, and the publication of decisions regarding approvals.<sup>3</sup> For example, the Nightingale Collaboration argued that:

It is in the interest of students and prospective students that full information about training establishments is published so they can make an informed decision about their choice of training provider. This should include full curriculum details, accreditation details, inspection reports, remedial actions required by the regulator, etc.

6.38 The British Pharmaceutical Students' Association argued that this proposal would “act to drive up the quality of Master of Pharmacy courses within an increasingly competitive higher education market”. NHS Greater Glasgow and Clyde agreed with the proposal on the basis that it would “reinforce public confidence and engagement”.

6.39 Some suggested additions to the duty. The Professional Standards Authority felt that the regulators should be required to publish:

all decisions around approvals of courses, programmes and institutions, as well as the decision-making process they adopt. This is useful information for sharing good practice and it is helpful for students, commissioners and other agencies with an interest in the quality of education delivery

6.40 NHS Education for Scotland felt that the duty should include “practice placement areas”. The Department of Health agreed, and the Scottish Government also felt that the duty should be extended to include “establishing and maintaining an approved list of practice placements publication”. Similarly, the Department of Health, Social Services and Public Safety for Northern Ireland suggested that the publication requirements “should also specify approval of placements”.

6.41 The Professional Forum of the Pharmaceutical Society of Northern Ireland stated that “all accreditation reports produced by the regulators should be made publicly available”.

**Provisional Proposal 6-4: The statute should require education institutions to pass on to the regulator in question information about student fitness to practise sanctions.**

6.42 A large majority agreed that education institutions should be required to pass on information about student fitness to practise sanctions.<sup>4</sup> For example, the Professional Standards Authority argued that:

It would benefit public protection if relevant information about student fitness to practise was available when a decision is taken about registration. Admission to the register should not neglect any

<sup>3</sup> Of the 192 submissions which were received, 43 expressed a view on this proposal: all agreed.

<sup>4</sup> Of the 192 submissions which were received, 44 expressed a view on this proposal: 36 agreed, 5 disagreed, whilst 3 held equivocal positions.



information which may have a bearing upon an assessment of fitness to practise.

6.43 The National Clinical Assessment Service supported the proposal because an “education institute has a duty to act in the patient public interest”. The British Pharmaceutical Students' Association argued that such a requirement would “remove the need for a student register”.

6.44 Several consultees suggested that the proposal reflected existing practice. The General Chiropractic Council pointed out that a similar requirement is stated in its guidance. The Royal College of Physicians of Edinburgh argued that:

Medical directors and undergraduate deans have a professional responsibility to advise the regulator of fitness to practice sanctions at local level. It may be helpful to add an organisational responsibility.

6.45 The Pharmaceutical Society of Northern Ireland also argued that:

Educational institutions should inform regulators of student fitness to practice issues, which are above certain established and published thresholds as is the case with the universities we accredit ... However it is also incumbent on the universities to manage misconduct within the university disciplinary code, and to not see this as an abdication of their responsibility.

6.46 The UK-wide Nursing and Midwifery Council Lead Midwives for Education Group welcomed the proposal, whose implementation the Group thought would promote a “move away from needing student indexing”.

6.47 Some suggested amendments to the duty. Coventry and Warwickshire Partnership Trust argued that this information should be shared with other educational establishments. The General Medical Council suggested that the duty “should apply equally to service providers (such as NHS Trusts) which provide regulated education and training”.

6.48 The Scottish Government argued that the duty to share information about student fitness to practise sanctions should include “any other matters that question student conduct, character or general fitness to practise”.

6.49 However, some pointed to potential difficulties with the proposal. For example, the Nursing and Midwifery Council felt that:

In order to manage the information, it would be necessary to maintain some form of register of nursing and midwifery students, something that we have been discouraged from doing as it is not seen as part of our core function. We would suggest that the requirement should be for information to be provided “on request”.

6.50 It also argued that clarity is needed in cases where fitness to practise concerns are raised about students who are already registrants but are “undertaking a programme for another registrable qualification”.

6.51 The General Optical Council suggested that the regulators are given powers to request this information, since there are differences among the regulators “in respect of how student fitness to practise is managed, which a more flexible approach in the statute might more easily accommodate”.

6.52 The Royal College of Nursing felt that greater clarity is needed on what the regulators should do with this information, “for example – is the regulator expected to create what amounts to a ‘blacklist’?” It also felt that the requirement to share information about all sanctions was “too stringent”, for example this would include students subject to warnings.

6.53 A small number opposed this proposal outright. The Health and Care Professions Council argued that a duty was “unnecessary and disproportionate” since:

Our standards of education and training and approval process ensure that education providers have robust procedures in place to deal with concerns about the conduct of students. Where an education provider has “disciplined” a student but taken action short of removal from the programme, and that student has subsequently passed their programme, and therefore met the regulator’s standards, it is highly unlikely that the regulator would be justified in making the serious decision not to register them. Our concern therefore is that regulators would routinely receive information on which they would be highly unlikely to take any meaningful action.

6.54 It was therefore argued that this should be a discretionary matter that the regulator may wish to address in rules, standards or guidance.

6.55 The Optometry Course Team at the University of Ulster felt that:

whilst this would be appropriate for some fitness to practise matters, for more minor issues it may be viewed as unnecessarily punitive and may inadvertently result in institutions being reluctant to impose a minor sanction if they feel it is going to inappropriately result in a referral to the regulator. For example educational institutions, under their current statutes and ordinances, regularly deal with students who have committed minor indiscretions, often as a result of youthful immaturity. Whilst for the maintenance of the educational establishment’s reputation or to encourage the personal development of the student some consequences may be necessary, for the regulator to have to be informed would often be disproportionate. Obviously matters of a more severe nature, resulting in a criminal conviction or a severe sanction should be referred to the regulatory body as these may impede the possibility of future registration.

6.56 The Registration Council for Clinical Physiologists also generally opposed the proposal, but accepted that there “may be exceptions to this if there are serious issues that would result in a student not being fit to practise”.

6.57 The Association of Clinical Biochemistry argued that “the primary concern should be that the student meets the requirements for registration at the point they present themselves for assessment” and disagreed that “deficiencies which were resolved during pre-registration education should disproportionately be held

against an applicant". The Council of Deans of Health felt that such a "blanket requirement" would undermine the aim of "right touch" regulation and a "disproportionate response to the perceived level of risk posed".

- 6.58 The Society and College of Radiographers' opposition to the proposal was linked to its lack of support for student registers more generally. It was argued that "in the absence of a register, the regulator should have no use for information on sanctions against students".

**Question 6-5: Should the powers of the regulators extend to matters such as a national assessment of students?**

- 6.59 A majority felt that regulators should not have powers to introduce a national assessment of students.<sup>5</sup> For example, the Welsh Government did not support giving the regulators powers to introduce national assessments "as it would lead to examinations becoming Anglocentric". The Department of Health, Social Services and Public Safety for Northern Ireland also disagreed with the proposal.

- 6.60 The Dental Schools Council argued:

Undergraduate dental education is more than just a means of achieving registration; it aims to provide dental students with opportunities to demonstrate excellence in a range of clinical and academic domains as well as competence in those core skills and competencies required for registration. National assessment could not demonstrate the breadth of these skills and competencies in the same way as the overall programme of assessments delivered by dental schools.

- 6.61 The British Dental Association also pointed out that "dental schools have differing methods of assessment, influenced by a range of factors" and that a "standard assessment would prove invalid across the sector". The Association felt that the "regulator is not a recognised source of expertise in education; this resides within Universities". The Guild of Healthcare Pharmacists agreed that assessment is the "domain of education and training providers".

- 6.62 The Medical Defence Union argued that a national assessment of students would add little value "over and above the assessments that regulators currently make of applicants at [registration]" and would not ensure patient protection "when the information available relates generally only to their education and training" and "there is so little information available at this early stage in their career". NHS Education for Scotland also argued that national assessment was unnecessary given that "the regulator provides a code of conduct and standards for entry to the register" and would be "extremely difficult and expensive and questionable in respect to risk".

- 6.63 The British Medical Association felt that:

<sup>5</sup> Of the 192 submissions which were received, 54 expressed a view on this question: 12 said that the regulators should have such powers, 37 disagreed, whilst 5 held equivocal positions.

A national exam would do nothing further to ensure that medical graduates are suitably prepared for entry into the medical workforce, but would instead stifle the diversity of medical education in the UK - negatively impacting on the range of skills and strengths of our workforce ... There is a risk that a national exam from a regulatory body would supersede the existing finals examinations, which have been shown to be fair, transparent and rigorous, and homogenise the curriculum of undergraduate medical school to fit with a single, national idea of what makes a good doctor rather than allowing the freedom for schools to work with their graduates in a positive way to develop their own strengths.

6.64 The Patients Association felt that national assessment could become:

a box ticking exercise, ensuring that graduates meet the minimum requirements necessary and leaving it at that rather than seeking to provide a level of excellence and deeper understanding in students of what is expected of them when they qualify.

6.65 An individual consultee (Stephen King) queried whether the proposed extension of the regulators' powers was "really necessary", or whether it would "mean duplication of the regulatory body taking on the role of a quasi examination body". The risk of duplication was also a concern of the British Psychological Society.

6.66 The Council of Deans of Health felt that:

In setting robust standards for education and training, it should be unnecessary for regulators to take part in national assessments of students for the purposes of public protection.

6.67 The Professional Standards Authority argued there is only a case for a national assessment "in the absence of other quality assurance mechanisms".

6.68 However, some were in favour of giving regulators powers in this area. For example, the General Medical Council argued that:

Regulators should be able to introduce national assessment of students and trainees, auditing of data which highlights individual progression and other such approaches where they consider they offer effective and proportionate means of fulfilling their paramount duty.

6.69 Coventry and Warwickshire Partnership Trust argued that national assessment "will help to reduce the current inconsistencies in the approach of education providers to the assessment of students, especially at undergraduate level". The Royal College of Physicians of Edinburgh suggested that "consistency of standards on graduation from medical school has been a long standing issue and should be tackled by the regulator".

6.70 The British Pharmacological Society argued that national assessments can be preferable to reviewing the education process in individual institutions because:

- (1) those reviews are necessarily brief;

- (2) the evidence presented may be selected;
- (3) it can never be certain that even good educational opportunity actually translate into clinical competency;
- (4) in many areas of undergraduate education, such as prescribing, it is not yet known what constitutes the optimal approach to learning; and
- (5) when individual institutions choose their own methods of assessment the result is a highly variable approach.

6.71 The Society therefore supported national assessments which are restricted to:

specific competency in critical high risk areas for which a basic minimal standard is highly desirable and in the interests of patient safety. To this end we are working with the Medical Schools Council to develop the Prescribing Skills Assessment (PSA). The PSA is designed to assess the prescribing competencies expected of a foundation doctor, as stated by the General Medical Council. Prescribing is a core component of the work of a foundation doctor who is expected to write and review prescriptions from their first day of practice. There is clear evidence from a General Medical Council study that there are issues around prescribing competencies with 9% of hospital prescriptions containing errors. Therefore the PSA is a means of ensuring that core prescribing competencies are achieved by all new graduates prior to starting work in hospitals.

6.72 The General Pharmaceutical Council pointed out that it currently holds a national assessment for pre-registration pharmacy students and the statute should enable (but not require) this to continue and develop. It stated:

We believe that this is a helpful tool that contributes to ensuring only those students who are competent to practise are entered onto the register. However, we recognise that this registration assessment, introduced in 1993, reflects the unique circumstances of the pharmacy education model including the way in which pre-registration is managed and quality assured across Great Britain.

6.73 The Royal Pharmaceutical Society of Great Britain pointed out that this system is in addition to “a broad indicative syllabus” issued by the regulator for the undergraduate degree, and Schools of Pharmacy are accredited against standards to ensure the quality of the degree.

6.74 A number of regulators, including the General Osteopathic Council, General Dental Council and General Optical Council, thought that the regulators should be given a permissive power in this area. This was supported by the Department of Health, which felt that “it may be helpful for the regulators to have powers (rather than obligations) to set or ask others to set national assessments of students”.

**Question 6-6: Should the regulators be given powers over the selection of those entering education?**

- 6.75 A large majority argued that the regulators should not be given powers over the selection of those entering education.<sup>6</sup> For example, The General Chiropractic Council stated:

We do not consider that it is the business of the regulators to select students entering education. It would be impractical and costly to administer. We take the view that it is the role of regulators to have assurance that providers are running an effective selection system and implementing appropriate student fitness to practise procedures.

- 6.76 The General Medical Council argued that:

This would duplicate and usurp the roles of undergraduate educational institutions. It is also important to be clear that the individuals concerned would not at that stage be regulated professionals and so intervention by the regulator would be inappropriate. The regulator does, however, have a legitimate interest in the standards applied by educational institutions themselves in selecting students who, in time, may become registrants.

- 6.77 The British Psychological Society believed that the involvement of the regulators in the selection process would be “unwieldy and unworkable across a range of professions”.

- 6.78 The Medical Defence Union thought that “the selection process for healthcare students is far too remote from the regulators and they are better to concentrate on the curriculum and in assessing the quality of the institutions”.

- 6.79 An individual consultee (Jacqueline A Wier) noted that the proposed power would be “both unwelcome and unnecessary”. The British Society of Hearing Aid Audiologists did not consider that “regulators would add to the quality or effectiveness with which students are selected”. Furthermore, consultees also doubted that the regulators’ involvement in selection would add “patient safety value” (Royal Pharmaceutical Society of Great Britain).

- 6.80 The General Dental Council felt that the “existing legislation ensures fairness and equality of opportunity and it is for the institutions to ensure that they adhere to the law”. Several consultees agreed that selection was the proper responsibility of the institutions, including the Institute of Medical Illustrators who said that “the onus falls on the educational providers to ensure their graduates are ‘fit for purpose’”.

- 6.81 The UK-wide Nursing and Midwifery Council Lead Midwives for Education Group felt that the regulators should only be given such powers in relation to post-registration qualifications “where it will be a pre-requisite to have a recognised qualification”. The Patients Association also suggested that direct regulator

<sup>6</sup> Of the 192 submissions which were received, 54 expressed a view on this question: 6 said that the regulators should be given such powers, whilst 48 disagreed.

involvement may be more useful at the postgraduate stage “when graduates are specialising and particularly where they have direct contact with patients and service users in either a supervised or unsupervised fashion”.

6.82 The Department of Health argued that the selection of students should be left to education institutions but the regulator should have the power “as part of the standard setting or more generally, to specify selection criteria, for example two years post-registration experience” where this is important for public safety.

6.83 The Association of Clinical Biochemistry did not support the regulators having powers over selection, but did think that they “need to make clear to educational institutions who select candidates whether there are any issues that may render some applicants unregistrable at the outset”. The Royal College of General Practitioners also thought that some input from the regulators at an early stage in the process would be useful. It argued that “the regulator should set the standards for selection, but that it would be left to educational bodies to demonstrate that they meet those standards”.

6.84 The Scottish Government disagreed with extending the regulators’ powers in this area, but it felt that a Memorandum of Understanding between regulators and education providers might assist.

6.85 A small number supported giving the regulators powers in this area. For example, the British Medical Association argued that:

This allows the promotion of the key values of fairness, transparency, and widening access ... it is important that the regulator has a role in the medical school selection process to ensure that it is as fair and transparent as possible, and that there is equity in access. Selection to medicine is an important step to becoming a doctor for applicants from an extremely diverse range of backgrounds and qualifications, and is the gateway to a medical career.

6.86 The Nursing and Midwifery Council argued that:

Whilst education institutions set the level of education to be achieved (meeting EU requirements where appropriate), regulators should be able to set entry criteria within their standards to reflect the professional attributes required.

6.87 The Academy of Medical Royal Colleges suggested that “the regulator should set standards for selection but not necessarily prescribe the exact method”.

6.88 The Northern Ireland Practice and Education Council for Nursing and Midwifery for Nursing and Midwifery believed that “regulators should have a view with regard to the application and selection of individuals wishing to enter a pre-registration programme for a profession”.

6.89 Optometry Scotland was of the view that the regulators “do control those entering education through the standard setting process”.

**Question 6-7: Could our proposals go further in providing a framework for the approval of multi-disciplinary education and training, and if so how?**

6.90 A small majority felt that our proposals could not go further in providing a framework for the approval of multi-disciplinary education and training.<sup>7</sup> For example, the Health and Care Professions Council pointed out that it already produces:

standards of education and training which are applicable across 15 professional groups, which help to facilitate multi-disciplinary education and training, and the approval of multiple programmes at multi-professional approval visits.

6.91 The Royal College of Obstetricians and Gynaecologists said that:

Unless the whole philosophy of healthcare education is revisited, it is difficult to envisage a framework that would be sufficiently meaningful to the professions or to education providers.

6.92 The Royal College of General Practitioners suggested that:

Guidance on the regulation of multi-disciplinary education may well be useful – with the strong reservation that multi-disciplinary education is not always an appropriate model, that it should not be the place of these proposals to push this model, and that its extent should be left to the determination of the professions themselves.

6.93 The General Optical Council stated that:

Ensuring that enough flexibility is available in how and what we accredit would allow for multiple disciplinary training, but this should not be at the expense of our ability to assess against profession-specific requirements (for example competencies and practical experience). This may be more relevant to NHS-funded training.

6.94 The General Medical Council thought that it “would be helpful if the statute provided a facilitative framework which would permit the approval by different regulators of multi-disciplinary education and training”. The Academy of Medical Royal Colleges agreed with the idea of a framework, that could be used by regulators at their discretion.

6.95 Some consultees supported the concept of multi-disciplinary education and training, but were cautious about whether the Law Commissions’ reforms could deliver significant change. The Registration Council for Clinical Physiologists argued that multi-disciplinary training and education should be encouraged “but that this is not an area which should be dealt with in statute”. An individual consultee (Don Brand) said that “substantial shifts of attitude and practice on the parts of the professions involved” was a prerequisite for change. NHS Education for Scotland agreed that this was not a matter for statute, but suggested that

<sup>7</sup> Of the 192 submissions which were received, 44 expressed a view on this question: 14 said our proposals could go further, 23 disagreed, whilst 7 held equivocal positions.



“evidence of interprofessional education could be required in the regulatory process”.

6.96 In respect of multi-disciplinary training, the Department of Health argued that:

We consider that if there was more coherence between the approach to standard setting and quality assurance of education and training it would be easier to provide some level of global approval for multi-disciplinary education and training. If multi-disciplinary education and training become more prevalent, a framework for it might eventually be helpful.

6.97 The Scottish Government argued that more work is needed to develop a framework for multi-disciplinary education and training.

6.98 The Department of Health, Social Services and Public Safety for Northern Ireland supported a framework for multi-disciplinary education “where common standards apply”.

6.99 However, some felt that our proposals should go further. The Centre for the Advancement of Interprofessional Education argued that:

Common studies are not enough to further collaborative practice unless and until they are complemented by interactive learning between the professions. Hence, an increasing emphasis on joint interprofessional education between the professions, the universities and the service delivery agencies, supported by the regulators, is strongly advocated. Each university mounting courses for the medical health and social care professions should be required to present an interprofessional education strategy.

6.100 The British Pharmaceutical Students' Association stated that:

We would welcome a move towards compulsory multi-disciplinary education and training within the Masters of Pharmacy course. Making approval of multi-disciplinary education and training a compulsory component of course accreditation would ensure Schools of Pharmacy, and other health care courses, implement this solidly within their courses.

6.101 Coventry and Warwickshire Partnership Trust suggested that “a common first year syllabus for undergraduate training” might offer “greater opportunities for students to make career choices with a degree of knowledge and understanding of the roles” and “facilitate better multi professional learning and development for the future and reduce some of the barriers to multi disciplinary working that are currently visible”. However, the UK-wide Nursing and Midwifery Council Lead Midwives for Education Group disagreed with a common first year which it felt would lengthen the programmes and have funding implications.

**Question 6-8: Is too much guidance being issued by the regulators and how useful is the guidance in practice?**

6.102 Opinion was divided on whether too much guidance is issued by the regulators,<sup>8</sup> and in respect of its usefulness.<sup>9</sup>

6.103 Some were critical of the regulators' approach to guidance. For example, the Medical Protection Society argued:

We believe that, in general, there is too much guidance some of which is too prescriptive. It becomes difficult for professionals to make themselves aware of the published material, which obviates against its purpose.

6.104 The Royal College of General Practitioners stated that:

It is a common complaint from our members that the General Medical Council issues too much guidance and it is difficult for the busy professional to keep track of all developments. This is of particular concern, for example, where guidance has a bearing on fitness to practise, as with the Council's *Good Medical Practice* – guidance like this needs to be succinct, clear and specific, to avoid confusion and distress.

6.105 The Medical Defence Union gave the following example:

If *Good Medical Practice (GMP)* is classified as the General Medical Council's code of conduct, it might be assumed that guidance provided supplementary to that document is intended as "ethical guidelines and other guidance" because this supplementary guidance is intended to provide more detail of how to comply with *GMP* and so it could be assumed it has a different status. But for doctors who are required to comply with the guidance, it is often difficult to distinguish between the different documents and to try to determine their status. *GMP* frequently refers readers to relevant supplementary guidance and has numerous footnotes on each page, while the supplementary guidance begins by referring to *GMP*. The effect of this in practice is that the distinction between the different documents is largely artificial. All guidance is relevant and it is probably safer for doctors to assume that all documents have equal weight.

6.106 It argued that "to add further to the confusion" doctors need to consider guidance available from other bodies and ask "whether it in any way supersedes or is supplementary to the guidance produced by their own regulator".

6.107 The General Social Care Council considered that "professional regulators should pay greater attention to the efficacy and usefulness of guidance before issuing it".

<sup>8</sup> Of the 192 submissions which were received, 24 expressed a view on this question: 7 said there is too much guidance, 8 disagreed, whilst 9 held equivocal positions.

<sup>9</sup> Of the 192 submissions which were received, 23 expressed a view on this question: 7 said all the guidance was useful, 6 said most was useful, 4 said only some was useful, 3 said the guidance was sometimes unhelpful, whilst 3 said this depends on the regulator.

It suggested that the Professional Standards Authority “may wish to conduct an audit of the range of guidance which is currently available ... and how and whether this conflicts and overlaps”.

6.108 The Academy of Royal Medical Colleges thought that guidance was generally helpful, but noted that “regulators should be aware of the dangers of consultation and guidance overload”. The Pharmaceutical Society of Northern Ireland also acknowledged the “danger of overload”, but did not consider that it would be “acceptable for a regulator not to issue any form of guidance in relation to standards it is responsible for enforcing”.

6.109 Many felt that in practice, few practitioners read the guidance from their regulatory body, and some emphasised the role of professional bodies in producing effective guidance. The British Society of Hearing Aid Audiologists stated:

We strongly believe that quality of guidance is only assured if it has been produced with the involvement and approval of professional bodies. We believe that regulators should not assume the role of professional bodies but should work very closely with them in the production of guidance. An effective partnership between regulators and professional bodies minimises unnecessary duplication of guidance and should add weight and authority to such guidance when both regulators and professional bodies are in agreement with what such guidance should contain and how it should be reviewed.

6.110 The Society and College of Radiographers stated that:

Guidance produced by regulators should be complementary with that produced by professional bodies and should also take account of the fact that employers will also issue guidance affecting practise of registrants.

6.111 Coventry and Warwickshire Partnership Trust felt that an agreement should be formed by the Government, regulators and professional bodies “on who provides guidance on what and a process to ensure that it supports rather than conflicts”.

6.112 Charles Russell LLP expressed concerns about General Pharmaceutical Council guidance which registrants are expected to adhere to which is not publically available and can only be accessed by Royal Pharmaceutical Society members.

6.113 However, some argued that it is important for the regulators to issue guidance, and that the professions welcome clear statements from the regulator. For example, an individual consultee (Stephen King) felt that as a podiatrist the Health and Care Professions Council “does not give too much guidance and what it does is useful”. The Association of Clinical Biochemistry agreed that the Council issues the right amount of guidance.

6.114 The British Psychological Society felt that guidance was useful to “balance some of the pressures that come from employers and to provide support to members if

there is a conflict of interest”. The British Association for Counselling and Psychotherapy thought that guidance was “likely to respond to frequently asked questions”.

- 6.115 The Royal College of Nursing believed that there are certain topics on which the Nursing and Midwifery Council issues guidance – for example vulnerable adults, medicines management, accountability – which are “very important and helpful to practicing nurses”. However, it noted “that it is difficult to know how consistently such guidance is implemented and therefore what impact it has”.
- 6.116 Skills for Care believed that the regulators of social care professionals have issued an appropriate amount of guidance. It was concerned that this should not be lost in the transition from the General Social Care Council to the Health and Care Professions Council.
- 6.117 The Nightingale Collaboration argued that “too little guidance” is issued by the General Chiropractic Council and General Osteopathic Council and more is needed on the scope of practice in order to prevent practitioners from misleading the public about which conditions can be treated effectively by these professions.
- 6.118 The General Osteopathic Council noted that the answer to the Law Commissions’ question would “depend on the profession concerned”. The Council pointed out that osteopaths only receive one piece of guidance.
- 6.119 The General Medical Council warned against dismissing “what might seem high level and generalised statements in some guidance”. It said that:

The consultation document questions the value of guidance which prohibits sexual relations between healthcare professionals and their patients because such principles should be obvious. The fact remains, however, that regulators continue to have to take action in relation to individuals who have disregarded guidance in this area. The fact that we know sexual assault is wrong does not remove the need for the Sexual Offences Act. The existence of the guidance establishes expected principles of professional behaviour and helps regulators frame the appropriate sanctions when those standards are ignored.

- 6.120 It argued that the quantity of guidance produced often reflects the fact that it will frequently have more than one audience and be used in a variety of different contexts. It stated that:

General Medical Council guidance will usually be directed primarily at doctors, but it will also have implications for employers (as in the case of NHS appraisal), educators (the development of curricula and outcomes for training), and for the way patients understand what they can expect of their doctors (we plan to introduce a patient version of our core guidance *Good Medical Practice* in 2012).

- 6.121 It was also argued that General Medical Council guidance often underpins the guidance provided by other bodies, such as the medical defence organisations, the British Medical Association and the medical Royal Colleges.

6.122 The Health and Care Professions Council argued that:

The level and volume of guidance published will inevitably vary from regulator to regulator – dependent on factors such as how developed the “professional infrastructure” in each profession is (eg the existence of professional bodies and colleges) and whether the regulator regulates a single profession or a number of professions.

6.123 The Nursing and Midwifery Council disagreed that there should:

be a presumption that if a topic is covered elsewhere, for example, through National Institute for Clinical Excellence standards or workplace guidelines, it should not also be the subject of guidance from regulators. The “contract” between a regulator and its registrants demands that registrants have a right to clarity about which aspects of practice are critical to their continued registration.

6.124 Similarly, the General Optical Council argued that:

The fact that guidance is produced by another related regulator or other organisation should not preclude more tailored guidance being issued by regulators for their own audiences.

6.125 The Professional Standards Authority stated that:

There are clearly many areas of commonality in the work the regulators undertake that would benefit, from the perspective of the intended audiences, from a common or shared approach. For example, guidance for education providers on student fitness to practise is something that could perhaps be usefully produced as a single piece of guidance.

6.126 Furthermore:

We have tried to gather information from the regulators about the impact of their guidance on registrants through our annual performance review, but this has not yielded much data. For individual registrants we are aware, from a literature review we commissioned recently on the major behavioural influences on health professionals’ performance, that there is little if any evidence supporting the effects of regulators’ guidance on behaviour.

6.127 The Scottish Government argued that “it is for the regulators to ascertain the volume of guidance produced in accordance with their statutory functions”. However, it wanted to explore further whether the statute could encourage joint guidance in some areas and help clarify “the roles of regulators and professional bodies in developing and disseminating guidance and ensuring good practice”.

**Provisional Proposal 6-9: The statute should require the regulators to issue guidance for professional conduct and practice.**

- 6.128 An overwhelming majority agreed with this proposal that the regulators should be required to produce guidance for professional conduct and practice.<sup>10</sup> For example, the Professional Standards Authority stated that:

It is very difficult, if not impossible, to see how the regulators can successfully protect the public in the absence of fundamental core standards of conduct and practice.

- 6.129 The National Clinical Assessment Service supported the need for clear guidance provided by the regulators and also suggested a single code of conduct across all regulated professionals. NHS Education for Scotland also supported a single code.

- 6.130 Some consultees thought that guidance for professional conduct and practice was an important source of information for the public. For example, the Nursing and Midwifery Council said that such guidance is:

the means by which the assurance provided by professional regulation is made manifest to the public, and by which registrants understand how they can remain in good standing.

- 6.131 An individual consultee (Jane C Hern) also agreed that guidance assisted “both the profession and the public”.

- 6.132 The General Optical Council and the Royal College of Nursing both noted that the proposal reflects current practice.

- 6.133 Some suggested specific amendments to the proposal. NSPCC argued there should be a duty on the regulators “to include the issue of safeguarding of vulnerable children in their codes of practice or codes of conduct”. The London Fire Brigade suggested that the codes should require registrants to identify fire risks and for training to be mandatory. Many questioned whether “guidance” is the appropriate term for a professional code of conduct.

- 6.134 A small number disagreed with the proposal. Optometry Scotland argued that “guidance should be provided by the professional bodies and not placed in statute”. The Optical Confederation suggested that the duty should be to “ensure that guidance is issued” therefore enabling the retention of the current system “by which the College and the Association of British Dispensing Opticians develop guidance for the two professions which is then endorsed by the regulator”.

<sup>10</sup> Of the 192 submissions which were received, 46 expressed a view on this proposal: 44 agreed, whilst 2 disagreed.

**Provisional Proposal 6-10: The statute should provide for two separate types of guidance: *tier one guidance* which must be complied with unless there are good reasons for not doing so, and *tier two guidance* which must be taken into account and given due weight. The regulators would be required to state in the document whether it is tier one guidance or tier two guidance.**

- 6.135 Opinion was divided on the proposal that the statute should provide for two tiers of guidance.<sup>11</sup>
- 6.136 The Association of Regulatory and Disciplinary Lawyers felt that the proposal would be “a helpful clarification given the amount of guidance being issued”. The Royal College of Nursing agreed there can be confusion between various types of guidance and standards, and that the regulators should be clear “about the purpose and weight of communications which they issue, for example being clear about how they expect registrants to use them”.
- 6.137 The General Dental Council felt the proposal reflected the approach adopted by its Standards Review Working Group which has developed new guidance consisting of “patient expectations, standards and guidance” whereby “the standards equate to tier 1 (the mandatory ‘what’) and the guidance to tier 2 (advice on the ‘how’)”. The Council agreed that guidance must clearly state its legal status and “the possible consequences of serious or continued breaches”, and “the language in guidance should be consistent between regulators”.
- 6.138 An individual consultee (Jane C. Hern) felt that the proposal would be helpful “to highlight and distinguish the ‘must do/not do if at all possible’ from the more aspirational ‘good practice’”. The Patients Association felt that the statute should also set out “a defined list of those areas that ‘must’ be tier one guidance, for example professional standards”.
- 6.139 The Medical Protection Society argued that the proposed two tier approach would be clearer “than the General Medical Council’s current use of the words ‘should’ and ‘must’ which can be confusing”. The Royal College of General Practitioners also observed that *Good Medical Practice* included a diverse range of activities or failures which “potentially put a doctor in breach, where some might appear relatively trivial where others are clearly very serious”.
- 6.140 Optometry Scotland noted that a “two tier approach was introduced by the College of Optometrists some time ago and is endorsed by the General Optical Council”. It saw no reason to amend this system.
- 6.141 The Institute of Health Visiting agreed with the proposal but was concerned that “‘tier two’ guidance should not be seen as optional, if it is about good practice”. The Professional Forum of the Pharmaceutical Society of Northern Ireland supported the proposal but argued that issuing second tier guidance should be a function of the professional body.

<sup>11</sup> Of the 192 submissions which were received, 60 expressed a view on this proposal: 25 agreed, 22 disagreed, whilst 13 held equivocal positions.

6.142 The Professional Standards Authority was supportive of the intentions behind the proposal but said:

We can foresee a situation arising where potential inconsistencies may arise if one regulator classifies something as tier one when the same guidance is classified as tier two by another. This could prove problematic for multidisciplinary teams, especially if concerns arise about fitness to practise.

6.143 It was suggested that the statute should identify “requirements” and “guidance”, or provide for two types of guidance, “one a ‘must do’ and the other a ‘how to’”.

6.144 The Osteopathic Alliance was also concerned about the impact of two tiers of guidance in fitness to practise proceedings. It thought that, if the proposal was adopted, it should be:

written into the statute that it is an acceptable defence that in the clinician’s considered clinical judgment at the time it was not appropriate to follow that guidance, whatever the outcome.

6.145 However, some disagreed with this proposal. The Department of Health, Social Services and Public Safety for Northern Ireland questioned how the courts would interpret this proposal and felt it was unhelpful to distinguish between mandatory and optional guidance.

6.146 The Health and Care Professions Council felt that its governing legislation already provided clarity “about the distinction between standards and guidance” in that “standards set a requirement which must be met by a registrant or an education provider” and “guidance sets out ways in which those standards might be met”.

6.147 The British Chiropractic Association thought that two tiers of guidance may “produce unnecessarily cumbersome Codes of Practice and Standards of Proficiency which may serve to leave registrants unsure of their obligations”. The Department of Health felt that having two tiers of guidance might be helpful in some cases but was concerned that this approach may become “overly complicated”. It suggested that it might be better to “first consider what sort of issues need guidance and then decide if the regulators should be required to issue such guidance or have discretion”.

6.148 The General Medical Council felt that the proposal:

fails to recognise the extent to which our guidance is integrated into all of our regulatory functions, from education to fitness to practise. This sort of disaggregation of the standards would bring practical problems. The assumption would appear to be that failure to observe tier one guidance would result in fitness to practise action. But the implications of persistent and cumulative disregard of tier two guidance are less clear even though this may have a significant bearing on an individual’s professional performance.

6.149 It contended that *Good Medical Practice* already recognises “the nuances of distinction between guidance which must be complied with and behaviours which



should be followed” through the use of “must” and “should”. The Council argued further that the proposal:

fails to recognise the extent to which tiers might apply differently across different UK jurisdictions, thus adding unnecessary and dangerous complexity to the challenges of regulating a common set of enforceable standards across the four countries.

- 6.150 The Medical Defence Union felt that in practice it is “almost impossible to distinguish between guidance that must be complied with and guidance that must be taken into account and given due weight”. It argued that:

If a regulator publishes guidance and it is in the public domain, in practice the registrant has to comply with it unless he or she can demonstrate good reasons to do otherwise.

- 6.151 The Scottish Government agreed that “benefit could be obtained from having the two tiers of guidance proposed” but suggested that “exemplars already exist which could provide a starting point” such as *Good Medical Practice*. It was also concerned that there is the potential for disparity between the regulators “for example in determining which areas are tier one or tier two, which would serve to confuse the public and result in less rather than more transparency”.

- 6.152 It also pointed to the use of “must” and “should” in *Good Medical Practice*:

We do not see the distinction between must and should as producing two-tier guidance but as recognition from the regulator that in some circumstances all registrants are required to comply, but in others, registrants are required to comply only as far as is in their power and as it is reasonable for them to do.

- 6.153 The General Pharmaceutical Council felt that its own approach, whereby a “‘standard’ is something which must be met”, whereas guidance is a non-mandatory “description or advice about how to meet the standard”, was more consistent with the ordinary use of the term “guidance”. It also argued that the proposal may not achieve any clarity of definitions of standards and guidance because professional bodies also publish “a range of guidance and use a range of descriptors such as ‘standards’ or ‘guidance’ or advice ‘bulletins’”.

- 6.154 The General Osteopathic Council pointed out that while the *Osteopathic Practice Standards* differentiates between standards that must be complied with and associated guidance, the reality is more finely nuanced.<sup>12</sup> The Council said:

In the *Osteopathic Practice Standards* we draw a distinction between “must”, “may” or “should” to guide and support osteopaths in their professional decision-making. This immediately suggests that more than two tiers may be required ... We believe that this is an area where it would be better for the regulators to continue to evolve individual approaches and for best practice and innovation to emerge without a single prescribed approach.

<sup>12</sup> General Osteopathic Council, *Osteopathic Practice Standards* (2012).

- 6.155 The General Social Care Council also felt that the regulators should be given “maximum flexibility” to issue guidance and standards. It argued that:

Whilst the guidance and standards that are issued by regulators are important, it is ultimately for the registered professional to take responsibility for their practise. Whilst guidance and standards may be useful in informing this practise professionals themselves should be trusted to make decisions without the need to refer, in advance, to guidance. They should be held to account against the standards issued by the regulator but also against standards issued by other bodies.

- 6.156 Many commented on the terminology used in the proposal. The Academy of Medical Royal Colleges argued that calling both tiers “guidance” can be confusing “as requirements are rules and guidance is advisory”. The Nursing and Midwifery Council preferred the terms “code” and “standards” since they have “meaning and currency in professions and should be retained”.

- 6.157 The General Optical Council was not clear what was added by “the proposed terminology of ‘tier one’ and ‘tier two’ guidance ... relative to the current distinction between standards/codes and guidance”. It felt that the word “guidance” itself implies that it is non-binding and therefore “the concept of binding guidance may cause confusion”. The Council also questioned whether the:

distinction between tier one guidance that “must be complied with *unless there are good reasons for not doing so*” and other guidance that must be “taken into account” is sufficiently clear.<sup>13</sup>

- 6.158 The Pharmaceutical Society of Northern Ireland agreed with the rationale behind the proposal but preferred its own system whereby mandatory professional standards are indicated by “must” and “have to” and guidance on good practice is indicated by the words “should”, “might”, “may”, “would”, “will” and “could”.

- 6.159 The Society and College of Radiographers felt that the use of terms such as “tier one guidance” is less important than “stating clearly the importance of the document”, for example that “this guidance is important to your registration and ability to work”.

- 6.160 Unite believed that “tier two guidance should not be reduced to ‘nice to do if we have the money’, which would mean that it would be unlikely that it would be done”.

**Question 6-11: How should the legal framework deal with the regulators’ responsibilities in relation to professional ethics?**

- 6.161 Opinion was divided over how the statute should deal with professional ethics.<sup>14</sup>

<sup>13</sup> Emphasis added.

- 6.162 Some called for a clear separation between ethics and standards. The Association of Regulatory and Disciplinary Lawyers argued there is an “important distinction between standards of practice (conduct and performance) and ethical codes, and the latter should be “in the form of a set of core principles which are common across all the health and social care regulators, which would be in the interests of clarity for the public”. An individual consultee (Lucy Reid) felt that practitioners would welcome a separate requirement for the regulators to provide ethical guidance and while there is some overlap with standards for practice, ethics can be “more sensitive to the nuances of the situation”. Coventry and Warwickshire Partnership Trust also agreed that it “would be useful if the regulator clearly separated ethics and standards”.
- 6.163 Others pointed to the difficulties in making a clear distinction. The Medical Defence Union felt “it is often difficult and anyway not necessary to separate ethics from conduct and practice” and “if ethical guidance is relevant to practice it should be incorporated into guidance on conduct and practice”. The General Osteopathic Council disagreed that “ethical standards should be treated separately from standards of conduct and performance” since “together they provide a framework for professional behaviours to be exercised and within which fitness to practise is a requirement”. The Association of Clinical Biochemistry regarded ethical guidelines as “a sub-set of codes of practice”.
- 6.164 The General Dental Council provided the following example:
- Respect for a patient is an ethical approach but it is demonstrated by actions covered in standards in varied ways such as the giving of adequate information, checking that the patient understands, encouraging shared decision making and referring on if appropriate.
- 6.165 The General Medical Council argued that it would be helpful:
- to start from the premise that ethics deals with discussion and understanding of an issue while “standards and professional conduct” provide advice on how to put ethics into practice. On that basis, we could regard regulators’ role in providing advice on ethics as a statutory power, but advice on standards and conduct as a duty.
- 6.166 The General Optical Council felt that regulators did have some role in relation to ethics, which should be set out in the statute. However, the Council also wished to retain flexibility about how it discharged its role. The Department of Health stated that the regulators’ responsibilities “in relation to professional ethics should be related to public protection and the overall suitability of a professional’s fitness to practise”.

<sup>14</sup> Of the 192 submissions which were received, 37 expressed a view on this question: 6 said that professional ethics should be dealt with separately, 12 said this should be dealt with within professional standards, 7 emphasised the role of the regulator, 9 emphasised the role of professional bodies, 2 said that there should be uniform code of ethics across the regulators, whilst 1 gave an equivocal response.

- 6.167 Many argued that ethics are not a matter for the regulator. The British Association for Counselling and Psychotherapy argued that “the development of ethics is the responsibility of the profession” and “the use of those ethics in conduct matters is for the regulator”. Similarly, the British Medical Association argued “it is for professions to determine appropriate ethical standards and for the regulator to apply them, taking into account any relevant legislation”. However, Unite argued that “the legal framework should ensure that regulators are not solely relying on professional body guidance as membership of a professional body is optional”.
- 6.168 The Professional Standards Authority disagreed with giving regulators responsibility for professional ethics since “it is more appropriate and accessible for all stakeholders to cover these issues within a framework of professionalism”. The Scottish Government considered that “professional ethics are an integral part of an individual’s character and suitability to be a registered healthcare professional” and “given that the distinction between standards and ethics cannot be sharply defined” they should not be separated in the legal framework.
- 6.169 An individual consultee (Dr Susan Blakeney) argued that the statute should retain existing arrangements whereby the College of Optometrists produces the *Code of Ethics and Guidelines for Professional Conduct* which supplements the General Optical Council’s Code of Conduct.
- 6.170 The Nursing and Midwifery Council argued that:
- What matters is that the framework for professional regulation supports and requires regulated professionals to take professional responsibility for navigating the ethical complexity with which they work. It is also important that regulators provide a framework within which that important work is done, including through the use of professional codes.
- 6.171 The British Association of Social Workers felt that the “code of conduct/ethics should be enshrined in statute and common to all the health care professions”. Similarly, the Professional Forum of the Pharmaceutical Society of Northern Ireland argued that the “minimum standards, the ‘do no harm’ statements” could be common across all health care professions. The General Social Care Council also suggested that the statute:
- should require regulators to issue standards in relation to ethics, however, they should be encouraged to develop common standards of professional ethics governing all the professions subject to regulation. There is no good reason why the ethical behaviour of a doctor should differ from that of a social worker.

**Provisional Proposal 6-12: The statute will require the regulators to ensure ongoing standards of conduct and practice through continuing professional development (including the ability to make rules on revalidation).**

- 6.172 The vast majority agreed with this proposal.<sup>15</sup> For example, the Professional Standards Authority said that the “statute should oblige regulators to make rules in this area”. The Authority also said that the statute should:

make provision for an appropriate and proportionate response from regulators to changes in risks associated with ongoing standards of conduct and practice over time.

- 6.173 The British Association and College of Occupational Therapist saw the Authority itself as having a “strong role to play” in encouraging the sharing of good practice in this area.

- 6.174 The Royal College of Physicians of Edinburgh stated that the duty to ensure ongoing standards will require the regulator “to work closely with the medical Royal Colleges”. The Medical and Dental Defence Union of Scotland argued that continuing professional development “must reflect the sphere of work the registrant is engaged in and therefore must be relevant” and argued that in dentistry continuing professional development “is too input focussed and could be construed as a ‘tick box’ exercise”. Unite recommended the Health and Care Professions Council’s approach to continuing professional development “which is standards based and emphasises application of knowledge to practice and insists on a mixed format of continuous learning”.

- 6.175 The Institute of Health Visiting expressed concern about the “lack of rigour concerning continuing professional development for health visitors”, arguing that portfolios are rarely audited and there is no requirement for “relevant learning”. It stated:

This means that some employers claim their staff have met all their continuing professional development requirements if they have attended, eg annual fire, moving and handling and cardiac resuscitation study days, which easily covers the requisite 35 hours in three years. However, it will not have advanced or even maintained the practitioners’ professional knowledge or skill in their particular field.

- 6.176 The Institute also argued that because health visitors are regulated primarily as nurses or midwives, the Nursing and Midwifery Council requires them to demonstrate the completion of “450 hours current practice in nursing or midwifery, as well as in specialist community public health nursing”. This causes particularly difficulties for “direct-entry midwives” who unlike nurses are not allowed to “double count” their hours.

<sup>15</sup> Of the 192 submissions which were received, 56 submissions expressed a view on this proposal: 54 agreed, whilst 2 disagreed.

- 6.177 NHS Greater Glasgow and Clyde pointed to the difficulties caused by the Nursing and Midwifery Council when it introduced a requirement that midwives must demonstrate a specific number of hours in “delivery” per year. This had to be abandoned when it became apparent that midwives working in special care baby units could not satisfy this requirement.
- 6.178 The Royal College of Nursing expressed concern that employers do not always allow nurses to undertake continuing professional development and felt that in the current economic climate this will increase. It also criticised the Nursing and Midwifery Council for not routinely checking nurses’ post-registration education and practice portfolio.
- 6.179 Some consultees suggested enhanced duties in this area. For example, the Nightingale Collaboration argued that the statute should place a duty “on the registrant to review and take account of new scientific evidence and meta-analyses” and ensure that “all practice must be based on the consensus of sound scientific evidence”. The Osteopathic Alliance argued that that the power to set standards for continuing professional development should be limited to those areas with a direct bearing on patient safety. It also pointed out that:

requirements for continuing professional development have a financial impact not just for organisations such as the NHS but also for practitioners in private practice (including most osteopaths), who will have to take unpaid time out of work to provide the evidence.

- 6.180 The Optical Confederation argued that that the statute should not require ongoing standards of conduct and practice *through* continuing professional development but instead the regulators should be able to consider other means of achieving the same ends. Similarly, an individual consultee (Anonymous) argued that in an era of right-touch regulation, it should be open for the regulators to argue that the ongoing standards can be maintained through “the standard setting in education and fitness to practise process” and that it should be “for employers and individual practitioners to ensure their on-going fitness to practise”.
- 6.181 West Sussex County Council thought that:

The key to [that] continuing professional training and learning is not a rigid compliance with competencies for practice but the ability to demonstrate such competencies within the context of critical reflection and practice analysis.

### **Revalidation**

- 6.182 A number of consultees commented specifically on revalidation. The Patients Association argued that revalidation should be part of the continuing professional process and enshrined within the statute. It felt that:

It does not seem logical to have continuing professional development but not revalidation. Revalidation makes sure that the information gathered during continuing professional development is properly assessed as well as ensuring codes of practice are being followed by practitioners.

- 6.183 The Scottish Government argued that “the intensity and frequency of revalidation for the health care professions should be proportionate to the risks inherent to their work”. It also argued that “a degree of oversight and scrutiny/monitoring would be needed in relation to the introduction of revalidation” in order to ensure “proportionality and effectiveness and minimising costs” and to “identify any issues that may affect individuals’ performance rather than being picked up at a later stage eg at fitness to practise hearings”.
- 6.184 The General Pharmaceutical Council stated that it already requires all registrants to complete continuing professional development records and it needs powers “to make rules in connection with continuing fitness to practise (revalidation)”. It endorsed the key principle of revalidation that evidence of conduct and practice would be required from more than one source and not solely continuing professional development records.
- 6.185 The British Pharmaceutical Students’ Association supported giving the General Pharmaceutical Council powers to introduce revalidation. The General Dental Council welcomed “the recognition that revalidation will be a part of the future healthcare regulatory landscape”.
- 6.186 The Association of Clinical Biochemistry supported the proposal but was concerned over “the potential for revalidation systems to be disproportionately burdensome and expensive to run”. Optometry Scotland stated:

We would hope that the revalidation process is left to the discretion of the regulator so this is fit for purpose and proportionate to the risk to the public. In addition the process should be flexible to cover different standards of clinical practice across the UK.

- 6.187 The Welsh Government argued that “it is important that any costs are proportionate to the benefits of introducing revalidation for all professionals”.
- 6.188 The Medical Defence Union argued that “given that most practitioners within the NHS are practising in managed environments and their institutions are also subject to regulation” it must not be assumed that revalidation is the most effective way of protecting patients. Any introduction of revalidation must be “subject to strict cost-benefit analysis” and the regulator should be required to demonstrate that revalidation would bring “substantial additional benefits for public protection that justify the additional and substantial cost and administrative burden upon the profession”.
- 6.189 The Department also wanted to explore further whether there is scope for the regulators to have powers to “quality assure assessments made on the professional standards of staff” to ensure “local processes are working effectively rather than waiting until an issue is raised through fitness to practise procedures”.
- 6.190 The Health and Care Professions Council felt that greater clarity was needed over what is meant by revalidation and how this differs from continuing professional development. Furthermore:

The introduction of any revalidation system should be subject to a formal impact assessment and public consultation ... The regulators will consider impact and risk as a standard part of their policy

development and consultation processes. However, unlike government departments and non-departmental public bodies, they may not routinely produce formal impact assessments ... We are particularly supportive of an express requirement to publish an impact assessment before implementing revalidation or establishing a voluntary register (a current requirement in the relevant legislation).

6.191 The Royal College of Radiologists emphasised that under revalidation “the focus should be on remediation with appropriate time allowances made for those involved in or assisting in the process”.

6.192 The Department of Health had concerns about the introduction of revalidation in the “non-medical professions”. It thought that:

At the very least the non-medical regulators should be required to publish an impact assessment for consultation before introducing any new requirements and should have to have regard to the principle of proportionality in setting any standards.



## **PART 7**

### **FITNESS TO PRACTICE: IMPAIRMENT**

**Question 7-1: Should the statute: (1) retain the existing two-stage approach for determining impaired fitness to practise; or (2) implement the recommendations of the Shipman report; or (3) remove the current statutory grounds which form the basis of an impairment and introduce a new test of impaired fitness to practise based on whether the registrant poses a risk to the public (and that confidence in the profession has been or will be undermined)?**

- 7.1 A small majority supported the removal of the existing statutory grounds and the introduction of a new test of impaired fitness to practise based on whether the registrant poses a risk to the public (and that confidence in the profession has been or will be undermined) – option three.<sup>1</sup>

#### ***Option one: consolidation of the current framework***

- 7.2 Many of those who supported option one felt that there was no need to change the existing system. For example, the British Chiropractic Association argued that the “current listed grounds for a finding of impaired practice are clear and unambiguous”. The Optical Confederation thought that the existing scheme protected registrants, whereas the alternatives did not “strike the appropriate balance of fairness between the registrant and the public”.
- 7.3 The Association of Regulatory and Disciplinary Lawyers argued that “the current position regarding the categories of impairment and their meaning has been clear for some years” and added:

There is no such thing as a new test that beds in with no further need for interpretation or judicial guidance on its application. For that reason we think that there must be an appreciably good reason to change the process, given the certainty that exists now about the definition and scope of the current categories or grounds of impairment. We have not identified such a reason in the discussion in the consultation paper.

- 7.4 The General Dental Council argued that “any change would be disruptive and there would be many legal challenges before the system could once again work smoothly and predictably”.
- 7.5 The General Optical Council agreed with retaining the current system but accepted there are difficulties that should be addressed. It noted that:

<sup>1</sup> Of the 192 submissions which were received, 62 expressed a view on this question: 19 supported option one, 8 supported option two, 33 supported option three, whilst 2 held equivocal positions.

The current definitions are rigid, and perhaps do not place public safety/protection at the heart of the decision. We would support exploration of a more modern and flexible set of grounds of impairment, which might include issues of trust and confidence in the profession.

7.6 The Nursing and Midwifery Council argued that “the more immediate issue needing to be addressed is the current separation of processes and committees for these different statutory grounds”. It continued, “once a single Fitness to Practise Panel is introduced, as is proposed, this will remove many of the remaining concerns [regarding efficiency and effectiveness]”. The Council also preferred a term such as “deficient performance” or “poor performance”, rather than “lack of competence”, since the latter is a “narrower concept which has not been regarded as very flexible in its application to performance cases”.

7.7 The Professional Standards Authority also felt that the current system works best where the regulator has a unitary Fitness to Practise Panel “that can deal with all impairment issues holistically” and supported:

a move to require all the regulators to conduct their fitness to practise final hearings in front of such unitary committees, and to abandon the distinction between conduct, performance and health allegations, thus enabling them to consider “mixed” allegations in the round at the same hearing in the way that the General Medical Council already does. The benefit of this would be that, for example, fitness to practise cases involving matters relating to both the professional’s health and conduct, could be considered as one, rather than separately.

7.8 The Authority also queried whether our proposal for the statutory grounds would actually apply to barring decisions, given that such determinations do not include findings to the effect that a person’s fitness to practise is impaired.

7.9 However, a number of consultees were opposed to option one. The Health and Care Professions Council felt that the existing system is “difficult to understand for complainants and the public”, and leads to “the practical difficulty that health cases must be dealt with by a separate committee”.

7.10 The Royal College of Nursing argued that the current system:

causes problems for members of the public and registrants alike. In our opinion, the definition of misconduct is now so wide and diluted that a large category of activity is caught by it. It also does not help in the strict legal analysis of cases either.

7.11 The Equality and Human Rights Commission opposed this option unless it was amended to remove the references to good health and character.

***Option two: Shipman recommendations***

7.12 This option was supported by Rescare which argued it would provide for “objective standards in the investigation”, and “at adjudication there will be a

requirement to examine both past and future and the process is consistent with the judicial process”.

7.13 Newcastle City Council argued that this option protects the public by enabling practitioners to be suspended while an investigation takes place and therefore alleviates the responsibility on employers to take such action.

7.14 The Professional Forum of the Pharmaceutical Society of Northern Ireland also supported this option on the basis that:

The inclusion of a clear definition of impaired fitness to practise ensures objectivity and clarity. There is also the ability for the Fitness to Practise Panel to consider the effect of the registrant’s conduct on the reputation of the profession, which the Forum supports. The use of the final test, realistic prospect of a prosecution, is also supported as this should reduce the number of minor or irrelevant cases. The Professional Standards Authority supported implementing the Shipman report with some minor amendments to “make it clear that, absent a risk of future repetition, a past failure is not sufficient to amount to current impairment of fitness to practise”.

7.15 The United Chiropractic Association also felt that option two had the potential to ensure that only appropriate cases were pursued. It considered that a large number of cases brought under the current system could be considered to be “unnecessary and costly”.

7.16 However, several consultees opposed option two. The General Pharmaceutical Council argued that it “appears very legalistic, it requires different tests at different stages and in our view is likely to lead to delays and additional costs”. The Medical Defence Union felt that some aspects would be “very difficult to put into practice”, for example, it would be difficult “to establish satisfactorily how someone is liable to act in the future”.

7.17 The Association of Regulatory and Disciplinary Lawyers felt that the Shipman recommendations were not “sufficiently flexible” since they suggest that if any of the criteria are found then impairment follows. This was described as “overly prescriptive” and inconsistent with “modern case law on the role of personal mitigation”. Furthermore, this option would permit a finding that a registrant’s fitness to practise “is impaired (present tense) on the basis of future risk alone”. It argued that “any finding of impairment must be based on past misconduct” and “an assessment of future risk flowing from it, not future risk alone”.

7.18 Similarly, the General Dental Council argued that the Shipman recommendations were flawed because “at adjudication all past misdeeds would need to be investigated and a surmise made about future conduct” which would be “disproportionate and unhelpful”.

***Option three: removal of the statutory grounds***

7.19 The Patients Association said this option was “clearer, has the potential to be more efficient and we particularly welcome the inclusion of a ‘reasonable person’ test”. An individual consultee (Lucy Reid) preferred this option because:

Given that the overriding objective for the regulators is to protect the public and for the practitioner it is to act in the best interests of their patient, introducing a new test based upon whether a risk is posed would be most logical.

7.20 The British Society of Hearing Aid Audiologists felt that option three “relates most closely to the basic regulatory function of protecting the public from the risks resulting from the practice of a registrant whose fitness to practise is impaired”. The Society and College of Radiographers and the Wales National Joint Professional Advisory Committee both agreed that option three was properly concerned with risk to the public and confidence in the professions.

7.21 The General Medical Council supported “the removal of the statutory grounds and the introduction of a new simpler test that would be more easily understood by the public”. However, it suggested that the test should be “based on whether the registrant poses a risk to the public or that confidence in the profession has been or will be undermined”.<sup>2</sup>

7.22 The Health and Care Professions Council argued that option three “is clearer, much more straightforward and aligns with what is suggested to be the paramount duty of professional regulation”. The Council felt that while this option could reduce the threshold for allegations and lead to an increase in the number of investigations, this danger could be addressed by a “standard of acceptance for allegations” which makes it clear:

what the regulator considers to be a fitness to practise issue and ensures that consideration is given to whether the allegation meets the realistic prospect test before referral to formal fitness to practise proceedings.

7.23 The British Association for Counselling and Psychotherapy felt that “the removal of grounds and categories enhances the regulators’ option to consider a much wider field of potential cases/complaints” and therefore will “enhance public confidence”. It also felt that the risk of a larger number of referrals “needs to be managed at the initial investigation stage”.

7.24 The Patients Association disagreed “that the increase in the number of fitness to practise cases should be a concern” since:

This is not a lowering of the threshold but a widening of the scope of what fitness to practise means which fits much more with public perception and is entirely consistent with the regulators’ duties to uphold the paramount duties.

7.25 The Royal College of Nursing supported an amended version of option three whereby the risk ground is “worded in the present tense (‘is a risk’)” and therefore the concept of “making a judgment at the date of hearing (and thus taking into account remedial steps, remorse, reflection, etc) is maintained”. The Royal College of Nursing suggested further amendment in order to ensure that the registrant must pose a “significant risk” to the public “in the course of their

<sup>2</sup> Emphasis in the original.

professional activities”, thus reducing the ability of fitness to practise panels to intervene in matters of private morality. On this basis, it was argued that the additional threshold of impaired fitness to practise would be “unnecessary” and could be removed since if a registrant posed a significant risk it would be obvious that fitness to practise is impaired.

7.26 The General Pharmaceutical Council supported a hybrid approach whereby option three is supplemented by “a duty on the regulators to identify impairment criteria for use in practical decision-making”. It was felt this would provide “predictability and specificity which is helpful in fairness terms, without the stultifying effect of having the criteria defined in detail in the statute”.

7.27 However, several consultees opposed option three. The General Optical Council stated:

We are not yet convinced that this change would have benefits that would justify the risks of introducing an entirely new system, and believe that under such a system there is a possibility that we may end up having similar legal arguments under another name.

7.28 The British Chiropractic Association felt that:

to not limit evidence to any predetermined categories runs the risk of an apparent “scattergun” approach to evidence that is likely to result in registrants facing a disparate range of allegations thereby making it increasingly difficult for a registrant to understand properly the case he/she is facing.

7.29 The Professional Standards Authority argued that option three omits “an important element of the purpose of fitness to practise proceedings – the declaring and upholding of professional standards”. It said that this option will not achieve consistency in the ways in which the regulators undertake fitness to practise cases. Furthermore, the Authority stated:

We have not been able to envisage any scenarios involving conduct which do not fall within the legal definition of either misconduct or one of the other statutory grounds of impairment, in relation to which a regulator would wish to bring fitness to practise proceedings.

7.30 The Association of Regulatory and Disciplinary Lawyers queried whether this option “adds anything to the current position” since a risk to the public has been “central to a finding of impairment since the introduction of the current scheme in 2004”. It added that:

The requirement to characterise the facts found proved as misconduct, deficient performance etc defines the issues and provides the decision-maker with a rigor of approach to the facts and a route-map to the decision on impairment, and indeed sanction, which should not be abandoned in favour of a focus on the *consequences alone* of what he has done (future risk to the public, undermining public confidence); we predict that if there is no codified requirement to categorise the essence of the complaint by reason of which it is said the practitioner's fitness to practise is impaired, competent panels will continue to do so anyway, (demonstrating the need to codify the requirement for all panels).<sup>3</sup>

7.31 The Nursing and Midwifery Council was concerned that:

Considerable legal costs would undoubtedly be incurred on all sides in implementing the new provisions and in building up a new body of case law to assist in the interpretation of the new risk-based definition. We would also suggest that, even if the statutory grounds are removed, some non-exclusive reference to them, as part of the definition of impairment, may still be helpful. This would illustrate the varying ways in which a risk to the public may be established, for example, misconduct, poor performance, ill-health. This would enable reliance to still be placed on the helpful body of case law that has built up in this field.

7.32 RadcliffesLeBrasseur argued that option three would lead to “uncertainty” and produce:

a three stage test; establishing the facts, establishing risk to those whom the registrant treats from those facts and then establishing impairment. There would be the prospect that the third stage would be meaningless and/or otiose ... It is hard to see a Fitness to Practise Panel concluding that the doctor was a risk to patients but that he was unimpaired. There is a fear that risk is being proposed to make it easier to impose sanctions/restrictions.

7.33 It was also argued by RadcliffesLeBrasseur that the adoption of a risk threshold would have the following consequences:

One strand of fitness to practise decision making is that panels hand down sanctions in order to mark disapproval of past conduct in order to set standards for the profession. They may do so based on a finding of impairment despite accepting evidence of remediation, in other words even where they find no risk. The adoption of a risk threshold for the imposition of sanctions would remove that option.

7.34 The Equality and Human Rights Commission expressed concern that option three might allow a wider range of relevant evidence to be gathered and could result in “inappropriate evidence being incorrectly perceived as relevant” in relation to assumptions “about people, for instance in relation to their physical or

<sup>3</sup> Emphasis in the original.

mental health”. A consultee at an event organised by a law firm argued that this option might have an impact on sanctions, given that the practice of some regulators is to limit certain sanctions to different categories of case.

- 7.35 The Department of Health felt that the existing framework should be maintained as “there is a large body of case law to support it” and the case to radically depart from it had not been made. The Scottish Government considered that the current arrangements are “appropriate, familiar to the regulators, work well and are supported by established case law”.

***Other comments***

- 7.36 The British Association for Music Therapy asked the Law Commission to consider the definition of fitness to practise in relation to “registrants working as educators of students in training, rather than as practitioners working with patients”. It was argued that “different standards may be appropriate for each context, and that clarification is needed” and furthermore, “some educators may not be registered ... and so would not be subject to the same standards (and possible sanctions) as their registered colleagues”. This had been prompted by a recent fitness to practise case where students brought allegations of deficient professional performance against a registrant in her role as their tutor.

- 7.37 The Association of Clinical Biochemistry felt that the statute must clarify “what sort of physical or mental health ‘problems’ may constitute a risk to the public”. It gave the example of:

where a practitioner contracts a sexually transmitted disease which is treatable and may have been acquired faultlessly from a spouse or civil partner; or be suffering from stress and depression caused by excessive demands at work. It is also possible that in some situations carrying out an investigation could contravene the Equalities Act 2010 if a healthy individual would not be investigated in the same circumstances.

- 7.38 The Patients Association felt that the key stumbling block is the order in which cases are being considered, in that facts are first established and then it is considered whether the professional’s fitness to practise is impaired. It suggested the following reordering of the process:

- (1) whether, if the alleged acts took place, there would be a risk to the public or to public confidence;
- (2) if there would be a risk to the public or to public confidence, would a professional’s fitness to practise be impaired;
- (3) whether there is evidence that those acts took place; and
- (4) if they then can be proven, what sanctions should be brought.

- 7.39 Several consultees acknowledged that this was a difficult area, and stressed that whichever option was adopted, “the main focus ... should be consistency across all professions” (Coventry and Warwickshire Partnership Trust). An individual consultee (Jane C Hern) agreed that a clear framework was required:

as it will not be conducive to maintaining the confidence of either the profession, or the public, if regulators are perceived to be able to do whatever they like in the name of patient protection and according to a fuzzy definition of impairment.

**Question 7-2: If a list of statutory grounds of impaired fitness to practise is retained, should it refer to a broader range of non-conviction disposals?**

7.40 A majority disagreed that the statutory grounds should include a broader range of non-conviction disposals.<sup>4</sup> For example, the Department of Health felt that the statutory grounds should not include a broader range of non-conviction disposals.

7.41 The Health and Care Professions Council felt that it was “already able to handle effectively a range of non-conviction disposals”. It will “investigate the circumstances which led to that action being taken, in order to determine whether an allegation of misconduct should be made”.

7.42 The Medical Defence Union argued that:

In the interests of a fair procedure, it should not be assumed that a non-conviction disposal amounts to impaired fitness to practise. The registrant may have agreed to such a disposal for all sorts of reasons and the matter has not been tested by the courts. Further, its relevance to fitness to practise will be dependent on the facts of the specific case. The regulator will need to investigate the matter in the usual way and, if the allegations seem to raise questions of impaired fitness to practise, apply the realistic prospect test.

7.43 The Association of Regulatory and Disciplinary Lawyers stated:

Our concerns about “other disposals” arise principally because the other potential disposals will almost certainly result from procedures that are inappropriate to found a disciplinary sanction that could permanently terminate a professional person’s ability to work in his or her chosen profession.

7.44 Similarly, the Medical Protection Society argued that non-conviction disposals should not be included because they “concern suspected and unproven offences and they also concern a lesser category of offence”. It referred to *R v Hamer* in which the Court of Appeal held that a fixed penalty notice:

constituted neither an admission of guilt nor any proof that a crime had been committed. It was not to be regarded as a conviction and it was not to be admissible in evidence as an admission of an offence as payment of any penalty does not create a criminal record. However, we recognise a regulator’s right to investigate what appears to be a pattern of behaviour.<sup>5</sup>

<sup>4</sup> Of the 192 submissions which were received, 27 expressed a view on this question: 9 said the list should include non-conviction disposals, whilst 18 disagreed.

<sup>5</sup> [2010] EWCA Crim 2053, [2011] 1 WLR 528.



7.45 UNISON argued that:

Cautions, which are also currently accepted as a statutory ground, are less robust. Registrants often state that they were not aware of the impact on their registration of accepting a caution, and if they had realised would not have done so. Any disposal process that has an element of compromise or consent could be undermined if the impact of doing so goes beyond the issue that the disposal is addressing.

7.46 The Pharmaceutical Society of Northern Ireland was opposed to the introduction of a broader list. It thought that a “standardised definition of what constitutes misconduct” would be preferable to a “prescriptive list”.

7.47 However, some consultees argued that the statutory grounds should include a broader range of non-conviction disposals. The General Optical Council stated:

Although the presence of a criminal conviction/non-conviction disposal does not automatically lead to a finding of impairment, such matters do raise a question about a registrant’s fitness to practise. A single fixed penalty notice may not merit an investigation or concern but a string of them might.

7.48 The General Medical Council noted that a shift in police policy towards an increased use of fixed penalty notices meant that reference to a broader range of disposal would help to “future proof” the legislation. An individual consultee (James Kellock) saw the problem of increasing non-conviction disposals in different terms:

Parliament has considerably expanded the number and range of non-court disposals of allegations and the application of the various options by different police forces appears to be inconsistent.

7.49 An individual consultee (Lucy Reid) argued that:

I think that it should refer to a broader range but also should consider the conviction criteria – potentially having to consider a fitness to practise case because of a parking or speeding ticket appears over the top.

7.50 The Scottish Government argued that the list of non-conviction disposals should be expanded to cover, for example:

fixed penalty notices in contexts such as theft and public order offences (but not in relation to other contexts such as speeding or parking offences unless these have resulted in wider public order issues or offences). We would suggest that if this list was expanded to include speeding/parking fines and/or penalties, this would suggest a punitive rather than a public protection function.

**Question 7-3: How adequate are the powers of the regulators to require disclosures from the Independent Safeguarding Authority and Disclosure Scotland? What practical difficulties, if any, arise as a result of differences between the protection of vulnerable groups schemes in England, Wales, Northern Ireland and Scotland?**

- 7.51 A majority agreed that the regulators' powers to require disclosures from the Independent Safeguarding Authority and Disclosure Scotland were inadequate.<sup>6</sup> Several consultees pointed out that up until recently the Independent Safeguarding Authority did not have powers to share the reasons for barring decisions with regulators. The Authority itself argued that this will be addressed by the Protection of Freedoms Act 2012. The Department of Health agreed that the new legislation will address some of the current problems. It argued there should be "broad enabling powers to apply to information sharing" between the regulators, and the relevant safeguarding bodies.
- 7.52 However, the General Medical Council argued that under current transitional arrangements the provision of reasons by the Independent Safeguarding Authority "is still extremely patchy". It also argued that the legislation is "unclear about the types of cases that should be referred and about the timing of referrals" and it had been pressing the Government for official guidance to be issued.
- 7.53 The Health and Care Professions Council reported that where the Independent Safeguarding Authority has reached a decision not to bar the individual, "there is no way for [us] to know this unless we had made the referral in the first place". The Independent Safeguarding Authority therefore "may hold information that is relevant to fitness to practise which does not reach the threshold to bar the individual, but this is not disclosed to the regulator".
- 7.54 The Nursing and Midwifery Council stated:
- We face significant hurdles in seeking relevant information and evidence from all agencies, particularly the Independent Safeguarding Authority, the Police Service of Northern Ireland, various other police forces, and Disclosure Scotland. This is despite the fact that we regularly assist these agencies and we have a memorandum of understanding with many of them. We acknowledge that there have also been deficiencies on our part in complying with the Independent Safeguarding Authority requirements and in responding to requests for disclosure. Some of the difficulties lie in the lack of clarity regarding the overlap between the powers of disclosure to and from these bodies and current data protection legislation.
- 7.55 The General Osteopathic Council stated that "the current powers are not clearly defined and there is confusion about what can be disclosed and used".
- 7.56 Some consultees suggested specific amendments to legislation. For example, the General Optical Council argued that its power to require "relevant" information from the Independent Safeguarding Authority should be amended to ensure that:

<sup>6</sup> Of the 192 submissions which were received, 20 submissions expressed a view on this question: 6 said the powers were adequate, 14 said they were inadequate.

any decision about relevance is a matter for the regulator and not the person holding the information. It is assumed that regulators have sufficient experience in the field of public protection that information will be used appropriately, shared only with those who are either a party or a decision maker, and where necessary sensitive information is dealt with in a private hearing.

7.57 RadcliffesLeBrasseur argued there should be a requirement that the regulator and the Authority “inform the professional when and the circumstances in which information is being passed from one to another about that professional”.

7.58 The General Social Care Council argued that a barring decision by the Independent Safeguarding Authority “should be treated as evidence (rather than conclusive proof) that the fitness to practise of a registrant is impaired”.

7.59 The Independent Safeguarding Authority suggested that all health and social care professional regulators should be able to use a barring decision and the reasons for the bar “as ‘findings of fact’ in their fitness to practise processes”. It suggested that this position is not consistent across all regulators. It agreed that a barring decision should be one of the statutory grounds, but said that:

it should be noted that there may be work that a health and social care registrant could legally undertake that would not be a regulated activity (work they are barred from). An example of this would be a barred medical doctor undertaking research work with no contact with children or vulnerable adults.

7.60 The General Dental Council said that:

It would be useful if the Authority and Disclosure Scotland had an obligation to disclose to the regulators when they make a decision to bar or are in the process of barring a registrant, and that reasons were given, not just the outcome.

7.61 In relation to requests for information from the regulators, the Independent Safeguarding Authority suggested that there is a lack of understanding about how its processes differ from standard fitness to practise processes. It felt that:

This means that regulators may request information that is not relevant for their purposes. Further engagement in relation to establishing memoranda of understanding ... should assist this understanding and the development of appropriate information sharing arrangements.

7.62 Some consultees provided examples of practical difficulties which arise as a result of differences between the protection of vulnerable groups schemes in England, Wales, Northern Ireland and Scotland.<sup>7</sup>

<sup>7</sup> Of the 192 submissions which were received, 6 gave examples: 3 said that there was a lack of clarity around legal responsibilities, 2 said that complex systems and guidance had to be put in place, whilst 1 said that there were potential problems regarding delay.

7.63 The General Medical Council reported that as a result of the differences between the different schemes it operates two different referral systems, which “is complex and increases the risk either that we will treat doctors differently depending on where they are living or that an individual case may get overlooked”.

7.64 The Royal College of Midwives expressed:

major concerns with differences in the manner in which the organisations in different countries operate and in the level of scrutiny and evidence that is consulted before a decision is made. In many systems the individual has only limited ability to challenge a ruling. The regulators must take these into account but should be free to challenge them, however this does not help a registrant whose livelihood has been removed on the basis of unchallenged evidence.

7.65 In relation to differences between England and Scotland, the Scottish Government stated that the policy intention is that:

Separately, and subject to the appropriate regulations being made in the future, Disclosure Scotland will provide the nine health regulators with a copy of a Protecting Vulnerable Groups Scheme Record if the applicant provides details of their registration at the time of their initial application to join the Protecting Vulnerable Groups Scheme. The power to provide that copy of the Protecting Vulnerable Groups disclosure record would be separate from the health regulatory bodies being able to request a Protecting Vulnerable Groups disclosure record for their regulatory purposes *per se*.

7.66 It pointed out that there are differences between the English and Scottish systems in relation to the sharing of “soft intelligence” in that Disclosure Scotland “share this type of information with the regulators, but leave the regulators the decision of what to do with the details”. It added:

We are also aware that there is the possibility of future changes to the scheme in England. We understand that the proposals are for only one certificate to be issued to the applicant rather than two as now; to the applicant and the registered person. The registered person will know that the application has been made as they will have countersigned the form. The change in England therefore is that the subject will be able to see and challenge a disclosure before anyone else gets to see it.

7.67 An individual consultee (Lucy Reid) felt that “it is very easy for practitioners to become career tourists in order to elude detection of issues”.

# PART 8

## FITNESS TO PRACTISE: INVESTIGATION

**Question 8-1: Should the new legal framework remove the concept of an allegation entirely and instead give the regulators broad powers to deal with all information and complaints in such manner as they consider just (subject to a requirement that cases where there are reasonable prospects of proving impairment must be referred for fitness to practise proceedings)?**

- 8.1 A majority agreed that the legal concept of an allegation should be removed and the regulators should be given broad powers to deal with all information and complaints in such manner as they consider just.<sup>1</sup> For example, the General Optical Council supported the proposal on the basis that “the ability to take a proactive approach is key”.
- 8.2 The Medical Defence Union argued that the concept of an allegation is “too constraining” and most regulators already “investigate information from a number of sources, including taking it upon themselves to investigate matters of which they become aware”. The Medical and Dental Defence Union of Scotland could “see force in the fact that the straitjacket of one, simple allegation may not capture all matters of concern to the public” and agreed with broad powers to initiate an investigation but with “an important caveat in relation to anonymous complaints”.
- 8.3 The British Association for Counselling and Psychotherapy felt that the proposal would “help to remove the adversarial landscape in some instances, thus enabling ... alternative dispute resolution processes”. The General Dental Council argued that “a flaw in the current system is that the regulator has to identify individual heads of charge at too early a stage”. Similarly, the National Clinical Assessment Service felt that the “legalistic concept of allegation” encourages “a litigious or vexatious approach” and its removal was consistent with the approach taken in Australia and New Zealand.
- 8.4 The Nursing and Midwifery Council agreed with the suggestion in the question “insofar as it relates to the ‘form’ of an allegation” but did not support:
- any wording which might suggest that the regulators should be dealing with any complaints that do not include an allegation of impaired fitness to practise in the broadest sense.
- 8.5 RadcliffesLeBrasseur agreed there is “no need to preserve the concept of an allegation which is artificial” but argued the power of the regulators to initiate an investigation should be “objectively justifiable” due to the “chilling effect” of the initiation of an investigation for registrants.

<sup>1</sup> Of the 192 submissions which were received, 55 expressed a view on this question: 36 said the concept should be removed, 10 said it should remain, whilst 9 held equivocal positions.

- 8.6 The Health and Care Professions Council noted that it is already implementing the proposed approach in certain aspects of its procedures. The Council considered that the proposal gives regulators “flexibility in dealing with matters that fall short of finding that a registrant’s fitness to practise is impaired, but which nonetheless raise concerns”. The British Society of Hearing Aid Audiologists also welcomed the flexibility offered by the proposal to manage “information proportionately to the risk to public safety”.
- 8.7 However, several consultees did not support removing the concept of an allegation entirely. For example, the Association of Regulatory and Disciplinary Lawyers argued that “it is important to maintain a clearly identifiable gateway to the fitness to practise processes”.
- 8.8 The Osteopathic Alliance argued that the removal of the concept of an allegation “is open to abuse” and could lead to “McCarthy style witch-hunts based on personal prejudices”. The British Psychological Society felt that it might “make individuals more vulnerable to malicious or misguided complaints”. This view was shared by several others, including an individual consultee (Robin McCaffery) and the Association of Clinical Biochemistry.
- 8.9 The Professional Standards Authority felt this “would result in greater inconsistency between the regulators and within the regulators” in relation to the handling of fitness to practise matters, “as well as resulting in increased uncertainty for both registrants and the public”.
- 8.10 The General Pharmaceutical Council said that it did not feel able to comment on the proposal to remove the concept of an allegation, “without an understanding” of what would replace it.

**Provisional Proposal 8-2: The statute should provide that all the regulators will be able to consider any information which comes to their attention as an allegation and not just formal complaints.**

- 8.11 A large majority agreed that all the regulators should be able to consider any information which comes to their attention as an allegation, and not just formal complaints.<sup>2</sup> For example, the British Association of Counselling and Psychotherapy said that if regulators were not able to do so, it would “make a mockery of stated aims of public protection”. The Professional Standards Authority agreed that the proposal was “clearly in the public interest”.
- 8.12 The General Pharmaceutical Council argued the proposal was “consistent with the principles of openness [and] transparency, as well as supporting equality and diversity”. Most of the regulators noted that this proposal was consistent with their existing powers. The General Osteopathic Council supported this approach since “it makes the status of a ‘Registrar’s complaint’ much clearer where there is no complainant/patient involved”.
- 8.13 An individual consultee (James Kellock) agreed that there needs to be “a shift from regulators being entirely reactive” and described the current system as “to some extent hit and miss” in the sense that “while one member of the public will

<sup>2</sup> Of the 192 submissions which were received, 51 expressed a view on this proposal: 42 agreed, 7 disagreed, whilst 2 held equivocal positions.

complain about a particular aspect of a registrant's behaviour/performance another will choose not to". He also felt that the proposal was important given "how few complaints regulators appear to receive from members of the profession about their colleagues".

8.14 The Scottish Government supported the proposal and felt there may be merit in providing guidance to regulators "in relation to policies and procedures that may assist complainants following the submission of information and/or the making of an allegation". It also supported the proposal that there is no set format for allegations.

8.15 The Royal College of Nursing agreed with the proposal but raised concerns about "overzealous" and "disproportionate digging" by the regulators. It noted:

For example, we are aware that senior nurses and other staff have been requested by the Nursing and Midwifery Council to examine at length past complaints and patients records in healthcare settings where there some issues have been identified. This fishing exercise can be an onerous and costly one for employers and can lead to unmeritorious complaints being advanced in the name of public protection. In further examples in South West and South Wales, police investigations involving the allegation of neglect in relation to a patient in a nursing home, the Nursing and Midwifery Council required the referral of all nurses who had been working on the day and night shifts either side of the incident to be referred to the fitness to practise process. Many of the nurses had no contact with the particular patient and their cases were later dropped, but only after considerable anguish and cost had been expended.

8.16 The Royal College of Midwives thought that the proposal should be subject to a requirement for "clear evidence before such a case could proceed".

8.17 However, some consultees opposed the proposal. The College of Chiropractors argued that "regulators should concern themselves with formal complaints only". Unite argued that the statute should define the difference between "allegation" and "formal complaint".

8.18 The United Chiropractic Association felt that "formal complaints should be the bedrock of any investigation". It continued:

The process itself is still adversarial in nature and without a complainant there are issues and concerns as to whether a registrant can receive a fair trial. If a registrar is a complainant there is a real concern that a panel will have difficulty exercising sufficient independence to ensure that a registrant receives a fair hearing pursuant to Article 6 [of the ECHR].

8.19 The British Pharmaceutical Students' Association opposed the proposal, as it thought that "ad-hoc information may not be sufficiently robust to form a true allegation".

**Provisional Proposal 8-3: The statute should contain a clear statement that there is no set format for allegations.**

- 8.20 An overwhelming majority agreed that the statute should contain a clear statement that there is no set format for allegations.<sup>3</sup> For example, the General Medical Council pointed out that the proposal is consistent with the Council's existing legislation and stated:

We would like to retain this flexibility in order to respond to changes in the context in which we work, such as the complexity of cases, technological developments and changes in public expectations.

- 8.21 The British Association for Counselling and Psychotherapy agreed with the proposal insofar as it was "in support of accessibility aims and to enable vulnerable groups to complain". Similarly, the General Pharmaceutical Council noted the potentially positive impact of the proposal on equality and diversity.

- 8.22 The Professional Standards Authority agreed generally with the proposal but recognised that in practice it will be "difficult (or in some cases impossible) for a regulator to progress an investigation without a certain minimum amount of information". The Authority suggested that "encouraging the use of a standard format for such notifications, where appropriate, may enable the regulators to make more efficient use of their resources".

- 8.23 The Association of Regulatory and Disciplinary Lawyers agreed with the proposal but also stated that there should be:

a requirement that any complaint should be provided in written form in order to avoid subsequent dispute as to the precise content of the initial complaint and to provide an unambiguous factual basis for the initial screening process.

- 8.24 Similarly, the Medical Protection Society contended:

While we accept that information/allegations need not be required in writing *initially*, we say there should be a requirement that the regulator *record* verbatim the content of all communications with a complainant until, if he so chooses, he commits the complaint to writing. This would mean transcribing all telephone conversations and meetings between the regulator and a complainant.<sup>4</sup>

- 8.25 The Association of Clinical Biochemistry agreed that allegations must be "attributable and written, not oral".

- 8.26 An individual at a consultation event supported the principle behind the proposal, but cautioned that "regulators should not become a hot-line for rants from those who are generally unhappy with everything".

<sup>3</sup> Of the 192 submissions which were received, 40 expressed a view on this proposal: 37 agreed, whilst 3 disagreed.

<sup>4</sup> Emphasis in the original.



- 8.27 Some made suggestions for the wording of the statement. The Medical Defence Union felt that “it may be clearer if the statute said allegations can be made in any format, as that seems less prescriptive than putting it in a negative”. The Professional Standards Authority suggested that the wording should be that the “regulators are not entitled to reject an ‘allegation’ solely because it is not provided in the format the regulator specifies”.
- 8.28 However, a small number of consultees disagreed with the proposal. The Health and Care Professions Council argued that the statute should require that “an allegation must be made in the form required by Council”. The Council pointed out that it currently publishes “a standard of acceptance for allegations” which sets out “what the appropriate format is and allows allegations to be taken via other means – for instance through the taking of a statement of complaint”.
- 8.29 The British Medical Association disagreed with the proposal and argued that “there must be an element of responsibility taken by the complainant through registering their concerns formally”. Furthermore, it felt that the proposal would have significant resource implications since the regulators would have to “go out actively seeking information that might suggest misconduct from all the sources of information that are freely available, for example online social media”.

**Question 8-4: Should the statute prohibit the regulators from setting a time limit for bringing an allegation against a registrant or should there be a consistent time limit for allegations across the regulators (and if so, what should it be)?**

- 8.30 A significant majority argued that the statute should set a consistent time limit across the regulators (and of those, a majority said it should be five years).<sup>5</sup>
- 8.31 The General Medical Council supported a time limit because “it is difficult to conduct an effective investigation many years after the events that gave rise to the concerns” and “there is no public interest in pursuing cases that involve a protracted investigation with a low success rate”.
- 8.32 The Royal College of Nursing supported the General Medical Council’s current approach. The College reported that it had had:

little success in challenging, in the High Court as abuses of process, the very stale cases (which also involve long delays to advance them due to the availability of witnesses or poor recollection of events after such a time). Similarly, we acknowledge the difficulties placed on regulators in advancing stale cases as above. It is also anachronistic to run such stale cases when the adjudicating Panel is required to judge the registrant’s current impairment and not focus on the level of that person’s fitness to practise up to a decade ago.

<sup>5</sup> Of the 192 submissions which were received, 51 expressed a view on this question: 9 said there should be no time limit, 39 said there should be a consistent time limit, whilst 3 held equivocal positions. Of those who said there should be a consistent time limit, 1 said it should be two years, 24 said five years, 1 said six years, whilst 2 said the limit depended on the seriousness of the case.

8.33 The British Medical Association argued that:

It is unfair – and may lead to flawed judgements - for regulators to be able to investigate a complaint so long after the event that the complained-against will have no recall of, or access to the records of, a particular case. Moreover, the accuracy of testimony of key witnesses, including the complainant, may lessen over a period of time. After several years, the case should be able to lapse or not proceed further.

8.34 Similarly, Rescare also noted that “relevant people can forget over a period of time and relevant evidence can disappear”.

8.35 The Health and Care Professions Council stated that its legislation – which includes no such time limit (“even before the person was registered”) – caused “significant practical difficulties” when allegations were not reported “in a timely manner” and it was therefore forced to set a five year rule in its standards.

8.36 The Association of Regulatory Disciplinary Lawyers also agreed that the possibility of imposing time limits should be retained, although it “acknowledged that any prescribed time limit is to an extent arbitrary”. The Association considered that a five year limit that was subject to exceptions would strike the “balance between the protection of registrants from having to meet old allegations and public protection”.

8.37 Several consultees emphasised the importance of exceptions to the time limit in certain cases. For example, the British Psychological Society stated this would be important:

in cases of allegations of sexual abuse as a child where the victim only becomes fully aware in adulthood of having been the victim of abuse, or, for other reasons, had not felt able to proceed earlier.

8.38 The Health and Care Professions Council suggested that there should be an exception where the allegations relate to criminal convictions, cautions and regulatory determinations “as there is no need to ‘go behind’ the decision of the court or tribunal which imposed the conviction”. Many consultees also argued that there should be a further exception where there is a significant public interest.

8.39 The General Dental Council suggested that the statute should specify the following exceptions to the five year time limit:

- (1) where the patient has only recently found out about the poor treatment, or was a child at the time of the treatment;
- (2) in cases of assault or impropriety where there was good reason for the complainant not to have come forward before;
- (3) where dishonesty has just come to light; and
- (4) where delays have been caused through action taken by another body or person (eg a lengthy criminal prosecution).

- 8.40 The Professional Standards Authority suggested that the statute should specify that the time limit shall not apply:

to allegations which are so serious that there is a real prospect that, were they to be found proved, a sanction of suspension or erasure would result – until such time as it is established that there is no real prospect of those allegations being found proved. That would ensure that the most serious allegations are at least the subject of a preliminary investigation by the regulator – who might only then reject them on the basis of the time limit if there is insufficient evidence to prove them.

- 8.41 The Scottish Government felt that any time limit should be waived “in certain/exceptional circumstances”. It was also suggested that “the ability of regulators to close vexatious complaints should be considered” and that “the need to deal with matters efficiently and consistently should be explicitly stated”.

- 8.42 The Department of Health, Social Services and Public Safety for Northern Ireland generally supported the proposals and stated in relation to time limits that:

Serious activity coming to light after years should not be set aside because it is out of time. Of course this needs to be considered in the context that serious cases may contribute to crucial activity.

- 8.43 However, the Nursing and Midwifery Council was not convinced that the introduction of a time limit would be beneficial. It said that:

Any such time limit would always have to be subject to being waived in exceptional circumstances in the interests of public protection. We are aware that at the General Medical Council where a five year time limit is in place, it has resulted in challenges and litigation from both sides over its application.

- 8.44 Instead, it was argued that the statute should make clear that at the initial consideration stage, “regulators are entitled to take into account the age of the allegation”. Similarly, the Royal College of Midwives argued that the regulators should have the option “to consider time elapsed since an incident or incidents when initially deciding whether to proceed with an investigation”.

- 8.45 The General Social Care Council also argued against a time limit as:

This would restrict the flexibility of the regulators and their ability to protect the public. Serious concerns about the behaviour of a registrant should be subject to investigation irrespective of when they were committed or brought to the attention of a regulator.

- 8.46 The General Chiropractic Council and the British Society of Hearing Aid Audiologists were also among those consultees who opposed the introduction of a time limit.

- 8.47 The Medical Defence Union argued that “the time limit itself may need to differ between the regulators, as it may depend on circumstances specific to that profession”.

**Provisional Proposal 8-5: All the regulators should have the power to establish a formal process for the initial consideration of allegations (such as screeners).**

8.48 All consultees who expressed a view agreed that all the regulators should have the power to establish a formal process for the initial consideration of allegations.<sup>6</sup> For example, the General Chiropractic Council said that it was “particularly pleased” with the proposal.

8.49 The National Clinical Assessment Service supported this proposal and noted that it currently provides such a service under contract to the General Dental Council. It said:

Together we believe that the provision of this expert independent advice adds robustness, timeliness and aids defensibility. There may also be an opportunity to provide early advice on practice which may be sufficient to allay concerns raised and is also proportionate and outside the formal process.

8.50 The General Optical Council noted that it is currently required by legislation “to open an investigation into every complaint made”, even those cases which are “relatively minor”. It further argued that:

If this power is available to regulators, it would allow procedures to be adapted to deal effectively with any changes in the health sector or respond to issues raised by the media. For instance, if a media report has the effect of raising a large number of complaints about a particular issue, with a number of similarities, the regulator could adopt a process to deal with such complaints.

8.51 The General Medical Council welcomed the proposal for an “enabling power”. The Council considered that such a power would allow the regulators to introduce systems that were appropriate to the number of complaints they received, which it noted “varies significantly”.

8.52 The Nursing and Midwifery Council supported the proposal but stated:

In our view, closure of cases at this initial stage is best carried out against clear agreed criteria, by properly trained staff whose decisions can be recorded, checked, audited and quality assured in order to ensure consistency. Appropriate clinical advice may also be needed in some cases. The test at that initial stage should be whether the nature of the allegation made is such that [the] regulator’s investigation process needs to be engaged at all. Screeners, as provided for in our current legislation, and as used previously by the General Medical Council, did not fulfil this function or add any value to the process. We would not support their retention in the new statute.

<sup>6</sup> Of the 192 submissions which were received, 51 expressed a view on this proposal: 51 agreed.

8.53 The Scottish Government agreed with the proposal and also suggested:

We would like to explore whether there is a place in the new statute for having a central cadre of screeners/case handlers who would deal with the initial consideration of all allegations.

8.54 The Professional Standards Authority argued that any powers to sift out cases should be restricted to cases where the allegation:

- (1) does not relate to a registrant;
- (2) is vexatious;
- (3) is made anonymously and no evidence to support it can be obtained; or
- (4) where it does not concern a matter that could impair the registrant's fitness to practise.

8.55 It was also argued that there should be a duty on the regulator to refer any matter to the relevant body (such as another professional regulator, a professional body, Care Quality Commission or Ombudsman).

8.56 An individual consultee (Lucy Reid) argued that the legal framework should include a "requirement for local investigation and resolution to be attempted before escalating to the regulator".

8.57 The Royal College of Nursing argued for greater consistency between the regulators. It stated:

We have seen cases arising from the same incident in a workplace, where the General Medical Council has decided that no action is needed against a doctor at the screening stage where the doctor faces similar charges to a nurse, whose case is referred on to a Nursing and Midwifery Council Investigating Committee. The doctor is spared the anxiety and cost of defending himself at this early stage by a screening process which examines the early evidence. The nurse or her representatives are obliged to fully investigate and respond to the early allegation (which will inevitably include collecting statements and testimonials) and will have had to suffer the impact of reporting the referral to her employers (with the associated stigma). In the end, generally, no case will be found against the nurse and so both professionals arrive at the same outcome, but the differing screening process of their respective regulators will result in a far more detrimental experience for the nurse.

8.58 The Health and Care Professions Council noted that it does not currently use its power to refer cases to screeners since "such a process adds unnecessary delay to the fitness to practise process", but agreed that the power should exist.

8.59 A number of consultees raised concerns about the situation where regulators receive a complaint but decide not to pursue it. The registrant is not informed and the information is retained and may be used if further complaints are received. The Medical Defence Union argued this was "clearly unfair because the first the

registrant knows about the initial complaint is when a further (and possibly entirely different) complaint is received". Similarly, the Royal Pharmaceutical Society of Great Britain stated that "it does not allow the registrant to build a defence against these complaints or to take remedial action to redress the issue".

8.60 Several consultees argued that complainants must be made aware that their name and address will be made available to the professional involved and any other health care body who may be approached for information relating to the case. For example, the Royal Pharmaceutical Society of Great Britain said that this approach "should minimise the risk of malicious allegations being made against any registrant".

8.61 The Professional Standards Authority felt that the statute should make clear that a regulator "may take forward an allegation even in circumstances where the complainant at a later date seeks to withdraw their allegation". It said:

We are aware that some complainants regard the allegation as being "their" complaint, and may fail to understand that a regulator is acting in the general public interest in investigating it rather than acting in their individual interests.

**Provisional Proposal 8-6: The regulators should have the power to prohibit certain people from undertaking the initial consideration of allegations and specify that only certain people can undertake this task.**

8.62 All of the consultees who expressed a view on this proposal agreed that the regulators should have the power to prohibit certain people from undertaking the initial consideration of allegations and specify that only certain people can undertake this task.<sup>7</sup> For example, the Society and College of Radiographers supported the proposal, and said that it "was accustomed to working in this way under the Health and Care Professions Council arrangements and believed this works well".

8.63 The Professional Standards Authority supported the proposal, but questioned:

the basis for the decision ... not to codify the prohibition on certain individuals from the initial consideration of cases. Doing so would provide greater consistency and might improve public confidence in the regulatory system.

8.64 The General Medical Council argued that Council members should be prohibited from this role (as well as investigation and adjudication). Subject to this, it was argued that the regulators should have discretion about who should undertake this task. Similarly, the Medical Protection Society thought that the "statute should set out the power, though not specify who should and should not undertake the task".

8.65 The Royal Pharmaceutical Society of Great Britain said that a "robust open/transparent system should be put in place to justify the selection".

<sup>7</sup> Of the 192 submissions which were received, 46 expressed a view on this proposal: all agreed with the proposal.

8.66 However, the Medical Defence Union argued that:

The legislation should make it clear that regulators have an obligation, and not just a power, to prohibit certain people from undertaking initial consideration of information and specify that only certain people can undertake this task.

**Provisional Proposal 8-7: The regulators should have powers to establish referral criteria for an investigation and specify cases which must be referred directly to a Fitness to Practise Panel.**

8.67 The vast majority agreed that the regulators should have powers to establish referral criteria for an investigation and specify cases which must be referred directly to a Fitness to Practise Panel.<sup>8</sup>

8.68 The General Dental Council argued this proposal “would avoid unnecessary time and expense in processing cases where referral to a practice committee is inevitable”. The General Pharmaceutical Council – which currently has powers to set referral criteria – also agreed with the proposal.

8.69 The General Optical Council noted that it is seeking to amend its rules so that “serious criminal convictions will be referred directly to the Fitness to Practise Committee”. The Council believed that “regulators should have the power to establish their own referral criteria based on a risk analysis of their complaints and field of regulation”.

8.70 The Medical Defence Union supported the proposal, but suggested that “such criteria and specifications should only be agreed subject to consultation with stakeholders”. The Pharmaceutical Society of Northern Ireland agreed that any exercise of the proposed power “should be validated through a public consultation process”.

8.71 The Association of Regulatory and Disciplinary Lawyers argued that the statute should limit those complaints which are to be referred to the Fitness to Practice Panel without further investigation as being “those relating to (a) certain serious criminal offences or (b) sentence”.

8.72 The Health and Care Professions Council agreed with a power to establish referral criteria but disagreed that cases should be referred directly to a Fitness to Practise Panel. It argued that an “important procedural safeguard” was provided by ensuring a two-stage process, whereby an Investigation Committee “reviews the investigative efforts and determines whether there is a ‘case to answer’”.

8.73 The Scottish Government and NHS Education for Scotland thought that this was an area that would benefit from a consistent approach across the regulators. NHS Greater Glasgow and Clyde agreed and suggested that the Professional Standards Authority may have a role to play in promoting such broad agreement.

8.74 A small number of consultees disagreed with the proposal outright. For example, the Optical Confederation felt the proposal would be “too prescriptive and fetter

<sup>8</sup> Of the 192 submissions which were received, 49 expressed a view on this proposal: 46 agreed, whilst 3 disagreed.

the powers of the Investigation Committee to make their determination” based on the individual circumstances of the case.

8.75 The Nightingale Collaboration objected to the proposal. It stated:

We believe that consistency across the regulators is essential and that if this consistency is not achieved, the public will see the resulting disparity as some professions being held to lower standards than others – we do not believe this can be good for public confidence in that regulation.

8.76 The General Medical Council stated that it is seeking powers to give the Registrar the authority to order the erasure of registrants convicted of certain serious offences without the need for a hearing (with a right of appeal to the High Court).

**Question 8-8: Should the statute impose more consistency in relation to the criteria used by regulators to refer cases for an investigation or the cases that must be referred directly to a Fitness to Practise Panel?**

8.77 A majority answered this question in the affirmative.<sup>9</sup> For example, Coventry and Warwickshire Partnership Trust argued that:

The greater the consistency of process the better health professionals and Trusts will understand the process, the more divergent processes are the greater the possibility that allegations and cases will be overlooked or not acted on. This would also mean that people from separate disciplines, being investigated for the same incident could be treated differently, which could cause confusion in the eyes of the public.

8.78 An individual consultee (Lucy Reid) argued there is currently too much variance across the regulators in this respect. She noted that:

The Nursing and Midwifery Council is very inconsistent in standards of investigation and referral to fitness to practise and interim orders. One example is a case where a nurse had been arrested and released on bail for criminal neglect where the Nursing and Midwifery Council only referred to an Interim Orders Panel following a complaint to the Chief Executive.

8.79 The Professional Standards Authority felt the statute should require the regulators to establish referral criteria “in order to make their decision-making more transparent” and provide that:

All convictions resulting in a custodial sentence should automatically be referred directly to a Fitness to Practise Panel, rather than leaving this to the discretion of the individual regulators. A lack of consistency

<sup>9</sup> Of the 192 submissions which were received, 48 submissions expressed a view on this question: 32 said that the statute should impose more consistency, 15 disagreed, whilst 1 held an equivocal position.



in this area will not improve public confidence either in the individual regulators or in the system as a whole.

8.80 An individual consultee (Jacqueline A Wier) also thought that consistency “ensures that each registrant is treated fairly and with equity”, and so would increase public confidence in regulation.

8.81 An individual consultee (James Kellock), although cautious about the extent to which consistency could be imposed, argued that:

It would look very odd if for example one regulator mandated that all allegations involving a conviction for rape should go straight to a Fitness to Practise Panel while another was content that they should not, and be the subject of investigation.

8.82 The General Optical Council supported consistency “in relation to the types of cases” which should be referred directly to a Fitness to Practise Panel.

8.83 The Department of Health answered the question in the affirmative. The Scottish Government also argued that there should be greater consistency. It felt that:

This might counter the view that different professions are treated differently and would assure the public that their allegations were being considered and treated equally by all the regulators.

8.84 The Patients Association thought that there should be a “minimum ceiling before cases are referred on to investigation that is defined in statute”. It said that the “definition did not need to be especially prescriptive but a general definition of principle here would be useful”.

8.85 However, some consultees disagreed outright with greater consistency. The General Dental Council argued “the professions are very different and disciplinary matters are context specific” and therefore:

consistency could be imposed in only a very few types of case (for example murder) and these are so obvious there is no advantage in listing them in statute.

8.86 Bupa argued that a “general practitioner should be more accountable than a nurse” since it is generally the general practitioner that prescribes the treatment. The British Medical Association felt that “it should be for the regulator to ensure consistency” and did not think that “statutory imposition would help this process”.

8.87 The Pharmaceutical Society of Northern Ireland argued that:

Regulators should have the flexibility to decide how to manage allegations according to specific context and resources. The contextual patient safety risk remains different from regulatory body to regulatory body. What may be a proportionate fitness to practise process for one regulatory body may not be for another, on the basis of presented risk.

- 8.88 Similarly, the Optical Confederation cautioned against a “one size fits all” approach to regulation. It thought that:

Account should continue to be taken by each regulator of the risk associated with each profession. In the case of optometry and dispensing optics, these are low risk professions and whilst there is scope for greater consistency in the rules of procedure across the regulators the issue of risk must not be disregarded.

- 8.89 The Confederation suggested that the “use of indicative guidance may assist”.

- 8.90 The Scottish Social Services Council referred to its own procedures, and said that:

We have found that the route set out in our Rules is an efficient way to proceed. We have been free to design this route because our legislative framework and Rules do not specify any particular structure for this work.

**Provisional Proposal 8-9: The statute should enable but not require the regulators to establish an Investigation Committee.**

- 8.91 A significant majority agreed that the statute should enable but not require the regulators to establish an Investigation Committee.<sup>10</sup> For example, the British Chiropractic Association supported the proposal, and said that, in respect of its members, it would favour the abolition of the Investigation Committee.

- 8.92 The General Medical Council stated that an Investigation Committee is “one model for making a decision about which cases to refer to a Fitness to Practise Panel but there are a variety of other models”. The General Chiropractic Council stated that it “has no intention to establish an Investigation Committee under the new Act if it can possibly be avoided”.

- 8.93 The Health and Care Professions Council also agreed with the proposal but wanted to retain an Investigating Committee in its structure. It said that:

Due to the range of professions we regulate, and the small size of some of those professions, the use of Investigating Committee panels is an effective approach. It may prove difficult to obtain the profession specific input required, particularly for the smaller professions, using an alternative, such as case examiners .... The costs of operating Investigating Committee panels are relatively fixed (daily fee for panellists, plus expenses) and can be budgeted for with a high degree of accuracy.

- 8.94 The Association of Regulatory and Disciplinary Lawyers also supported the proposal, but on the basis that:

<sup>10</sup> Of the 192 submissions which were received, 45 expressed a view on this proposal: 39 agreed, 5 disagreed, whilst 1 held an equivocal position.

Such committees may neither be the most efficient nor cost effective means of determining whether a complaint should be routed to a fitness to practise panel or some other disposal ordered.

- 8.95 The Royal college of Midwives agreed that “especially for those smaller regulators who receive few referrals, Investigation Committees may be an inefficient use of resources”.
- 8.96 An individual consultee (James Kellock) supported the proposal but warned:
- First there is a danger that case examiners, if individually used too often, might become settled into a routine and not be sufficiently “fresh” or removed from the regulator. Second the structure of having as few as two case examiners obviously limits the amount of discussion and variety of views that are taken into account in reaching a decision, when compared with a committee of seven or eight people.
- 8.97 The Professional Standards Authority agreed with the proposal but argued that if the regulator imposes a warning at the investigation stage which will be published on the register, then it will be necessary to establish an Investigation Committee (or similar) in order to remain Article 6 compliant “ie to provide an opportunity for the registrant concerned to have a hearing before the warning is imposed”.
- 8.98 Some suggested that the title “Investigation Committee” is misleading since the Committee does not usually question witnesses or obtain reports, but instead makes decisions on the papers presented by the regulator’s staff.
- 8.99 The Medical Defence Union questioned “whether it is even necessary to specify an investigation committee in the statute”. It suggested, in light of the broad powers proposed in the next proposal, that:
- It would be worth exploring whether there might be a more appropriate way to provide in the legislation for an investigation process that includes appropriate safeguards without mentioning investigation committees as that may prove too constraining.
- 8.100 The UK-wide Nursing and Midwifery Council Lead Midwives for Education Group supported the proposal, on the condition that whatever investigation process regulators implemented, “it must be clear and transparent and seen to be in the interest of the public and not the registrant”.
- 8.101 The Royal College of Obstetricians and Gynaecologists thought that the establishment of an Investigation Committee should “depend on the case and not the profession”.
- 8.102 However, a small number of consultees disagreed with the proposal. The Royal Pharmaceutical Society of Great Britain argued that investigating someone’s fitness to practise is so important that statute should “dictate that the professional being investigated should be investigated by a committee that contains a member of his/her own profession”.
- 8.103 The Medical Protection Society also disagreed and said that:

While some smaller regulators may feel there is no benefit, an Investigation Committee does provide a necessary route to avoiding full fitness to practise hearings in specific circumstances ... Having an Investigation Committee, which sits in public enables registrants and the public to understand the regulator's expectations, which screening decisions may not.

8.104 UNISON argued "there should be consistency across all regulators" on matters relating to investigation including "the requirement for thorough investigation and triaging of issues and the investigation committee model is a tried and trusted method of ensuring this".

8.105 The Royal College of Nursing stated:

Our concern is that if there is no independent Investigating Committee intervening, a significant number of the cases which are considered and dismissed by the Committee currently will be escalated to a Panel and final hearing ... we consider that the potential costs saving could be swamped by the additional costs of having to process and hear unmeritorious cases.

8.106 The Department of Health agreed that the regulators should be free to decide whether to have an Investigation Committee or not, although it noted that for some regulators this does allow for oral hearings to take place when issuing warnings (such as the General Medical Council).

**Provisional Proposal 8-10: The regulators should be given broad rule and regulation-making powers concerning how and by whom an investigation is carried out.**

8.107 All consultees who expressed a view agreed that the regulators should be given broad rule-making powers concerning how and by whom an investigation is carried out.<sup>11</sup> For example, the Society and College of Radiographers thought that "allowing regulators flexibility to determine the processes for investigation might mean less delay in hearing cases and less cost to registrants".

8.108 The National Clinical Assessment Service stated:

Our experience of working with three regulators is that the investigation of a single incident does not give a view on safety across the full scope of clinical practice. However, a full assessment is not always indicated. [We have] therefore developed a process of local record review which could be used as a screening tool and which could potentially add swiftness and timeliness to investigations and subsequent resolution. An independent view is helpful in providing triangulation of evidence.

8.109 The General Optical Council agreed with the proposal but was concerned about "how this sits with the idea of harmonisation of process and public

<sup>11</sup> Of the 192 submissions which were received, 40 submissions expressed a view on this proposal: all agreed.

understanding". The Professional Standards Authority also supported the proposal but considered that there should be:

consistency about the circumstances in which performance/health assessments may be requested and/or any measures the regulators should be able to take in relation to non-compliance by registrants. The current rules differ significantly across the regulators, for no good reason in our view.

- 8.110 The Royal College of Nursing agreed that the regulators should have broad rule-making powers "concerning how and by whom an investigation is carried out" provided the regulators are "required to establish a consistent system" including an investigating committee. It felt that:

Consistency is key. We are aware from cases involving registered nurses and other clinicians, that the General Medical Council appears to adopt a far more thorough screening process leading to cases against doctors being closed at an early stage whereas the linked case against a nurse involved in the same set of facts will often proceed to a lengthy and costly investigation before being considered months later by the Investigating Committee.

- 8.111 Some consultees commented on the proposed powers for regulators to determine by whom an investigation is carried out. The British Pharmaceutical Students' Association said that "guidance or indication on who can carry out these investigations would be necessary to enjoy fairness". Similarly, the Royal Pharmaceutical Society of Great Britain thought that:

Statute should dictate that the professional being investigated should be investigated by a committee that contains a member of his/her own professions, to provide context to the investigation.

- 8.112 The Department of Health, Social Services and Public Safety for Northern Ireland supported our proposals and stated that "legislation should simply accord [the regulators'] right/responsibility to carry out investigations".

**Provisional Proposal 8-11: The statute should give all the regulators a general power to require the disclosure of information where the fitness to practise of a registrant is in question.**

- 8.113 The vast majority agreed that the statute should give the regulators a general power to require the disclosure of information where the fitness to practise of a registrant is in question.<sup>12</sup> For example, an individual consultee (James Kellock) thought that "one of the areas where the investigation of complaints could be improved is by giving regulators more powers to obtain relevant information". Bupa considered that the "current system is fundamentally deficient in respect of powers to require disclosure of information".

- 8.114 The General Medical Council stated that:

<sup>12</sup> Of the 192 submissions which were received, 49 submissions expressed a view on this proposal: 47 agreed, whilst 2 disagreed.

This power is critical in enabling us to carry out our public protection role. In most cases, information is provided willingly and voluntarily but in a small number of cases we experience difficulties in obtaining information and, in these cases, it has been very important that we have the power to require disclosure. Recently, we have had to use this power to require the Independent Safeguarding Authority to disclose its reasons for placing a doctor on a barred list, where its own legislation does not provide powers to disclose such information to us.

- 8.115 The Nursing and Midwifery Council also agreed with the proposal on that basis that it “reflects our current powers and is essential for our public protection role”. The Royal College of Nursing also supported the proposal “as this is the only way in which an expeditious and appropriate investigation can be conducted”.
- 8.116 The Scottish Government agreed in principle with a power to require disclosure of information but felt that it was not always clear what information can be demanded and that guidance was needed on such matters.
- 8.117 Some consultees thought that there should be some restrictions on such a power. The Professional Forum of the Pharmaceutical Society of Northern Ireland reiterated that it did not support a “power enabling phishing exercises being carried out against registrants”. UNISON noted that the powers must be “human rights and data protection compliant”.

**Question 8-12: Are the existing formulations of the power to require disclosure of information useful and clear in practice?**

- 8.118 A majority of consultees thought that the existing formulations of the power to require disclosure of information were useful and clear in practice.<sup>13</sup> For example, Optometry Scotland was of the view that “the current powers are clear to all concerned”.
- 8.119 The General Medical Council and the Nursing and Midwifery Council were both satisfied with their current powers to require disclosure, but noted that “robust enforcement” and “sanctions for non-compliance” would improve their effectiveness.
- 8.120 The Royal College of Nursing said that it “would welcome this as an opportunity to provide clarity for the regulators that the usual course for disclosure would be to seek to enforce any request in the civil courts”.
- 8.121 However, some consultees thought that the existing formulations could be improved. For example, Coventry & Warwickshire Partnership Trust said that “further clarification and simplification of the powers would be beneficial”.
- 8.122 An individual consultee (Lucy Reid) stated that:

<sup>13</sup> Of the 192 submissions which were received, 28 expressed a view on this proposal: 18 said that the formulations are clear, whilst 10 said that the formulations are not clear.

The existing arrangements are not clear in practice neither are they useful, however this is largely due to a lack of clarity regarding the power to require disclosure versus the Data Protection Act and the understanding of such. The existing legislative framework is confusing and contradictory.

- 8.123 The General Optical Council believed that “some consideration needs to be given to ... providing primacy to the view of the regulator that the information requested is relevant and ought to be disclosed”.
- 8.124 The Scottish Government thought that “the existing formulations of the power could be clearer and as the powers vary between regulators; it is not straightforward what information can be demanded”.

**Provisional Proposal 8-13: The power to require information should be extended to include the registrant in question.**

- 8.125 A large majority felt that the power to require information should be extended to include registrants themselves.<sup>14</sup> For example, the Patients Association believed that it is “important that specific provision is made in statute to ensure that the importance of disclosure is understood fully”.
- 8.126 The Medical Defence Union agreed “because our experience is that the regulators already require information from the registrant” and “registrants are also under a duty of cooperation with inquiries”. It also pointed out that this power would “of course be subject to the rights of any registrant and especially the rights in respect of self-incrimination”. The General Dental Council agreed with the proposal and argued that “it is not self-incrimination to require the production of documents” and that “disclosure should be limited to matters which are relevant to the registrant’s practice and not, for example, private emails and private financial records”.
- 8.127 The General Medical Council also felt that the power should only be used to require registrants to disclose “key information that is critical to progression of a fitness to practise case such as the names and details of their employers”. It continued:

We are sensitive to the issues relating to self-incrimination in relation to the registrant’s response to the allegations that have been made. We are also mindful of the needs of sick doctors in this context and would urge caution in requiring registrants to disclose their response to allegations. That said we believe that more can be done to establish a culture of openness between ourselves and doctors during an investigation and we are piloting meetings with doctors at the end of an investigation to support such openness.

- 8.128 The Nursing and Midwifery Council stated:

<sup>14</sup> Of the 192 submissions which were received, 37 submissions expressed a view on this question: 29 agreed, 5 disagreed, whilst 3 held equivocal positions.

We think a permissive power to require some factual information to be provided by the registrant, such as their personal identification number, employer or agency details, current address and contact details, details of criminal proceedings or consent for us to obtain records relating to a conviction, would be very beneficial. We would also urge that this power to require disclosure be exercisable at all stages of the process. At present we can only require such information after an allegation has been referred to a practice committee.

- 8.129 The Health and Care Professions Council considered that the power to require information from the registrant “should extend only as far as requiring any patient and service user records held by the registrant concerned”, because:

Although such requests can be made by the data subject (complainant), in practical terms it would assist with case investigations and provide clarity if such records could simply be demanded directly from the registrant by the regulator.

- 8.130 However, the Council thought that the power should not extend to “any relevant material” and “requiring submissions from registrants”. It felt that:

Registrants should be able to maintain the right to remain silent or choose not to engage in the fitness to practise process. Evidence of genuine insight is especially important to panels that make fitness to practise decisions and any requirement for registrants to provide submissions or engage could potentially hamper a panel in forming a balanced view of the case and of assessing any likely risk of repetition.

- 8.131 The General Social Care Council agreed that the proposed power would need to be limited to the registrant’s practice, but also acknowledged that “in social work, this can also involve matters outside of a work setting”.

- 8.132 The Association of Regulatory and Disciplinary Lawyers agreed with the proposal provided:

(a) that the registrant is entitled to rely upon his privilege against self-incrimination as a shield to such disclosure and (b) the power is restricted to the disclosure of information and not his case.

- 8.133 A small number of consultees disagreed outright with this proposal. The Medical and Dental Defence Union of Scotland argued that:

In matters of professional regulation it is for the registrant to decide the extent to which he wishes to put forward his own defence and not to be required to disclose material which would otherwise not be compellable or which might tend to self-incriminate. If those charged with pursuing the allegation, are not in a position to prove their complaint then that should allow the complaint to fail.

- 8.134 The Medical Protection Society disagreed for the following reasons:



- (1) the power could effectively shift the burden of proof from the regulator;
- (2) the registrant's right to respect for his private and family life may be breached;
- (3) legal arguments about the justification for requiring the disclosure sought will cause delay; and
- (4) the power would be susceptible to abuse (for example, a vindictive or vexatious complainant or informant could gain access to information that they otherwise would not be able to see).

8.135 The Association of Clinical Biochemistry queried why the absolute right to remain silent under caution in criminal cases should be any less rigorous in fitness to practise investigations. The Royal Pharmaceutical Society of Great Britain also asked "where the balance between self incrimination under criminal law would be".

8.136 RadcliffesLeBrasseur argued that:

There should be no obligation on the registrant being investigated to provide information. Such a power would make a hearing otiose and would be likely to work unfairly. The request for information could be a request that he admit the allegations, with a sanction if he failed to answer ... Many registrants engaged in fitness to practise proceedings face significant difficulties as they no longer work in the environment in respect of which the complaint was made. Indeed in many instances the complainant is their former employer. Consequently the registrant has no or limited access to information or evidence and a limited capacity to carry out any investigations.

**Question 8-14: Should any enforcement powers be attached to the power to require information?**

8.137 A majority felt that enforcement powers should be attached to the power to require information.<sup>15</sup> For example, the General Chiropractic Council considered that there would be "little point in having the power [to require information] unless the power has some teeth". The Professional Standards Authority agreed that enforcement provisions would be required to make the power effective, but said that "it would be helpful to understand what these enforcement powers might be".

8.138 The General Medical Council argued that:

Enforcement powers are critical to the effectiveness of disclosure provisions. We have experienced difficulties enforcing our powers in some cases and we are currently progressing legislative change to make that enforcement effective by introducing a power for an Interim Orders Panel to make an interim suspension order where a doctor has refused to comply with a requirement to disclose his employer/contractor for services.

<sup>15</sup> Of the 192 submissions which were received, 43 expressed a view on this question: 32 said there should enforcement powers, 4 disagreed, whilst 7 held equivocal positions.

- 8.139 The General Dental Council felt that where a registrant fails to comply with a disclosure request there should be an automatic referral to a Fitness to Practise Panel and “a scheme of fines should be an option but not mandatory”.
- 8.140 The Nursing and Midwifery Council felt that non compliance should be a separate ground of impairment and the regulators should also have powers to impose an interim suspension order pending compliance. Coventry and Warwickshire Partnership Trust agreed that a model whereby a “failure to respond by the registrant would in itself be misconduct could be applied here”.
- 8.141 The Health and Care Professions Council pointed out that its legislation makes it a criminal offence to fail to comply with a request without reasonable excuse.<sup>16</sup> Between April and December 2011 the power to request was used 16 times (out of 376 cases) and to date it has not been necessary to prosecute.
- 8.142 The Professional Forum of the Pharmaceutical Society of Northern Ireland said that it would “only support the use of enforcement powers which have been granted for a specific purpose by a Court of Law”.
- 8.143 However, some consultees disagreed with enforcement powers. The Medical Defence Union argued that “there is already the safeguard of recourse to the courts”. Similarly, the Association of Clinical Biochemistry disagreed since “the facility exists to present evidence to a court and obtain a court order, then contempt of court rules apply”.
- 8.144 The National Clinical Assessment Service felt “there should be a duty of co-operation to provide information as requested and non compliance should be taken into account by the regulator”.
- 8.145 The Medical and Dental Defence Union of Scotland felt there was force in the argument that inferences may be drawn where a registrant:
- fails voluntarily to disclose material but we do not feel that a registrant should be compelled to do so. This is still an adversarial and not a consensual process and that is the essential difference between regulatory process and civil proceedings.
- 8.146 The Royal College of Nursing felt that the registrant should not be compelled to make a disclosure but that the regulator should be permitted to “ask a registrant for disclosure with the request expressly stating that the failure to assist may result in a number of outcomes”, namely that the case “may take longer to be resolved” and failure to assist “may be brought to any panel’s attention ... and the registrant may face certain consequences from having refused a reasonable request to do so”.
- 8.147 The Royal College of Midwives thought that the issue of enforcement powers was a “difficult concept”, and considered failures by a range of information holders, rather than just registrants. The College stated that:

<sup>16</sup> Health and Care Professions Order 2001, SI 2002 No 254, art 39(5).

Healthcare providers have a duty to provide such information and there could be sanctions where they refuse, as to the registrant themselves and other professionals it is less clear.

8.148 The Department of Health wanted to explore further whether additional enforcement powers are necessary.

8.149 The Scottish Government was equivocal on enforcement powers and wanted to explore the option of “making non-responsiveness or non-disclosure ... grounds for professional misconduct”.

**Provisional Proposal 8-15: The statute should provide that the test for all referrals to a Fitness to Practise Panel across the regulators is the real prospect test.**

8.150 The vast majority agreed that the test for referrals to a Fitness to Practise Panel across the regulators should be the real prospect of establishing impairment.<sup>17</sup> For example, the General Optical Council thought that “applying a consistent test across all regulators would support harmonisation and provide clarity for the public that there is parity in the way that all complaints against any health care professional are treated”.

8.151 The General Dental Council agreed on the basis that “this test is the one used by courts now”, there is “a body of case law as to its meaning” and “it is understood and workable”. The General Medical Council argued:

In our experience the test is effective in ensuring that cases are only referred to a hearing if a finding of impairment is a real possibility. It is in no-one’s interests for cases to be referred to a hearing where there is no real prospect of a finding of impairment.

8.152 The Health and Care Professions Council pointed out that although its legislation does not contain the real prospect test, this test has been adopted by its Investigation Committee.

8.153 The McTimoney Chiropractic Association also supported the proposal, which it considered could “significantly reduce costs without impacting on public protection” by providing an alternative to the:

current system where, should a conflict in evidence exist, (virtually all complaints), this must be referred to the Professional Conduct Committee, often resulting in a “no case to answer” finding.

8.154 However, some consultees disagreed with the proposal. The Nightingale Collaboration feared that “allegations could be dismissed before sufficient investigation has been carried out”. It continued:

<sup>17</sup> Of the 192 submissions which were received, 44 expressed a view on this proposal: 43 agreed with the proposal, whilst 1 held an equivocal position.

We believe this could also be seen as a lack of transparency and accountability because of possible bias and conflicts of interest. We recommend that any allegation that falls within the remit of the regulator should fully investigated and put before a Fitness to Practise Panel.

**Provisional Proposal 8-16: The regulators should have powers to issue or agree the following at the investigation stage: (1) warnings; (2) undertakings; (3) voluntary erasure; and (4) advice to any person with an interest in the case. The regulators would be given broad powers to make rules governing the use of such powers. This would include rules governing who or which body can issue them and the circumstances in which the powers can be agreed or imposed.**

8.155 A significant majority agreed that all the regulators should have powers to issue or agree warnings, undertakings, voluntary erasure and advice at the investigation stage, and broad powers to make rules governing the use of such powers.<sup>18</sup>

8.156 The Royal College of Nursing argued:

The availability of these new sanctions at an early stage would encourage registrants and their representatives to engage in the fitness to practise process earlier. There are cases that we see at the current time, where the lack of lesser sanctions available to the Nursing and Midwifery Council at this stage, mean that it would not be in the registrant's best interests to make admissions and share information. This means that these less serious cases therefore proceed on into the fitness to practise process incurring time and costs of investigation. All parties would therefore be encouraged to explore a more practical outcome in these less serious cases.

8.157 The Medical Defence Union argued that "it must be left to the individual regulators to propose which of these powers it chooses" and "to change their rules in respect of these 'sanctions' including withdrawing the use of any of them at any time, again subject to consultation".

8.158 A consultee at a consultation event was concerned that allowing the regulators "to pick and choose exactly which disposals they adopt" is unhelpful and the approach to these types of disposals already varies between the regulators who impose different criteria for warnings.

8.159 Several consultees noted the potential advantages of being able to resolve cases at an early stage. Bupa considered that the proposal would "save time and costs". Similarly, the Medical and Dental Defence Union of Scotland supported the proposal "because of the cost, distress, and delay of requiring fitness to practise hearings to be held in cases which can be otherwise resolved by consensual means". The College of Social Work felt that the proposed powers would offer a "more flexible and proportionate response to less serious lapses".

<sup>18</sup> Of the 192 submissions which were received, 47 expressed a view on this proposal: 42 agreed, 1 disagreed, whilst 4 held equivocal positions.

### **Advice**

- 8.160 Several consultees commented specifically on the power to give advice. For example, the General Medical Council argued that advice should be issued under a general rather than specific power, to ensure that it remains an “informal mechanism” and therefore “would not engage publication and disclosure requirements”. It said that:

Under a general power a letter of advice can still be referred to at the impairment and sanction stage of a fitness to practise hearing as a matter of fact. This reflects our current practice.

- 8.161 The Medical Protection Society was concerned that in relation to advice “any person with an interest” would be too wide “in that any person could claim to have an interest simply by virtue of being a member of the public”. Similarly, the Association for Regulatory and Disciplinary Lawyers argued that this provision:

raises what may be a contentious issue as to who may have an interest in the case. Further that interested party may not have been engaged or engaged fully in the investigative process and thus any advice issued may be founded on incomplete information.

### **Consensual disposals**

- 8.162 A number of specific comments were made in relation to the use of consensual disposals. On the one hand, the Patients Association described consensual disposals as “inappropriate, unfair and obscure”. It said that:

A closed room with just representatives of the regulator and the registrant making a plea bargain feels deeply unjust ... We fear that this public perception will ultimately damage the reputation of the professions and confidence in professionals, contrary to the proposed paramount duty.

- 8.163 On the other hand, the General Medical Council pointed out that its role is public protection rather than punishment, and said that:

Where a doctor is willing to accept the sanction we believe necessary to protect the public, we cannot see the purpose of holding a hearing. Giving evidence at hearings is very stressful for witnesses and sometimes witnesses choose to withdraw from our procedures rather than give evidence at a hearing.

- 8.164 In cases of consensual disposal, it argued that the requirements of transparency and accountability do not require a public hearing. It thought that:

Transparency and accountability could, for example, be assured by publishing details of the concerns and full details of the decision on the doctor’s online record and by independent auditing of the decisions to ensure they reflect published criteria. The Professional Standards Authority could also be empowered to oversee such outcomes and challenge them if appropriate. We have invited the Professional Standards Authority to review the outcomes of the cases in our pilots later this year.

- 8.165 The General Optical Council argued that in relation to consensual disposal, the preferred concept is that the regulator issues these outcomes, rather than their being “agreed” with the registrant. It stated that:

It is important that disposal of complaints prior to a formal hearing should not be seen as the registrant benefiting from a lesser outcome or collaborating with the regulator to avoid a public hearing. We would suggest that where a registrant has been issued with any of these outcomes, it may be appropriate for these to be a matter of public record. In any event, the meaning and purpose of any outcomes issued at this stage should be clear, relative to warnings and sanctions applied following a hearing.

- 8.166 The Royal College of Nursing argued that in order to provide an incentive to registrants, an assurance should be given that “admissions made in the consideration of an early consensual disposal of a case, could not be revealed at the final fitness to practise hearing”. It was argued this would also help the regulator in that the registrant would not be able to bring to a panel’s attention the fact that the regulator had considered consensual disposal but decided against it.
- 8.167 Several consultees argued that the granting of voluntary erasure in fitness to practise cases “should always be based on the presumption that the doctor will not seek to be restored to the register at a future date”.

### ***Warnings***

- 8.168 Some consultees commented on the use of warnings. The Nursing and Midwifery Council felt it was “unhelpful” to allow warnings to be issued at two different stages in the process. Its system of “cautions” can be imposed only following a finding of impairment, whereas at other regulators they can be issued by investigators where there is no realistic prospect of proving impairment. The Council said that:

If [warnings] are most effective when used as a sanction in cases falling short of impairment, then they should be imposed at this stage, but if they are properly regarded as a less serious sanction than suspension or conditions following a finding of impairment, then they should not be available at the investigation stage. In our view they cannot be used at both stages.

- 8.169 Similarly, the Royal College of Midwives argued it was:

unclear what the purpose of a warning at investigations stage could be. Perhaps where a registrant admits the charges but it is clear that they do no amount to impairment of practice they could be used but perhaps a condition of practice order might be more appropriate. Warnings should perhaps be reserved for the hearing stage.

### ***Other comments***

- 8.170 The General Medical Council argued that “suspension and erasure should also be available” at the investigation stage.

8.171 An individual consultee (James Kellock) felt that there should also be a “power to agree financial reimbursement to the patient”. He asked:

Why should a patient who has undergone inappropriate or incompetent treatment and paid for it have to initiate a separate process to recover the sum he should not have paid?

8.172 Some consultees argued that there should be a power for the regulators to require an apology from the registrant.

8.173 The Professional Standards Authority argued that:

There would be significant value in terms of improving public understanding of and confidence in the regulatory framework if the regulator’s rules about the issuing/agreement of these outcomes were consistent. We also consider it important for the regulators to establish clear criteria and processes for decision-making in relation to these outcomes, as well as to demonstrate rigorous quality assurance of the decisions actually made .... Our preference would be to ensure that such decisions are only taken after sufficient investigation of the underlying concerns, and that there is provision for robust oversight of such decisions.

**Question 8-17: Should the statute require that any decision to use any power listed in provisional proposal 8-16 at the investigation stage must be made or approved by a formal committee or Fitness to Practise Panel? Alternatively, should the powers of the Professional Standards Authority to refer decisions of Fitness to Practise Panels to the High Court be extended to cover consensual disposals?**

8.174 A majority felt that any decision to issue warnings, undertakings, voluntary erasure and advice at the investigation stage must be made or approved by a formal committee or Fitness to Practise Panel.<sup>19</sup> For example, the British Dental Association was concerned “that a *published* warning could be given by a small group of case examiners” and therefore “another tier is needed when measures are taken that could adversely affect the practitioner’s livelihood”.<sup>20</sup>

8.175 The Health and Care Professions Council considered that “it is appropriate for cases to be considered for consensual disposal only once a case to answer decision has been made” – this “prevents regulators from diverting cases which would not otherwise have been referred to final hearing through this process”. Under its rules the decision to dispose of a case via consent is considered by a Fitness to Practise Panel and therefore the Professional Standards Authority has the jurisdiction to review cases.

8.176 The Professional Standards Authority argued that “public confidence would be compromised” if there was no independent oversight of these decisions and that:

<sup>19</sup> Of the 192 submissions which were received, 46 expressed a view on this question: 29 said that the statute should so require, 16 disagreed, whilst 1 held an equivocal position.

<sup>20</sup> Emphasis in the original.

If such decisions were approved by fitness to practise panels, they might automatically fall within [our] jurisdiction if they amounted to “final” decisions. If they did not amount to “final” decisions they might nevertheless fall within our initial stages audits. However, the audits only look at a sample of each regulator’s caseload, so provide less assurance in relation to individual outcomes than the scrutiny of “final” fitness to practise decisions.

8.177 The General Chiropractic Council stated that it would “ensure there was proper oversight, particularly of any consensual disposal” but the particular form of oversight should be left to the regulators.

8.178 The Patients Association argued, in relation to consensual disposals, that:

If they must be done, these hearings must be done in the open or at the absolute very least the patient/complainant must have a role in the consensual disposal process.

8.179 However, the General Medical Council opposed any requirement that a formal panel should approve or make any such decisions. It said that:

This suggests that the Registrar is incapable of entering consensual arrangements that are appropriate and in the public interest. We have been using consensual disposal with great success for many years and all use of discretion is subject to review by the courts and can be challenged. Introducing such internal formal constraints will introduce substantial delays and bureaucracy when there is no evidence that such restraints are necessary.

8.180 The Medical Defence Union argued that it would be “counter productive to require a regulator to seek approval from a formal committee” for decisions made through consensual disposal. It continued:

This would have to result in a mini-hearing and engender much of the delay and additional cost that currently exist and that are part of the main rationale for the introduction of consensual disposal. It is unlikely that consensual disposal would work in terms of making the efficiencies and savings that are envisaged if there was a requirement for decisions to be approved by a committee or Fitness to Practise Panel. The procedure is not meant to be punitive and there will be lay and legal involvement in decisions that are made and we can see no good reason, therefore, to prolong the decision-making process by building in a further approval stage.

8.181 Several other consultees thought that a requirement of approval by a formal committee or panel would undermine the benefits of concluding matters at the investigation stage. For example, the British Chiropractic Association said that “such a requirement will negate the swifter nature of screening and consensual disposal”. The Association of Regulatory and Disciplinary Lawyers agreed that approval would “defeat the objective of dealing with such cases efficiently and expeditiously”.



8.182 The Society and College of Radiographers did not believe that consensual disposals should have to be approved by a formal committee or panel but suggested “these agreements should be audited to ensure consistency across individual cases and between professions” and that such audits should be undertaken by the Professional Standards Authority.

8.183 As an alternative to a formal panel, the Medical Protection Society suggested that:

- (1) the complainant and registrant should be allowed “a reasonable opportunity to make representations to the regulator where the use of a power is being contemplated”;
- (2) any decision to use a power “must be made unanimously by two case examiners comprising one lay member and one member from the registrant’s profession”;
- (3) any decision to use or not use a power should be explained by the case examiners by providing their reasons in writing; and
- (4) any person or body that the regulator considers to have a sufficient interest in the case or indeed the regulator itself, could seek a review of the decision.

8.184 The Department of Health agreed that the regulators should have broad powers to issue or agree warnings, undertakings, voluntary erasure and advice at the investigation stage. It also argued that where there is a disagreement about the use of these powers, cases should be referred to a panel.

8.185 An individual consultee (James Kellock) said that:

if both the regulator, acting in the public interest, and the registrant, agree the facts, the basis for impairment and the sanction, it is difficult to see why the profession, and ultimately the public, should bear the cost of expensive proceedings (the need for public understanding can be met in ways other than a public hearing, for example by a reasoned decision being published).

8.186 Similarly, the General Optical Council said that:

This is about public protection and doing so in a proportionate way. Only a small number of cases will fall into this category, and the guidance could provide that the most serious cases must be referred. We would refer back to the point that fitness to practise is not about punishment. By restricting or removing a registrant’s right to practice, the public is protected. We understand that there may be a desire to see a public hearing in all cases, but we believe that a balanced approach could accommodate disposal of cases without a hearing.

- 8.187 A large majority felt that the Professional Standards Authority's powers to refer decisions of fitness to practise panels to the High Court should be extended to cover consensual disposals.<sup>21</sup>
- 8.188 However, a small number disagreed. UNISON argued that this would inhibit the use of consensual disposals. The General Osteopathic Council felt that it would be more appropriate "to include any 'undue lenience' concerns around consensual disposals within the rights to initiate a review". An individual consultee (Jacqueline A Wier) considered that "the ability of the fitness to practise panel to approve a decision at the investigation stage should be sufficient without recourse to the Professional Standards Authority".
- 8.189 The General Dental Council thought that the Professional Standards Authority's powers to refer decisions to the High Court should only be extended in respect of voluntary erasure. The Council said that:
- Voluntary erasure is an exception as the circumstances leading to it are so diverse. Some of these are appropriate for the Professional Standards Authority's powers of referral and some are not. The General Dental Council would suggest that there need to be rules setting out which are the appropriate circumstances.
- 8.190 The Department of Health felt that an impact assessment should be completed before any decision is made about extending the powers of the Professional Standards Authority to refer cases to the High Court.

**Provisional Proposal 8-18: The Government should be given a regulation-making power to add new powers to those listed in provisional proposal 8-16, and to remove any powers.**

- 8.191 A large majority agreed that the Government should be given a regulation-making power to add or remove disposal powers.<sup>22</sup> The General Medical Council argued that a Government power would "future proof the process should a different approach be considered necessary at a later date". The Royal College of Nursing agreed that the inclusion of a Government regulation-making power in the statute would future proof the legislation.
- 8.192 The General Dental Council agreed with the proposal but felt there would not be any circumstances where any of those powers would be removed.
- 8.193 However, some disagreed outright with the proposal. UNISON argued that this proposal "gives Government too much power and could undermine the independence and confidence of regulators". The Society and College of Radiographers felt that Governments "may be swayed by political considerations which may occur due to a particular case" and wished to "avoid the perception that professional regulation is subject to political 'knee jerk reactions' to specific cases". The Royal College of Midwives shared these anxieties and thought that the purpose of the proposal was "unclear and brings in political interference".

<sup>21</sup> Of the 192 submissions which were received, 35 expressed a view on this question: 27 said that the power should be extended, 6 disagreed, whilst 2 held an equivocal position.

<sup>22</sup> Of the 192 submissions which were received, 38 expressed a view on this proposal: 33 agreed, 2 disagreed, whilst 3 held equivocal positions.

- 8.194 The Professional Forum of the Pharmaceutical Society of Northern Ireland proposed that such powers should be “subject to the agreement of the devolved administrations”.

**Question 8-19: Does the language used in the proposed list of powers contained in provisional proposal 8-16 convey accurately their purpose?**

- 8.195 A majority felt that the language used to describe the proposed powers accurately conveys their purpose.<sup>23</sup> For example, the Medical Defence Union said that it was “not aware of any difficulties with the language and believe it is easily understood”. The General Osteopathic Council was also “content with the categories as described”.
- 8.196 However, some consultees thought that the language required further consideration. For example, the Royal College of Radiologists said that “if the test of the language used is public confidence, then the terms should be clarified to enable this”.
- 8.197 Of those who disagreed, most argued that the term “voluntary erasure” was not clear.<sup>24</sup> The Nursing and Midwifery Council questioned the use of the term when many regulators do not use the phrase “erasure”. The General Dental Council felt that “voluntary erasure” implies that “this is purely at the registrant’s choice and that they may have evaded a just disposal of the matter” and therefore suggested “agreed erasure”. Alternative suggestions included “erasure by mutual consent”, “consensual erasure”, “voluntary removal” or “removal by consent”.
- 8.198 The General Medical Council suggested that the term for “voluntary erasure” must be distinct from the term used when a Fitness to Practise Panel erases a doctor from the register or “when, under the consensual disposal provisions, the regulator demands and the registrant agrees that their name be removed from the register”.
- 8.199 Some consultees felt that the term “warnings” was not appropriate and preferred “caution”. An individual consultee (Lucy Reid) felt that the term “warnings” can be misunderstood and can be seen by the public as “merely a slap on the wrist”.
- 8.200 The General Dental Council felt that “undertakings” suggests that “a registrant has simply promised to behave properly; it does not in itself imply that there are conditions or monitoring in place” and suggested “conditions” or “agreed conditions”. Similarly, NHS Greater Glasgow and Clyde suggested that it should be made clear that “undertakings” are mandatory, by using the term “conditions”.
- 8.201 The General Social Care Council felt that “‘undertaking’ would be viewed as obscure by members of the public and does not fully capture the nature of the arrangement” whereby “the registrant has agreed to amend his or her practice or behaviour as a condition of being allowed to hold a licence to practice”.

<sup>23</sup> Of the 192 submissions which were received, 39 submissions expressed a view on this question: 24 said that the language does convey the purpose, 15 disagreed.

<sup>24</sup> Three consultees said that the term “warnings” was not clear, 4 said that “undertakings” was not clear, 11 said that “voluntary erasure” was not clear, whilst 1 said that “advice to any person with an interest in the case” was not clear.

- 8.202 The Scottish Government supported the General Medical Council's proposal "to replace the term 'voluntary erasure' with 'erased by mutual consent'". It stated:

However, we consider that this sanction needs to be supported by robust safeguards before this step is taken to assure patients that adequate steps have been taken to protect their interests and maintain their confidence in the professions (for example all outstanding concerns, allegations or potential fitness to practise issues would need to have been satisfactorily addressed and answered before such an application was finally processed).

**Question 8-20: Is the use of mediation appropriate in the context of fitness to practise procedures?**

- 8.203 A majority felt that mediation was appropriate in the context of fitness to practise procedures.<sup>25</sup> For example, an individual consultee (Robin McCaffery) described the proposal as "a good idea not based on confrontation".

- 8.204 The Scottish Mediation Network argued that:

Mediation can be particularly useful where the registrant has made a mistake that has caused harm to a complainant, but is unlikely to repeat the mistake, and is assessed as being currently fit to practise. The regulator may choose not to impose any restrictions on the registrant and this may lead the complainant to feel that their complaint has not been taken seriously. Mediation can be used in such circumstances to facilitate a face to face discussion allowing complainants to receive an explanation and, where appropriate, an apology. It may also enable registrants to improve the quality of their future practice through hearing first hand about the impact of their actions on complainants.

- 8.205 The United Chiropractic Association also supported mediation and argued that:

Many complainants would much prefer resolution of their complaints by way of an apology and assurances in relation to improvements in practice/communication in the future. Many are not aware of the severe implications on the professional of disciplinary hearings and if they were so aware would not wish to pursue the complaint.

- 8.206 An individual consultee (James Kellock) felt that mediation was appropriate where "the registrant appears not to understand the impact [their] behaviour has had on the patient" and "where the fundamental issue concerns communication":

I am a mediator and know how beneficial mediation can be to both parties in a dispute in terms of moving on. I can quite see that some registrants against whom allegations have been made would be receptive to, and would benefit from, mediation in understanding how they can improve their professional practice to provide better service and to enhance patients' experiences.

<sup>25</sup> Of the 192 submissions which were received, 59 expressed a view on this question: 41 said mediation is appropriate, 12 disagreed, whilst 6 held equivocal positions.

- 8.207 Several consultees suggested that mediation should take place before an investigation has concluded. For example, the General Osteopathic Council argued this would ensure that mediation determined “the nature of the allegations rather than for there to be a mediated outcome to a panel decision on impairment”. In contrast, the Medical Protection Society felt that mediation should be used after a finding of impairment by a Fitness to Practise Panel, “either in addition to or (in appropriate cases) in place of a sanction being imposed”.
- 8.208 The Medical and Dental Defence Union of Scotland felt that mediation:
- could be used at an early stage to resolve complaints based on misunderstanding or to acknowledge mistakes but [we] do not believe it should be used in relation to determinations or negotiated outcomes. Equally, the involvement of the regulator itself in mediation is problematic and compromises the ability of both the regulator and registrant to take adversarial views where properly necessary.
- 8.209 Rescare commented that “mediation may be appropriate in a limited number of fitness to practise cases, where a mistake or omission is unlikely to be repeated”. Thompsons Solicitors thought that “mediation could be useful and that it could avoid lengthy hearings if it is agreed to by both the registrant and the complainant”.
- 8.210 The Professional Standards Authority said that it:
- did not see much scope for mediation for those complaints which are likely to pass the ‘real prospect’ test for the obvious reason that by definition there is a public interest in the matter being dealt with fully if there is a real prospect of a finding of current impairment being made. Similarly we see little scope for mediation where there is no complainant as such (eg in cases arising from notification of criminal convictions or in cases arising from ill-health).
- 8.211 The Department of Health was not convinced that mediation has a role in fitness to practise proceedings – given that the purpose is to determine impaired fitness to practise. But it also noted that litigation is expensive and time-consuming and wished to explore the issue of mediation further.
- 8.212 The Scottish Government, although generally not supportive of mediation, felt that it does give complainants and other injured parties “the opportunity to explain how they were affected by the events in question” and “provide registrants with the opportunity to apologise and/or explain what happened, depending on the individual circumstances of the case”. Thus “appropriate sanctions could then be determined on this basis”. It also argued that if a mediation scheme is adopted, this would benefit from “a central resource that all regulators could use rather than each regulator adopting individual systems and processes for medication”.
- 8.213 However, a number of consultees remained opposed to mediation in a fitness to practise context. The General Medical Council argued that:
- Regulators must always seek the minimum outcome necessary to protect the public and retain confidence in the profession. If such an outcome was subject to negotiation with the registrant, by implication

the final agreed outcome could be less than that necessary to protect the public.

8.214 Charles Russell LLP argued that:

Unlike civil claims, the registrant does not have the ability to compromise the proceedings, so avoiding the costs of a final hearing. If mediation were to take place at an early stage, registrants will be hampered by the fact that they may not have received all the evidence which the regulator will be intending to rely on, any may not have had the opportunity to formulate their defence, including instructing any expert witnesses, or obtaining witness statements.

8.215 The General Social Care Council did not consider that “mediation in relation to fitness to practise issues in the context of social work would be appropriate”.

8.216 UNISON referred to the Health and Care Professions Council’s consultation on mediation, and said that “the fact remains that [mediation] is rarely used”. It went on to say that whilst it:

is very keen to explore all possible alternatives to the costly, resource intensive and extremely stressful process of going to a hearing we urge caution in this area.

8.217 The Department of Health, Social Services and Public Safety for Northern Ireland questioned “the value of mediation and where it fits in”.

**Provisional Proposal 8-21: All regulators should be given rule and regulation-making powers to introduce a system of mediation if they wish to do so.**

8.218 A large majority agreed that all regulators should be given rule-making powers to introduce a system of mediation if they wish to do so.<sup>26</sup> For example, the British Pharmaceutical Students’ Association said that:

It is difficult to predict the role of mediation within the General Pharmaceutical Council but giving regulators the power to introduce mediation would enable them to fully research its advantages and disadvantages whilst also consulting with the profession and public.

8.219 Several consultees argued that mediation should be enabled by the statute but subject to proper safeguards and limited circumstances. In addition, the Health and Care Professions Council pointed out it will begin a mediation pilot next year.

8.220 The Society of Chiropractors and Podiatrists agreed with the proposal to give regulators powers in this area, but noted that:

<sup>26</sup> Of the 192 submissions which were received, 50 expressed a view on this proposal: 39 agreed, 8 disagreed, whilst 3 held equivocal positions.

there is no comment on how mediation would be paid for. We would expect regulators to weigh up whether mediation would save money in the long run by resolving disputes without recourse to fitness to practise processes, or simply create an extra burden of activity.

8.221 The Professional Standards Authority felt that the statute should impose:

a degree of consistency across the regulators in terms of the types of cases that might be suitable for mediation as well as the overall framework of the mediation processes to be used. Otherwise they may develop inconsistent criteria, which will not improve public confidence in the regulatory system more generally.

8.222 The Welsh Government supported giving the regulators powers to mediate, but said that:

it is important that all regulatory bodies apply a similar model to demonstrate equity of management of fitness to practice cases. Rule and regulation powers may not be appropriate but a sharing of good practice and applicability across all regulatory bodies would be supported.

8.223 The General Optical Council argued that the regulators should have the power to “finance services for mediating complaints about the quality of goods and services provided by registrants that do not relate to fitness to practise concerns”, such as the Optical Consumer Complaints Service.

8.224 Several consultees agreed with the proposal but retained some reservations about the use of mediation. For example, the Patients Association stated that:

There appears to be some cognitive dissonance amongst the regulators who claim that mediation is wrong and opaque yet are in favour of using consensual disposals which are certainly not transparent. We are not wholly in favour of using mediation as it may not be the most effective tool in protecting future patients. That being said, mediation allows patients and service users to be directly involved in the process.

**Provisional Proposal 8-22: The statute should provide for a right to initiate a review of an investigation decision in relation to decisions: (1) not to refer a case for an investigation following initial consideration; (2) not to refer the case to a Fitness to Practise Panel; (3) to issue a warning; or (4) to cease consideration of a case where undertakings are agreed.**

8.225 An overwhelming majority agreed with the proposal regarding which decisions could be reviewed.<sup>27</sup> For example, an individual consultee (Lucy Reid) said this would be a “very welcome amendment”.

8.226 The Medical Defence Union argued the power to review should also include “the ability to review a decision to refer a case to a Fitness to Practise Panel”. An

<sup>27</sup> Of the 192 submissions which were received, 43 expressed a view on this proposal: 41 agreed, whilst 2 held equivocal positions.

individual consultee (James Kellock) pointed out that the General Dental Council and the General Optical Council already have a power to review decisions to refer cases to a Fitness to Practise Panel. He said that:

This is useful in rare cases where further information comes to light and whilst it is true to say a Fitness to Practise Panel can be left to deal with it, surely the better view is that if the referrer no longer thinks the case passes the real prospect test it is unfair on all parties, but especially the registrant, that the weight of proceedings should hang over his head for a further period.

- 8.227 The Patients Association argued the proposal should include an ability to review the use of mediation or consensual disposal “if they are included in the framework”.
- 8.228 Whilst the Professional Forum of the Pharmaceutical Society of Northern Ireland supported the proposal, it cautioned that “care be taken where a complainant is simply not satisfied with an investigation and purely seeks to prolong [a case] or victimise a registrant”.

**Provisional Proposal 8-23: Anyone who has an interest in the decision should be able to initiate a review of an investigation decision, including but not limited to the Registrar, registrant, complainant and the Professional Standards Authority.**

- 8.229 A majority agreed that anyone with an interest should be able to initiate a review.<sup>28</sup>
- 8.230 A number of consultees emphasised that anyone with an interest could request a review, but that the decision would be for the regulator. For example, the Medical and Dental Defence Union of Scotland said that “those with an interest should be able to initiate a review but they should not be able to compel one”. The Optical Confederation thought that the “right to initiate a review should remain with the regulator and the registrant”.
- 8.231 The Medical Defence Union agreed on the basis that there is no “automatic right for an interested party to have a review” but rather a right to seek or request a review “because reviews can only be undertaken if specified grounds are met”.
- 8.232 The Professional Standards Authority suggested that employers should specifically be able to initiate a review. UNISON argued that a complainant should not be able to initiate a review “as this is not a complaints process” and the current external scrutiny of decisions by the Professional Standards Authority is sufficient.
- 8.233 Several consultees pointed out that difficulties may arise in defining who may have an interest in the decision over and above the complainant and the registrant. The Royal Pharmaceutical Society of Great Britain argued that:

<sup>28</sup> Of the 192 submissions which were received, 38 expressed a view on this proposal: 26 agreed, 9 disagreed, whilst 3 held equivocal positions.



the vagueness of [the] wording “anyone who has an interest” is too overarching and empowering for anyone to request a review just because they are unhappy with the outcome.

- 8.234 Several consultees were concerned that the current wording of the proposal left open the possibility of the right being abused. The British Chiropractic Association said it “would expect to see firm guidance in relation to parties that constitute ‘anyone interested’”. The General Osteopathic Council referred to the need for “safeguards to prevent vexatious requests from complainants ..., and unmeritorious attempts by registrants to stall the progress” of cases against them.
- 8.235 The Department of Health also expressed concerns that giving “anyone including the registrant” the ability to initiate a review might be too wide and could potentially include anyone who happened to disagree with the decision.
- 8.236 The Department of Health, Social Services and Public Safety for Northern Ireland also supported the proposals but also felt that there needs to be “clear terms as to who can initiate a review”.

**Provisional Proposal 8-24: The grounds for a review of an investigation decision should be that new evidence has come to light which makes review necessary for the protection of the public or the regulator has erred in its administrative handling of the case and a review is necessary in the public interest.**

- 8.237 A large majority agreed with the proposed grounds for a review.<sup>29</sup> For example, the British Pharmaceutical Students’ Association thought that the proposal would “ensure fairness is maintained for registrants who have fallen foul of proceedings”. The General Optical Council also supported the proposed grounds, which it pointed out reflect its current legislation. The Council also said that it would “support a harmonised approach being adopted to rejecting requests which are based purely on the fact that a complainant does not agree with a decision”.
- 8.238 The General Medical Council argued that the grounds should include that an investigation decision was wrongly decided. It stated:

To ensure we protect the public effectively we need an ability to review and overturn a decision in those exceptional circumstances where, on review, it appears it was flawed. This is also important in encouraging a culture of learning within the organisation. We currently have such a power.

- 8.239 The Royal College of Nursing supported narrow criteria for a review which include a requirement that a review is necessary and proportionate. The Optical Federation felt that a “significant” administrative error should be required before a review can take place.
- 8.240 However, the Professional Standards Authority supported a broader threshold which did not include references to “public protection” or “public interest”. Instead it suggested the threshold should be:

<sup>29</sup> Of the 192 submissions which were received, 29 expressed a view on this proposal: 24 agreed, 4 disagreed, whilst 1 held an equivocal position.

if the new evidence/error is considered to be material enough to raise the real prospect that a decision-maker looking at the matter afresh would reach a different decision to the one that was originally made. We would also add a third ground for a review of an investigation decision, namely where a decision has been made following an incorrect interpretation of the law.

8.241 RadcliffesLeBrasseur argued that the proposed grounds “are too narrow and one sided” and that a review should be initiated “where new information demonstrates that that is in the interests of justice”. The Health and Care Professions Council felt that a review should only take place where the *Ladd v Marshall* criteria apply, namely when relevant new evidence becomes available.

8.242 The Nursing and Midwifery Council stated that the statute should define the meaning of “public interest”. UNISON argued that there should be definition of “what would be construed as an administrative handling error”. The Health and Care Professions Council thought that “the grounds should be provided for within the statute”.

**Provisional Proposal 8-25: The statute should give the regulators broad rule and regulation-making powers on all aspects of the process for the review of an investigation decision, except those matters specified in provisional proposals 8-22, 8-23 and 8-24.**

8.243 The vast majority agreed that the regulators should be given broad rule-making powers.<sup>30</sup> For example, the General Medical Council argued that:

The volume and nature of the concerns raised will vary considerably between the different regulators and flexibility is needed to ensure we have the flexibility to maintain an efficient and effective process to suit the context within which we work.

8.244 The Scottish Government agreed generally with the proposals but warned that:

Adequate constraints and safeguards would need to be in place to ensure that such reviews had an objective basis (rather than individual differences of opinion), could be justified and would withstand any test of external scrutiny. This would be necessary to prevent the potential for excessive demands on resources in the event of too many requests for a review being made with the associated impact on costs.

8.245 The Nursing and Midwifery Council agreed with the proposal, but suggested that “a common approach to the drafting of these rules may be beneficial and cost-saving”.

8.246 The Royal Pharmaceutical Society of Great Britain sought had “some reservations” about the proposal. It sought “clarity as to whom, and what internal, and professional consultation, there would be for the designation of the proposed

<sup>30</sup> Of the 192 submissions which were received, 36 expressed a view on this proposal: 34 agreed, whilst 2 disagreed.

broad powers to make Rules". It also asked "for assurances that professional opinion will be sought and listened to with such an important area of innovation".

- 8.247 Several consultees argued that any right to review must be subject to strict time limits such as two years (Medical Protection Society) or five years (James Kellock), and that the review itself must be subject to timescales. The Professional Standards Authority suggested that the time limit could be "linked to the timing of the discovery of new evidence/administrative error". It also felt that "the registrant should be invited to comment on the case before the review is undertaken" and the statute should also specify "the nature of any information that is to be published generally and/or disseminated to the parties following any review about its outcome".
- 8.248 The General Optical Council argued that the reviewing body must not be the Fitness to Practise Committee "as this would increase cost and administrative burden" but rather an Investigation Committee or Case Examiners. An individual consultee (James Kellock) argued that the review should be conducted by "the same person/body that took the original decision" on the basis of "familiarity with the matter ... consistency of decision-making [and] lower costs".

## **PART 9**

# **FITNESS TO PRACTISE: ADJUDICATION**

**Question 9-1: Should the statute require the regulators to ensure that they establish a structure which is compliant with Article 6 of the European Convention on Human Rights without taking into account the role of the higher courts?**

- 9.1 A significant majority agreed that the statute should require Article 6 compliance without taking into account the role of the higher courts.<sup>1</sup> For example, the Optical Confederation thought that the statute:

should require that the structure of adjudication across all the regulators is Article 6 compliant and there should be clear separation of investigation and adjudication to ensure public and professional confidence.

- 9.2 The Health and Care Professions Council reported that it is currently reviewing its structures to ensure “internal” Article 6 compliance. It stated:

We were the first regulator to put its panels at “arm’s length” and end the practice of Council members sitting as panellists. Similarly, we have always respected the concept of “equality of arms” and ensured that lawyers who regularly appear as presenting officers in fitness to practise cases are not involved in policy development or the training of panellists. We have also never had any form of review or “sign-off” arrangements for individual panel decisions, recognising that any such process would undermine their independence and impartiality.

- 9.3 The Association of Regulatory and Disciplinary Lawyers criticised the relevant jurisprudence which allows for “rescue by appeal”. It said:

We do not regard this as an appropriate response to procedural defects in a mature fitness to practise jurisdiction. Indeed, from the early days of the Human Rights Act the courts have not advocated reliance on “rescue by appeal” as an answer to non-compliance: see Lord Cooke in 2001, “a disciplinary system in which a hearing satisfying Article 6(1) could be secured only by going as far as the Privy Council could not be commended”. Although we accept that due to the regulators’ significantly improved Article 6 compliance in recent years, “rescue by appeal” does not feature often in the modern appeals, it is still available as an argument. The statutory provision suggested by the joint Commissions would appropriately eliminate such an option.

- 9.4 Charles Russell LLP argued that ensuring hearings comply with Article 6 is crucial because, for the majority of its pharmacist clients, an appeal to the higher courts is not a realistic possibility “due to the legal costs they will incur

<sup>1</sup> Of the 192 submissions which were received, 60 expressed a view on this question: 49 said that the statute should so require, 10 disagreed, whilst 1 held an equivocal position.

(particularly if they lose)". RadcliffesLeBrasseur also argued this would "reduce the number of challenges to first instance decision making". Optometry Scotland further noted the potential efficiency savings if fewer cases were referred to the higher courts.

- 9.5 The Administrative Justice and Tribunals Council said that it "recognises the difficulty of specifying this in the statute", but that it:

would welcome a requirement for regulators to establish their own Article 6 compliant structures, perhaps with guidance being issued on the sorts of issues to be considered and taken into account.

- 9.6 An individual consultee (Walter Merricks) broadly agreed that the role of the higher courts should be excluded when considering Article 6 compliance, but stated that:

If the regulators' proceedings are self contained, it is reasonable to ask whether it is then necessary to maintain a full right of appeal on fact and law by way of re-hearing – without any requirement of leave ... It would be relevant to look at the volume of appeals and the burdens that these place on the higher courts. One option would be to abolish the right to appeal. The scope of judicial review encompasses decisions that have been made where there has been an error of law, so challenges on law can be accomplished through that route. I would question whether an appeal on fact should be permitted.

- 9.7 The Department of Health, Social Services and Public Safety for Northern Ireland supported the inclusion of a statement requiring Article 6 compliance.

- 9.8 However, a number of consultees disagreed that the statute should require Article 6 compliance. The General Medical Council stated that compliance is already secured through the establishment of the Medical Practitioners Tribunal Service and a right of appeal. Furthermore, it stated:

Although we believe that fitness to practise procedures should reflect best practice, the inclusion of requirements in the statute in relation to Article 6 over and above the role of the higher courts is likely to lead to protracted arguments at hearings that will cause delay and increase costs.

- 9.9 Similarly, an individual consultee (Anonymous) thought that:

Current arrangements where regulators put panels at arms length from the Council etc should be sufficient to ensure compliance with Article 6. It would be costly, unnecessary and disruptive to include in statute requirements that might suggest further independence from that currently applying is needed.

- 9.10 The Nursing and Midwifery Council felt that a statement requiring Article 6 compliance "will add nothing in terms of the protection of human rights", especially since "there is no proposal that the rights of appeal to the higher courts are removed and no proposal for a complete separation of functions, along the lines of the Office of the Health Professions Adjudicator." The Council noted that

Article 6 will apply to the other aspects of its adjudication processes. Furthermore, the Council considered that:

There is though a serious risk that it will involve the regulators in protracted and potentially costly and disruptive legal arguments about the nature of their adjudication structures, which will only result in resources being deflected from their work in protecting the public.

9.11 The Department of Health disagreed that the statute should require Article 6 compliance since this would, in effect, amount to “gold-plating” and would go beyond the requirements of the European Convention on Human Rights.

9.12 The Scottish Government commented that the regulators’ systems are already Article 6 compliant. It was “unsure regarding the effect of the proposals” and did not consider that “additional steps or safeguards are necessary”. It went on to say:

If the primary aim of explicitly stating that compliance with Article 6 is required is to ensure that the various requirements of procedural fairness have been met, there may be benefit in setting these out in the new statute. However we do not consider this to be essential and are concerned that the regulators could look upon any criteria specified as a checklist rather than minimum standards and consider these rather than looking more closely at the rights guaranteed by the Convention.

9.13 The Medical Protection Society argued that:

Given that each case is fact sensitive in terms of whether there has been Article 6 compliance, it follows that any structure would have to be very general and widely drawn such that it may only have limited application.

9.14 The General Chiropractic Council stated that it is “required as a matter of law to comply with Article 6 ... so statute telling us to comply with the law seems to us to be unnecessary”.

9.15 Some consultees felt that a better alternative would be for the Professional Standards Authority to monitor the regulators’ compliance with Article 6. The Law Society of Scotland took the view that “measures and procedures should be adopted by each regulator in order to ensure Article 6 compliance”, rather than reliance placed on statements in the statute.

**Question 9-2: Should the new legal framework ensure the separation of investigation and adjudication, and if so how?**

- 9.16 A majority agreed that the new legal framework should ensure the separation of investigation and adjudication.<sup>2</sup> Of those who specified how this should be achieved, a majority felt that there should be a separate adjudication body.<sup>3</sup> For example, the Association of Regulatory and Disciplinary Lawyers described as a source of regret the demise of the “wholly independent” Office of the Health Professions Adjudicator. Similarly, the Patients Association stated that:

The Office of the Health Professionals Adjudicator had the potential to be a truly independent adjudication function. Its abolition rather than development is disappointing, but we believe that the regulators should now aim to provide as independent an adjudication procedure as possible.

- 9.17 The Professional Standards Authority argued that separation will not be achieved following the abolition of the Office of the Health Professions Adjudicator, but that:

The legal framework should do as much as possible to ensure public confidence in the overall process by separating the investigative and adjudicative functions where possible. If the Medical Practitioners Tribunal Service (MPTS) were to offer its adjudicative services to other regulators that might assist in establishing its credibility as separate from the General Medical Council. It may be difficult for the Council to demonstrate convincingly that the MPTS is operationally independent of it unless it provides further clarity about the governance arrangements and, possibly, gives the MPTS control over its own budget.

- 9.18 An individual consultee (Walter Merricks) argued that “it is unjust that doctors should have access to a more independent process while other professionals do not”. Coventry and Warwickshire Partnership Trust said that:

A single adjudication provider would be best understood by the public and therefore an extension of the General Medical Council proposals for this may be the best to take forward, although there would need to be consideration given to the costs.

- 9.19 The Scottish Social Care Council also thought that the “separation of adjudication and investigation can only be achieved fully by establishing an adjudicating authority, with a separate legal identity”.

- 9.20 However, the Medical Defence Union also expressed the following concerns:

<sup>2</sup> Of the 192 submissions which were received, 59 expressed a view on this question: 43 said that the new legal framework should ensure separation, whilst 16 disagreed.

<sup>3</sup> Of the 192 submissions which were received, 30 expressed a view: 18 supported a separate body, 6 said that separation could be achieved through the use of internal committees, whilst 6 said that the matter should be left to the discretion of the regulators.

The General Medical Council's Medical Practitioners' Tribunal Service may be one way of achieving separation of adjudication that is acceptable to all parties, though it does not provide complete independence from the regulator. Such a model may be too expensive for smaller regulators who will need to consider other arrangements, for example, merging or combining with one or more other regulators to provide an adjudicatory function.

9.21 The Medical Protection Society suggested that separation should be achieved by:

- (1) the adjudicating body being accountable to Parliament rather than the regulator;
- (2) the independent appointment of panellists to the adjudicating body;
- (3) an independent audit of the adjudicating body's decisions; and
- (4) the operational separation of investigation.

9.22 However, not all consultees agreed with a separate adjudication body. The British Association for Counselling and Psychotherapy felt that such a body "may not be fully cognisant of the peculiarity and specifics of the regulated profession under scrutiny".

9.23 The Scottish Government considered that "the case has not been made to have an entirely separate body for adjudication from investigation" and that the Medical Practitioners Tribunal Service would introduce a high degree of independence into the adjudication of fitness to practise cases:

Whilst we accept that it is unlikely that most of the regulators would have the available resource for such a service, it is possible that the General Medical Council's service could be used by the other regulators in the future in the interests of promoting efficiencies, consistency, cost savings and economies of scale.

9.24 The General Social Care Council argued that:

The legal framework (either through rules or primary legislation) should clarify lines of accountability between panel members and officers of the Council, set out the appointment and appraisal arrangements for Panel members and confirm the status of guidance issued to panel members (for example indicative sanctions guidance). The Commission should be particularly aware of the opportunities for officers to place pressure on Panel members through appraisal and appointments and through this to compromise their independence.

9.25 The Professional Forum of the Pharmaceutical Society of Northern Ireland felt that separation was already achieved in Northern Ireland, where the inspectorate is based in the Department of Health, Social Services and Public Safety and adjudication is provided by the statutory committee of the Society. The Department of Health, Social Services and Public Safety for Northern Ireland agreed with separation and stated "this already pertains in Northern Ireland (pharmacy)".



- 9.26 The General Chiropractic Council felt that the statute should be enabling and that it should be left to the regulator “to ensure the necessary separation to satisfy the European Convention”. The General Dental Council expressed a similar view, and the General Osteopathic Council agreed that “there should be flexibility for the regulators to determine how this separation is achieved in practice”.
- 9.27 Many argued that a lack of institutional separation was less troubling than the lack of good panel members, and suggested that a robust appointments process was crucial. The Health and Care Professions Council felt that a better approach would be to focus on the appointment process for panel members and prohibit them from sitting on cases that they have already considered at a previous stage. The Department of Health argued that the new legal framework should allow the regulators to demonstrate separation of investigation from adjudication through the creation of a “quasi-independent function within the organisation with responsibility for selecting, training and providing guidance to panellists”.
- 9.28 UNISON said that the deployment of panel members, as well as their appointment, was relevant:

The new legal framework should emphasise that the final determination of an allegation at a hearing should be only be carried out by those who have not been party to any of the preliminary proceedings that have preceded this, and that all material, including witness statements should be reviewed to ensure the final hearing is human rights compliant.

- 9.29 The Medical and Dental Defence Union of Scotland agreed that there should be a separation of investigation and adjudication but did not consider it to be of “sufficient importance to the impartiality of the process that it needs to be enshrined in statute”.
- 9.30 The General Pharmaceutical Council felt there was a “compelling case” for further structural separation between investigation and adjudication but that it needs to be done consistently and jointly across the regulators.

**Question 9-3: Should the statute allow for the option of the regulators’ adjudication systems joining the Unified Tribunals Service?**

- 9.31 A small majority agreed that the statute should allow for the option of the regulators’ adjudication systems joining the Unified Tribunals Service.<sup>4</sup> For example, an individual consultee (Melanie McDonald) said that “the long term objective of bringing fitness to practise proceedings within the First-tier Tribunal system under the management of the Ministry of Justice should be promoted”. The Department of Health, Social Services and Public Safety for Northern Ireland also answered the question in the affirmative.
- 9.32 The Administrative Appeals Chamber of the Upper Tribunal argued that the adjudication function should be transferred to the First-tier Tribunal (Health, Education and Social Care Chamber). It was also suggested that:

<sup>4</sup> Of the 192 submissions which were received, 46 expressed a view on this question: 27 said the statute should allow for this option, 14 disagreed, whilst 5 held equivocal positions.

There is a wider debate about the extent to which there should be entirely separate tribunals in Scotland, Northern Ireland and Wales even where the jurisdiction concerns reserved matters.

9.33 The First-tier Tribunal (Health, Education and Social Care Chamber) agreed:

The transfer to a clearly independent body satisfies the criticism of repeated public enquiries ... and is the only action that will act to fully restore, in the long term, public confidence in the regulation of health professionals. The reform of this area need not be incremental and seen as forced upon unwilling professions piecemeal as some form of dogged retreat from isolation. It is clearly within both the professions' and the public's interest that a truly independent body safeguards their standards.

9.34 It also argued:

The drive for greater efficiency can be met by a transfer to the First-tier Tribunal because the mechanism and systems for such appeals already exist; the Tribunal would need only to modify in a small way its administration to absorb the presently nine separate administrations dealing with fitness to practice matters, plainly that offers an ideal opportunity for efficiencies. Nor is it difficult to construct a model which would be of benefit to both the public and the professions who presently fund all nine administrations and their various panels. No doubt agreement could be reached for the professions to fund the tribunals at the present rate per type of case and that figure either discounted to the professions for the anticipated savings or a guarantee of inflation only cost increases.

9.35 It was argued that the First-tier Tribunal has amassed a great deal of particular health related expertise due to its existing jurisdiction over social workers, care standards and Primary Health Lists. It was also noted that many Tribunal members sit on their respective professional disciplinary bodies.

9.36 The Administrative Justice and Tribunals Council also felt that this option was:

The most efficient and appropriate arrangement, so that all fitness to practise adjudication systems can benefit from, and be consistent with, the experience of other analogous First-tier Tribunal jurisdictions.

9.37 Some consultees argued that a right of appeal to the Unified Tribunal Service would be more affordable for registrants.

9.38 The General Medical Council had no objection to the statute allowing for this option but stated it would not support the transfer of its own adjudication service. Several regulators expressed an interest in this option. The Medical and Dental Defence Union of Scotland felt this option would not be appropriate "where there is a considerable specialist volume of regulatory work, such as in the General Medical Council and the General Dental Council".

- 9.39 A number of consultees disagreed that the statute should allow for the option of the regulators' adjudication systems joining the Unified Tribunals Service. The British Medical Association argued that the Medical Practitioners Tribunal Service "should be allowed to become properly established" and felt that the Unified Tribunal Service would not have the same level of expertise. NHS Greater Glasgow and Clyde objected to the proposal on the basis that "the last thing you want is another layer of bureaucracy".
- 9.40 The Association of Regulatory and Disciplinary Lawyers said it could "see no advantage in permitting regulators to opt for joining the Unified Tribunal Service structures". The Medical Protection Society also queried whether the proposal offered "any real advantage". In addition to its principled objections, the Society objected to the proposal on the basis that "joining the Unified Tribunal Service would be a costly, complex and lengthy process".
- 9.41 The Nursing and Midwifery Council felt that the Unified Tribunals Service "has a limited role in dealing with contested fact-finding decisions" and questioned "whether the skills needed for regulatory tribunal or panel work are comparable to those working in that more appellate environment". Thompsons Solicitors felt that the Unified Tribunal Service is already "overburdened".
- 9.42 The Royal College of Midwives argued that transferring all adjudication to the Unified Tribunals Service would lead to a rise in fees and be unaffordable for registrants. The General Dental Council argued that the transfer would raise significant devolution issues "because the legal system of Scotland is guaranteed to be separate".
- 9.43 The Department of Health felt that any transfer of powers to the Unified Tribunals Service would involve "a complicated and lengthy process to establish the new system" and "the added value of a Tribunal Service led process of adjudication is also difficult to identify".
- 9.44 A small number argued that this should not be a matter for Government to decide. For example, the UK-wide Nursing and Midwifery Council Lead Midwives for Education Group felt that this decision should be left to the regulators.

**Provisional Proposal 9-4: The statute should give all the regulators a broad power to establish rules for case management.**

- 9.45 All consultees who expressed a view agreed with this proposal.<sup>5</sup> For example, Thompsons Solicitors said that it "would welcome case management processes being rolled out across all regulators".
- 9.46 The General Optical Council felt that "procedural matters such as this ought to be left to the individual regulators" although it also expected that "there will be a degree of similarity" in how this is achieved by the regulators.
- 9.47 The Medical Protection Society argued that:

<sup>5</sup> Of the 192 submissions which were received, 46 expressed a view on this proposal: 46 agreed.

To ensure fairness, case managers should be independent. Furthermore, there should be a mechanism for appeal or review of case management decisions. Any sanctions for non compliance with case management directions should be equal in force against both parties.

- 9.48 The Scottish Government supported the proposal but felt that there should be “greater consistency between the regulators and ... limited discretion in the interests of fairness, openness and transparency”. It also suggested that the Professional Standards Authority should provide “detailed guidance and oversight”.
- 9.49 The Nursing and Midwifery Council suggested that case management powers should include “sanctions for non-compliance, where appropriate, whilst recognising that the use of such sanctions may be less relevant in a regulatory context”. This was supported by the Professional Standards Authority. Several consultees pointed to the importance of being able to cancel hearings in certain circumstances and to allow for some decisions to be made on the papers.
- 9.50 The Professional Standards Authority questioned whether this should be a duty rather than a power on the basis that there are no circumstances where case management would be inappropriate.
- 9.51 An individual consultee (Walter Merricks) expressed concern about how case management currently operates. He stated that:

Judicial case management is effective when the judge gives directions and then tries the case. The irony is that in the General Medical Council a case manager is not allowed any role in the hearing itself, and the chair of the panel is not permitted any role in case management: a sure recipe for ineffective case management. One can add to this the natural reluctance of a defence lawyer to pay any heed to case management requests from an individual appointed by the very body that is launching proceedings against that lawyer’s client.

- 9.52 The Royal College of Nursing argued that an independent organisation should be responsible for case management. It argued that “the absence of case management (akin to directions hearings in the Second-tier Tribunal)” means that “frequently hearings will over run and significant delays can be experienced”. It pointed to a recent case which was “adjourned part-heard on no less than three occasions and a decision on sanction is only expected at the fourth reconvened hearing date” and with no avenue for redress “other than perhaps the High Court on a costly abuse of process application”.
- 9.53 UNISON felt that some existing case management arrangements are “so heavily weighted against the registrant that they prejudice their right to a fair hearing”. For example:

The Health and Care Professions Council currently provide that the hearing bundle need be served on the registrant only 42 days before the hearing. This routinely consists of witness statements not previously disclosed and hearsay and other evidence that would be

considered inadmissible by other regulators such as the Nursing and Midwifery Council.

The registrant is then given only 14 days to submit papers in response. This is clearly unacceptable, especially where significant new evidence is introduced. There is no forum in place to object to this other than the final hearing where an adjournment would have serious financial and other detrimental implications, not least for the registrant.

**Provisional Proposal 9-5: The statute should provide that the overriding objective of the Civil Procedure Rules – that cases must be dealt with justly – is made part of the regulators’ fitness to practise procedures.**

9.54 A large majority felt that the overriding objective of the Civil Procedure Rules should be made part of the regulators’ fitness to practise procedures.<sup>6</sup> For example, the General Medical Council noted that it is “currently pursuing inclusion of [the overriding objective] in the statutory changes to support the establishment of the Medical Practitioners Tribunal Service”. The Health and Care Professions Council felt that the overriding objective should be “provided for within statute as a clear statement of intent, purpose and belief”.

9.55 The Administrative Justice and Tribunals Council agreed generally with the proposal but argued that:

Since fitness to practise adjudication is more akin to a tribunal, rather than a court process, the procedural rules governing the new unified tribunal system might provide a more appropriate and directly relevant model than the Civil Procedure Rules.

9.56 It noted that the Tribunal Procedure Rules introduced an overriding objective to deal with cases “fairly and justly”, including an obligation on parties to co-operate with the Tribunal, which could be made part of the regulators’ fitness to practise procedures. The Administrative Appeals Chamber of the Upper Tribunal also supported the inclusion of the overriding objective of the Tribunal Rules.

9.57 The General Dental Council felt that the proposal would help standardise the regulators’ rules on matters such as evidence and case presentation, but noted that this would “be dependent also on the rules in the devolved administrations being compatible in these respects”.

9.58 However, some did not support the proposal. The Association of Regulatory and Disciplinary Lawyers felt it would add little “to existing fair trial principles” and “has the potential to provide another source of procedural argument as to meaning/scope etc, in addition to those under Article 6 and the common law”.

9.59 The Medical Protection Society argued that:

<sup>6</sup> Of the 192 submissions which were received, 47 expressed a view on this proposal: 40 agreed, 3 disagreed, whilst 4 held equivocal positions.

Regulatory and civil proceedings are completely different in terms of their purpose and objectives and as such should be independent of one another. Whilst some of the features of the civil overriding objective may apply to regulatory proceedings, others do not and so it would make no sense to import it as a whole. Given that Article 6, in effect, prescribes an overriding objective for regulatory proceedings we question whether this needs to be expressed in terms in the statute.

9.60 The Medical and Dental Defence Union of Scotland was also not “convinced that the overriding objective of the Civil Procedure Rules” was the correct test. The Professional Standards Authority “was unclear what the overriding objective would add that is not already covered by the rules of natural justice and the Article 6 rights”.

9.61 The Nursing and Midwifery Council preferred the inclusion of a duty to “conduct proceedings expeditiously” because:

Our proceedings are not about balancing the interests of two litigating parties but about balancing the interests of the registrant against the need to act to protect the public or otherwise in the public interest. Rather, we consider that the statute should make explicit the duty of the regulator to act “in the public interest” and that this concept should include protection of the public, maintaining public confidence in the profession and maintaining public confidence in the regulator.

9.62 The Society of Chiropractors and Podiatrists agreed that cases should be dealt with justly, but that this “should not be at the expense of dealing with cases expeditiously”. It continued that “if cases are not dealt with expeditiously, that in itself is unlikely to be just”.

9.63 However, several consultees did not support a requirement that fitness to practise proceedings must be conducted “expeditiously” (as currently stated in the Health and Care Professions Council’s governing legislation). For example, the British Pharmaceutical Students’ Association felt this would encourage “a culture of rushed fitness to practice proceedings”. The Department of Health added that in its view any duty to act expeditiously would be unhelpful since it is already implicit in the existing duty of public protection and Article 6.

9.64 An individual consultee (David Bleiman) queried how a paramount duty would interact with the overriding objective. It was argued that fitness to practise panels “cannot always and everywhere place protection of the public above everything else”; for instance some decisions require significant weight to be given to the interests of the registrant, such as whether to proceed with a hearing in their absence. Thus, he argued that the paramount duty should be placed on Council members and staff, while panels should be subject to the overriding objective. Similarly, RadcliffesLeBrasseur argued that the paramount duty will have to be made subject to the overriding objective.

9.65 An individual consultee (James Kellock) argued that a panel’s ability to give directions would be strengthened by having legally qualified chairs.

**Provisional Proposal 9-6: The statute should require each regulator to establish Fitness to Practise Panels of at least three members for the purpose of adjudication.**

- 9.66 All consultees who expressed a view agreed that the statute should require each regulator to establish fitness to practise panels of at least three members.<sup>7</sup> For example, the Professional Forum of the Pharmaceutical Society of Northern Ireland supported the proposal “for the purposes of balance and fairness”.
- 9.67 The General Medical Council agreed that in relation to the number of panel members, this should be “expressed as a minimum to allow the regulators to decide their own approach depending on volumes of hearings and resources”.
- 9.68 The Royal College of Nursing argued that “to exceed three panellists can be daunting for registrants and can lead to unnecessarily long hearings”. The Professional Standards Authority argued that “for the purposes of achieving consistency and driving efficiency across the sector” the statute should specify the number of panel members (rather than leaving it open to regulators to have panels of more than three members). It also argued that the proposal was not compatible with “the notion of regulators sharing adjudication expertise”.
- 9.69 The General Dental Council felt that the statute should require the regulators to make rules, but should not specify numbers because “there are some occasions when a single member panel could be appropriate and this should be left to the rules to provide for”. It also argued that the statute should provide for the eventuality of a panel losing a member part way through a case and allow the hearing to continue even though the requirement of a particular composition can no longer be fulfilled.

**Provisional Proposal 9-7: The statute should: (1) require the regulators to establish a body which is responsible for all aspects of the Fitness to Practise Panel appointment process and which is separate from the Council; and (2) prohibit Council members and investigators from membership of Fitness to Practise Panels; and (3) require that each Fitness to Practise Panel must have a lay member.**

- 9.70 The vast majority agreed that the regulators should be required to establish a body which is responsible for panel appointments, and Council members and investigators should be prohibited from panel membership.<sup>8</sup>

***Appointments***

- 9.71 The General Chiropractic Council agreed that a separate appointment process must be established but queried our use of the term “a body” since it is considering appointing a President for this purpose. Similarly, the General Osteopathic Council felt there needed to be flexibility to take account of the needs of the small regulators where “it may be appropriate to appoint an individual to carry out this process or to be able to commission the work from another organisation”.

<sup>7</sup> Of the 192 submissions which were received, 48 expressed a view on this proposal: 48 agreed.

9.72 The General Medical Council argued that while the appointment body may be operationally separate from the Council, “that body may in governance terms be accountable to the Council in relation to overall performance” and like the Medical Practitioners Tribunal Service may need to report periodically to the Council as well as directly to Parliament.

9.73 An individual consultee (Walter Merricks) felt that one of the “great weaknesses in the panel system” is the absence of a judicial head of the panels (except at the General Medical Council). He stated:

Panellists having been appointed to be independent, they have no sense of allegiance or accountability. Incompetent panellists cannot be sanctioned or removed. Who actually sits on each panel is up to the regulator. It is as if the prosecution was able to select which magistrates should sit to hear a case.

So the independence of the system can easily be subverted by the regulator by not calling particular panellists to sit, or calling those they feel are likely to be most sympathetic to the regulator’s case.

On the other hand regulators, having made the appointments of their panellists, feel inhibited in communicating with them about anything other than mundane matters. And from the panellists’ point of view there is no one to whom they can turn to look for guidance or for performance feedback and no one who will be appraising them or calling them to account.

9.74 The Administrative Justice and Tribunals Council felt that the new appointing body should be based on the arrangements for the Judicial Appointments Commission. The United Chiropractic Association felt that professional panel members should be elected by polling the profession.

9.75 The Department of Health was not convinced that Councils should be required to set up a separate body for appointments and suggested that the regulators should have powers to make arrangements for panel member appointments with other regulators and organisations.

9.76 The Scottish Government supported the proposals but also did not agree that the Councils should be required to establish a body responsible for Panel appointments. It thought that “it is for each regulator to make arrangements for the recruitment and training of its panel members”, but went on to state that:

However, we do consider that efficiencies and consistency could be provided through partnership approaches and collaboration in relation to recruitment and retention of panel members, and that Memoranda of Understanding could assist with this.

<sup>8</sup> Of the 192 submissions which were received, 53 expressed a view on this proposal: 52 agreed, whilst 1 held an equivocal position.



### ***Composition of the panel***

- 9.77 Some argued that the statute should specify the balance between lay and registrant panel members. For example, the Association of Regulatory and Disciplinary Lawyers argued that “the numbers should not permit ... a lay majority decision”. The United Chiropractic Association contended that:

The current deference of the High Court to decisions of professional disciplinary tribunals renders illogical a requirement for a majority membership of lay panel members.

- 9.78 A number of consultees also suggested that panels should include a member from the same profession as the registrant. For example, the Guild of Healthcare Pharmacists said:

We would also seek another requirement that the panel be required to have a member with detailed understanding of the sector/specialty of practice of the registrant.

- 9.79 UNISON agreed that there should be a requirement “that one panel member must be from the same occupational group as the registrant”. Similarly, the Medical Defence Union argued that “one member of the panel must be of the same profession as the registrant”.

- 9.80 However, others did not support registrant membership. The Nightingale Collaboration argued that registrants should not be panel members since “any specialist knowledge required can best be obtained from appointed expert advisors or expert witnesses called and open to cross-examination”. Similarly, the Royal College of Midwives preferred the use of a “mutually agreed expert” who can “attest to how care in the circumstances of the case should be managed”. It felt that:

It is not appropriate as at present for a member of the Panel who is a specialist in community midwifery, for example, to provide information to inform fellow panel members on the care to be provided in a high tech delivery unit or vice versa.

- 9.81 The Nursing and Midwifery Council suggested that that fitness to practise panels “should always have more lay than registrant members” in order to achieve the “necessary degree, and appearance, of independent scrutiny”.

- 9.82 An individual consultee (Anonymous) thought that there “should be two lay members on each panel to achieve the necessary degree, and appearance, of independent scrutiny”.

- 9.83 The Professional Standards Authority felt that the statute should specify that – to maintain public confidence – there should be “parity between lay and professional members, and the chair of a panel should be a lay person”.

- 9.84 Others expressed concern about lay membership. The United Chiropractic Association felt that “lay representatives are often in reality professional tribunal members and their independence and impartiality is not always guaranteed”. The Administrative Appeals Chamber of the Upper Tribunal felt that there are now “very few truly lay members of tribunals” and instead members should be

“expected to bring a degree of expertise, which in this instance would be in professional standards”. Furthermore, it argued that:

If there is appropriate lay membership at the investigation stage and if the Professional Standards Authority has the role proposed for it, we are not convinced that the size of the panel should be expanded to provide for a lay member who does not hold any health care or social care qualification.

- 9.85 Some argued for consistency across the regulators on this matter. An individual consultee (James Kellock) stated:

I think the public would not understand if one health care regulator were able to mandate lay majorities whilst another allowed a registrant majority. My view is that since the paramount duty emphasises the impact of the profession on the public ... that there should be lay majorities.

- 9.86 The Professional Forum of the Pharmaceutical Society of Northern Ireland felt that if an individual is a Council member at one regulator, they should not be eligible for membership of another Council's fitness to practise panels.

- 9.87 The General Medical Council felt that the requirement for panels to include a registrant and lay member should be dealt with in rules.

#### ***Legal chairs and legal assessors***

- 9.88 Several consultees supported legally qualified chairs. For example, the Royal College of Nursing argued:

We would like to see a rule that the chair should be legally qualified. This would remove the requirement for a legal assessor at every hearing, which is costly for the regulator. The interventions of the legal assessor can be time consuming, as they have to repeat the standard advice that they will be giving to the Panels, without necessarily adding valuable insights. The involvement, engagement and value added of legal assessors in cases can be variable. We think that appropriately trained legal chairs would be confident enough to create more efficient hearings and advise the panel on the legal aspects relevant to the subject case.

- 9.89 However, the Health and Care Professions Council disagreed, stating that:

Chairs should be focused on ensuring hearings progress swiftly. They should not become drawn into legal disagreements, but maintain their focus on resolving disputes as quickly as possible. Legal assessors are able to talk to both parties in advance of proceedings starting and will often facilitate common points of opinion to be agreed. Because of their position of independence, they are able to intervene when appropriate, eg if questioning of witnesses is unnecessary or questions being put to witnesses are unfairly phrased. For a panel chair to be involved in these types of issues it could easily lead to

impressions being made that their opinions were biased towards one party or another.

- 9.90 Similarly, Thompsons Solicitors supported the role of the legal assessor. It stated that:

The legal assessor is independent and assists the panel, regulatory body case presenter and registrant. It is particularly useful when, for example, a dispute arises between the parties, to have an independent person who can intervene without the involvement of the Panel to see if a resolution can be found before taking the issue to the Panel.

- 9.91 The Professional Standards Authority suggested that there should be “procedural consistency” in the use of “legal advisers/assessors and specialist advisers to Panels”.

**Provisional Proposal 9-8: Other than on those matters specified in provisional proposals 9-6 and 9-7, the regulators should have broad powers to make rules on the constitution of their Fitness to Practise Panels.**

- 9.92 A large majority agreed that the regulators should have broad powers to make rules on the constitution of their fitness to practise panels.<sup>9</sup>

- 9.93 The General Optical Council felt that “consideration would also need to be given as to how this proposal would align with there being an independent adjudicator, if one were established”.

- 9.94 The Medical Protection Society agreed with the proposal but felt that “in order to ensure consistency, statute should lay down broad parameters for the constitution of Panels”. The Optical Confederation and NHS Greater Glasgow and Clyde both also supported a degree of consistency between the regulators.

- 9.95 The British Pharmaceutical Students’ Association believed that the regulators should be required to consult on rules about the constitution of fitness to practise panels.

**Provisional Proposal 9-9: All regulators should be given broad rule-making powers on most procedural aspects of fitness to practise hearings.**

- 9.96 A large majority agreed that the regulators should be given broad rule-making powers on most procedural aspects of fitness to practise hearings.<sup>10</sup>

- 9.97 Many argued that the statute should not preclude the possibility of a common approach across the regulators. The Administrative Justice and Tribunals Council went further and argued that “the ideal position would be to work towards the

<sup>9</sup> Of the 192 submissions which were received, 45 expressed a view on this proposal: 44 agreed, whilst 1 disagreed.

<sup>10</sup> Of the 192 submissions which were received, 41 expressed a view on this proposal: 35 agreed, 4 disagreed, whilst 2 held equivocal positions.

harmonisation of the procedural rules for fitness to practise hearings across all the regulatory bodies”.

- 9.98 The Scottish Government felt there should be “greater consistency between the regulators and ... limited discretion in the interests of fairness, openness and transparency”. It also suggested that the Professional Standards Authority should provide detailed guidance and oversight.
- 9.99 The Royal College of Nursing argued that the statute should “endorse the procedural safeguards of Article 6”.
- 9.100 A small number disagreed with the proposal. For example, the Professional Standards Authority stated:

We do not consider that the benefits of the proposed flexibility outweigh the benefits that would be achieved by ensuring greater consistency in relation to the procedural aspects of the regulators’ hearings. From our experience of reviewing all the final fitness to practise decisions made by all the regulators, we can see little value in the variations in the procedures that are currently in place.

- 9.101 UNISON said:

We do not agree that regulators should be given broad rule-making powers on most procedural aspects of fitness to practise hearings. As previously stated, consistency across regulators on generic issues is desirable and this is one of those areas.

Procedural rules have the potential to compromise the right to a fair hearing. Isolated development hinders the benefits of sharing good practice and learning points.

**Question 9-10: Should the statute require that fitness to practise hearings must take place in the UK country in which the registrant is situated or resides?**

- 9.102 A small majority felt that hearings should not be required to take place in the UK country in which the registrant is situated or resides.<sup>11</sup>
- 9.103 The Nursing and Midwifery Council described its legal duty to hold hearings in the relevant UK country as “unhelpful, inefficient and costly” and argued that the duty:

does not allow for cases to be held where they would be most convenient for all involved, including vulnerable or disabled witnesses or registrants working away from home. For instance, under this proposal, an allegation relating to matters that occurred at a nursing home in Southern England would, if the registrant had moved to Scotland before the hearing, have to be held there.

<sup>11</sup> Of the 192 submissions which were received, 54 expressed a view on this question: 17 said that the statute should so require, 29 disagreed, whilst 8 equivocal positions.

- 9.104 The General Medical Council felt that the venue should be left to the regulators to decide “taking into account their individual requirements”. For example, the Council has recently moved its hearings to Manchester based on the need to increase the “efficiencies of its operation” and secure “the delivery of significant savings for registrants as a whole”. The General Osteopathic Council also suggested that a requirement to hold hearings in the relevant UK country would not be proportionate or cost effective for the smaller regulators.
- 9.105 The General Optical Council agreed, but said that it would “be interested in exploring avenues by which regulators could potentially collaborate or share resources to facilitate hearings in the devolved administrations”.
- 9.106 The Department of Health felt that it must be for the regulator to decide where to hold a hearing. It said that:

There may be reasons of practicality why a hearing can't take place in the country where the registrant works or lives. Indeed, in some cases this may be different and provided there are ways of ensuring fairness then rigid rules about where hearings should occur need not be necessary.

- 9.107 The General Dental Council opposed the proposal on the basis that the “requirement would be complex and expensive to administer”.
- 9.108 The British Medical Association also argued “it would be difficult to gain a fair hearing in geographically smaller areas, such as Northern Ireland”. Many professional bodies argued that the negative impact of the publicity associated with fitness to practise hearings is multiplied when hearings are held in Northern Ireland or Wales and this could have a long term detrimental effect on the livelihood of registrants whose fitness to practise is found not to be impaired.
- 9.109 Others pointed to further anomalies that could arise. For example, the Society and College of Radiographers argued that a registrant living in Northumberland might find it easier to get to Edinburgh rather than London, or that those living in North Wales may find Birmingham easier than Cardiff. The General Social Care Council argued that the primary consideration should be “ensuring reasonable access to justice and not the UK country in which the registrant is situated or resides”.
- 9.110 However, many supported a requirement that hearings should take place in the relevant UK country. The Health and Care Professions Council described its existing legal duty in the following terms:

Hearings are not confined to Belfast, Cardiff, Edinburgh and London and we seek to take a flexible approach to hearing venues taking into account the finite resources available and the needs of those individuals who must attend a hearing. We consider that such an approach is fair and reasonable and accords with principles of open and transparent justice.

Registrants should not be prohibited from attending a hearing simply because they cannot afford to attend. Cost savings should not and cannot be a bar to ensuring fairness and justice.

9.111 The Royal College of Nursing argued that a requirement:

makes practical sense (in our experience most of the witnesses will live near the registrant), will enable the panels to have some local knowledge and intelligence, will limit the often exorbitant travel and accommodation costs being laid at the door of the registrants and will prevent regulators simply listing hearings for their own administrative convenience.

9.112 The Department of Health, Social Services and Public Safety for Northern Ireland argued that hearings should take place in the relevant UK country and felt that such a duty “would provide local identity in a UK-wide framework but costs should be taken into account”.

9.113 An individual consultee (Jacqueline A Wier) thought that holding hearings in the UK country of the registrant “would enable both the registrant and members of the public access to hearings which would support accountability and transparency”.

9.114 Others felt there should be a presumption that a hearing will take place in the relevant UK country, but that this could be overridden if necessary. The Medical Protection Society argued that hearings “should take place as close as possible to the registrant’s place of residence, balanced against the convenience of the witnesses for both parties” and that “venue should not be decided in favour of the regulator on purely cost grounds”. UNISON argued that the duty should be to hold the hearing in the relevant UK country “unless the registrant consents to another location”.

9.115 The Scottish Government argued that, while this should be a matter for the regulator to decide:

Where possible hearings should be held in the country where the registrant is situated in or resides. There are also other factors such as where a registrant mainly works which could complicate satisfaction of this requirement. We consider that fairness is more important than the legal rules surrounding where the hearings should take place.

9.116 The Medical Defence Union felt that the regulators should be encouraged to consider whether there are “better and more effective ways to hold panel hearings that meet their needs and equally those of registrants and witnesses throughout the UK” but that this should not be a statutory requirement. The Association of Clinical Biochemistry suggested that “any reasonable special needs of both registrant and complainant should be accommodated to ensure the process is fair and transparent”.

9.117 Some consultees argued that the location of the hearing should be where the alleged incident took place or where the person practises rather than resides. The Wales National Joint Professional Advisory Committee queried what would happen if the registrant lives and works in different countries. The Patient and Client Council felt that hearings should be held in the locality of the patient. Bupa said that to hold hearings elsewhere than the country where the incident took place “would necessitate all witnesses travelling which is inequitable”.

**Provisional Proposal 9-11: The statute should apply the civil rules of evidence to fitness to practise hearings. The relevant rules should be those that apply in the part of the UK in which a hearing takes place.**

9.118 A significant majority agreed that the civil rules of evidence should apply to hearings.<sup>12</sup>

9.119 The General Medical Council stated that it currently operates its own rules of evidence but understood the benefits of harmonisation. However, it sought clarity on which particular aspects of the civil rules would be applied.

9.120 The Patients Association said that, “for the sake of procedural certainty”, the applicability of the civil rules of evidence “should be made clear to complainants”. The Department of Health, Social Services and Public Safety for Northern Ireland was generally supportive but stated “there are cases that could go through court proceedings and then further referred to the regulator, so we expect the court evidence would apply”.

9.121 The Association of Regulatory and Disciplinary Lawyers was divided on this issue. Some members felt that the use of the civil rules would be consistent with the procedural rules adopted by most of the health professional regulators and those outside the field of health care. Furthermore, they felt that “fitness to practise proceedings are not criminal proceedings”. However, other members disagreed that proceedings are essentially civil in nature, and pointed out that most of the relevant case law in this field is “based on criminal jurisprudence or criminal legislation as interpreted by the criminal courts”. In effect, to adopt the criminal rules “avoids the re-litigating of much settled law”.

9.122 RadcliffesLeBrasseur also argued in favour of the criminal rules, and noted that:

The regulator has the power to prevent the registrant practising their chosen profession and earning their living. The criminal rules of evidence have been applied without significant injustice being identified. The criminal rules are very flexible.

9.123 The United Chiropractic Association also thought that the criminal rules should apply to:

matters of such importance to a health professional as their vocation, their hard earned career and reputation (not to mention their living and ability to support their family and their employees).

9.124 The Medical Protection Society expressed concern about importing either the civil or the criminal rules. It stated:

We submit that many of those rules are neither appropriate nor applicable to regulatory proceedings. For example, the Criminal Procedure Rules in relation to disclosure are far better suited to regulatory proceedings. Apart from anything else the Civil Procedure Rules do not contain any provision relating to unused material.

<sup>12</sup> Of the 192 submissions which were received, 43 expressed a view on this proposal: 36 agreed, 5 disagreed, whilst 2 held equivocal positions.

- 9.125 Some argued that the rules should not vary across the UK. RadcliffesLeBrasseur stated:

We are a small country and health care professionals move from one country to another within the UK. Others practise on the boundary and will see and treat people from more than one jurisdiction. This is a recipe for uncertainty.

- 9.126 Similarly, the Royal Pharmaceutical Society of Great Britain felt that the rules should be “overarching and applicable across the UK and not [depend on] where a hearing takes place”.

**Provisional Proposal 9-12: Fitness to Practise Panels should be able to admit evidence which would not be admissible in court proceedings if the admission of such evidence is fair and relevant to the case.**

- 9.127 A large majority agreed with the proposal.<sup>13</sup>
- 9.128 Many, such as the Nursing and Midwifery Council, agreed on the basis that the purpose of professional regulation is public protection, rather than resolving civil disputes. In addition, the General Dental Council noted that “the civil rules of evidence in Scotland are different from those elsewhere in the UK” and therefore “the use of the formula ‘fair and relevant’ would be helpful because it would clearly apply to all jurisdictions”.
- 9.129 The General Optical Council supported the proposal but also expressed concerns about the late service of evidence “with the regulator not being provided with sufficient time to respond or being criticised for delay in the proceedings when asking for an adjournment”.
- 9.130 Several consultees suggested alternative formulations. The Medical Defence Union felt that – based on the General Medical Council’s rules – panels should not be able to admit such evidence “unless they are satisfied that their duty of making due inquiry into the case before them makes its admission desirable”. The Administrative Justice and Tribunals Council preferred the General Dental Council’s approach of such evidence being “helpful” and “in the interests of justice”. The Society and College of Radiographers felt that the Health and Care Professions Council’s wording should be adopted whereby evidence can be submitted if it is “fair, relevant to the case and in the public interest”. The Medical Protection Society argued that evidence should only be admitted if it is relevant, it is “in the interests of justice to hear such evidence”, there is “no prejudice to the registrant” and “all reasonable efforts have been made to procure and adduce the evidence in accordance with the usual rules of admissibility”.
- 9.131 The Royal College of Midwives noted the need to ensure “natural justice and that the evidence can be subjected to challenge”. NHS Greater Glasgow and Clyde also commented on the right of appeal.

<sup>13</sup> Of the 192 submissions which were received, 50 expressed a view on this proposal: 44 agreed, 2 disagreed, whilst 4 held equivocal positions.



9.132 A small number supported the proposal only on the basis that the starting point was inadmissible evidence in criminal rather than civil proceedings.

9.133 RadcliffesLeBrasseur disagreed outright with the proposal, and felt that:

There is a danger that cost efficiency and the convenience of witnesses may lead to a pattern of reliance on hearsay evidence or remote evidence giving. There should be a presumption that evidence that is contested should be given by the witness present in the Panel hearing room and that should only be departed from with good reason.

9.134 UNISON also disagreed, arguing that “a registrant’s right to a fair hearing enshrined in Article 6 would be compromised by this wording”.

9.135 The Royal Pharmaceutical Society of Great Britain said that it “would need more assurance and transparency as to what individual regulators would consider ‘fair and relevant to the case’”.

**Provisional Proposal 9-13: The statute should require the civil standard of proof in fitness to practise hearings.**

9.136 The vast majority agreed with this proposal.<sup>14</sup> For example, the Health and Care Professions Council argued that the “the civil standard of proof is appropriate in a protective jurisdiction (such as the one in which the regulators operate)”. The General Medical Council, which has operated the civil standard of proof since 2008, reported no difficulties with the move from the criminal standard.

9.137 However, the Medical and Dental Defence Union of Scotland was concerned that the civil standard:

operates severely to the prejudice of registrants in serious cases where there are disputes of fact and where there are consequences which affect the livelihood of the practitioner. We do believe that some form of sliding scale remains the most appropriate and fair approach but acknowledge that traditional authorities are presently against this proposition.

9.138 The Wales National Joint Professional Advisory Committee expressed concern that “the civil standard of proof may not be sufficiently robust” and referred to “the likelihood of miscarriages of justice”. It argued that a sliding scale should be adopted “in line with the degree of seriousness of the matter under investigation”.

9.139 The Royal Pharmaceutical Society of Great Britain felt that:

The use of the civil standard of proof must be monitored by the regulator, Professional Standards Authority and Government to ensure a fair outcome for the public, and registrant. It should not be used to develop harsh regulation but more to be able to assess professional behaviour and judgment.

<sup>14</sup> Of the 192 submissions which were received, 44 expressed a view on this proposal: 40 agreed, whilst 4 disagreed.

- 9.140 The Medical Protection Society thought that the civil standard “should only apply to the facts and not the decision on impairment”.
- 9.141 RadcliffesLeBrasseur argued that the move from the criminal to the civil standard was supported in Parliament “on the basis that it would make no difference because the civil standard was flexible”, only for that concept to be rejected by the House of Lords.<sup>15</sup> It was further argued that the civil standard “is itself ambiguous because of the cases on the difficulty of proving on the balance of probabilities an inherent improbability”.
- 9.142 The Association of Clinical Biochemistry opposed the proposal “as the sanctions applied by the regulators can be far more punitive than those applied in a criminal court for issues of a similar seriousness”.

**Provisional Proposal 9-14: The statute should require that all fitness to practise hearings must be held in public unless one or more of the exceptions in the Civil Procedure Rules apply.**

- 9.143 A large majority agreed with the proposal.<sup>16</sup>
- 9.144 The Royal College of Midwives supported the proposal, but argued that:
- the setting in which the hearings take place must ensure the safety of the registrant and that they cannot be subjected to threats in any form from the complainant or their supporters as has occurred to Royal College of Midwives members in the past.
- 9.145 However, opinion was divided over whether or not there should be a default position of private hearings for health and interim order hearings.
- 9.146 The Department of Health suggested that the regulators should determine when and why hearings should be in private and consult on their reasoning.
- 9.147 The Scottish Government agreed with the proposal but also stated:
- However, where the regulators consider that hearings (or part thereof) should be heard in private, they must set out their reasons for such a request (eg publicity would defeat the object of the hearing, the case involves confidential information and publicity would damage that confidentiality, or a private hearing is necessary to protect the interests of any child, vulnerable person or protected party) and consult on any proposals.
- 9.148 The Health and Care Professions Council argued against such a default position because if there is a need to hold such a hearing in private one of the exceptions of the Civil Procedure Rules would apply. The Association of Regulatory and Disciplinary Lawyers agreed that the exceptions in the Civil Procedural Rules would include “not just the current rules relating to interim orders (interests of

<sup>15</sup> *Re Doherty* [2008] UKHL 33, [2008] 4 All ER 992.

<sup>16</sup> Of the 192 submissions which were received, 44 expressed a view on this proposal: 34 agreed, 5 disagreed, whilst 5 held equivocal positions.

justice exception) and health (confidentiality exception)", but also "the common law which currently underpins the decision-making on this topic". An individual consultee (Walter Merricks) argued that other courts and tribunals "do not normally regard the fact that evidence will be given about a person's state of health or a medical condition as requiring a hearing to be in private".

9.149 However, many argued for automatic private hearings. The Association of Clinical Biochemistry said that "as all health cases involve confidential information they should be held in private unless the registrant specifically states otherwise".

9.150 The General Medical Council contended that automatic private hearings were necessary in health and interim order cases, otherwise registrants would be forced to apply for the hearing to be held in private and that:

The result will be that panels will have to consider such applications at the outset of hearings in a large number of cases. This in turn will lead to considerable delays at a time when the increasing hearing length is a concern and we are doing everything we can to reduce it.

9.151 In relation to health cases, it further argued:

Doctors, like patients, have a right to confidentiality about their health and the public right to information in such cases is outweighed by the need to protect vulnerable doctors who are unwell. As much of a hearing as possible should be heard in public so where a case involves a number of issues, only those issues that relate to a doctor's health should be heard in private and the rest of the hearing should be in public. This reflects our current practice.

9.152 In respect of interim order hearings, the Council argued that:

The use of interim powers is critical to our effectiveness but we also recognise that they can be draconian from the point of view of the individual doctor. A referral may be made to an interim orders hearing on the basis of information that may, in some cases, be limited and nothing is proved at that stage. We believe that in balancing the rights of the public to information and the rights of individual doctors, hearings should be in private but any order made should be published.

9.153 The Medical Defence Union also argued that:

Hearing interim orders cases in public could result in professionals having their reputations damaged irreparably in circumstances where safeguards do not apply. There is no minimum period of notice and by their very nature Interim Order Panels deal only with serious allegations which are laid out in circumstances where, as noted, there is no proof of wrong-doing. These allegations will no doubt be of interest to the public and could make good copy for the media, but the legitimate public interest in these cases is limited only to the need to ensure that the public is protected through the use of interim orders if they are appropriate. There is no need to have a public hearing in order to achieve this.

9.154 Furthermore, it felt that the registrant is on “the back foot as far as any defence is concerned” and to be “in a position to have to argue at the same time for a private hearing cannot be considered in any way fair”.

9.155 Similarly, the Royal College of Nursing argued that:

The Nursing and Midwifery Council does not screen out many cases at the very early stages. The complaint may have been made maliciously. Often, interim order hearings are held about cases within a week or two of the complaint reaching the Nursing and Midwifery Council, and then those cases are dismissed at the investigating committee stage. The press frequently publishes information about interim order hearings. Accordingly, we see damaging coverage of nurses due to press coverage of interim order hearings before there has been any attempt to establish that there might be an arguable case at all. We would prefer a standard presumption that interim order hearings should be held in private unless there is a public interest in holding them in public.

9.156 An individual consultee (James Kellock) noted that interim order hearings:

are not fact finding hearings and the legitimate interest of the public in knowing if a practitioner is not allowed to practise is met by publicising the result where an interim order has been made.

9.157 RadcliffesLeBrasseur felt that the exceptions in the Civil Procedure Rules may not cover all cases where a private hearing is needed, such as:

where the registrant is the subject of a very damaging allegation where the mere publicity of the allegation may be unfair although it may not defeat the object of the hearing. An example is where allegations of child abuse are made against a paediatrician. The public interest would be served by making the transcripts and the outcome public if the allegations are proved.

9.158 The General Dental Council felt its current rules work well, whereby hearings are held in private where “the interests of the parties or protection of the private and family life of the respondent or any other person” require it or where “publicity would prejudice the interests of justice”. It was suggested that the use of the Civil Procedure Rules would lead to “increasing challenges and litigation for no substantial benefit”.

9.159 The Patients Association stated that:

All hearings should be in public except where to do so would be unjust or where the specific circumstances of the case outweigh the public interest in an open hearing, noting Article 8 ... . This will ensure accountability in public and help ensure ongoing public confidence in the operation of the regulators.

9.160 The Nursing and Midwifery Council noted that its legislation allows certain cases to take place in “meetings rather than hearings, where no evidence needs to be called and there is no public interest in a hearing being held”. This was seen as a

“useful provision” which enables the Council to deal with certain cases, such as uncontested interim order reviews, “more cost-effectively and efficiently”. However, an individual consultee (Anonymous) felt there should be a provision for such meetings to be held in public.

**Provisional Proposal 9-15: The statute should provide that a witness is eligible for assistance if under 17 at the time of the hearing or if the Panel considers that the quality of evidence given by the witness is likely to be diminished as a result of mental disorder, significant impairment of intelligence and social functioning, physical disability or physical disorder. In addition, a witness should be eligible for assistance if the Panel is satisfied that the quality of the evidence given by the witness is likely to be diminished by reason of fear or distress in connection with testifying in the proceedings.**

- 9.161 An overwhelming majority agreed with our proposal for when a witness would be eligible for assistance.<sup>17</sup> For example, an individual consultee (Don Brand) supported the proposal, which he thought was “particularly important in relation to social work, where many of the people using services constitute ‘vulnerable witnesses’”.
- 9.162 The Medical Protection Society was “firmly of the view that all vulnerable witnesses should be protected”, and thought that this should be dealt with as part of the regulators’ case management procedures.
- 9.163 In addition, the Nursing and Midwifery Council suggested that panels should be given “residual discretion” to provide suitable arrangements “for any other witnesses in exceptional circumstances, where to do so is in the public interest”.
- 9.164 The General Social Care Council supported the proposal but also felt that “the terminology relating to the individual requiring assistance should be amended as this is currently outdated and offensive”. Others suggested that a more appropriate starting point might be the definition of disability in the Equality Act 2010 or a “vulnerable adult” in the Safeguarding Vulnerable Groups Act 2006.
- 9.165 The General Dental Council was unclear to what extent this proposal overlapped with other statutory requirements. It noted that:
- It appears, for example, that this would be a positive duty going beyond the requirement to make “reasonable adjustments” in equality legislation. It would be helpful if language was harmonised and the extent of any differences in intention made clear.
- 9.166 However, a small number of consultees disagreed with the proposal. South Staffordshire and Shropshire Healthcare NHS Foundation Trust (Social Care) argued that vulnerable witnesses should be given “the right to be appropriately supported” irrespective of any “considerations of whether evidence is diminished”. The General Medical Council argued that the definition of a vulnerable witness should be dealt with in rules rather than in the statute.

<sup>17</sup> Of the 192 submissions which were received, 47 expressed a view on this proposal: 44 agreed, whilst 3 held equivocal positions.

- 9.167 The Scottish Government argued that in relation to witnesses eligible for assistance, the statute would need to take into account the different legal requirements in the part of the UK in which the hearing is taking place. NHS Education for Scotland agreed that provisions in respect of vulnerable witnesses “should be based upon the law of the [relevant] country”.

**Question 9-16: Should the statute provide for special measures that can be directed by the Panel in relation to witnesses eligible for assistance, such as screening witnesses from the accused, evidence by live link, evidence in private, video recoded evidence, video cross examination, examination through intermediary, and aids to communication?**

- 9.168 A large majority agreed that the statute should provide for special measures that can be directed by a panel in relation to witnesses eligible for assistance.<sup>18</sup> For example, the British Psychological Society considered this to be “an excellent proposal and recommend[ed] that it be developed with appropriate safeguards for all parties”. Optometry Scotland was in favour of “any measure that might aid the process and permit a full, fair and balanced hearing”.

- 9.169 An individual consultee (Jacqueline A Wier) thought that:

The ability to utilise technology to facilitate witnesses would help foster confidence in the professions through ensuring greater accessibility to hearings for witnesses. It would also support the robustness of the decision making process as a consequence of additional information provided through improved access to witness evidence.

- 9.170 The Association of Regulatory and Disciplinary Lawyers felt that the special measures should be stated in the statute, “there being no good reason why they should not apply consistently across the board”. An individual consultee (Anonymous) argued that the statute should also state expressly that the registrant or applicant cannot cross-examine relevant witnesses in cases involving sexual misconduct and sexual offences.

- 9.171 Several consultees felt that the statute should provide for such measures to be set out in rules. The Health and Care Professions Council argued:

We are concerned that it might be unnecessarily restrictive for the statute to provide for special measures that can be directed by the Panel given the pace of societal and technological change.

- 9.172 The Medical Defence Union was not persuaded that the proposed level of detail needed to be included in the statute, but thought that it could be left to the discretion of the regulators. The General Dental Council suggested that there should be a “permissive power for the regulators to make rules on these matters”.

- 9.173 The General Osteopathic Council felt that “the actual measures appear to us to be matters of good practice which may be best dealt with in guidance rather than

<sup>18</sup> Of the 192 submissions which were received, 51 expressed a view on this question: 44 said that the statute should so provide, 1 disagreed, whilst 6 held equivocal positions.

needing to appear in statute”. The General Medical Council argued that special measures should be a matter for case management using a general power in the rules and that the rules should provide for “the parties to seek directions from a case manager prior to the hearing”.

- 9.174 The Administrative Justice and Tribunals Council suggested that the provisions of the Equality Act 2010 may also be applicable “in terms of the need to make reasonable adjustments to enable a disabled or vulnerable witness to give evidence”. RadcliffesLeBrasseur noted the proposal “is only for witnesses and not the registrant which is an apparent gap”.
- 9.175 The Scottish Government argued that the statute should provide for special measures “including but not limited to the examples in the question” and “these measures should be equally available to both parties”.
- 9.176 The Professional Forum of the Pharmaceutical Society of Northern Ireland said it would only support the use of special measures such as those proposed “in the most extreme circumstances”. The Royal Pharmaceutical Society of Great Britain said it was “conscious of potential cost implications”.

**Provisional Proposal 9-17: The statute should require the regulators to establish a system for imposing and reviewing Interim Orders.**

- 9.177 An overwhelming majority agreed that the statute should require the regulators to establish a system for imposing and reviewing interim orders.<sup>19</sup>
- 9.178 The Department of Health agreed with the proposals but also noted that in some cases it can take a regulator up to 30 days to impose an interim suspension order and that this was not conducive to public protection.
- 9.179 The UK-wide Nursing and Midwifery Council Lead Midwives for Education Group also commented on the time it can take regulators to impose interim orders. It said that:
- The decisions need to be immediate so any processes to be put in place need to take this into account. The decisions to impose an interim order cannot take weeks but should be 24 hours due to the seriousness of the referral.
- 9.180 The National Clinical Assessment Service also supported the “need for a speedy interim orders process to be in place for the protection of the public”.
- 9.181 The Scottish Government supported the proposal, but also considered that interim order hearings are an area where “the regulators could work together to establish common standards”. It also argued that the Professional Standards Authority should monitor “the reasonableness, appropriateness and consistency of extended orders”.
- 9.182 The General Medical Council suggested that the statute should enable the Registrar to carry out the review where the regulator’s proposals are uncontested

<sup>19</sup> Of the 192 submissions which were received, 46 expressed a view on this proposal: 44 agreed, whilst 2 disagreed.

in order to “maximise the efficiency of our procedures and avoid unnecessary hearings where there is no dispute between us and the defence”.

9.183 The Administrative Justice and Tribunals Council argued that rather than having separate arrangements for interim order panels these cases should be heard by fitness to practise panels.

9.184 An individual consultee (Melanie McDonald) argued that “the jurisdiction to make an interim suspension order should be transferred to the county court”. It was suggested that regulatory panels would retain powers to make interim conditions of practice orders, and have the right to review interim suspension orders made by the court at regular intervals and refer back to the court if there are grounds for the order to be lifted. It was noted that:

Interim orders at the moment are often made in cases where the allegations cannot properly be characterised as serious. Panels seem unable to distinguish between those cases of immediate and significant risk to the public and those – for example medication errors – where the risk can properly be contained by restricting the registrant's practice.

**Provisional Proposal 9-18: The statute should require each regulator to establish panels of at least three members for interim order hearings (including a lay member). In addition, Interim Order panels must be appointed by a body which is separate to the Council and there would be a prohibition of Council members and investigators from sitting on such Panels.**

9.185 The vast majority agreed that panels must consist of at least three members (including a lay member) and must be appointed by a body which is separate to the Council, and that Council members and investigators would be prohibited from sitting on panels.<sup>20</sup>

9.186 The General Medical Council stated that:

As above for fitness to practise panels, the body responsible for all aspects of the interim order panel appointment process should be operationally separate from the Council and Council members should not play a role in the selection or appointment of panellists or the decisions of panels. However, that body may in governance terms be accountable to the Council in relation to overall performance.

9.187 The Professional Standards Authority argued that the statute should ensure a lay majority on interim order panels. It also sought clarity on what we meant by the term “investigators”. Other consultees – such as UNISON – felt that the statute should require that a panel shall include “at least one registrant member from the same occupation as the respondent”.

<sup>20</sup> Of the 192 submissions which were received, 46 expressed a view on this proposal: 44 agreed, whilst 2 held equivocal positions.



- 9.188 However, the Association of Regulatory and Disciplinary Lawyers said that it did “not believe that reviews of interim orders need a three member panel; they can be undertaken by the panel chairman without a hearing”.

**Question 9-19: Should the statute prohibit Interim Order Panellists sitting on a Fitness to Practise Panel (either in relation to the same case or more generally)?**

- 9.189 An overwhelming majority felt that the statute should prohibit interim order panellists sitting on a Fitness to Practise Panel in relation to the same case.<sup>21</sup> A small majority disagreed that the statute should prohibit interim order panellists sitting on any Fitness to Practise Panel.<sup>22</sup>

- 9.190 The Medical Defence Union agreed that there should be a prohibition in relation to the same case because interim order panellists:

have been involved in making a decision at an earlier stage where, for example, evidence that may have been put before an Interim Orders Panel is not later put before a Fitness to Practise Panel.

- 9.191 Similarly, the General Medical Council argued:

We do not believe that panellists are in the same position as professional judges whose training enables them to disregard knowledge obtained in previous proceedings where that knowledge is considered prejudicial. Panellists are not legally trained and, in order to ensure the process is fair for doctors, they should be protected from potentially prejudicial knowledge in the same way that juries are protected in the criminal justice system.

- 9.192 The Patients Association agreed that the presence of an interim order panellist on a Fitness to Practise Panel in the same case “may introduce undue prejudice, unintentional or otherwise, which may make rulings unsound.”

- 9.193 The Association of Regulatory and Disciplinary Lawyers suggested that a panellist who has sat on an Interim Order Panel should be prohibited from the Fitness to Practise Panel convened to hear the case, or any “linked” case. An example of a linked case was said to include one in which “the accused practitioners practised in the same practice, or the alleged modus operandi and experts to be called by the regulator are the same”.

- 9.194 The Department of Health, Scottish Government and the Department of Health, Social Services and Public Safety for Northern Ireland all agreed that interim order panellists should be prohibited from sitting on a Fitness to Practise Panel in relation to the same case.

<sup>21</sup> Of the 192 submissions which were received, 43 expressed a view on this question: 42 said that the statute should so prohibit, whilst 1 disagreed.

<sup>22</sup> Of the 192 submissions which were received, 37 expressed a view on this question: 16 said that the statute should so prohibit, whilst 21 disagreed.

- 9.195 Several consultees stressed that if a panellist has considered the case at an interim order hearing they should not be excluded from considering the case again at future reviews of any order given. It was also questioned whether this prohibition would extend to considering reviews of fitness to practise suspension or conditions of practice orders. In addition, some argued that the statute should not prohibit interim order panellists from sitting on a fitness to practise panel:

There is huge benefit in having panellists with the ability to sit across all types of cases. Furthermore, from a purely practical basis, given the requirement to have a registrant from the same part of the register as the registrant concerned to sit on the panel, it would be logistically challenging to have such a prohibition and this could adversely impact upon the administration of justice.

- 9.196 Similarly, the General Osteopathic Council said that “maintaining a separate pool of panellists would not be economic or practical”. It continued:

The need to manage conflicts of interest between registrant panellists and parties to a complaint is also more difficult within a small profession and supports the need for a single larger pool of panellists rather than separate pools.

- 9.197 A small number of consultees disagreed with any statutory prohibitions on panel membership. For example, the Nursing and Midwifery Council stated this should be left to each regulator to determine. Coventry and Warwickshire Partnership Trust did not feel that either prohibition was necessary. It said that:

in other areas of health practice, there is an agreement that review panels and appeals panels may have one person from a previous panel sitting. This could be used with interim order panellists, and would allow for two of the three panellists to be new, and allow one member of the panel to be able to review the evidence previously considered and explain the thinking of the interim panel.

**Provisional Proposal 9-20: The test for imposing an Interim Order should be that it is necessary to protect, promote and maintain the health, safety and well-being of the public (and maintain confidence in the profession).**

- 9.198 A large majority agreed that the test for imposing an interim order should be that it is necessary to protect, promote and maintain the health, safety and well-being of the public (and maintain confidence in the profession).<sup>23</sup> For example, the Patients Association agreed with the proposal, on the basis that “it is proportionate but still subject to the paramount duty”.

- 9.199 Some suggested additional criteria. The General Medical Council felt the test should also include “the interests of the registrant” since:

<sup>23</sup> Of the 192 submissions which were received, 44 expressed a view on this proposal: 35 agreed, 6 disagreed, whilst 3 held equivocal positions.

On occasion, if a doctor feels under pressure to continue to work, it is helpful to be able to make an order so that they can get the help that they need in order for their health to improve.

9.200 Similarly, the Health and Professions Council suggested that an order may also be required “in the interests of the person concerned”.

9.201 The Association of Regulatory and Disciplinary Lawyers also argued that:

The “public interest” ingredient is important, even if it is rarely used by the Interim Orders Panel, because it provides the flexibility that [the Panel] occasionally requires (see *Sandler v General Medical Council* [2010] EWHC 1029 where the doctor had committed criminal offences in connection with his completion of forms for cremation, which had no public safety element but suspension was deemed to be in the public interest).

9.202 The British Chiropractic Association was concerned that a test based on the need to promote and maintain public health, safety and well-being would be too broad and result in interim orders being too readily applied. The General Dental Council argued that the use of the word “well-being” would be too wide.

9.203 The Medical Defence Union disagreed with the proposal and preferred the test contained in the Medical Act 1983: “it is necessary for the protection of members of the public or is otherwise in the public interest, or is in the interests of a fully registered person”.

9.204 UNISON also preferred a different test and believed that:

the Nursing and Midwifery Council guidance more accurately reflects the emergency nature of such orders, namely: “A committee must be satisfied that there is real risk of significant harm to the health, safety or well being of a patient, visitor or colleague if an order is not made. It is not enough for the Committee to take the view that such a step would be desirable”. This should be the only criteria, it is not appropriate to make a judgement on the “wider public interest” or “confidence in the profession”, especially when there has been no finding of fact.

9.205 The Optical Confederation argued that the test should be whether the registrant poses a risk to the public only, and that maintenance of confidence in the profession “should not be considered at this stage but is relevant at the substantive hearing when considering impairment”. Similarly, RadcliffesLeBrasseur argued that:

The reference to maintaining confidence in the profession begs the question of whose confidence is being maintained ... . The time for the regulator to mark its disapproval of conduct or to set standards is after a fact finding hearing and the Interim Orders Panel expressly does not make such findings.

9.206 The General Osteopathic Council agreed that “the types of issues that require an interim order are such that they are solely about public protection rather than maintaining confidence”.

9.207 However, an individual consultee (James Kellock) did not think that the public would understand:

why a registrant convicted of serious dishonesty was not susceptible to being subject to an interim order, which would be the consequence of limiting the test to the first part of the proposal.

**Provisional Proposal 9-21: On all procedural matters in relation to Interim Order hearings (except for those specified in provisional proposal 9-18) the regulators should have broad rule-making powers.**

9.208 An overwhelming majority agreed that the regulators should have broad rule-making powers on procedural matters in relation to interim order hearings.<sup>24</sup> For example, the Patients Association agreed that regulators should have powers “subject to the paramount duty”, and RadcliffesLeBrasseur supported the proposal “subject to the application of the overriding objective”.

9.209 The Medical Defence Union agreed with the proposal but also argued that:

The statute should retain the current requirement for the regulator to apply to the court to extend an order beyond the statutory period. This is a helpful safeguard that encourages regulators to ensure they investigate promptly and it should be retained.

9.210 Some consultees felt that the statute should impose greater consistency. The Health and Care Professions Council pointed out that it has no specific procedural rules that relate to interim order hearings. Instead, all such hearings are held in line with the relevant rules of procedure relating to each of the practice committees – Investigating, Conduct and Competence, or Health. The Council also argued that the regulators should be required to make rules on the following matters:

- (1) the criteria for review hearings (including timescales and the availability of new evidence);
- (2) the powers of the Panel;
- (3) the time period of orders (for example 18 months) and renewals;
- (4) the rights of the person concerned to appear before the Panel;
- (5) the rights of representation; and
- (6) the process of notification.

<sup>24</sup> Of the 192 submissions which were received, 41 expressed a view on this proposal: 38 agreed, whilst 3 disagreed.

9.211 In addition, the statute should retain the requirement for the regulator to have to apply to the court to extend an order beyond the period initially set. An individual consultee (Anonymous) also suggested that the statute should state maximum periods for interim orders of 18 months and regular reviews.

9.212 The Royal College of Nursing suggested that the statute should clarify that while “no final findings of fact are to be made and so the decision has to be based on something less than a full consideration of the allegations”, nevertheless “the inquiry must be proportionate”. It argued that the Nursing and Midwifery Council’s guidance is “clearly insufficient” on this matter since it states that allegations can be accepted at “face value”.

9.213 The Professional Standards Authority opposed the proposal. It said:

We consider that it would have been helpful for the consultation document to have identified good practice and suggested its consistent adoption across the regulators. We can see little justification for divergence in the procedure to be followed at interim order hearings.

9.214 UNISON was also concerned about the impact of interim orders on registrants, particularly in cases where the main hearings are subject to significant delays. It said:

We are not aware of any initiative by any regulator that expedites prosecuting cases where a registrant is suspended over one where no order is in place. There is evidence therefore that external impetus is necessary to achieve this, and we believe that could be achieved through a set of standards applicable to all regulators.

**Question 9-22: Should the statute guarantee the right of registrants to give evidence at Interim Order hearings?**

9.215 An overwhelming majority agreed that the statute should guarantee the right of registrants to give evidence at interim order hearings.<sup>25</sup> For example, the Society and College of Radiographers considered that the right would “help to ensure fairness, equity and due process”. The College of Social Work said that “given the devastating effect on someone’s future career of being subject to such action they should have a right to be heard”.

9.216 The Health and Care Professions Council argued that:

Given the nature of the hearings and that the Panel’s role is not to make any findings of fact, it is rare for any person other than the registrant concerned to give oral evidence before the Panel. Guaranteeing the right of registrants to give oral evidence ensures fairness to the registrant concerned and does not place any unnecessary burden on the Panel to make an assessment of whether it would be desirable to hear specific evidence.

<sup>25</sup> Of the 192 submissions which were received, 47 expressed a view on this question: 43 said that the statute should guarantee this, whilst 4 disagreed.

9.217 The Association of Regulatory and Disciplinary Lawyers argued that:

The Interim Orders Panel is often assisted in making its decision by hearing the registrant. The hearing frequently takes place before evidence can be compiled of the impact of an interim order on the registrant, and calling him or her is the only way of providing the Panel with the required information.

9.218 It also argued that, in “exceptional circumstances”, it might be important for the Panel to receive “evidence about the complaint or the complainant in order to assess if an interim order is appropriate”.

9.219 The Royal College of Nursing argued that the interim order procedure can be contrary to the common law and Article 6 if it fails to provide the registrant with a proper opportunity of dealing with the allegations made against them.

9.220 Several consultees supported the proposal, but noted that it should not be “possible to compel registrants to give evidence”.

9.221 The Department of Health, the Scottish Government and the Department of Health, Social Services and Public Safety for Northern Ireland all agreed that the registrant should have the opportunity of being heard in all cases.

9.222 The General Dental Council agreed with the proposal, provided that it is clear that “the interim orders hearing may still proceed where a registrant fails to appear or there is delay which could prejudice patient safety”. The General Optical Council felt that regulators should retain flexibility in this area and that the “default position should be that oral evidence is not taken, but that there is discretion to admit it where appropriate”.

9.223 The British Dental Association and the Royal College of Midwives both agreed that the statute should make provision for a case to continue in the absence of the registrant. The Local Supervising Authority Midwifery Officers Forum UK suggested that there “would have to be a ‘prior notice’ arrangement to avoid unnecessary costs being incurred”.

9.224 However, the General Medical Council disagreed and felt that:

It would be inappropriate to introduce a guarantee for registrants to give evidence (which would include a right for them to be cross-examined) where the function of the panel is not to make findings of fact. A guaranteed right would also mean the hearing could not proceed until the registrant was ready to give evidence which could introduce very significant delays. This would have considerable public safety risks.

9.225 The Nursing and Midwifery Council argued that if a right to give evidence was guaranteed, a full hearing would have to be arranged “on every review in case the registrant attended without prior notice, which would be neither proportionate nor efficient”.

**Provisional Proposal 9-23: The right of appeal against an Interim Order should continue to be to the High Court in England and Wales, the Court of Session in Scotland and the High Court in Northern Ireland.**

- 9.226 An overwhelming majority agreed that the right of appeal against an interim order should continue to be to the High Court in England and Wales, the Court of Session in Scotland and the High Court in Northern Ireland.<sup>26</sup> For example, the Patients Association agreed that the proposed appeals process is acceptable “so long as it is equally applicable to complainants and registrants”.
- 9.227 However, the Administrative Appeals Chamber of the Upper Tribunal disagreed and argued that there should be a right of appeal to the First-tier Tribunal. UNISON agreed that the Unified Tribunal Service could “provide a cheaper and more accessible process”. An individual consultee (James Kellock) and the Professional Standards Authority both felt that the county court might be preferable.

**Provisional Proposal 9-24: All Fitness to Practise Panels should have powers to impose the following: (1) erasure from the register; (2) suspension; (3) conditions; and (4) warnings.**

- 9.228 An overwhelming majority agreed that fitness to practise panels should have powers to order erasure from the register, suspension, conditions and warnings.<sup>27</sup> For example, UNISON supported the proposal, as it has been concerned about “the inequity experienced by different healthcare professionals” in this area.
- 9.229 The Department of Health agreed with the proposal on the range of sanctions available to panels. However, it noted that erasure in health cases “needs careful consideration on a case by case basis”.
- 9.230 Some queried the role of suspensions on the basis that they have a punitive element. An individual consultee (Walter Merricks) argued that “a suspension deprives the professional of continued practice familiarity, which just means that the professional is more of a risk on returning to practice.”
- 9.231 The Nursing and Midwifery Council felt that warnings should not be available at both the investigation and sanction stages “as their effect and purpose will be confused”. The General Optical Council supported the proposal but noted that at present its panels can only issue a warning if there is no finding of impairment.
- 9.232 The Medical and Dental Defence Union of Scotland felt that the current system of a warning appearing on the registrant’s record for five years is “unfairly onerous and prejudicial” considering this is supposed to be a sanction of less significance. The Osteopathic Alliance similarly said that it would like to see a “time limit on how long an admonishment or restriction of practice should remain on a registrant’s record”.

<sup>26</sup> Of the 192 submissions which were received, 39 expressed a view on this proposal: 36 agreed, 2 disagreed, whilst 1 held an equivocal position.

<sup>27</sup> Of the 192 submissions which were received, 48 expressed a view on this proposal: 45 agreed, whilst 3 held equivocal positions.

- 9.233 Several consultees supported additional sanctions being made available, such as a power to order financial reimbursement to the patient (an individual consultee (James Kellock)), a requirement to make an apology (consultation event) and a power to end pension rights (an individual consultee (John Bradfield)). The Professional Standards Authority said “it is not clear to us why the list excludes some of the sanctions that some of the regulators’ panels currently have (eg to impose fines)”.
- 9.234 RadcliffesLeBrasseur argued there should be a “specific power to take into account a period of interim suspension and, in the case of an appeal, any immediate period of suspension pending an appeal”.
- 9.235 Several consultees pointed out that there should be a power to take no further action after a finding of impairment. An individual consultee (Andrew Lockley) also thought that reprimands should be available where “‘no order’ is not enough, and conditions are too much or – more often – impracticable”.

**Provisional Proposal 9-25: The Government should be given a regulation-making power to introduce systems of financial penalties and cost awards.**

- 9.236 Opinion was divided on the proposal that the Government should be given a regulation-making power to introduce financial penalties.<sup>28</sup> Almost half of those who responded to this proposal agreed with a regulation-making power to introduce costs awards.<sup>29</sup> The General Dental Council noted that the introduction of such systems would be “contentious and therefore arguably would be more easily accepted if the onus were on Government to introduce them”.
- 9.237 The General Medical Council felt that there should be:
- A power to make costs awards against either party in circumstances where the behaviour in the conduct of the proceedings has been unreasonable. Such a sanction would have widespread benefits by ensuring that case management is effective. Experience within the tribunal sector suggests that a costs regime is a valuable and effective tool which can be used against a recalcitrant party who simply ignores case management directions, such as discovery.
- 9.238 Charles Russell LLP pointed out that the General Pharmaceutical Council uses its powers to make costs awards sensibly in situations where “the prosecutor or registrant has acted particularly unreasonably”.
- 9.239 Others agreed that costs awards should be available in limited circumstances, such as where there is a clear and deliberate breach of a case management direction, or where the registrant or their representative has acted vexatiously, abusively or disruptively. The Royal College of Nursing thought that “carefully utilised costs orders would assist in achieving equality of arms”. The Scottish

<sup>28</sup> Of the 192 submissions which were received, 45 expressed a view on this proposal: 16 agreed, 22 disagreed, whilst 7 held equivocal positions.

<sup>29</sup> Of the 192 submissions which were received, 54 expressed a view on this proposal: 26 agreed, 20 disagreed, whilst 8 held equivocal positions.



Government supported the proposal, but was cautious that a system of financial penalties could be seen as punitive rather than rehabilitative.

9.240 The Health and Care Professions Council agreed with the Government being given a regulation-making power, but disagreed with the principle of financial penalties and costs awards.

9.241 The Medical Defence Union argued that costs should never be borne by the regulators. It felt that this would:

require registrants to indirectly foot the bill for costs penalties incurred by a body over whose management of cases they had no direct control, and in circumstances where they have no option but to continue to pay the annual retention fee.

9.242 It also argued that costs awards may serve as a disincentive to the registrant:

To take an example of a registrant who was offered a sanction during a consensual disposal process, but who did not believe the facts were proven and who thought that his or her case should be heard before [a Panel]. The fact that if that registrant were to be found to have impaired fitness to practise and therefore liable for costs sanctions would be a considerable disincentive to that registrant taking advantage of his or her right to a full and proper defence.

9.243 An individual consultee (Andrew Colman) also thought that “any costs jurisdiction must be reciprocal to be fair”. He noted that the costs paid by regulators would exceed those received, thus “adding to the costs of regulation to be borne by those practitioners whose fitness to practise is not in question, rather than diminishing them”.

9.244 The Osteopathic Alliance opposed the introduction of financial penalties and costs awards as “the financial, emotional and health costs to a registrant undergoing a Fitness to Practise hearing are immense already, whatever the outcome”. It thought that “the regulator itself should be subject to cost awards to a registrant” if an allegation is found to be not proven. The British Chiropractic Association also said that if costs were introduced:

it would expect to see measures to ensure that registrants are appropriately compensated in matters where the Fitness to Practice Panels have failed in their statutory duty or erred in their decision-making.

9.245 The Association of Regulatory and Disciplinary Lawyers argued that:

A costs model based on “costs follow the event” is inappropriate; firstly, the registrant is compelled to engage in this litigation and has no control over the costs, and consensual disposal (which in any event is not the same as settling) may not be an option; secondly, it is often not possible to say which side has won or lost (how should a case that results in a warning, or a case in which misconduct but not impairment is found, be treated).

9.246 Some argued that disciplinary cases differ from fitness to practise cases and it is not open to the parties to negotiate an agreed settlement and so avoid the costs of proceeding to a hearing. Thus routine costs awards against registrants would be unfair. Several consultees argued that costs awards would only achieve an increase in the cost of the procedures themselves, directly since the parties will disagree about the awards, and through satellite litigation.

9.247 The Royal College of Midwives argued that it is unfair to further punish registrants who are often suspended without pay “by applying a financial order with which they are unlikely to be able to comply”. Some disagreed with fines and costs awards on the basis that the regulatory process is concerned with public protection and not punishment.

9.248 The Society of Chiropractors and Podiatrists was one of several consultees who thought that the proposal required further consideration. It highlighted a number of potential consequences of the imposition of costs orders:

If a registrant is found to be unfit to practise and is given the relevant sanction, the award of costs against the registrant would effectively be a double sanction. Furthermore, the prospect of costs being awarded against a complainant when there is “no case to answer” could deter members of the public from making justified complaints.

On the other hand, the power to award costs could deter members of the public from making vexatious or trivial complaints.

9.249 The British Association for Counselling and Psychotherapy suggested that rather than any new powers to issue costs, non compliance should be considered as a serious misconduct issue.

9.250 The Allied Health Professions Federation argued that the power to impose financial penalties and award costs should lie with the courts, not the regulators. The Department of Health argued that the power to introduce financial penalties and costs awards should be vested in the Privy Council.

**Provisional Proposal 9-26: All Fitness to Practise Panels should have powers to agree undertakings and voluntary erasure.**

9.251 The vast majority agreed that fitness to practise panels should have powers to agree undertakings and voluntary erasure.<sup>30</sup> For example, the Royal College of Nursing argued that:

Currently, the inflexible menu of sanctions available at the Nursing and Midwifery Council requires even trivial cases to be run to a final hearing where there is no public interest in that hearing, and the distress caused to the registrants and the drain on resources to the Nursing and Midwifery Council and registrants’ representatives is considerable. Similarly, when the registrant just wants to retire with dignity and the issue is health or competency in a long-serving nurse

<sup>30</sup> Of the 192 submissions which were received, 44 expressed a view on this proposal: 40 agreed, whilst 4 held equivocal positions.

who has begun to show signs of failing to keep up to date, the current arrangements are inhumane. Providing a mechanism to take such cases out of the system will free up the Nursing and Midwifery Council's resources to focus upon the cases that should be heard in public. We also think that involving the registrant in finding a suitable resolution in less serious cases will require the registrant to take responsibility for their actions that will aid their insight and reduce the sense of bitterness about the sanction that we frequently observe at the end of a case.

9.252 The Health and Care Professions Council supported the proposal and said that:

Such powers provide regulators with flexibility in their adjudicative approach. In providing such flexibility, however, care has to be taken to ensure justice, fairness, openness and transparency whilst also ensuring public protection.

9.253 Consultees' concerns about the use of consensual disposals were also reflected in their responses to provisional proposal 8-16 (see Part 8 of this document) in relation to the range of actions available to the regulators at the investigation stage. In addition, Action Against Medical Accidents stated that:

Even where a health professional has already left the register, regulators should have a power (and a duty) to investigate and record findings to mitigate the risk of that health professional re-joining the register at a later stage without the concerns having been addressed, or the health professional registering in a different country without the concerns coming to light.

9.254 The General Dental Council stated that regulators should have the power to make rules to introduce voluntary erasure should they wish to do so.

9.255 The Professional Standards Authority argued that any system of consensual disposals should provide:

a guaranteed degree of transparency in relation to the outcome, including publication of a clear statement which specifies the nature of the misconduct (or other basis for the impairment finding) that has been committed and which sets out the consequences of any failure by the registrant to comply with any undertaking or, in the case of voluntary erasure, any attempt to reregister in future.

9.256 The National Clinical Assessment Service acknowledged the need to deal with fitness to practise cases quickly and in a non-punitive way, but felt that:

there is a danger when not holding a (public) hearing that the public perception will be one of healthcare professionals being dealt with by other healthcare professionals behind closed doors.

9.257 In relation to voluntary erasure, the Department of Health argued that the regulators should be required to maintain a list of persons whose applications for voluntary erasure were granted before the conclusion of an investigation. It also suggested that voluntary erasure could be limited to cases where the practitioner

and regulator produce “a statement of agreed facts, which is published, and so avoids disputes in the future as to the factual basis of a case”. The Department felt this would mean that “where someone wishes to be restored to the register that the fitness to practise issue can also be revived if necessary”.

- 9.258 The Scottish Government also supported the proposal on consensual disposals but only on the basis that voluntary erasure is:

carefully considered in particular in relation to any individuals that may have been harmed as a result of the action of the registrants and the need for them to be protected and be afforded some form of redress.

- 9.259 It also argued that the regulators should be required to maintain a list of those practitioners who have agreed to voluntary erasure and “to share this information with other European Economic Area competent authorities”.

**Provisional Proposal 9-27: The regulators should have powers to introduce immediate orders (or use Interim Orders for this purpose).**

- 9.260 An overwhelming majority agreed that the regulators should have powers to introduce immediate orders (or use interim orders for this purpose).<sup>31</sup>

- 9.261 The Health and Care Professions Council argued that interim orders should be used to cover the appeal period before a fitness to practise sanction takes effect. It did not see a need for the introduction of a separate immediate order power “which could confuse the public and registrants”. In addition, the Council suggested that any interim order made to cover an appeal period “should be made by way of a separate decision (albeit within the same hearing), to ensure that the registrant has the right to make submissions”.

- 9.262 In contrast, the Nursing and Midwifery Council supported the use of immediate orders and felt that the use of interim orders in this instance was inappropriate. The Royal College of Midwives also felt that immediate orders should be used on the basis that “it is not proposed that they be reviewed in a set time”.

- 9.263 However, the Professional Forum of the Pharmaceutical Society of Northern Ireland argued that the use of immediate orders should be limited to “the most extreme cases” and “with the caveat that such orders could be appealed immediately to the High Court”.

- 9.264 The General Optical Council argued that the power to issue immediate orders should be available following review hearings. The Optical Confederation thought that “immediate orders should be provided for in the new statute and these should be able to be sought by either party”.

- 9.265 The Department of Health felt that interim orders could be applied by fitness to practise panels without the need to convene a separate Interim Orders Panel. It argued that the order-making power in relation to new sanctions should be vested in the Privy Council.

<sup>31</sup> Of the 192 submissions which were received, 42 expressed a view on this proposal: 38 agreed, whilst 4 disagreed.

9.266 The Scottish Government also commented that some regulators have the power to impose an interim order without the need to convene a separate Interim Orders Panel and “this could be extended to all the regulators and would afford a more speedy form of public protection”.

**Provisional Proposal 9-28: The test for imposing any of the sanctions listed in provisional proposal 9-24 and consensual disposals in 9-26 should be to protect, promote and maintain the health, safety and well-being of the public (and maintain confidence in the profession).**

9.267 A significant majority agreed with our proposed test for imposing sanctions and consensual disposals.<sup>32</sup> For example, a consultee at a consultation event thought the proposal was “necessary and is a focus which is currently missing at some regulators”.

9.268 A number of consultees pointed out that the use of the word “and” implies that a sanction could only be imposed on the ground of public confidence where there was also an issue of risk or potential risk. It was suggested that the test should be based on whether the registrant poses a risk to the public “or” that confidence in the profession has been or will be undermined.

9.269 The Health and Care Professions Council agreed with the proposal and also argued that “public faith in the regulatory process” is crucial to the imposition of sanctions and operation of consensual disposals. The General Dental Council also raised concerns about the use of the term “well-being” which it felt was “inappropriate” (see discussion on the main duty in Part 3).

9.270 The Medical Protection Society agreed with this proposal, but also added that:

- (1) the sanction must be proportionate – the Panel must balance the interests of the public against those of the registrant;
- (2) the sanction must not be punitive – it must aim to protect patients and the wider public interest; and
- (3) the Panel must take into account “mitigation, remediation, testimonials, insight and apology” when deciding sanctions.

9.271 The Professional Standards Authority disagreed with the proposal and argued that the statute should retain the current three stage test of:

- (1) public protection;
- (2) declaring and upholding professional standards; and
- (3) maintaining confidence in the profession.

9.272 It was also argued that the test should be expanded to include the need to maintain confidence in the regulatory system.

<sup>32</sup> Of the 192 submissions which were received, 45 expressed a view on this proposal: 40 agreed, 4 disagreed, whilst 1 held an equivocal position.

- 9.273 UNISON also disagreed and argued that the test should be public protection rather than maintaining confidence in the profession.

**Provisional Proposal 9-29: The regulators should be given broad powers to make rules in relation to the sanctions listed in provisional proposal 9-24 and consensual disposals in provisional proposal 9-26.**

- 9.274 The vast majority agreed with the proposal.<sup>33</sup> For example, the British Pharmaceutical Students' Association acknowledged that the General Pharmaceutical Council's rules may be "proportionate for pharmacy but may not be proportionate for other healthcare professions".
- 9.275 The Medical Defence Union agreed "with the proviso that the adjudicatory function is separated from the regulator", as has been implemented at the General Medical Council. It felt that:

We have long-standing concerns about advice/guidance circulated routinely to panellists by regulators which may amount to advice given to adjudicating panellists by the prosecuting arm. In order to provide a safeguard against this, we believe there should be a further stipulation that advice/guidance to panellists should be issued by the regulator/separate body responsible for the Fitness to Practise Panel and not the prosecuting arm of the regulator.

The duty upon the adjudicatory body should be no greater than to consider indicative sanctions guidance provided by the regulator as the body responsible for setting standards; but the adjudicatory body must be free to determine sanctions as it sees fit.

- 9.276 The Health and Care Professions Council argued that the statute should provide for "mandatory reviews of suspension and conditions of practice orders and the length of time such orders should be imposed for" which "should not be left to the discretion of individual regulators".
- 9.277 However, the Professional Standards Authority disagreed, and stated:

We believe that it would be preferable for a degree of consistency to be achieved by imposing a common sanctions framework across the regulators. This is particularly important for the maintenance of public confidence in the regulators generally, given the concerns that arise about different sanctions being imposed in closely connected cases.

- 9.278 The Royal College of Nursing called for "a mechanism for oversight so that there is consistency". UNISON suggested that "consistency and economies of scale could be achieved if a basic rules standard is applied across all regulators".
- 9.279 The Department of Health called for "constraints to ensure consistency of approach in relation to issues touching on the fairness of applying particular sanctions in particular cases", for example health cases. The Scottish

<sup>33</sup> Of the 192 submissions which were received, 42 expressed a view on this proposal: 40 agreed, whilst 2 disagreed.

Government expressed caution in relation to broad rule-making powers. It urged that “a consistent approach is applied, particularly in relation to issues which cover certain sanctions in relation to health cases”.

**Provisional Proposal 9-30: The Government should be given a regulation-making power to add new sanctions and consensual disposals to those listed in provisional proposals 9-24 and 9-26, and to remove any sanctions and consensual disposals.**

9.280 A large majority agreed that the Government should be given a regulation-making power to amend the statute to add or remove sanctions and consensual disposals.<sup>34</sup> For example, the Patients Association said that:

There does indeed need to be a process through which new sanctions may be added to the list of possible sanctions available to the regulators. The Government, with the appropriate oversight of Parliament, is the right body to undertake this function.

9.281 The General Medical Council said:

The nature of risk is dynamic and changes over time as the context in which professionals work changes and evolves. Society’s appetite for risk also evolves. It will be important that there is a mechanism to make changes over time.

9.282 A small number of consultees expressed concern about this proposal. The main arguments are set out in Part 8 in the discussion concerning the powers of regulators to dispose of cases during the investigation stage.

9.283 RadcliffesLeBrasseur did not think it was “clear why it should be thought that the powers given to erase, suspend or impose conditions are not wide enough”. The Medical Protection Society questioned “whether in practice it would ever be necessary for the Government to invoke this power”.

9.284 Some consultees emphasised that the competence of the devolved administrations must be adequately respected if this proposal is adopted. For example, the Scottish Government noted that its support for the proposal was “on the proviso that the competence of the Scottish Parliament is respected where applicable”.

<sup>34</sup> Of the 192 submissions which were received, 40 submissions expressed a view on this proposal: 34 agreed, 3 disagreed, whilst 3 held equivocal positions.

**Question 9-31: Does the language used in the proposed list of sanctions and consensual disposals contained in provisional proposals 9-24 and 9-26 convey accurately their purpose?**

- 9.285 A majority agreed that the language did convey the sanctions' purpose.<sup>35</sup> For example, the Department of Health and Scottish Government considered that the language used in the consultation paper was appropriate.
- 9.286 Some felt that the term "warning" was not appropriate and preferred "caution". An individual consultee (Lucy Reid) felt that "warnings" can be misunderstood and seen by the public as "merely a slap on the wrist". The Health and Care Professions Council felt that a "caution" is understood as an "official rebuke" but it was not necessarily expected to appear on a registrant's record, whereas a "warning" is viewed as "a more familiar term, carrying more weight and implying a formal procedure".
- 9.287 The General Dental Council felt that "undertakings" suggests that "a registrant has simply promised to behave properly; it does not in itself imply that there are conditions or monitoring in place" and suggested the terms "conditions" or "agreed conditions" instead. The General Social Care Council felt that "undertaking" would be viewed as "obscure by members of the public". It also felt that the current language "does not fully capture the nature of the arrangement" whereby "the registrant has agreed to amend his or her practice or behaviour as a condition of being allowed to hold a licence to practice".
- 9.288 Several consultees argued that "erasure" is not clear, and the General Medical Council said the term was "overly technical and legalistic". Alternative suggestions included "striking off", "struck off", and "removal from the register". For example, the Patients Association argued that "striking off" is "clear, in widespread use and understandable". The General Pharmaceutical Council, however, reported that it avoids using the term "striking off" or "struck off" which in its view is "emotive, unhelpful and old-fashioned".
- 9.289 The General Medical Council suggested that the term for "voluntary erasure" must be distinct from the term used when a Fitness to Practise Panel erases a doctor from the register or "when, under the consensual disposal provisions, the regulator demands and the registrant agrees that their name be removed from the register".
- 9.290 The Pharmaceutical Society of Northern Ireland was also concerned about the language used in respect of consensual disposals. It said:

The language inaccurately conveys the purpose of these powers. There is considerable scope for confusion around the terms voluntary erasure and consensual disposal and the language does not accurately communicate or reflect the outcomes. In plain English, the terms do not identify to the public that the registrant has been subject to due process and has been judged at the same threshold as a final fitness to practise panel.

<sup>35</sup> Of the 192 submissions which were received, 43 expressed a view on this question: 27 agreed with the language, 2 disagreed, whilst 14 held equivocal positions.



- 9.291 The Professional Standards Authority argued that the priority is to communicate clearly to the public and employers “the extent/lack of any difference in the impact of a sanction depending on whether it is consensual or has been imposed at the end of the hearing process”. The British Association for Counselling and Psychotherapy said that the “perception of protection for the public is crucial”, and so the “language needs to be emphatic in this instance”.
- 9.292 Many consultees combined their answer to this question with their response on consultation question 8-19 regarding the nomenclature used to describe the disposals available at the investigation stage (see Part 8 of this document).

**Provisional Proposal 9-32: The statute should require all the regulators to establish a system of review hearings for conditions of practise and suspension orders. In addition, the regulators should have powers but would not be required to establish review hearings for warnings and undertakings.**

- 9.293 An overwhelming majority agreed that the statute should require all the regulators to establish a system of review hearings for conditions of practise and suspension orders.<sup>36</sup> A significant majority agreed that the regulators should have powers to establish review hearings for warnings and undertakings.<sup>37</sup> For example, the Patients Association supported the proposal, “particularly ... that the process should be specifically defined in the statute”.
- 9.294 However, several consultees felt that there should be a duty to establish a system of review hearings for undertakings. For example, the Professional Standards Authority argued that undertakings are in effect conditions that have been imposed with a registrant’s consent and, therefore, should not be treated differently in terms of review requirements.
- 9.295 Some disagreed with a system of reviews for warnings. For example the General Medical Council stated that:

There would be no expectation that a registrant carry out remedial action following a warning and the only matter that might be considered on review would be whether the behaviour had been repeated in the interim period. In that case, a regulator could in any event take action in the event of repetition and a review process would be unnecessary and overly burdensome.

- 9.296 Similarly, the Medical Defence Union stated that:

These are meant to be a way of admonishing the registrant that does not require any action and there is no requirement upon a registrant to demonstrate anything in response to a warning. Its purpose is to lie on the file in an advisory capacity, for a specified period. We cannot see, therefore, how a review of a warning would work in

<sup>36</sup> Of the 192 submissions which were received, 44 expressed a view on this proposal: 41 agreed, 2 disagreed, whilst 1 held an equivocal position.

<sup>37</sup> Of the 192 submissions which were received, 41 expressed a view on this proposal: 35 agreed, whilst 6 disagreed.

practice and would strongly resist any suggestion that warnings should be in any way extended after the set period has elapsed.

9.297 However, RadcliffesLeBrasseur disagreed and said that:

A warning can have serious consequences. At present it appears that insurance companies will remove a medical registrant from their approved list of providers if a warning is given. There should be a requirement to offer a registrant a hearing if he does not wish to be warned.

9.298 The General Dental Council thought that the “regulators should have rule-making powers in this respect”,

9.299 The Health and Care Professions Council disagreed generally with the proposal and argued that the statute should specify the requirements and systems for review hearings in order to ensure “transparency and consistency”. The Professional Standards Authority also argued that:

There is little value to be obtained from achieving consistency in the name of the sanctions that can be imposed if, in reality, the same named sanction may have a very different impact, eg if a “warning” will be reviewed by one regulator, but not by another.

9.300 The Scottish Government supported the proposed duty to establish review hearings, but also noted that:

This is an area where there is already a degree of commonality between the regulators and would suggest that this could be an area where joint working may be appropriate.

9.301 It also argued that the Professional Standards Authority should monitor and scrutinise the review procedures adopted.

9.302 The Royal College of Obstetricians and Gynaecologists also thought that “all regulators should work the same way” in respect of undertakings and warnings.

**Provisional Proposal 9-33: The regulators should have broad rule-making powers to establish the procedures for review hearings.**

9.303 The vast majority agreed that the regulators should have broad rule-making powers to establish the procedures for review hearings.<sup>38</sup> For example, the Professional Forum of the Pharmaceutical Society of Northern Ireland supported the proposal, “with the appropriate safeguards being created by the process of full stakeholder consultation”.

9.304 However, many argued that full hearings are not always necessary. For example, the Nursing and Midwifery Council suggested that some reviews could be “conducted, by consent, at meetings without the need to convene a full hearing”.

<sup>38</sup> Of the 192 submissions which were received, 38 expressed a view on this proposal: 36 agreed, whilst 2 disagreed.

The Royal College of Nursing felt that regulators should only hold review hearings if there is a dispute regarding the continuation of the existing sanction.

- 9.305 The General Medical Council felt that the statute should not “require reviews to be carried out by the Registrar where the proposals are uncontested”. It felt that:

This would avoid unnecessary hearings and prevent adjudication resources being diverted from interim orders and fitness to practise hearings by large numbers of review hearings.

- 9.306 It also argued that registrants should have a right of appeal against review decisions.

- 9.307 The Medical Defence Union argued that a review of undertakings by a Fitness to Practise Panel would be “disproportionate and unnecessary”, since:

The purpose of undertakings is that they are a faster way of achieving the same protections as conditions, without a fitness to practise hearing. It would defeat their purpose for them to be reviewed by a Fitness to Practise Panel.

- 9.308 The Administrative Justice and Tribunals Council argued that the procedures for review hearings should be “harmonised across the board”. Similarly, the Professional Standards Authority felt there was “little justification for significant divergence in the appropriate procedure”.

**Question 9-34: Should the regulators be given an express power to quash or review the decision of a Fitness to Practise Panel where the regulator and the relevant parties agree that the decision was unlawful? If so, should complainants and other interested parties be able to prevent or contribute to any decision to use this power?**

- 9.309 A small majority felt that the regulators should be given an express power to quash or review such decisions.<sup>39</sup> A slim majority felt that complainants and other interested parties should have a role.<sup>40</sup>

- 9.310 The Nursing and Midwifery Council supported the introduction of such a power on the basis that:

At present, even if we actively encourage the Professional Standards Authority to pursue an appeal against a panel decision that we consider to be wrong, and then consent to the decision being quashed, we may still find ourselves liable to pay a significant sum in costs. This proposal would avoid such a situation.

<sup>39</sup> Of the 192 submissions which were received, 53 expressed a view on this question: 30 said the regulators should have such a power, 16 disagreed, whilst 7 held equivocal positions.

<sup>40</sup> Of the 192 submissions which were received, 14 expressed a view on the question: 8 agreed with the question, whilst 6 disagreed.

- 9.311 The Administrative Appeals Chamber of the Upper Tribunal noted that section 9 of the Tribunals, Courts and Enforcement Act 2007 enables the First-tier Tribunal to review its decisions on the ground of error of law.
- 9.312 An individual consultee (Andrew Lockley) suggested that only part of a panel's decision might be unlawful and therefore "it should also be possible for regulators to quash only that part of the decision, rather than the parties have to go to appeal".
- 9.313 The Department of Health, Social Services and Public Safety for Northern Ireland generally supported the idea that a regulator should be able to quickly remedy an error. It sought clarity over whether the original Panel which made the decision would need to recognise its mistake and take action itself, or whether a new panel would "scrutinise the legality or otherwise of a decision".
- 9.314 The Medical Defence Union felt that the power to quash or review decisions should only apply where the regulator and the registrant agree the decision was unlawful. The complainant and any other interested parties should have "no part in such decisions" since "they may have an interest in the outcome, but have no rights in the procedure as they are not a party to it". However, the General Osteopathic Council believed that the "consent of the regulator, registrant and complainant" would be required before any exercise of the power.
- 9.315 Similarly the Association of Regulatory and Disciplinary Lawyers stated:
- We do not think that the complainant should have any role in this decision; he or she is not a party to the proceedings, and if the regulator is in error in agreeing to the quashing of a finding on the basis of unlawfulness, the Council for Healthcare Regulatory Excellence can refer the matter to the High Court for resolution.
- 9.316 The Professional Standards Authority was generally supportive but also stated:
- We are, however, unclear as to the review mechanism that is proposed - would the matter be put before another panel, or would the decision-maker be the Registrar or other individual? We would have concerns about public confidence in the process if the review were to be conducted by someone other than a panel. If the basis for the review is unlawfulness, it is difficult to see the relevance of any contribution that the complainant/other interested party could make.
- 9.317 However, many consultees disagreed with the introduction of a power to reconsider decisions. For example, the General Medical Council argued that such a power would:
- introduce significant bureaucracy which will divert regulatory resources away from the core functions of investigation and adjudication. In addition, we believe that the overturning of a decision of a Fitness to Practise Panel should, as now, be overseen by the courts.
- 9.318 The Scottish Government felt "uncomfortable" with such powers being given to regulators. It said:

It is our view that without the necessary checks and balances and involvement of external/higher authorities, it is possible to envisage the situation whereby this mechanism could become more frequently used than initially intended (and, in some cases, misused), has the potential to become a regular feature of the process and could lead to undermining of the fitness to practise process.

9.319 RadcliffesLeBrasseur argued such a power would:

undermine confidence in the independence and integrity of the fitness to practise process if the prosecution and defence (with or without others) can set aside their decision.

9.320 The Royal College of Surgeons of Edinburgh was concerned that such a procedure might “create a legal loophole” whereby:

legal technicalities may cause a case to be dropped (as it is deemed “un-lawful”) despite there being sufficient evidence of the individual concerned not being fit to practise.

9.321 The Department of Health considered that, unless “the scope for reconsideration is tightly constrained”, this power could become a mechanism to challenge and overturn legitimate decisions “without recourse to a formal appeal”.

9.322 The Patients Association stated that:

Where the complainant or registrant alone is raising the problems, there should be an effective appeal procedure in place which operates internally as well as the option to seek judicial review.

9.323 An individual consultee (Walter Merricks) felt it would be “unduly complicated to provide for an informal quashing mechanism”. He also argued that:

Where both parties and other interested parties all agree that a decision should be quashed then obtaining orders to that effect from the Administrative Court is not onerous. At least in that process there is the possibility of external oversight.

9.324 The Administrative Justice and Tribunals Council argued that fitness to practise panels should be able to review their own decisions. Similarly the General Chiropractic Council felt that panels “should be given a slip rule of power, ie where there is an obvious mistake, to correct that mistake within [the] 72 hours”.

9.325 UNISON also argued that “other interested parties”, such as complainants, should not have any role since “these are not complaints procedures” and “are funded by registrants and should not stray beyond the issue of a registrant’s fitness to practise”.

9.326 However, several consultees were in favour of other interested parties having some limited involvement in any review. Coventry and Warwickshire Partnership Trust said:

Best practice would suggest that the complainant and other interested parties should be made aware of the decision, and why the decision has been taken, but this does not necessarily mean that they have a right to prevent the decision being taken, however it may be necessary to seek their opinion in order to allow reviews to happen in a timely and fair manner and prevent subsequent appeals.

- 9.327 Rescare thought that “complainants and other interested parties should have some legal recourse, in limited situations”. The British Dental Association saw “no reason why there should be any trammelling of the power by any interested party, but they might be able to contribute to the review”.

**Provisional Proposal 9-35: All professionals should continue to have a right of appeal against the decision of a Fitness to Practise Panel to the High Court in England and Wales, the Court of Session in Scotland and the High Court in Northern Ireland.**

- 9.328 The vast majority agreed with this proposal.<sup>41</sup> For example, the Professional Forum of the Pharmaceutical Society of Northern Ireland said it “believes [the right of appeal] is a fundamental protection for all registrants and continues to fully support this practice”.
- 9.329 However, several consultees pointed out that the costs involved in pursuing an appeal to the higher courts make this more of a theoretical right than a real one. UNISON argued that this is a particular problem for those registrants who are not members of a professional association or trade union. It was suggested that the regulator should be able to establish internal appeals procedures.
- 9.330 In addition, the General Social Care Council considered that:

The range of professions which are now subject to regulation and the different levels of income received by these professions are vastly different and this should certainly be a consideration when determining whether the High Court is the most appropriate place to hear appeals against the decision of professional regulators. An impact assessment should be conducted on this issue – taking into account whether the cost of a High Court appeal may be more prohibitive for certain regulated groups – before this proposal is finalised in primary legislation.

- 9.331 The Administrative Appeals Chamber of the Upper Tribunal argued that the Upper Tribunal (Administrative Appeals Chamber) would be “a more appropriate destination for appeals than the High Court and the Court of Session”. This was supported by the Administrative Justice and Tribunals Council. An individual consultee (James Kellock) felt that appeals should be transferred to the “county court in England, and the equivalents in Scotland and Northern Ireland”.
- 9.332 The General Chiropractic Council pointed out that it has powers to establish an internal appeals committee if a registrant is found unfit to practise due to ill health

<sup>41</sup> Of the 192 submissions which were received, 47 expressed a view on this proposal: 44 agreed, 2 disagreed, whilst 1 held an equivocal position.

and thereafter, a further appeal to the High Court is available. It therefore considered:

That both in respect of appeals against a decision on health and erasure, either permanently or temporary suspension, an internal appeal process should be available as in other professions. To avoid frivolous appeals, the registrant should be required to pay the costs of an appeal in advance which of course would be returned in the event of a successful appeal.

- 9.333 The Professional Standards Authority agreed that “the advantages of such an approach would principally relate to efficiency and cost, given the length of time it takes the courts to hear appeals”.

# **PART 10**

## **THE PROFESSIONAL STANDARDS AUTHORITY**

**Question 10-1: How effective is the Professional Standards Authority in performing the role of scrutinising and overseeing the work of the regulators?**

- 10.1 A slim majority felt that the Professional Standards Authority was effective.<sup>1</sup> For example, most of the regulators were positive in this regard. The General Medical Council felt that the Authority “provides a vital oversight role and is an important component in the system for ensuring the accountability of health regulators”. The Health and Care Professions Council described the Authority as “effective in scrutinising and overseeing the work of the regulators”. The Nursing and Midwifery Council noted that the Authority “has contributed positively to the regulatory landscape and the effectiveness of the regulators”. The General Dental Council argued that the Authority’s “approach to scrutiny has been constructive and proportionate”.
- 10.2 The Department of Health argued that the Professional Standards Authority has “successfully improved the performance of professional regulators, and created greater alignment across the sector”.
- 10.3 The Scottish Government argued that the Authority “has provided an important function in overseeing and scrutinising the regulators” but also expressed concern regarding the Authority’s “ongoing capacity” to undertake reviews and “to perform the increased responsibilities that the new system would bring”.
- 10.4 Several consultees expressed concerns about the Authority’s annual performance review process. For example, the General Osteopathic Council argued that the current way in which the review is conducted “means that every regulator is scrutinised in the same way every year”. It said “it would be more useful to take a risk-based approach to individual regulators and a more targeted or thematic approach to key areas of performance”. Similarly, the General Optical Council argued that:

There are still areas in which the annual performance review process could be made less onerous and more targeted around risks and performance issues, particularly for smaller regulators.

- 10.5 The McTimoney Chiropractic Association commented:

The evidence we have seen thus far seems to indicate that regulators carry out their own self-assessment on behalf of the Professional Standards Authority, which is effectively a tick box exercise. We do not regard this to be effective oversight of a regulator.

<sup>1</sup> Of the 192 submissions which were received, 39 expressed a view on this question: 21 said it was effective, 7 said its powers were not extensive enough, 3 said that its remit was confusing or too large, whilst 8 made other comments.



- 10.6 Unite argued that the reports are “comprehensive and helpful but unfortunately sometimes ignored”.
- 10.7 The Department of Health, Social Services and Public Safety for Northern Ireland argued that the Authority’s:
- culture has changed remarkably in recent years from a challenging function to one that appears much more benign, concerned more with relationships than with rigorous challenge. [It seems] to be sensitive to political dimension and not prepared to speak with an authoritative voice.
- 10.8 Several consultees accused the Authority of failures in respect of the crisis at the Nursing and Midwifery Council. For example, the Institute of Health Visiting argued that the Authority’s response had been:
- disappointing, especially when ultimately one whistle blower was forced to stand down from her position of Vice Chair of Council following complaints made to the Department of Health about internal bullying behaviour at the Nursing and Midwifery Council. These concerns should have been picked up by the Professional Standards Authority as they had recently reviewed the Nursing and Midwifery Council.
- 10.9 The Royal College of Nursing argued that the Authority “could have acted sooner to prevent the severity of the issues which the Nursing and Midwifery Council now faces”.
- 10.10 Several further issues were raised by consultees. The Royal Pharmaceutical Society of Great Britain described the role of the Authority as being “the lynchpin to successful regulation” but expressed concern that it “could grow disproportionately relative to its roles and function”.
- 10.11 The Medical Defence Union was concerned that the Authority fails to represent the interests of registrants. It felt that:
- It is inequitable that in future registrants will provide funding for the Professional Standards Authority through a levy on their annual registration fees but they have no interest in or control over an organisation that does not represent their interests in its oversight role.
- 10.12 The Royal College of Nursing expressed concern at the “lack of accountability of the Professional Standards Authority” which is no longer “under the ambit of the Department of Health or any other department whatsoever and will no longer be a non Departmental Body”.
- 10.13 The Committee of Contact Lens Educators argued that the Authority’s role was “unnecessary” and merely duplicated the role of the regulators. The Royal College of Midwives felt that the Authority’s interventions “seem against simplification and in cases unduly punitive in approach”.

- 10.14 The British Osteopathic Association argued that the Australian Health Practitioner Regulation Agency model “has many benefits that we could learn from, which in the UK could be translated into extending the remit of the Professional Standards Authority”.

**Provisional Proposal 10-2: The current powers and roles of the Professional Standards Authority (including those introduced by the Health and Social Care Bill 2011) should be maintained in as far as possible.**

- 10.15 The vast majority agreed that the current powers and role of the Professional Standards Authority should be maintained.<sup>2</sup> For example, the South Staffordshire and Shropshire Healthcare NHS Foundation Trust (Social Care) thought that the Authority’s “current powers should be retained” and its role “should be enhanced through the numerous provisions within the [consultation paper]”.
- 10.16 The General Dental Council argued that the Authority’s role “should not be expanded to make it into a regulator; this would alter the fine balance achieved at present and would be more expensive”.
- 10.17 However, the General Pharmaceutical Council stated that the role of the Authority is “confusing” due to its wide range of functions, and that this:

is reflected by the lack of clarity about whether the Professional Standards Authority is a meta-regulator (for example section 29 appeals and the proposal to bring into force its powers to investigate complaints about the regulators under section 28) or whether it is carrying out what the consultation refers to as a “systemic model” of oversight rather than regulation. We have concerns about how any organisation which has such a wide array of functions and responsibilities, particularly as they grow with an enhanced role in quality assuring voluntary registers, can develop a truly strategic role.

- 10.18 Some consultees commented on the Authority’s new role of ensuring the quality of voluntary registers. The Association for Nutrition was critical of the “costs and regulatory burden of assured voluntary registers” which “provide little incentive and no public protection”. The Nursing and Midwifery Council called for the development of a voluntary register in the field of “nursing care”.
- 10.19 The Health and Care Professions Council and the Professional Forum of the Pharmaceutical Society of Northern Ireland felt that the Authority’s remit should be extended to cover the regulation of social workers by the Care Councils in Scotland, Wales and Northern Ireland.
- 10.20 The Authority was generally supportive of its existing powers and role. The only exception was in respect of its section 28 power to consider complaints about regulatory bodies (see provisional proposal 10-6).
- 10.21 However, some consultees thought that the Authority’s powers and roles required further consideration. The Patients Association argued that the Authority needs

<sup>2</sup> Of the 192 submissions which were received, 34 expressed a view on this proposal: 34 agreed, whilst 3 held equivocal positions.

“sufficient powers and ‘teeth’ to make a genuine and tangible impact when regulators are failing”. The Professional Standards Authority itself argued that “with stronger powers” it could have been “more effective in overseeing the regulators”, for example:

with powers to require people to cooperate with investigations we have been asked to undertake, or in certain circumstances to require the regulators to act in particular ways.

10.22 The Institute of Health Visiting said that the Authority’s:

non-response to correspondence, lack of attention to whistle-blowers and view that concerns about the public served by health visitors represent ‘sectional interests’ only mean that we have little confidence in the Professional Standards Authority as it is currently constituted.

**Provisional Proposal 10-3: Appointments to the Professional Standards Authority’s General Council should be made by the Government and by the devolved administrations. Appointments would be made in accordance with the standards for appointments to the health and social care regulators made by the Professional Standards Authority.**

10.23 A large majority agreed with this proposal.<sup>3</sup> For example, Optometry Scotland said that it “would accept this proposal subject to suitable safeguards for review and scrutiny of appointees”.

10.24 The Scottish Government supported the proposal that “each devolved administration should appoint one member” of the Council. It argued that the Authority should be required to “make and publish rules on the appointment of its members” with the requirement that “such rules have first been approved and ratified by the Government and the devolved administrations”. It also disagreed with any suggestion that the Authority “should be allowed to regulate its own constitution as this would not afford the requisite degree of transparency and accountability”, and would provide the Authority “with almost unfettered discretion to exercise its duties”.

10.25 However, some argued for additional Parliamentary oversight. The Registration Council for Clinical Physiologists expressed “deep concerns” over this proposal “as this would seriously compromise the body’s independence from political interference”. It argued that all Council appointments should be approved by the Health Select Committee. The General Pharmaceutical Council stated that:

As the Professional Standards Authority is to be accountable to Parliament, it would seem more appropriate that its Council Members’ appointments should be scrutinised by Parliament itself as well as the Scottish Parliament and Welsh Assembly and Northern Ireland Assembly for UK regulators.

<sup>3</sup> Of the 192 submissions which were received, 31 expressed a view on this proposal: 27 agreed, whilst 4 disagreed.

10.26 The Professional Standards Authority stated that:

If there is to be an increased and more explicit line of accountability to Parliament, and if the Professional Standards Authority has a strengthened role in oversight of the regulators, we believe our chair appointment should be subject to a hearing by the Health Committee (or other Parliamentary Committee as decided).

10.27 The Department of Health argued that because the Professional Standards Association is a UK-wide body, the Privy Council should undertake appointments. Otherwise, it argued that the Authority should be allowed to make its own appointments.

10.28 The Patients Association argued for a “firm constitution for the Professional Standards Authority” so that it is “protected from day to day policy changes and changes of Government”.

10.29 The Association of Regulatory and Disciplinary Lawyers felt this proposal would have implications for the Authority’s perceived independence, and therefore argued that an independent office should be established to undertake such appointments. The Nursing and Midwifery Council and Royal College of Midwives argued that – in line with our proposed approach for the regulators – the Authority should be given the power to appoint its own members.

**Provisional Proposal 10-4: The Professional Standards Authority’s general functions should be retained, but modernised and reworded where appropriate.**

10.30 The vast majority agreed that the Professional Standards Authority’s general functions should be retained.<sup>4</sup> For example, the Nursing and Midwifery Council said:

Given the Professional Standards Authority’s overarching role, we feel that it is appropriate that the description of its powers is broad and high-level. We feel that the current wording is clear and would support an updating of the statement of the Professional Standards Authority’s general functions to reflect recent changes to its powers.

10.31 The Patients Association argued that the existing functions of the Authority are “still necessary though we are concerned about the hesitancy sometimes shown to use these powers to compel the regulator to perform its duties”.

10.32 The Professional Standards Authority stated that:

We consider that the general functions and powers of the Authority give us scope for interpretation and for taking appropriate action to protect the public and improve regulation; we wish to retain these general functions and powers. We agree, however, that our overall aim, particularly in the light of our power to accredit voluntary occupational registers, needs to be revised and modernised. This

<sup>4</sup> Of the 192 submissions which were received, 36 expressed a view on this proposal: 35 agreed, whilst 1 held an equivocal position.

may even more be the case if the Authority were to acquire an enhanced role in the accountability framework for the regulators.

- 10.33 The Pharmaceutical Society of Northern Ireland also noted that “any modernisation or rewording should reflect the final structures and processes resulting from this consultation”.

**Question 10-5: Is the Professional Standards Authority’s power to give directions still necessary?**

- 10.34 A large majority agreed that the Professional Standards Authority’s power to give directions is still necessary.<sup>5</sup> For example, the British Psychological Society considered it important to maintain the power “even if it is utilised only occasionally”. An individual consultee (Jacqueline A Wier) thought that the “additional power has meant that the regulators are given extra assistance when necessary”.

- 10.35 The Health and Care Professions Council stated that:

Although such directions should rightly only be made as a “last resort” ... such powers may still be needed, particularly given that the new legislative framework would mean a greater degree of discretion for the regulators in addressing some matters in rules that have hitherto only been specified in primary or secondary legislation.

- 10.36 Similarly, the Royal College of Midwives argued that “once health regulators have greater freedom to determine the governance, processes and rules, there could be a future need for this power”.

- 10.37 The General Medical Council said:

We share the Law Commission’s view that this power should be retained since it is an important means by which regulators can be held accountable. The effectiveness of the Professional Standards Authority in such areas is also important in reinforcing the case for the independence of the regulators from Government intervention.

- 10.38 The Department of Health suggested that the power to give directions could be augmented to “require regulators to comply with anything the Professional Standards Authority considers necessary” and that the Privy Council be given an order-making power to provide for whether and how this power is used.

- 10.39 The Scottish Government thought that the “power should be the subject of careful monitoring, scrutiny and analysis to ensure that it has been exercised appropriately and consistently”.

- 10.40 The Department of Health, Social Services and Public Safety for Northern Ireland agreed that the general functions should be retained and that the power to give

<sup>5</sup> Of the 192 submissions which were received, 36 expressed a view on this question: 28 said that the power was still necessary, 5 disagreed, whilst 3 held equivocal positions.

directions is necessary “but the Professional Standards Authority appears reluctant to use it”.

10.41 However, the Nursing and Midwifery Council felt that “the mature and effective relationship that exists between the Authority and the regulatory bodies would preclude this power (if ever enacted) from being used” and it should be discontinued.

10.42 The Association of Regulatory and Disciplinary Lawyers questioned whether this power is necessary given that “the Secretary of State would retain a power to intervene”. The General Chiropractic Council also thought that the power to give directions was no longer required.

10.43 The General Osteopathic Council argued that:

As this power has not been switched on it is not clear that it is required. We believe that the power to give directions should rest with the Secretary of State ... [who] should seek the advice of the Professional Standards Authority before making a direction. In any case, we envisage that in most circumstances where the Secretary of State considers giving a direction it is likely to be at the prompting of the Professional Standards Authority.

10.44 The General Dental Council argued that the legal framework must be clear “that this has a different function from any direction of last resort which can be given by the Secretary of State”.

10.45 The Professional Standards Authority stated that this power:

has an important symbolic value and would be important if used, although in practice it is far more likely that change can be achieved by consent. Any power to give directions should be considered a last resort. There are circumstances in which the advice we have given has failed to be acted on by regulators. This limits our effectiveness as we have no further means of ensuring that reforms and improvements are made.

**Provisional Proposal 10-6: The existing power for Government to make regulations for the investigation by the Professional Standards Authority into complaints made to it about the way in which a regulator has exercised its functions should be retained.**

10.46 An overwhelming majority agreed with this proposal.<sup>6</sup> For example, the Nursing and Midwifery Council argued that this power “will enable the Authority to address issues of concern in the performance of a regulator’s functions in a more formal way than at present”.

10.47 An individual consultee (Benita Rae Smith) commented that:

<sup>6</sup> Of the 192 submissions which were received, 33 expressed a view on this proposal: 32 agreed, whilst 1 held an equivocal position.

There is a problem with democratic accountability, as there is no mechanism whereby registrants can formally complain of unjust treatment by the Health and Care Professions Council either to the Professional Standards Authority or to any other body.

- 10.48 Some felt that the power should be circumscribed. The Pharmaceutical Society of Northern Ireland argued that the Professional Standards Authority's remit should be limited to complaints specifically about "the way in which a regulator has exercised its functions ie the process" rather than "specific decisions given for example in fitness to practise cases". Similarly, the Nursing and Midwifery Council argued that the power should not be used "to challenge or undermine properly-made fitness to practise decisions by regulators". The Royal College of Midwives argued that it is important to ensure that the Authority "is not seen as another source of redress for aggrieved individuals except where a regulator has failed to perform its functions adequately".
- 10.49 The General Dental Council argued that "an Ombudsman service as such is not appropriate for the service provided by regulators" since this would "add another, inappropriate, tier of complaint or quasi-appeal to registrants or patients aggrieved by the outcome of fitness to practise proceedings".
- 10.50 The Patients Association argued that "public awareness of complaints procedures within the regulators will be essential for such a system to work" and "many patients and service users are simply not well enough aware of the regulators or their function at present".
- 10.51 The Medical Protection Society said it was important that:
- Professional Standards Authority staff should have and demonstrate the necessary competencies to deal with complaints fairly, looking at the issues dispassionately and without bias. We believe that there is scope for considerable improvement and are concerned that the Professional Standards Authority must set a high standard if it is to command the respect of the regulators which are subject to its oversight.
- 10.52 The Pharmaceutical Society of Northern Ireland felt that the power to make regulations should rest with the Northern Ireland Executive in relation to the Society's responsibilities. This was supported by the Professional Forum of the Pharmaceutical Society of Northern Ireland.
- 10.53 The Professional Standards Authority expressed concern about the statutory wording of this power but nevertheless felt there was "value in a limited power to investigate matters of maladministration".

**Question 10-7: Should the Professional Standards Authority's power to refer cases to the High Court in England and Wales, the Court of Session in Scotland and the High Court in Northern Ireland: (1) be retained and exercised alongside a regulator's right of appeal, in cases when the regulator's adjudication procedure is considered to be sufficiently independent; or (2) be removed when a regulator's right of appeal is granted in such circumstances; or (3) be retained and rights of appeal should not be granted to regulators, although regulators should have a power to formally request the Professional Standards Authority to exercise its power?**

10.54 This question divided opinion at consultation. However, most consultees favoured options one and three.<sup>7</sup>

***Option one***

10.55 This option was supported by the General Medical Council which stated that:

The two rights of appeal need not be seen as mutually exclusive. For the Professional Standards Authority it provides an important tool for practical oversight of the operation of the regulators and for helping to ensure appropriate outcomes. For the General Medical Council it is both a consequence of and reinforces the separation of the investigation and adjudication functions and the independence of the Medical Practitioners Tribunal Service ... [and] provides a solution in cases where fitness to practise panels make decisions which do not stand up.

10.56 The Nursing and Midwifery Council also argued:

While mindful of the potential for duplication, we would support the right of regulators to appeal the decisions made by their adjudication panels, in the same circumstances as appeals made by the Professional Standards Authority under section 29, in order to reflect and underline the separation of function.

10.57 The Professional Standards Authority agreed that it should retain the right of appeal in addition to that exercised by the General Medical Council, but expressed the following concerns:

- (1) two levels of appeal will be more complicated and increase costs;
- (2) General Medical Council appeals may not be independent or enhance public confidence;
- (3) there will be different appeal processes for different regulators which may be confusing the public and registrants;

<sup>7</sup> Of the 192 submissions which were received, 41 expressed a view on this question: 15 supported option 1, 4 supported option 2, 18 supported option 3, whilst 4 held equivocal positions.



- (4) any change should be part of a longer term strategy to create a coherent and cost effective appeal process;
- (5) there are legal and technical problems which need to be resolved if any new process is to work; and
- (6) the proposal is not consistent with Government policy to simplify regulation and reduce its cost.

10.58 The Department of Health was attracted by a model “whereby the Professional Standards Authority’s right to appeal should be retained and exercised alongside a regulator’s right of appeal”, but the Authority’s power should only be exercised if the regulator has decided not to appeal. However, if the regulator does bring an appeal, the Authority should still be able to intervene. The Department stated that it is still exploring this issue and has not yet reached a final view, but that it may legislate before the introduction of any legislation resulting from our review.

10.59 The Scottish Government favoured option one since this would “reinforce the regulator’s central role in establishing and ensuring standards and the Authority’s role in overseeing the actions and decisions of regulators”. It said that:

As is currently the case, this power should only be used when the imposition of a relevant sanction is considered to have been unduly lenient or, in relation to a decision not to impose sanctions or to restore a person to the register, when the decision should not have been made. It must also be desirable for the protection of members of the public

### ***Option two***

10.60 The Association of Regulatory and Disciplinary lawyers favoured this option on the basis that “it is unnecessary to provide for two routes to challenge a decision” and “it is best if challenges are made within the statutory framework”. Charles Russell LLP argued that this option “will remove the expense and uncertainty of both regulators attempting to refer the same decision”.

### ***Option three***

10.61 The Health and Care Professions Council supported this option and argued that:

The Professional Standards Authority as an independent oversight body is in a better position to assess which cases should be referred to the Court, not the regulator given that they are a party to the proceedings.

10.62 An individual consultee (Jane C Hern) agreed that the right to appeal should be conferred on the Professional Standards Authority to ensure independence. She noted that:

The difficulty for any regulator in exercising such a power is that the decision, although made by an independent committee, or even the new General Medical Council tribunal, is still made under the aegis of the regulator, who inevitably has a vested interest in the outcome. It is inevitably still the regulator that still has to deal with any adverse [publicity], whether dissatisfaction is expressed by the public or the profession or both.

10.63 The Patients Association argued that “the protection of patients and service users overrides the concerns about double jeopardy in these circumstances” and that option three would “provide an independent and impartial forum for appeals from all parties concerned, including patients and service users”. The British Association for Counselling and Psychotherapy also thought that option three would have a positive impact, by lessening “the danger that the public will suspect professional protectionism”.

10.64 The General Osteopathic Council felt that if the preferred approach is to be option three, then the Professional Standards Authority should be required to justify “why it chose not to exercise its right of appeal following a request from a regulator”.

***Other comments***

10.65 The Medical Defence Union felt that the “the right of review/appeal should be exercised by only one body” (but expressed no preference between options two and three) since it would be:

unfair to expose registrants to further jeopardy in circumstances where both parties would in effect be seeking the court’s view on the same matter and on the same facts.

There is of course the further cost point because whichever body brings the appeal, it will be ultimately be funded principally by registrants through registration fees. The appeals process must be reasonable and proportionate to the perceived risk to the public.

10.66 The Society of Chiropractors and Podiatrists felt that the “greater concern” is that the Professional Standards Authority can only refer cases to the High Court where it feels a regulator has been too lenient. The Society suggested that, “in the interests of fairness”, the Authority should also be able “to refer cases where they feel a regulator has been too severe”. A similar point was made by the British Osteopathic Association.

10.67 The General Dental Council commented that “if a different model of independent adjudication from that currently used by the regulators were to be introduced, then the necessity for the power should be revisited”. The General Optical Council also said that the answer to the question would “depend on the approach taken to the separation of investigation and adjudication”.

10.68 The Medical Protection Society proposed an alternative solution, which would provide for “the regulator to be granted the right to formally request a review by the Professional Standards Authority which will then proceed under the procedures and precedents” applicable to its section 29 power.

# PART 11

## BUSINESS REGULATION

**Question 11-1: To what extent does regulation in a commercial context make a difference to how the regulators approach the task of professional regulation and does the law provide adequately for professional regulation in a commercial context?**

11.1 A majority felt that regulation in a commercial context makes no difference to the task of professional regulation,<sup>1</sup> and opinion was divided over whether the law provides adequately for professional regulation in a commercial context.<sup>2</sup>

11.2 The General Medical Council argued that:

Regulation within the independent (as distinct from NHS) sector does not, and should not, require a fundamentally different approach or the application of different standards. A regulator will, inevitably, need to adjust the way it implements standards to reflect the different context in which independent healthcare is practised. For example there are areas of practice that may be much more closely regulated than others or where the registrant may work on their own as opposed to being surrounded by colleagues. This argues for legislation which is focused on high level principles, duties and powers and allows the regulator to adapt its methodology according to the context.

11.3 The Health and Care Professions Council agreed that its task was not significantly different in a commercial context. It thought that:

All regulators in performing their roles need to be alert to the contexts in which practitioners work. This might affect, for example, any requirements the regulators set for continuing professional development or revalidation.

11.4 The Association of Clinical Biochemistry said that the “commercial context of the regulator is irrelevant”.

11.5 The General Dental Council, together with several others, drew a distinction between the regulation of individuals in a commercial context, and the regulation of businesses. It said:

<sup>1</sup> Of the 192 submissions which were received, 23 expressed a view on this question: 15 said that regulation in a commercial context makes no difference, 8 said that the commercial context does make a difference.

<sup>2</sup> Of the 192 submissions which were received, 16 expressed a view on this question: 7 said that the law was adequate, 5 said the legal framework needs to be updated, whilst 4 said that the current system over-regulates in the commercial context

The General Dental Council believes that the regulation of professionals is not dependent on the business model in which they work. However, the General Dental Council would wish to take the opportunity of the new legal framework to explore the potential for regulating dental entities (the teams within practices/businesses, irrespective of the business model) as an adjunct or alternative to regulation of individuals, in the interests of greater public protection.

- 11.6 The General Pharmaceutical Council argued that it is not a business regulator but instead regulates the services provided by registered pharmacies many of whom operate in a commercial setting. Therefore, while financial pressures are a “relevant factor”, the key factor was “the provision of patient care”.

- 11.7 The Patients Association expressed similar views. It said:

Pharmacists working for Sainsbury’s or a private dentist working for the Harley Street Group should still be under the same rules, duties and oversight as those working in the public sector. We grant that certain procedures and apparatus may need to be different in order to work effectively in a commercial setting but materially, regulation should remain the same.

- 11.8 However, NHS Education for Scotland considered that the “commercial context makes for a more complex regulatory environment”. The Royal Pharmaceutical Society of Great Britain said:

We believe that regulation within a commercial setting does make a difference. The individual professional is often not in a position of genuine authority or influence and, therefore, is unable to affect decisions made in relation to systems and processes established within the commercial setting. In pharmacy this is particularly apparent with the recent establishment of the responsible pharmacist role, whereby the responsible pharmacist is taking responsibility for an environment they may not be in a position of influence to change.

- 11.9 The Society of Chiropractors and Podiatrists argued that regulatory decisions need to have a much closer regard to proportionality in a commercial context. It said that:

Podiatrists and other health professionals in private practice provide a valuable service to the public and must not be placed in a situation where their businesses are not viable.

- 11.10 The General Osteopathic Council pointed out that its registrants work predominantly in private practice and there has been “intense scrutiny” of advertising and promotion issues, and the sales of various items to patients.

This is a good example of an area where the duty of regulators should go beyond “safe and effective practice” and hence a broader duty to “maintain confidence” is required.

- 11.11 The General Optical Council acknowledged that “the commercial context of service provision may make some difference to the work of professionals and the

task of regulators”. In terms of the effectiveness of the current legal framework, the Council said:

Where businesses are registered with the General Optical Council, we can and do take action where it is identified that a business has breached our standards. At the extremes, however, the effectiveness of General Optical Council sanctions can be limited in an environment where businesses could restructure to avoid registration requirements, and continue operating.

11.12 The Scottish Government stated:

The statute should include additional provisions to take account of commercial issues that arise and pertain specifically to the exercise of private healthcare practice, for example financial management and probity, marketing and advertising, and anti-competitive behaviour. This would take account of the fees that are charged to patients in a private capacity (eg dentistry, medicine and chiropractic medicine) and those that arise in the commercial setting (eg optometry/opticians).

11.13 The Department of Health, Social Services and Public Safety for Northern Ireland argued that:

Regulators need to take into account effects on business and delivery of professional services. There needs to be some test of reasonableness both on the regulator and the recipient, the latter who would probably desire minimum regulation.

11.14 The Professional Standards Authority raised specific concerns about whistle-blowing in commercial contexts, commenting that:

In some instances there may be pressure to contain cases of poor conduct or performance “in-house” rather than to expose their organisation to public scrutiny and reputational damage as a result of a referral to a regulator.

11.15 Several consultees pointed out that other bodies (including the Care Quality Commission and Monitor) also have regulatory functions in respect of commercial providers of health care, and argued that the functions and roles of all regulators should not overlap. For example, the UK-wide Nursing and Midwifery Council Lead Midwives for Education group pointed out that the Nursing and Midwifery Council has powers to inspect a midwife’s equipment and any premises to ensure that safe and effective care can be provided. The British Dental Association was concerned that dentists “suffer from over-regulation” by bodies such as the General Dental Council, the NHS and the Care Quality Commission.

**Provisional Proposal 11-2: The statute should retain the existing premises regulation regimes of both the General Pharmaceutical Council and the Pharmaceutical Society of Northern Ireland.**

11.16 The vast majority agreed that the statute should retain the existing premises regulation regimes of both the General Pharmaceutical Council and the Pharmaceutical Society of Northern Ireland.<sup>3</sup>

11.17 The General Pharmaceutical Council stated:

We do see the current legislative framework and powers in relation to registered pharmacies as helpful in supporting patient protection and in enabling us to focus on compliance with standards at an organisational level, rather than purely issues of individuals' fitness to practise.

11.18 The Pharmaceutical Society of Northern Ireland felt that in respect of its own legal framework, "the accountability for pharmacists is well defined, clear and firmly established".

11.19 The Professional Leads for Allied Health Professions, Medics, Pharmacy and Psychological Therapies for South Staffordshire and Shropshire NHS Foundation Trust supported the retention of existing premises regulation as "retail issues can decrease public confidence in professions".

11.20 The British Pharmaceutical Students' Association supported the proposal, and suggested that any changes should be consulted upon.

11.21 The Department of Health agreed that the existing premises regulation regimes should be retained in the statute. It also noted "the review of penalties and sanctions flowing from the medicines legislation". However, the Department of Health, Social Services and Public Safety for Northern Ireland suggested that there needs to be reform.

**Question 11-3: Are any further reforms needed to the premises regulation regimes of the General Pharmaceutical Council and the Pharmaceutical Society of Northern Ireland?**

11.22 A small majority felt that further reform of the premises regulation regimes was needed.<sup>4</sup>

11.23 The Professional Standards Authority pointed to the need to:

ensure that business owners, who may by virtue of their position be able to exercise managerial control over registered professionals, are fit people to do so. The position of a pharmacy owner might also bring them into contact with vulnerable people, personal health information,

<sup>3</sup> Of the 192 submissions which were received, 15 expressed a view on this proposal: 14 agreed, whilst 1 held an equivocal position.

<sup>4</sup> Of the 192 submissions which were received, 15 expressed a view on this question: 6 said that no further reforms were needed, 8 said that further reforms were needed, whilst 1 held an equivocal position.

and prescription only medicines. Although we are aware of the standards that apply, we wonder whether there might also be benefit in some sort of “good character” test for people in this position.

- 11.24 The Authority also argued that sanctions or fines should be disclosed by a business to its shareholders. In addition, it restated its view that “a single UK pharmacy regulator would be desirable”.
- 11.25 The Scottish Government supported the proposal to retain the legal framework of the General Pharmaceutical Council. It also suggested the following reforms:
- (1) the regulators should be required to disclose any sanction, condition or financial penalty/notice issued against the business to the shareholders;
  - (2) the regulator should ensure that any sanctions, conditions or notices applied are complied with and that an enforcement process is in place in the event of non-compliance;
  - (3) the establishment of a business fitness to practise regime (along the lines of the General Optical Council model) which would allow the regulators to investigate allegations against those who are responsible for businesses that have failed to meet established standards and failed to comply with improvement notices; and
  - (4) more explicit requirements surrounding the supply of unlicensed herbal medicines.
- 11.26 An individual consultee (Peter Hopley) argued that the General Pharmaceutical Council’s remit should be extended to patients receiving medicines from a dispensing doctor, which currently comes under the NHS primary care organisations through their Dispensing Services Quality Scheme. The Royal Pharmaceutical Society of Great Britain also described this situation as an “anomaly” since different regulatory standards apply, and suggested it should be addressed as part of our consultation.
- 11.27 The British Pharmaceutical Students’ Association suggested that there was a “need for more focus on the provision of education and training” in registered pharmacies.
- 11.28 The Pharmaceutical Society of Northern Ireland felt that under its regime “the accountability for a body corporate is less well defined” and there should be “greater accountability to the board and directors of companies”.
- 11.29 The Professional Forum of the Pharmaceutical Society of Northern Ireland argued for an extension of the regulators’ powers “to ensure that pharmacists are not held solely liable for business failures which may have occurred due to the actions or directions of others”.
- 11.30 The Department of Health, Social Services and Public Safety for Northern Ireland suggested there needs to be a “differentiation of medicines regulation from professional regulation”. It also called for provisions “to enable non-pharmacist owners of pharmacy premises to be held to account”.

11.31 However, the General Pharmaceutical Council said:

It is too early in our establishment and our regulatory policy development for regulation of registered pharmacies to state definitely whether the law is adequate. However, we have not yet encountered any limitations in the legislation which we would need to review urgently, although the need to have our standards translated into Rules with Privy Council [approval] has a significant impact on the timeframe for bringing in the full range of powers provided to us.

11.32 A number of consultees did not think that any further reforms should be considered until the conclusion of the Council's consultation on draft standards for registered pharmacies.

**Question 11-4: Should the statute retain the existing systems for the regulation of bodies corporate?**

11.33 The vast majority agreed that the existing systems should be retained.<sup>5</sup> For example, the Medical Defence Union said that "its experience with the General Dental Council suggests this can work". The British Society of Hearing Aid Audiologists thought the current systems should be retained as "corporate regulation is established and necessary". The Department of Health agreed that the regulation of bodies corporate provisions should be retained.

11.34 The Medical Protection Society was also in favour of retaining the existing systems. It said:

In our view, the principles behind the existing systems for the regulation of bodies corporate are sound as they permit the public to raise concerns not only about an individual's fitness to practise, but also to raise concerns about the conduct of bodies corporate, for example in the way they deal with complaints or concerns about individual registrants.

11.35 The Scottish Government agreed that the provisions must be retained, but also stated that:

the new statute should go further in extending the requirement to register businesses to all individual high street outlets and thereby address the confusion that currently exists for both registrants and members of the public. The statute could also make provision for a more proactive system to monitor compliance with business standards. This would provide a more even-handed, consistent and transparent approach and serve to increase public faith and confidence. A model that encompasses the existing systems of the General Optical Council and the General Dental Council and the issues raised above would seem to be a reasonable starting point.

<sup>5</sup> Of the 192 submissions which were received, 20 expressed a view on this question: 18 said that the statute should retain the existing systems, 1 disagreed, whilst 1 held an equivocal position



- 11.36 The General Optical Council supported retaining its system but was interested to explore a new model of regulation:

that is based on the regulation of all providers of the services protected under the legislation, regardless of their business structure (with the possible exception of sole traders who are already individual professional registrants, to avoid unnecessary dual registrations).

- 11.37 It noted that significant parts of the business sector are not subject to its system of regulation, and suggested that “all commercial providers of primary ophthalmic services are subject to the same regulatory framework”. The Council also argued that it lacked powers available to other systems regulators, and the financial penalties available “are modest relative to the turnover of a large corporation”.

- 11.38 An individual consultee (Dr Susan Blakeney) suggested there is an anomaly that “a body corporate which uses a protected title must be registered” with the General Optical Council “but a partnership which uses such a title cannot be”. She further argued that the Council be given powers to decide “whether it is the *activity* that the business conducts that should be registered” and not the title.<sup>6</sup>

- 11.39 The Pharmaceutical Society of Northern Ireland said that the statute should “go further in defining corporate governance and accountability of bodies corporate”.

- 11.40 The Professional Standards Authority argued that “a fitness to practise regime does not sit well with a registration scheme for bodies corporate”. It thought that:

A more easily understood and appropriate concept in this context might be “fitness for business”. A broader application of the concept might be useful, anticipating the potential in future for a wider range of health services to be provided from single premises in a multidisciplinary setting, possibly with an owner who is not a registered professional in any of the areas of service being offered. From the perspective of the public, they would need to know that they were being treated by the relevant professional and not a professional in another discipline or a non-clinical professional.

- 11.41 The General Dental Council felt that some of its current provisions required further clarification (such as the letter of non-objection) and called for a review “of the purpose and effectiveness of the responsibility regarding names”. Some names are currently covered by the Dentists Act 1984 and others by the Companies Act 2006, which the Council felt was a “source of confusion”. It also stated that it wanted to “explore the potential for regulating dental entities (the teams within practices/businesses), irrespective of the business model”.

- 11.42 The British Dental Association felt that the General Dental Council should be able to regulate large businesses such as bodies corporate owning chains of practices. It noted that:

Currently, the General Dental Council can hold to account the dental directors of these chains, and we consider it essential that the

<sup>6</sup> Emphasis in the original.

majority of directors of a dental company should be dentists (or dental care professionals). The General Dental Council has not exercised its power very extensively, however, in spite of there being concerns about the influence of bodies corporate on the practice of professionals working for them, and it should take a broader view of its role in this regard. The previous requirement on the General Dental Council to list dental bodies corporate should be reinstated but as a requirement for registration.

**Question 11-5: Should the regulators have powers to finance or establish a complaints service?**

- 11.43 Opinion was divided amongst consultees on this question, although most disagreed that the regulators should have such powers.<sup>7</sup> For example, the Health and Care Professions Council argued that “the role of professional regulation is to protect the public, not to provide general resolution to consumer complaints”. The Medical Defence Union had “misgivings about the potential for cross-contamination between the General Dental Council’s complaints procedures and its fitness to practise functions”.
- 11.44 The Professional Forum of the Pharmaceutical Society of Northern Ireland argued that “every business should be required to have a complaints procedure and that this should be separate from any regulatory process”.
- 11.45 The Royal Pharmaceutical Society of Great Britain stated that:
- Dealing with consumer complaints would cloud professional regulation and have the potential for the regulator to become embroiled in financial redress rather than upholding public safety.
- 11.46 The Department of Health did not consider that the regulators should have a consumer complaints function since “this could detract from their core purpose”. The Northern Ireland Practice and Education Council for Nursing and Midwifery agreed that any involvement in a complaints service “would sit outside the core role of the regulator”. For this reason, an individual consultee (Anonymous) suggested that if regulators are to finance or establish services, “it should only be where there is not one already”.
- 11.47 However, several consultees felt the regulators should have such powers. An individual consultee (James Kellock) pointed out that consumer complaints and professional conduct can be “inextricably intertwined, for example a complaint that an optician supplied defective glasses might involve both”. Similarly, the General Osteopathic Council stated it had no desire to fund or establish a separate consumer complaints service, but recognised “it is not always clear where the boundary is between a complaint and a fitness to practise matter”.
- 11.48 The Professional Standards Authority argued that for regulators of registrants that “work outside a well-developed governance framework”, such as those who work

<sup>7</sup> Of the 192 submissions which were received, 37 expressed a view on this question: 15 said the regulators should have powers, 18 disagreed, whilst 4 held equivocal positions.

alone in single-handed practice, “a funded but organisationally separate complaints service could provide a useful mechanism”.

- 11.49 The Scottish Government also felt that the regulators should be able to fund a service that is run by another, independent organisation. It also stated that:

One option would be for all the regulators to contribute to the funding of one consumer health complaints service. This could provide economies of scale, reduce human and administrative costs and provide an opportunity for shared learning and the sharing of good practice based on customer feedback and complaints received. However, caution would need to be exercised to avoid the potential for duplication of existing forms of redress (eg the NHS complaints system).

- 11.50 Rescare agreed with the proposed powers in respect of complaints services as long as “such a service is independent of the regulators”.

- 11.51 The General Optical Council stated:

We believe that there is value for the regulator, registrants and for the public in having a mediation service in place where the sector is highly commercialised. For the regulator, it provides a clear avenue for directing complaints regarding poor products or services but not regarding fitness to practise. This helps minimise the number of minor complaints that regulators deal with and provides a way of helping satisfy complainants that their concern can be dealt with quickly and effectively. The work of the Optical Consumer Complaints Service can also be a useful contributor to our own work in setting standards and producing guidance for registrants on good practice.

- 11.52 It was also suggested that “regulators may in future want to share resources on such a service, and the statute should allow for that possibility”.

- 11.53 The Optical Consumer Complaints Service argued that:

There are adequate provisions in consumer law for contracting parties seeking a solution in a dispute, but mediation is an easier option than to resort to formal action. An independent service that can investigate a dispute and discuss a solution with the parties is an expedient means of dealing with consumer complaints. It is of particular value if the service, although independent, is close enough to the regulatory body to be aware of the standards expected of the professional's practice and be in a position to alert the regulatory body of any issue coming within its remit.

- 11.54 The General Dental Council supported the retention of its power to fund and manage the Dental Complaints Service since “not only does it resolve complaints but learning is fed back into the Council's other functions such as fitness to practise processes and setting standards”. It was suggested that such a service is necessary because in respect of private patients the Council is reliant on patient complaints “since it does not have a general power of inspection of dental premises”.

- 11.55 The Department of Health, Social Services and Public Safety for Northern Ireland queried if this work should be “resourced through the normal fee mechanism”.

**Provisional Proposal 11-6: The Government should be given a regulation-making power to extend to any regulator the powers given to the General Pharmaceutical Council or the General Optical Council to regulate businesses.**

- 11.56 A majority agreed with this proposal.<sup>8</sup> For example, the General Optical Council agreed that the statute should make provision for the extension of the power. It said that “given the potential impact of changes to regulatory approaches in this area, we agree that it should be for the Government to extend these powers to regulators”.

- 11.57 The Guild of Healthcare Pharmacists stated that:

All regulators should ... have the powers to set enforceable standards for owners and those undertaking or managing the healthcare environment that can provide support to registrants to maintain safe and effective practice. The public inquiry conducted by Mr Robert Francis QC into Mid Staffordshire NHS Foundation Trust is likely to raise issues in this area and professional regulation and the support of professionals working within an institution where patient care was routinely neglected by a Trust that was preoccupied with cost cutting, targets and processes and one which lost sight of its fundamental responsibility to provide safe care. Shortages of staff and a culture of bullying those professionals who raised concerns were key factors in creating that unsafe healthcare environment.

- 11.58 The General Dental Council also supported the proposal on the basis that:

Regulation of the individual registrant was appropriate for the model of sole practitioners or small partnerships but in today’s more complex environment patient safety would be better served by a more wide-ranging approach. Whilst existing arrangements include memoranda of understanding with premises regulators, we would like the opportunity to explore alternative models.

- 11.59 The Care Quality Commission agreed with the proposal since:

This would mean that the issue could be considered on the basis of the risk and then the most appropriate regulatory body would regulate. For example, this could be appropriate for a GP whose legal entity is required to be registered with the Care Quality Commission and who is also required as an individual to be registered with the General Medical Council.

<sup>8</sup> Of the 192 submissions which were received, 25 expressed a view on this proposal: 15 agreed, 4 disagreed, whilst 6 held equivocal positions.

- 11.60 The Osteopathic Alliance considered that any extension of the power to regulate businesses should be limited to circumstances “where it can be shown to be necessary for public protection”.
- 11.61 The General Osteopathic Council supported the proposal on the basis that in the future the regulation of osteopathic practices might be a more proportionate approach than regulation by the Care Quality Commission.
- 11.62 Pharmacy Voice expressed concern about individual GPs or practices that “adversely influence patient behaviour, for example by directly or indirectly suggesting patients take their prescriptions to a particular pharmacy”. It was argued that “inspection of premises by the General Medical Council, along with sanctions for inappropriate behaviour” may help to minimise conflicts of interests and protect patients.
- 11.63 The Allied Health Professions Federation argued that at an individual registrant level, key documents (such as codes of conduct and ethics and standards of proficiency) “should be inclusive of ethical business practice as an integral part of registrants’ scope of professional activity”. It also said that all regulators’ fitness to practise systems “should address alleged malpractice relating to registrants’ business activity”. In effect, it is not necessary “to introduce a different type of activity focused specifically on business regulation (nor to invest in separate regulators’ consumer complaints service)”.
- 11.64 Skills for Care thought there would be “risks if the Health and Care Professions Council was given powers to regulate social care businesses”. It said:
- it is hard to envisage how the regulatory power could be applied as the majority of social workers are not employed in “social work businesses” other than in a small number of cases as sole trader independent social workers, and it is likely to cause confusion amongst employers of social workers.
- 11.65 The Department of Health noted that there are similar “extant powers” in respect of Dental Corporations which are regulated by the General Dental Council. However, it stated that “the Government has no immediate plans to extend business regulations” and would have concerns about “the potential to cause confusion and overlap with the role of systems regulators”.
- 11.66 The Scottish Government did not support the proposal. It said:
- We have concerns that any alteration to the current powers would create confusion regarding the boundary between professional and systems regulators. In addition, the scope of systems regulators varies between countries, and bodies such as the Care Quality Commission do not operate in Scotland with the converse being true for Healthcare Improvement Scotland. However, we consider that there may be a place in the new statute for the development of joint working protocols/memoranda of understanding between the regulators and the various systems regulators in England, Wales, Scotland and Northern Ireland.

## PART 12

# OVERLAP ISSUES

### **Question 12-1: How could the legal framework establish clearer interfaces between the various regulatory systems?**

- 12.1 A number of views were expressed on how the legal framework might encourage clearer interfaces between the regulatory systems.<sup>1</sup>
- 12.2 Many pointed to the need for greater co-operation. For example, the General Medical Council said “there is growing recognition among regulators of the importance of better co-operation and joint working” and recognised that “more work is required for the various systems to interface effectively”. The Medical Defence Union agreed “that working between the different health care regulatory systems and other procedures such as the Ombudsmen is to be encouraged”.
- 12.3 Many consultees made general statements that relationships between professional and systems regulators were particularly complex and would benefit from clarification. The Parliamentary and Health Service Ombudsman “was particularly interested in securing collaborative working”. It said:

It is only by having a coherent and complete picture that decisions – whether about a particular health body, a particular service or, indeed, an individual health professional – can deliver a coordinated and effective response ... we view this consultation as an opportunity for introducing significant measures to strengthen the existing framework around joint working and information sharing.

- 12.4 Some gave examples of practical measures that could assist, such as public awareness campaigns and an improved central website. The British Pharmaceutical Students’ Association said:

Whilst the Professional Standards Authority has a central website whereby visitors can learn about the individual regulators it would require the public to know what the Professional Standards Authority is. A central website containing information on the individual regulators and which ones the public should contact regarding their concerns may be more acceptable to the public. This could well be integrated into another commonly used healthcare website.

- 12.5 Optometry Scotland said “a significant effort” would be required to “educate the public on the role and responsibilities of the various professions, especially when there are close working relations such as in primary care”.

<sup>1</sup> Of the 192 submissions which were received, 25 expressed a view on this question: 5 said that managing interfaces was a matter of good practice between the regulators, 10 said that the statute could define the interfaces such as through duties to co-operate, 11 said that interfaces would be clearer with a simpler system that did not have duplication.

- 12.6 The General Social Care Council felt that a practical solution would be for the Government to “provide guidance and a policy steer on how it envisages that each part of the regulatory framework should fit together”.
- 12.7 Several consultees, such as the British Dental Association and the British Association for Counselling and Psychotherapy, thought that the “removal of duplication” was a priority. The Department of Health and the Scottish Government agreed, and also identified poor information sharing as a problem in the current system, and argued for a “duty of cooperation”. The Scottish Government considered:
- that there could be a place in the new statute for clearly defining those matters which legitimately lie with the professional and systems regulators to address, and their respective roles and responsibilities.
- 12.8 It also called for a single body to deal with “allegations/complaints against all the regulators”. It felt that:
- This would enable any patterns of poor performance to be identified, including any team/systemic failures rather than focusing attention on individuals and their performance, and could enable organisational solutions to be identified. This could also provide efficiencies in terms of human and administrative costs, duplication of time, effort and resource (including providing repeated copies of documents/records and statements from staff) and would assure patients that, where necessary and required, appropriate steps (involving multiple agencies where relevant) are being taken to address concerns.
- 12.9 However, the Medical Defence Union was concerned that the rights of registrants should be protected in any moves towards closer cooperation, “especially when information is being exchanged between different regulatory systems”. It raised a specific concern “about the passing on of ‘soft information’ about registrants”, stating that “any sharing of information must take into account the rights of registrants and this must be clear in the legislation”.
- 12.10 The Professional Standards Authority suggested three ways in which the legal framework could establish clearer interfaces between regulatory systems:
- (1) by requiring regulators to take “reasonably practicable steps” to identify agencies with similar or overlapping remits;
  - (2) by requiring regulators to consult on the scope of their activities and to agree the means by which they will conduct operational activity where an interface exists, for example by the use of a memorandum of understanding; and
  - (3) by being clear on the roles and responsibilities of the regulators, and avoiding the possibility of extending functions into non-core areas.
- 12.11 The Patients Association also said that it would “like to see a clearer definition of where the regulators’ powers sit within the current and emerging healthcare landscape”.

- 12.12 The Nursing and Midwifery Council argued that the statute should require the regulators to “proactively share information” and “work together in a coordinated and targeted manner” where public safety is at risk. An individual consultee (Anonymous) felt that the “statute should make it clear that regulators must pass on information where public safety may be at risk even when the information does not fall under that regulator’s remit”. An individual consultee (Don Brand) considered that “effective links and joint working arrangements” were “particularly important in social work”.
- 12.13 The Department of Health, Social Services and Public Safety for Northern Ireland supported “the need for joint working to enable efficient and effective working practices”. It also felt that there needs to be a rigorous review of the costs of regulation and queried if it would be more efficient at a more corporate level.
- 12.14 However, the Medical Protection Society felt that clarity was unlikely due to regulators’ resistance and the risk of “protracted legal arguments regarding the jurisdiction”. It suggested that statutory guidance may be useful on the extent of a regulator’s responsibility.
- 12.15 Several argued that changes to the law would not provide a solution. The General Medical Council disagreed that “the issue here is fundamentally a problem of legal boundaries and jurisdiction”, but felt there was “a case for creating a clear and shared purpose for professional regulation in the new legislative framework”. The General Osteopathic Council agreed that it was:
- not obvious that the legal framework is the best way to improve cooperation and interface between regulatory systems; many of the problems appear to derive from professional, organisational and individual, cultures and behaviours.
- 12.16 The Health and Care Professions Council thought that this issue was “largely a matter of policy and practice for the regulators rather than a matter for statute”, and had “no suggestions to make for improvements to the proposals in this area”.
- 12.17 The General Optical Council considered “that the duties to cooperate and act transparently set out in the proposals in the consultation would be sufficient”.
- 12.18 NHS Greater Clyde and Glasgow suggested that “memoranda of understanding between various bodies may be the best way forward”.
- 12.19 The British Medical Association said that it was not sure that the interfaces required clarification.



**Question 12-2: What practical difficulties arise as a result of parallel criminal and fitness to practise proceedings?**

12.20 Various views were expressed about the practical difficulties that arise as a result of parallel criminal and fitness to practise proceedings.<sup>2</sup>

12.21 Delay was the most widely reported problem. Several consultees referred to delay in the context of not being able to obtain information. The General Medical Council said that it “sometimes experiences difficulties getting access to evidence as a result of the primacy of criminal proceedings and this can lead to delay in progressing our case”.

12.22 The Nursing and Midwifery Council made this point more strongly. It said that:

The agencies responsible for the criminal proceedings are very reluctant to share the information needed by us for our fitness to practise proceedings, which can mean that cases are delayed and that interim orders are not sought as early as they should be, through want of information.

12.23 Some pointed to the effect of delays caused by the primacy of criminal proceedings. For example, the General Optical Council commented that “the impact of this on registrants can be significant given the length of time of criminal cases”. Coventry and Warwickshire Partnership Trust feared that lengthy suspensions pending criminal proceedings do “not support a presumption of innocent until proven guilty”.

12.24 Several regulators reported widespread use of interim orders to manage such cases. The General Osteopathic Council stated that:

It is also likely that an interim suspension order will have been imposed on the registrant, which helps to protect the public but does – especially where the registrant is self employed – result in a loss of livelihood for the duration of the suspension order and there could in theory (though it does not happen often) be no conviction at the end of the process.

12.25 The Nursing and Midwifery Council also reported:

very long delays in being able to reach a substantive outcome in these cases which can lead to problems in proving current impairment at the fitness to practise hearing, and in maintaining or extending interim orders.

12.26 An individual consultee (Jacqueline A Wier) also commented on a:

<sup>2</sup> Of the 192 submissions which were received, 29 expressed a view on this question: 17 said that delay was a problem, 5 said that sharing information was a problem, 4 said that different evidential regimes was a problem, whilst 3 said that different outcomes were a problem.

propensity that information will not be shared and that communication will not be effective which could jeopardise outcomes to both criminal and fitness to practise proceedings.

- 12.27 Some consultees commented on the different evidential regimes between the two systems. The Health and Care Professions Council stated that:

As more restrictive rules of evidence will apply in criminal proceedings, there is a risk that evidence which has not been admitted at that trial may enter the public domain by being admitted in the course of the regulatory proceedings.

- 12.28 The Department of Health recognised that parallel criminal and fitness to practise proceedings often lead to delay, duplication, and “witness overload and confusion”. The Association of Regulatory and Disciplinary Lawyers also commented on the increased demands on witnesses required to participate in two sets of proceedings.

- 12.29 The General Dental Council and General Pharmaceutical Council both cited the financial implications of the regulators duplicating criminal investigations. However, the Professional Standards Authority suggested that waiting for the outcome of the criminal proceedings could actually have a cost benefit for regulators since they could “rely upon a conviction, rather than trying to re-prosecute any underlying misconduct”.

- 12.30 The General Pharmaceutical Council set out its approach to criminal cases:

At an operational level we have already moved away from an assumption that all fitness to practise cases should wait until relevant court cases have concluded, to considering on a case by case basis whether proceedings could be taken forward in an appropriate manner without undue risk to other proceedings.

- 12.31 Unite endorsed this approach, and said that “regulators should retain their own integrity and act as necessary in the circumstances”.

- 12.32 The Nursing and Midwifery Council and the UK-wide Nursing and Midwifery Council Local Midwives for Education Group both cited the possibility of different outcomes as a practical difficulty resulting from parallel criminal and fitness to practise proceedings. The Royal College of Obstetricians and Gynaecologists noted that “fitness to practise issues could easily follow criminal acquittal”.

- 12.33 The Professional Standards Authority said that “criminal investigations may take a long time to complete, be discontinued, or may only focus on some of the issues with which the regulator is concerned”. However, it felt that “these risks do not outweigh the importance of criminal investigations and prosecutions being allowed to proceed without interruption”. The Scottish Government also acknowledged that delay was appropriate in certain circumstances, as criminal convictions are subsequently often relevant to the fitness to practise proceedings.

**Question 12-3: What are the practical and legal difficulties associated with joint working?**

12.34 A number of consultees identified practical and legal difficulties associated with joint working.<sup>3</sup> For example, the Scottish Government identified the following potential issues:

Difficulties would include data protection issues and the sharing of panellists who may have been trained differently, different education and training standards, and different levels of remuneration that may have been paid to panellists. There may also be difficulties in ensuring that there are no potential conflicts of interest.

12.35 The General Osteopathic Council said that:

A major disincentive appears to be that that the marginal gains in cost savings often appear to be outweighed by the upheaval involved in securing those gains. Another significant reason why we think that it has been difficult to secure effective joint working is around governance and the focus in legislation on the role of the Council and its duties.

12.36 The General Dental Council also stated that:

The duties of the systems regulators are different to those of the professional regulators and even within professional regulation there are sufficient differences which could militate against joint working eg different approaches to quality assurance of education.

12.37 Some consultees said that poor communication was a problem, and the General Social Care Council stressed the:

importance of developing personal relationships between key personnel, understanding the different cultures which exist between different organisations and ensuring that there is a clear mechanism for resolving disputes.

12.38 The Care Quality Commission noted that the lack of a “common information sharing portal” was a barrier to joint working.

12.39 The Association of Clinical Biochemistry referred to “individual regulators’ suspicions of their own independence being compromised”. Optometry Scotland also felt that “defensive professional posturing has proven to be a barrier in the past when trying to establish joint ventures between various professions, even for those closely aligned”.

12.40 A number of consultees commented that difficulties arise from a lack of clarity about the division of legal functions and responsibilities in joint working

<sup>3</sup> Of the 192 submissions which were received, 12 identified practical issues such as the different working practices of each regulator and poor communication. 12 identified legal difficulties such as data sharing and uncertainty about legal responsibility.

arrangements. The Health and Care Professions Council felt that “each regulator would need to ensure that any joint working was appropriate and did not jeopardise their independence or the delivery of their regulatory functions”.

- 12.41 The Professional Standards Authority pointed to practical barriers to joint working:

There can be operational difficulties in terms of aligning work timetables, aligning different processes and in the training and working practices of staff. There can also be contractual issues relating to fitness to practise panellists, and sharing costs, responsibilities and liabilities.

- 12.42 Similarly, the British Association for Counselling and Psychotherapy noted that “practical difficulties could involve redundancies and other employment issues”.

- 12.43 However, several consultees felt that the difficulties were “not insurmountable where there is value in joint working” (General Medical Council).

**Provisional Proposal 12-4: The statute should include a permissive statement to the effect that each regulator may carry out any of its functions in partnership with another organisation.**

- 12.44 An overwhelming majority agreed with this proposal.<sup>4</sup> For example, the Association of Regulatory and Disciplinary Lawyers considered that “joint working ... is to be encouraged and promoted”.

- 12.45 The Pharmaceutical Society of Northern Ireland welcomed the “permissive nature” of the proposal. Similarly, the General Social Care Council said that:

The provisions within the legislation should be enabling provisions and should not require regulators to enter into partnership arrangements. Again, flexibility is important in such matters to take into account changed circumstances.

- 12.46 The British Pharmaceutical Students' Association argued that:

Pharmacists work with other health care professionals and therefore some proceedings may involve multiple professions and would therefore require the cooperation of different regulators.

- 12.47 A number of consultees suggested particular partnerships that would be beneficial. For example, the British Chiropractic Association felt that:

Given the similarities in statute and function of some regulators, for example, the General Chiropractic Council and the General Osteopathic Council, it seems sensible to introduce measures to permit functions being carried out in partnership.

<sup>4</sup> Of the 192 submissions which were received, 41 expressed a view on this proposal: 39 agreed, whilst 2 held equivocal positions.

- 12.48 The Department of Health argued that partnership arrangements could be particularly helpful to clarify the interface between the General Pharmaceutical Council and the Care Quality Commission. The National Clinical Assessment Service said that it would welcome “opportunities to work in partnership with regulators such as currently happens with the General Dental Council”.
- 12.49 Some emphasised that any decision to carry out functions in partnership with another organisation could not affect the regulators’ liability for the discharge of their statutory functions. The Local Supervising Authority Midwifery Officers Forum UK said that joint working must “not be to the detriment of the core function of the regulators”. The General Social Care Council considered “that it is important that the statute is clear that any such arrangements do not affect the liability of the regulator for the exercise of any of its statutory functions”. The Professional Forum of the Pharmaceutical Society of Northern Ireland also “did not see any reduction in the legal liability of any regulator for the discharge of their functions”.
- 12.50 A small number disagreed with the proposal. For example, NHS Greater Glasgow and Clyde preferred to limit the power to joint working between the regulators and statutory organisations.

**Provisional Proposal 12-5: The statute should enable formal partnership arrangements to be entered into between any regulator and one or more other organisations (including the other professional regulators) in relation to the exercise of their statutory functions. The statute should provide that any such arrangements do not affect the liability of the regulator for the exercise of any of its statutory functions.**

- 12.51 All those who expressed a view agreed that the statute should enable formal partnership arrangements to be entered into between any regulator and one or more other organisations.<sup>5</sup>
- 12.52 The Nursing and Midwifery Council felt that our proposal should go further and “encourage” the formation of certain partnerships in the public interest. The Council also suggested that the statute “should require regulators to have regard to certain considerations when selecting partners”.
- 12.53 The Medical Protection Society felt there were many areas in which formal partnership arrangements could be beneficial, such as joint consultations on new guidance and rules, joint training of panellists, the production of a consolidated set of procedural rules and shared hearing rooms.
- 12.54 An individual consultee (Dr Susan Blakeney) argued it would be appropriate for the General Optical Council and General Medical Council to have a formal partnership arrangement “when investigating a case of alleged impaired fitness to practise of a registered medical practitioner who is providing one or more of the protected optical functions”.
- 12.55 Other consultees were slightly more cautious in their support. The Osteopathic Alliance maintained its position that partnership should only be permitted in

<sup>5</sup> Of the 192 submissions which were received, 37 submissions expressed a view on this proposal: all agreed.

respect of certain functions. The Professional Standards Authority suggested that further work might be beneficial in order to consider “whether any potential for conflict of interests might exist and how these would be managed”. The British Association for Counselling and Psychotherapy suggested that partnership arrangements “may lead to more cost and complexity rather than less”. The British Pharmaceutical Students’ Association was “wary of the ability to move actual regulatory functions to another body that does not have an in-depth knowledge of the pharmacy profession”. The General Dental Council noted that the proposal was “not necessarily a complete solution to the problems of regulatory overlap and potential gaps”.

12.56 The Department of Health queried whether formal partnership arrangements are necessary if there is already a joint working power in the statute. The Scottish Government agreed, and also noted the regulators should be required to consult before entering any partnership arrangements.

12.57 The regulators’ liability for the discharge of their statutory functions was seen by many as a key issue. The Medical Defence Union used the example of the keeping of registers. It said:

We assume that such an arrangement would be an administrative one and that even if one regulator held and updated a register for another regulator, the responsibility for accuracy etc of information within that register would remain with the initial regulator and not the “host”. That is, if a registrant wished to complain about information that was available on his or her regulator’s register that was hosted by another regulator, the registrant should be able to complain to his or her regulatory body and not the host regulator.

**Provisional Proposal 12-6: The statute should impose a general duty on each regulator to make arrangements to promote cooperation with other relevant organisations or other persons, including those concerned with the:**

**(1) employment of registrants;**

**(2) education and training of registrants;**

**(3) regulation of other health or social care professionals;**

**(4) regulation of health or social care services; and**

**(5) provision/supervision/management of health or social care services.**

12.58 A significant majority of consultees supported the proposed general duty to promote cooperation.<sup>6</sup>

12.59 An individual consultee (Jacqueline A Wier) welcomed the proposal on the basis that “collaboration is a fundamental aspect which improves patient outcomes”. The Patients Association agreed that improved cooperation, notably between the

<sup>6</sup> Of the 192 submissions which were received, 46 expressed a view on this proposal: 40 agreed, 2 disagreed, whilst 4 held equivocal positions.

regulators and the Care Quality Commission, could “play a huge part in protecting patients from poor care”.

- 12.60 The Nursing and Midwifery Council was concerned that a failure to engage on the part of other organisations would prevent regulators complying with the duty. It concluded that it:

would favour permissive or encouraging provisions that could be overseen by the Professional Standards Authority, who could hold regulators to account through performance reviews.

- 12.61 The General Optical Council also considered that the statute should permit cooperation, but not impose a duty. It said:

We would possibly favour more a permissive statement in the statute rather than a specific requirement to make arrangements for cooperation. We would be wary of a substantial bureaucracy of partnership working arrangements that are either resource-intensive to maintain or are not supported by concrete activity.

- 12.62 The General Pharmaceutical Council expressed reservations about the proposed general duty. However, it concluded that:

There are opportunities and risks to setting out a general duty to cooperate. On the one hand it provides a clear requirement to work with others. On the other hand it could become mechanistic and artificial. On balance we think this suggestion is worthwhile.

- 12.63 Some consultees did not support the proposal in its current form. The General Social Care Council felt that the duty would not be effective unless the organisations and persons referred to were subject to a reciprocal duty. The Medical Protection Society was concerned that “there could be no obvious way to enforce [the duty to cooperate]”.

- 12.64 The British Association for Counselling and Psychotherapy queried whether the imposition of a general duty was feasible in light of what it considered would be “very heavy” resource implications. The Pharmaceutical Society of Northern Ireland felt that the “proposal has the capacity to create unnecessary duties particularly when specified to this extent”

- 12.65 Some consultees disagreed with the proposal, on the basis that cooperation was not a matter for statute. The General Chiropractic Council thought that:

there is a danger here of trespassing by statute into areas which should best be worked out by the regulators themselves. Our view is that there is a danger of over prescription.

- 12.66 An individual consultee (Anonymous) said:

I would hope this could all be established by good practice overseen by the Professional Standards Authority rather than needing to be said in statute. In particular the phrase “promote co-operation” could be interpreted as creating co-operation for its own sake rather than for public protection and if that took the regulators’ eye off their core functions this would be regrettable.

12.67 The Local Supervising Authority Midwifery Officers Forum UK thought that an imposition of the duty in statute could make the required cooperation “lengthy and burdensome”.

12.68 There were a number of comments about the proposed list of organisations with whom regulators would be required to promote cooperation. The Care Quality Commission felt that any list should not be exhaustive, whilst some consultees wanted to extend it to cover:

- (1) professional bodies and unions (Unite and Guild of Healthcare Pharmacists);
- (2) those involved in the registration of other professionals and occupations (Professional Standards Authority);
- (3) bodies responsible for commissioning NHS services (Department of Health); and
- (4) those involved in education and training of potential registrants (General Dental Council and Dental Schools Council).

12.69 The Department of Health also commented that any duty should apply to any “queries raised by other European competent authorities to the extent required by Directive 2005/36/EC”.

12.70 Action Against Medical Accidents stated that:

At the moment, there is no statutory requirement on employers (including, for example, GP or dentist practices) to share information about concerns or indicators of poor practice with potential new employers or other key stakeholders such as the regulators themselves. This means that bad health professionals can simply be passed on to another employer without issues being addressed and employers not notifying the regulator so that they can investigate and use their powers to protect patients.

12.71 It warned that this issue has been outstanding for some time, and that a “continued failure to address these issues will continue to undermine the capacity of the regulators to protect patients and therefore puts patients at risk”.



**Question 12-7: Should the statute specify or give examples of the types of arrangements that could be made under provisional proposal 12-6?**

- 12.72 A small majority agreed that the statute should specify or give examples of the types of arrangements that could be made under the general duty.<sup>7</sup>
- 12.73 The Scottish Social Services Council suggested that a “specific provision allowing the sharing of personal data” would “facilitate information sharing and obviate some of the practical difficulties currently experienced by regulators” when they are considering whether information should be shared. The National Clinical Assessment Service suggested that “examples could include provision of initial, expert, clinical, screening and provision of assessment and record review”.
- 12.74 The General Medical Council said that examples must not “on the one hand impose mandatory requirements or, on the other, represent an exhaustive list which would prevent co-operation in other areas where appropriate”. The Medical Schools Council agreed that any examples should be “illustrative”.
- 12.75 Some consultees said that providing examples would inhibit cooperation. The Professional Standards Authority felt that examples “may limit the way in which this general duty is developed within and across the regulators”. The Medical Defence Union thought that “regulators should be free to explore opportunities to co-operate as they consider it appropriate to do so”.
- 12.76 The Nursing and Midwifery Council felt that examples could be created under guidance. The General Osteopathic Council suggested that it may be “preferable for the regulators to be given a duty to publish an up to date scheme which sets out with whom and how they cooperate”. The Professional Forum of the Pharmaceutical Society of Northern Ireland agreed that it would be sufficient to require regulators to “consult upon and publish any formal schemes of cooperation”.
- 12.77 The Scottish Government stressed that “such examples should take account of any differing considerations in the devolved administrations”.

**Provisional Proposal 12-8: The statute should impose a specific duty to cooperate, which would apply when the regulator in question is:**

- (1) considering registration applications and renewals;**
- (2) undertaking the approval of education and training;**
- (3) ensuring proper standards of practice and conduct; and**
- (4) undertaking an investigation into a registrant’s fitness to practise.**

**This duty would apply to the same list of organisations and persons contained in provisional proposal 12-6. The requested authority would be required to give due consideration to any such request made by the regulator, and if it refuses to cooperate, must give written reasons.**

- 12.78 A significant majority supported the proposed specific duty to cooperate.<sup>8</sup>

<sup>7</sup> Of the 192 submissions which were received, 33 expressed a view on this question: 19 said that examples should be given, 13 disagreed, whilst 1 held an equivocal position.

- 12.79 The Scottish Government particularly welcomed the requirement of written reasons in support of any refusal to cooperate, and called for the statute to specify “the potential negative consequences associated with any failure to cooperate that may be deemed to be unreasonable (as judged from an objective standpoint)”.
- 12.80 The Association of Regulatory and Disciplinary Lawyers suggested that the duty “could extend to the joining of proceedings for different regulated professionals, with the aim of achieving consistent outcomes”. The British Pharmaceutical Students’ Association felt that the proposal would be beneficial in respect of education and training due to the increase in multi-disciplinary learning.
- 12.81 The General Dental Council noted that the general duty would only apply to regulators, whilst the specific duty could apply to bodies “not within the legislative competence of the Westminster Parliament”. In light of this, the Council felt that there must be a clear distinction between the two duties.
- 12.82 Some consultees reiterated their concerns in respect of the general duty, namely the risk of significant and unnecessary bureaucracy. The General Optical Council queried whether it would be preferable to have “a permissive statement in the statute rather than a specific requirement to make arrangements for cooperation”.
- 12.83 Some consultees were concerned about how the specific duties would be enforced. The General Social Care Council felt “it would be useful if greater sanctions were available to regulators in the event that, say an employer was unwilling to co-operate”. The UK-wide Nursing and Midwifery Council Lead Midwives for Education Group also queried the role of the legal system in the event of a failure to cooperate by an independent organisation.
- 12.84 The British Association for Counselling and Psychotherapy commented that the proposed duty could extend to “a very large number of organisations”, and did not consider that the “desired outcome of such cooperation” was clear.
- 12.85 However, others thought that it was beyond the scope of the statute to impose duties on other organisations. The General Medical Council said that:

It appears that this proposal imposes an absolute duty on the regulator to cooperate in the specified area, but a lesser duty on the requested authority merely to consider whether it wishes to cooperate ... We think it unwise for the statute to prescribe in absolute terms on operational matters as needs will vary according to circumstances and will also change over time. It may therefore, be more appropriate and balanced for the statute to impose a duty on regulators to consider the need for cooperation in the specified areas.

- 12.86 The Medical Defence Union was also:

not sure how the statute would be able to make it a requirement that requested authorities give due consideration to the regulator’s

<sup>8</sup> Of the 192 submissions which were received, 44 expressed a view on this proposal: 36 agreed, 3 disagreed, whilst 5 held equivocal positions.

request to co-operate because this would presumably need to be enshrined in the legislation. We do not object to the principle, but we think it may be difficult to give it legislative force given the number and variety of the authorities and the potential for any “list” of such authorities to change regularly or for authorities to be left off any list.

- 12.87 The Council of Deans of Health was particularly concerned about the impact of the proposed duties on universities as “information requested by regulators is not always held within the university, but within a trust or practice setting”.

**Question 12-9: Are there any other circumstances in which the specific duty to cooperate contained in provisional proposal 12-8 should apply?**

- 12.88 A small majority felt there were no other circumstances in which the duty should apply.<sup>9</sup> For example, the Medical Defence Union felt that the legislation is worded “widely enough to allow the regulators to request co-operation with other authorities as they think appropriate” even if the authorities or activities are not those listed by the statute.

- 12.89 However, a number of consultees did identify additional circumstances. The Professional Forum of the Pharmaceutical Society of Northern Ireland suggested that the statute should require information sharing about dual registered individuals. Similarly, the Medical Protection Society stated that:

As it is possible for an individual to be a member of more than one regulated healthcare profession, there should be a specific duty on each regulator, when considering an application for registration, to make enquiry of the other regulators as to whether or not there are any fitness to practise concerns.

- 12.90 The General Osteopathic Council identified “the investigation and prosecution of breaches of protected titles” as “another area where cooperation is required”. The General Dental Council suggested that the duty should include “considering continuing professional development submissions”. An individual consultee (Jacqueline A Wier) thought that the duty to cooperate should apply “when a service is being provided to vulnerable adults and children”. The Patients Association proposed that “undertaking action to prevent the compromise of service user safety or dignity” should be added to the proposed list of activities. The Professional Standards Authority felt that there should be greater cooperation “in specification of a common data set of regulatory metrics” in order to identify trends and support strategic planning. The Nursing and Midwifery Council suggested that the consideration of “fraudulent or incorrect entries in the register” should be included for completeness.

<sup>9</sup> Of the 192 submissions which were received, 20 expressed a view on this question. 11 said that there were no other circumstances in which the duty should apply, whilst 9 said that there were other circumstances.

## **PART 13**

### **CROSS BORDER ISSUES**

**Provisional Proposal 13-1: The statute should require the regulators to specify in rules which qualifications would entitle an applicant to be registered, including overseas qualifications.**

- 13.1 A large majority agreed with this proposal.<sup>1</sup> For example, the Pharmaceutical Society of Northern Ireland said the proposal was an “essential consideration within any new statute”.
- 13.2 Whilst most consultees did not explain why they agreed, those that did stressed that the rules are too detailed to be the subject of primary legislation and that this was an appropriate role for the regulator rather than Government.
- 13.3 In addition, the General Dental Council felt that this proposal would enable the regulators to stop a course or prevent graduates registering if the course was found to be inadequate. The Professional Standards Authority felt that the proposal would allow for “greater flexibility and agility in specifying the entitling qualifications as these change with time”.
- 13.4 However, some consultees thought that the proposal was too rigid. An individual consultee (Anonymous) said:

This is too prescriptive – it should be open to regulators to state in any way they see fit the standard of practice and/or competence that is expected rather than exactly which qualifications are relevant. In the case of multi-professional regulators and for non-EEA qualifications it would be too cumbersome to state in rules all the qualifications which might be relevant.

- 13.5 The General Optical Council thought it would be “more appropriate for rules to set out the process for assessment and recognition of applicants’ qualifications”.
- 13.6 Several consultees were of the view that the proposal should only apply to the sectoral professions, while the general systems professions require a case by case assessment. For example, the General Pharmaceutical Council commented that it could see:

significant challenges in implementing this proposal for those professionals exercising free movement rights under the general system as these applications are required to be assessed on a case by case basis, taking into consideration not only an applicant’s qualifications, but also their work experience and continuing professional development/continuing education.

- 13.7 The Department of Health and the Scottish Government questioned the practicality of specifying qualifications in rules, especially given the requirement for consultation each time the rules are amended. The Department also felt that

<sup>1</sup> Of the 192 submissions which were received, 40 expressed a view on this proposal: 30 agreed, 7 disagreed, and 3 held equivocal positions.

there should be an express duty on the regulators to ensure compliance with the Directive in any rules they make.

13.8 Other concerns raised by consultees included the following:

- (1) the rules would have to be updated frequently (the Medical and Dental Defence Union of Scotland);
- (2) the regulators may lack access to comprehensive information on overseas qualifications (Allied Health Professions Federation);
- (3) the proposed system might not be workable as regards non-EEA qualifications (the General Medical Council); and
- (4) there needs to be greater consistency between the regulators on this matter (UNISON).

13.9 The Department of Health, Social Services and Public Safety for Northern Ireland argued that in relation to nursing “entry should be based on meeting standards set for entry to the register, not on qualifications alone”.

13.10 Action Against Medical Accidents also criticised the consultation paper for not going further. It felt that:

The new arrangements should address the problems resulting from the freedom accorded to EEA registered health professionals to practise in the UK without the normal checks and balances which the regulators apply to all other health professionals from overseas, including checks on competence and English language skills. Health professionals from the EEA area make up an increasing proportion of the healthcare community in the UK and without closing these gaps a large number of health professionals will simply not be covered by the system of regulation which the Law Commission is considering.

### ***Language testing***

13.11 A number of consultees raised the question of a language check for EEA nationals, arguing that this was a crucial issue which should be clarified and tackled by the regulators. For example, NHS Greater Glasgow and Clyde expressed concerns that this issue had been devolved inappropriately to local employers, even though it raises concerns relating to patient safety. Pharmacy Voice considered that “health care professionals from overseas must be able to communicate effectively in the language of the country in which they wish to practise”.

13.12 The Royal Pharmaceutical Society of Great Britain argued that “language/communication must be assessed before a professional can register and practise”. Pharmacy Voice added that language testing should be “an automatic issue” which is addressed by the regulator.

13.13 Several consultees, including the Chartered Society of Physiotherapy, pointed to a need for all regulators to apply “profession-specific language tests”, instead of a “generic language test”.

**Provisional Proposal 13-2: The default powers of the Government should include the ability to intervene in cases where there is likely to be or has been a failure to implement the Qualifications Directive properly.**

- 13.14 An overwhelming majority agreed that the default powers of the Government should include the ability to intervene in cases where there is likely to be or has been a failure to implement the Qualifications Directive properly.<sup>2</sup> For example, the Association of Regulatory and Disciplinary Lawyers agreed that the proposal “is an essential safeguard that should reside with the Government for use in exceptional circumstances”.
- 13.15 The Department of Health agreed with intervention powers but felt these should rest with the Privy Council and not Government. It also argued that:
- The power should go wider than just the Qualifications Directive and extend to circumstances in which the regulators are failing to properly discharge any of their duties under a European Treaty to which the UK is party. The rationale for such a power would be to seek to prevent an infraction of the UK’s treaty obligations from occurring.
- 13.16 The Allied Health Professions Federation agreed with the proposal, and thought it “should also include the failure to adhere to the code of conduct for regulators relating to the Professional Qualifications Directive”.
- 13.17 Some consultees called for further clarity as regards the role of the Government in the interpretation and implementation of EU law. The General Osteopathic Council suggested that the Government should take the advice of the Professional Standards Authority before exercising this power.
- 13.18 Although the General Medical Council accepted that “it is reasonable that a Government would wish to avoid costly infraction proceedings in the event that the regulator’s actions would be in conflict with EU law”, it argued that the Localism Act 2011 already meets this concern. It also considered that this provision grants too much power to the Government and that “when EU issues raise interpretation issues, the regulator’s views aiming to protect public interest should prevail”.
- 13.19 The Professional Forum of the Pharmaceutical Society of Northern Ireland commented that “all default powers should only be used in conjunction with the devolved administrations”.

<sup>2</sup> Of the 192 submissions which were received, 35 expressed a view on this proposal: 33 agreed with the proposal, 1 disagreed, whilst 1 held an equivocal position.

**Provisional Proposal 13-3: The statute should include broad powers for the regulators to register those from non-EEA countries, including powers to set requirements as to the language, practice and education requirements.**

13.20 The vast majority agreed with this proposal.<sup>3</sup> For example, the Royal College of Nursing said it supported this approach:

in recognition that the UK regulators already carry out these functions, that the UK has traditionally been a destination country for large numbers of health professionals from outside the EU, and because it is important that migrants are treated fairly and transparently.

13.21 Many consultees, for example, the Academy of Medical Royal Colleges, stressed the need to set up similar checks for EEA nationals. The Association of Regulatory and Disciplinary Lawyers argued that in order to ensure transparency, the rules must be made public.

13.22 The Chartered Society of Physiotherapy and NHS Education for Scotland also stressed the need for consistent rules across the regulators. The Allied Health Professions Federation agreed that consistency was required, “given the common issues involved regardless of profession, and with regulators’ criteria and processes having evident transparency, fairness and rigour”.

13.23 The British Association and College of Occupational Therapists argued that the regulators should ensure that all health professionals who qualified abroad have “access to an adaptation course”. The Patients Association supported a minimum provision on language skills.

13.24 The National Clinical Assessment Service considered that “assessment of communicative competency in a professional and context specific setting is vital to ensure appropriate skills for maintaining and protecting patient safety”.

13.25 UNISON stated that although it supported the proposal, it is “the primary responsibility of employers to ensure that their employees have the requisite skills”. It added that the proposal should not lead to further controls, “as it risks feeding the media’s often negative perception of immigration”.

**Question 13-4: Would there be benefits in the same regulatory arrangements applying in the Channel Islands and the Isle of Man? If so, would the best way to achieve this be parallel legislation or a single statute?**

13.26 A large majority felt there would be benefits in the same regulatory arrangements applying in the Channel Islands and the Isle of Man. These benefits were said to include assisting professional mobility, avoiding duplication and providing a

<sup>3</sup> Of the 192 submissions which were received, 41 expressed a view on this proposal: 40 agreed, whilst 1 disagreed.

simpler framework.<sup>4</sup> A majority argued that the best way to address this would be through a single statute covering the UK and the British Islands.<sup>5</sup> For example, an individual consultee (Jacqueline A Wier) said that:

As these Islands are part of the UK it is important that they have access to the same regulatory arrangements so that consistency of regulation and health care professionals' standards is maintained. This should be included in a single statute to limit bureaucracy.

13.27 Optometry Scotland also agreed that "the preferred option would be to apply a single statute".

13.28 However, the Patients Association and the British Association for Counselling and Psychotherapy considered that parallel legislation would be the best way to implement the same regulatory arrangements.

13.29 The General Medical Council disagreed that regulation should be extended because there is "a significant number of British citizens living on the islands", since "the same argument could logically be extended to a number of other jurisdictions around the world". Furthermore, the Council argued that it can already take fitness to practise action against a registered doctor regardless of where the alleged offence has taken place. It felt that the more relevant concern "is the fact that some UK medical trainees undertake their training in the Channel Islands". In addition, doctors in the islands are not subject to the Responsible Officer provisions. As a result, the Council had to develop special provisions covering the revalidation of licensed doctors practising on the islands.

13.30 The Health and Care Professions Council stated:

For most of the professions we regulate, legislation passed by the Isle of Man Government ensures that professionals are appropriately ... registered and means that we can deal effectively with concerns about an individual's conduct and/or competence. However, the Isle of Man legislation has not caught up with professions brought into regulation by more recent UK legislation.

13.31 The General Dental Council stated that :

Concerns have been raised that certain professions are left unregulated in these jurisdictions and that fitness to practise regimes are insufficiently comprehensive and robust. In relation to dental care professionals, this has occurred because Jersey law has not been amended to reflect recent amendments to the Dentists Act 1984, for example the introduction of new dental care professionals groups in 2006. In addition, Isle of Man legislation refers to dental auxiliaries

<sup>4</sup> Of the 192 submissions which were received, 28 expressed a view on this question: 25 said that there would be benefits, whilst 3 said that there would not. Of those who said that there would be benefits: 5 said that it would aid mobility of professionals, 2 said that it would avoid duplication and 2 said that it would provide a simpler framework.

<sup>5</sup> Of the 192 submissions which were received, 14 expressed a view on this question: 10 said that there should be a single statute, 3 said that there should be parallel legislation and 1 said that there should be partnership arrangements.



established by regulations under section 45 of the Dentists Act 1984 – section 45 made provision for hygienists and therapists only and was repealed in 2006.

13.32 The General Osteopathic Council argued that the respective Channel Islands and Isle of Man jurisdictions should formally require practitioners to register, through “parallel legislation or even administratively”.

13.33 The Professional Standards Authority stated that:

the point of principle is that the same standards of professionalism and the same standards of care should apply irrespective of where in the British Islands treatment is being provided. This could be achieved through either one regulatory framework extended to the Islands or parallel legislations working closely together.

13.34 The Health and Social Services Department of Guernsey noted that doctors, dentists and pharmacists cannot practise unless they are registered by the UK regulators, and similar arrangements apply to the professions regulated by the Health and Care Professions Council. However, different arrangements apply to chiropractors and osteopaths who need to satisfy the Department that they have the equivalent competence to practise. It stated that it wishes to continue the current arrangements which apply in Guernsey and Alderney (Sark has its own arrangements). However, it expressed interest in extending some of its regulations, mainly in relation to premises regulation, and developing a memorandum of understanding with the Professional Standards Authority to ensure close working relations.

**Question 13-5: How could the new legal framework address the interface between the regulatory systems in the UK and the Channel Islands and the Isle of Man?**

13.35 A large majority felt that the statute should address the interface through joint working arrangements.<sup>6</sup> For example, the General Dental Council considered that “the issuing of joint standards or codes would be the preferred option that would most effectively address the interface between the regulators”. Optometry Scotland also supported joint standards and codes.

13.36 The General Medical Council thought that the “general duties of cooperation that are discussed elsewhere in the consultation document should be applicable without the need for additional measures in the statute”. The Health and Care Professions Council agreed that the proposed legal framework was “sufficient”.

13.37 The Local Supervising Authority Midwifery Officers Forum UK thought that the legal framework should “make the Nursing and Midwifery Council the regulator for the Isle of Man and Channel Islands”.

<sup>6</sup> Of the 192 submissions which were received, 8 expressed a view on this question: 6 said that joint working arrangements would address the interface, 1 said that the interface should be managed as with any other jurisdiction, whilst 1 said that the current legal framework is sufficient.

**Provisional Proposal 13-6: The regulators should be given an express power to approve and accredit overseas education institutions and courses and issue rules and guidance for the purpose of such activity.**

- 13.38 A majority agreed that the regulators should be given an express power to accredit overseas courses and institutions.<sup>7</sup> For example, the Patients Association felt this proposal “would make it clear from the outset which qualifications are acceptable for registrants who are seeking to work in the UK”, “clearer for patients and service users who may rely on these as an indication of skill and ability”. It would also “protect the UK regulatory system from fraudulent medical schools passing themselves off as competent”.
- 13.39 The Scottish Government agreed with the proposal but only “to the extent that overseas courses are attached to a UK provider”. The Institute of Medical Illustrators agreed that the proposal should only apply where “the overseas institutions were formally linked with UK based and regulated institutions”.
- 13.40 The Health and Care Professions Council supported the proposal but noted that its existing legislation does not allow the approval of “programmes delivered outside of the UK by a non-UK institution” or “where a programme is delivered under a collaboration or franchise agreement between UK and non-UK education providers”.
- 13.41 The General Medical Council and the Nursing and Midwifery Council supported the permissive nature of the proposal. The General Optical Council noted that it already has the proposed power, and said it would “appreciate flexibility in our approach in this area, including possibly the option of appointing others to perform quality assurance functions”.
- 13.42 Several consultees questioned why UK registrants should fund such activity. The General Dental Council and General Osteopathic Council argued there must be a power to charge the overseas institution. The Department of Health, Social Services and Public Safety for Northern Ireland commented that “this could be a very expensive process” and it was:
- uncertain that existing registrants should be required to cover the costs of this exercise. It would appear that free movement ... in the EU eclipses the proposed recommendation.
- 13.43 The Professional Standards Authority felt that the statute should avoid:
- allowing the development of UK accreditation as an international brand or mark of good quality if there is no clear evidence of a direct link back to the regulator’s fundamental responsibility for public protection.
- 13.44 The Chartered Society of Physiotherapy said:

<sup>7</sup> Of the 192 submissions which were received, 36 expressed a view on this proposal: 26 agreed, 3 disagreed, whilst 7 held equivocal positions.

There is ... the potential for confusion about the relationship between programme approval and graduates' registration with a UK regulator. More fundamentally, all these factors could undermine the standing and credibility of UK regulators' approval and therefore transparency and public understanding of its role. This could clearly have a significant and concerning impact on public protection

13.45 UNISON argued that due to the costs associated with accreditation of overseas education institutes, the regulators should work together on these matters.

13.46 The Council of Deans of Health felt it was questionable whether further UK regulatory activity overseas is necessary when those health courses are already subject to the regulation and quality assurance processes of the country in which these courses are delivered.

13.47 The Department of Health expressed concerns about the regulators approving and accrediting overseas institutions and programmes. It said that:

On the one hand, they have significant expertise in this area, which might be of benefit overseas. On the other hand though, quality assurance is undertaken against the standards and outcomes required of UK graduates who will be practising within the UK health care system - the delivery of education and training overseas can be delivered in a very different context to the UK and, consequently, we consider that it might be difficult for the regulators to properly quality assure institutions overseas.

13.48 However, the UK-wide Nursing and Midwifery Council Lead Midwives for Education Group was strongly opposed to the proposal. In addition to being concerned about costs and the proper scope of the regulators' remit, the Group felt that the focus needs to be on getting regulation "right in the UK first".

**Question 13-7: What are the practical difficulties which arise as a result of the requirement to quality assure UK qualifications which are awarded by institutions based overseas?**

13.49 A number of practical problems were highlighted in respect of quality assuring UK qualifications which are awarded by institutions based overseas.<sup>8</sup>

13.50 The General Medical Council identified the following practical challenges:

- (1) curricula taught and assessed in non-English speaking countries;
- (2) difficulties of ensuring that students gain an equivalent understanding of the organisational and economic framework of the UK health care system;
- (3) the risk that students will not get a UK equivalent experience in primary care and mental health because of the different overseas systems;

- (4) differences in ethical and legal issues, including the concept of professionalism;
  - (5) different approaches to equality and diversity, including the rights of gay people and those with mental health problems;
  - (6) differences in cultures that impact on clinical skills, for example some students may not be comfortable examining patients of the opposite sex; and
  - (7) diverting regulatory resources towards quality assurance activities which may bring little or no benefit for patients and the public in the UK.
- 13.51 The Council also noted that it is currently exploring whether its legislation should be amended to enable the award of a UK primary medical qualification overseas which would be different to a UK based qualification and would “reflect the different circumstances and context in which students were being educated and trained overseas”.
- 13.52 The General Osteopathic Council noted similar issues to the General Medical Council:
- (1) language differences;
  - (2) ethical and legal differences;
  - (3) cultural contexts of healthcare delivery; and
  - (4) cost of quality assurance activities and cost recovery.
- 13.53 The Professional Standards Authority felt that the main challenges for the regulators included:
- (1) meeting the cost of quality assurance activity overseas from UK registration fees;
  - (2) the risk that poor performance on a single programme may threaten the recognition of UK institutions when it is the institution that is the holder of the approval, not the programme or an individual course; and
  - (3) confusion may arise when an overseas regulator accredits a programme but this does not convey automatic registration rights on individuals who successfully complete the course.
- 13.54 The British Psychological Society felt that the key issues included that “quality assurance is increasingly based on self report and monitoring of processes”, overseas institutions may not have “access to peer contacts and support for new initiatives” and the difficulties of putting in place remedial measures.

<sup>8</sup> Of the 192 submissions which were received, 28 expressed a view on this question: 12 cited cost, 7 cited quality assurance, 6 cited the different practical environments of overseas institutions, 4 cited language difficulties, 1 cited different cultural values, whilst 1 cited the risk that approval is withdrawn from the parent provider.

- 13.55 The General Dental Council pointed to problems relating to “speed of response, intelligence and communications”. It said:

We can respond rapidly to a whistleblower in the UK. Reports of problems at dental schools may appear in the local press and are noted by students and others. This may be less likely in respect of overseas institutions.

- 13.56 The Department of Health noted the risk “that approval is withdrawn from the parent provider as there is not provision to just approve a local education provider”.
- 13.57 Rescare thought that a lack of knowledge of overseas institutions and their staff was a challenge for the regulators. The Local Supervising Authority Midwifery Officers Forum UK suggested that the system could be “open to fraudulent activity and entry under false purposes on the register”.

**Question 13-8: How might our statute enable the regulators to manage the issues that arise from distance service provision?**

- 13.58 Opinion was divided on this question.<sup>9</sup>
- 13.59 The Nursing and Midwifery Council felt that a “clear definition” of distance service provision was an important starting point. It considered that:

It would also be helpful to clarify whether distance service provision includes educational services or clinical services or both because these would require different management approaches

- 13.60 The General Medical Council doubted it was “practical, desirable or enforceable” to require that overseas practitioners who provide telemedicine services from outside the UK must be registered and licensed with the UK regulator. It noted that:

The more practical approach has been to put responsibility on UK health care providers and commissioners to ensure that any organisations or individuals with which they contract to provide services have arrangements in place to maintain the quality of the care provided. UK providers are then accountable to the systems regulators for ensuring that the appropriate arrangements are in place.

- 13.61 Similarly, the General Pharmaceutical Council stated that:

<sup>9</sup> Of the 192 submissions which were received, 32 expressed a view on this question: 8 cited joint-working arrangements with international regulators and other bodies such as the Medicines and Healthcare products Regulatory Agency, 8 said that the regulators should seek to impose regulatory standards on those providing services from overseas, 4 said that UK providers should be obliged to contract with overseas providers only if they achieve the standards of the UK regulatory system, whilst 5 said that this issue is beyond the remit of our statute.

If the individual providing the service is not based in the UK they still must be appropriately qualified and regulated in the country in which they are based for the specific service they are providing across borders. It should be the responsibility of the organisation that contracts with the service provider to ensure that this is the case and inform service users of the checks they have undertaken.

13.62 The Department of Health also argued that “it should be for the commissioner of any service to ensure that the provider was using appropriately qualified practitioners” but “there may be scope for giving the regulators power to advise commissioners”.

13.63 However, the Academy of Medical Royal Colleges disagreed with this approach, saying that:

Whilst contractual arrangements with overseas providers should specify standards and the system regulator has a responsibility for the quality of service, we believe there must be a locus for the professional regulator. In this case the legal framework has been overtaken by technological advances and this must be addressed.

13.64 The Pharmaceutical Society of Northern Ireland also argued for a role for the professional regulators. It thought:

There should be a provision in the statute to ensure that the provision of services outside the UK should, as a minimum, meet UK standards. Where these standards are not met then the regulator will make a referral to the competent authority in the state of establishment of the service.

13.65 Some consultees argued that regulatory standards should be imposed on overseas practitioners. The British Medical Association argued that:

Distance service provision must be regulated to the same standards. Those providing teleradiology, for example, for UK patients must be subject to the same regulatory standards, irrespective of where they might reside.

13.66 The Royal College of Radiologists argued that all doctors who provide care to NHS patients, even if they are providing those services from outside the UK by telemedicine, should be subject to the same regulation as those within the UK.

13.67 The Scottish Government argued that the new statute should ensure that:

the person making individual clinical decisions is appropriately qualified to give advice and suggest certain treatments. This would link with the increasingly high profile requirement to ensure that all healthcare providers act, behave and conduct themselves in a professional manner irrespective of their discipline, location or mode of healthcare delivery.

13.68 The British Psychological Society thought that:

It may be necessary for the statute to include specification of more aspects of the management of the relationships such as regularity and frequency of contacts, as well as clarification of what balance could be local and autonomous and what would mirror the host institution.

- 13.69 Some felt that more public information was needed. For example, the Professional Standards Authority stated that:

For those patients who seek to consult an overseas health professional directly, an element of *caveat emptor* applies. We wonder whether targeted public communications about the importance of using the systems that apply to check the registration of overseas health professional are used; and that the regulators in the UK, who are accustomed to using systems such as the Internal Market Information system to check the registration of professionals overseas (in this case, within Europe), make clear to the public that they will advise on how to check the status of an overseas professional.

- 13.70 The Health and Care Professions Council felt that the provision of joint guidance in this area might be appropriate. It suggested that:

For example, this might include working with others to produce cross-jurisdiction guidance on internet advertising or working appropriately with other agencies, such as the Medicines and Healthcare Products Regulatory Agency on ensuring compliance.

- 13.71 The General Optical Council noted that its existing accreditation and quality assurance powers are sufficient for it to “manage distance learning provision and [that there are] many such courses”. The Patients Association agreed that no additional specific provision is currently required, but that regulation-making powers for the Secretary of State would future proof the legislation.

- 13.72 The General Dental Council did not think that a “broad legal framework could be expected to deal with the practical difficulties” identified in the previous section. The Professional Forum of the Pharmaceutical Society of Northern Ireland was also unable to “see how any statute which is enacted in the UK will be able to successfully regulate health care services provided outside the jurisdiction”. The Medical Protection Society thought it might be “more pragmatic to rely on local regulation”.

## **PART 14**

### **OTHER ISSUES**

- 14.1 This Part includes extracts from consultation responses that did not address specific provisional proposals or consultation questions, but nevertheless raised important issues.

#### **THE LAW COMMISSIONS' APPROACH**

- 14.2 Some consultees expressed concerns about the Law Commissions' approach to law reform.
- 14.3 The British Osteopathic Association thought that:

the opportunity to carry out a root and branch review of the healthcare regulatory system has not been taken and in many ways this review concentrates on the detail of healthcare regulation without addressing the fundamental weaknesses within it which have developed as a result of history.

- 14.4 The Royal Pharmaceutical Society of Great Britain was "supportive of the ethos" of the consultation, but disappointed with the tone and timing of the review. It considered that:

The tone of the consultation is more appealing to those with an in-depth knowledge of the legal framework of regulation than those delivering the service within that framework.

- 14.5 The Society said that the consultation paper was "difficult to read", and believed that this had inhibited responses from its members and the public.

#### **REGULATING OTHER PROFESSIONALS**

- 14.6 An individual consultee (Sheila Try) thought that the review was "an ideal time to bring unregulated workers together under one regulator body". She said:

Healthcare Assistants are now performing many tasks that are nursing roles for which nursing students have to be trained, mentored and assessed and qualified nurses are regulated on while Healthcare Assistants do not. If Healthcare Assistants can perform these tasks without regulation why are nurses regulated and even trained to an expected higher standard?

...

It is time the Healthcare Assistant role was clearly identified, regulated and monitored to ensure patient and public safety as well as that of the Healthcare Assistant.

If nurses are subjected to regulated training, assessment and are held accountable for their actions it is surely common sense that any other personnel performing the same tasks must be treated in the same way and subject to fitness to practice guidelines.



## **FITNESS TO PRACTISE**

14.7 An individual consultee (Walter Merricks) suggested that “some testing of the public understanding” of concepts such as fitness to practise and impairment would be useful before their inclusion in the new statute.

14.8 Some consultees raised general concerns about the regulators’ fitness to practise procedures. We received responses from several Independent Speech and Language Therapists which raised similar issues. One example said:

1. If a complaint is made against you, you should be informed by the Health and Care Professions Council at once and told who and what the complaint is at the start of the enquiry. Currently you are not informed and if you enquire you are only told yes or no. Why is the accuser allowed to remain anonymous? Also this can affect professional indemnity insurance and access to legal help at a very stressful time. I think it might also encourage some malicious complaints.

2. At the enquiry stage both sides should be allowed a statement. Currently only the complainant can. If mediated at the enquiry stage it might stop so many cases from proceeding further saving the Health and Care Professions Council’s time and money.

3. Definite time limits should be set for each stage. Currently there are NO time limits in place. Cases can drag on for months and months affecting health, self esteem and finances.<sup>1</sup>

14.9 Another individual consultee (Melanie McDonald) said:

My experience of working as a lawyer for a regulatory body raised a number of concerns about the ability of the regulators to manage fitness to practice proceedings in a manner which achieves consistency of outcome, good quality decision making and to work in an open and transparent way so as to benefit both registrants and members of the public who depend on the probity and clinical competence of healthcare professionals at times when they are often at their most vulnerable.

## **IMPACT ASSESSMENT**

14.10 The Nursing and Midwifery Council had “significant concerns about the accuracy and adequacy of the impact assessment”, and provided detailed comments. These included querying the accuracy of some of the figures and calculations, and the extent to which the transfer of rule-making functions to the regulators would save costs for the Department of Health. For example, the Council said:

<sup>1</sup> Emphasis in the original

This paragraph, at the foot of page 5, refers to “the transfer of costs from the Department of Health on to the regulators who would be required to undertake the consultation and drafting associated with a change in the rules”. This statement is misleading, as the regulators already bear the costs of consultations and drafting related to all changes in their rules. The Department of Health is only responsible for the costs of consultations and drafting relating to section 60 orders or changes to primary legislation. The difference under these proposals is that the Department of Health will no longer have a scrutinising function in relation to any new rules. It is accepted that this will result in some costs savings in the Department. However, the impact assessment does not address the possible detrimental consequences of removing this degree of scrutiny of such legislation and the likely increased costs on the regulators, which would have to be passed on to their registrants, in having to “buy in” this level of legal expertise in statutory drafting.

14.11 The Royal Pharmaceutical Society of Great Britain was:

very concerned that the financial burden of change proposed by this consultation will fall on the individual pharmacy registrants, and correspondingly cause a raise in registration fees.

14.12 It sought “assurances that pharmacists will not be financially penalised by any Governmental reform”.

14.13 The Registration Council for Clinical Physiologists noted that the “financial cost of maintaining a voluntary register is high”.

#### **MIDWIFERY**

14.14 The consultation paper made no specific proposals regarding midwifery, but a number of responses commented on this aspect of the legal framework.

14.15 The Nursing and Midwifery Council assumed that our proposed legal framework would signal the end to the current statutory framework for supervising midwives (although it could continue to issue standards under the proposed two tier system of guidance). It argued that:

The supervisory framework for midwives is underpinned by the rationale of public protection. There is a body of knowledge about the contribution of supervision to the safety of mothers and babies and how effective use of the supervisory framework is considered to lead to improvements in the standard of midwifery care and better outcomes for women. There is also evidence suggesting that where there are weak employer systems or weak supervision of midwives, poor clinical outcomes will result.

14.16 The Royal College of Midwives warned that:

Even with these statutory protections, midwifery has had a constant fight to ensure profession specific regulation that recognises the role of the midwife, the level of responsibility and accountability, and the

potential for disaster for mother and baby should things go wrong. This fight, in large part, stems from midwives being regulated by the same body that regulates the much larger and fundamentally different profession, nursing.

From this perspective, the removal of midwifery specific provisions from statute is unacceptable to the Royal College of Midwives and to midwives. We do not believe that such changes will ensure on-going public protection for women and babies.

14.17 Thompsons Solicitors stated:

We share the concern of the Royal College of Midwives about the proposal to remove from the Local Supervising Authority Midwifery Officer the power to suspend midwives. Whilst we understand that this power is not exercised frequently it is an important one, particularly where midwives are working independently and not within a hospital environment.

14.18 However, not all consultees agreed. Independent Midwives UK felt that the additional layer of statutory regulation for midwifery “has evolved historically and the lack of a proper funding mechanism also impacts on how it functions”. It recommended this “is disbanded to bring midwifery regulation in line with the other professions”. An individual consultee (Anonymous) felt that “there may be a case for additional supervision for midwives but the evidence base for this should be clear” and it could be that “the additional supervision is a responsibility of employers and individual practitioners to arrange”.

#### **NAMES OF THE REGULATORS**

14.19 An individual consultee (Paul Sommerfeld) proposed that changing the names of the regulators could “significantly increase public understanding”. He gave the example of the British Medical Association and the General Medical Council, and said that the distinction between the two is “entirely opaque to members of the public”. He proposed that:

the names of *all* health and social care regulatory agencies should include the word ‘Regulatory’ eg General Medical Regulatory Council; General Pharmaceutical Regulatory Council; General Osteopathic Regulatory Council, Health Professions Regulatory Council, etc.<sup>2</sup>

... A further step would be, where possible, to include the common name of the profession regulated eg General Regulatory Council for Doctors; General Regulatory Council for Osteopaths; General Regulatory Council for Pharmacy Professions and Premises. Evidently, this may not be possible for multi-profession councils such as the Health and Care Professions Council.

<sup>2</sup> Emphasis in the original.

# **APPENDIX A**

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- (4) Dr Anton E A Joseph
- (5) John Bradfield
- (6) Connal Craig QC
- (7) British Osteopathic Association
- (8) Christine Bexton
- (9) Centre for the Advancement of Interprofessional Education
- (10) Scottish Mediation Network
- (11) Coventry and Warwickshire Partnership Trust
- (12) National Audit Office
- (13) Optical Consumer Complaints Service
- (14) Dr G Simmons
- (15) Ards Borough Council
- (16) Peter Hopley
- (17) Trevor Williams
- (18) Scottish Court Service
- (19) Rehabilitation Engineering Services Management Group
- (20) Community Pharmacy Wales
- (21) Lorraine Forster
- (22) Jane C Hern
- (23) Dental Schools Council
- (24) Stephen King
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- (29) Osteopathic Alliance
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- (33) Academy of Medical Royal Colleges
- (34) Institute of Physics and Engineering in Medicine
- (35) David Bleiman
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- (130) College of Social Work
- (131) Professional Forum of the Pharmaceutical Society of Northern Ireland
- (132) Care Council for Wales
- (133) Professional Standards Authority
- (134) Optical Confederation



- (135) Professional Leads for Allied Health Professions, Medics, Pharmacy and Psychological Therapies, South Staffordshire and Shropshire Healthcare NHS Foundation Trust
- (136) South Staffordshire and Shropshire Healthcare NHS Foundation Trust (Social Care)
- (137) Central and North West NHS Foundation Trust
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- (187) NHS Education for Scotland

- (188) Executive Nurse Directors of NHS Scotland
- (189) Scottish Government
- (190) Welsh Government
- (191) Royal College of Nursing
- (192) Department of Health

## **APPENDIX B CONSULTATION EVENTS**

- |      |   |                |
|------|---|----------------|
| (1)  | Professional Standards Authority event at Cumberland Lodge                | 8-9 March 2012 |
| (2)  | College of Optometrists – Jo Mullen                                       | 12 March 2012  |
| (3)  | Association of Regulatory and Disciplinary Lawyers                        | 13 March 2012  |
| (4)  | 39 Essex Street   | 15 March 2012  |
| (5)  | Sandwell Safeguarding Adults Board  | 20 March 2012  |
| (6)  | General Optical Council   | 22 March 2012  |
| (7)  | Medical Defence Union   | 23 March 2012  |
| (8)  | Action Against Medical Accidents  | 26 March 2012  |
| (9)  | Charles Russell LLP   | 26 March 2012  |
| (10) | Field Fisher Waterhouse   | 27 March 2012  |
| (11) | Essex Basildon Safeguarding Conference                                    | 27 March 2012  |
| (12) | 39 Essex Street   | 27 March 2012  |
| (13) | Health and Care Professions Council                                       | 29 March 2012  |
| (14) | General Osteopathic Council   | 29 March 2012  |
| (15) | Administrative Justice and Tribunals Council                              | 18 April 2012  |
| (16) | College of Optometrists   | 18 April 2012  |
| (17) | Kings Social Care Workforce Research Unit                                 | 20 April 2012  |
| (18) | Federation of (Ophthalmic and Dispensing) Opticians                       | 24 April 2012  |
| (19) | Department of Health Social Partnerships Forum                            | 26 April 2012  |
| (20) | RadcliffeLeBrasseur   | 26 April 2012  |
| (21) | Sussex University   | 1 May 2012     |
| (22) | Unite   | 3 May 2012     |
| (23) | Northern Ireland Practice and Education Council for Nursing and Midwifery | 3 May 2012     |
| (24) | Northern Ireland Social Care Council                                      | 3 May 2012     |
| (25) | Pharmaceutical Society of Northern Ireland Council                        | 3 May 2012     |

- (26) Pharmaceutical Society of Northern Ireland Professional Forum  
3 May 2012
- (27) Professional Standards authority  
4 May 2012
- (28) Royal College of Nursing, Royal College of Midwives, UNISON and  
Unite, Community Practitioners' and Health Visitors' Association  
15 May 2012
- (29) Independent Safeguarding Authority  
15 May 2012
- (30) Capsticks Solicitors LLP  
16 May 2012
- (31) General Dental Council  
18 May 2012
- (32) Wales National Joint Professional Advisory Committee  
21 May 2012
- (33) Care Quality Commission  
22 May 2012
- (34) Bridge the Gap  
22 May 2012
- (35) Council of Deans of Health  
23 May 2012
- (36) Scottish stakeholders conference  
24 May 2012
- (37) Scottish Government  
24 May 2012
- (38) General Social Care Council  
28 May 2012
- (39) Medical Defence Union  
29 May 2012
- (40) Isle of Man Government  
29 May 2012
- (41) Blake Laphorn LLP  
29 May 2012
- (42) Institute of Health Visitors  
30 May 2012