

3. The future of fitness to practise: from incremental change to radical reform

Chapter summary

- 3.1 This chapter sets out the Professional Standards Authority's (the Authority) vision for a new approach to fitness to practise for professional regulation in the UK, building on the arguments for reform in *Rethinking regulation*,⁵¹ and on the outline proposals we set out in *Regulation rethought*.⁵² In doing so, it examines the purpose and role of fitness to practise, and considers some of the key challenges and opportunities for reform presented by existing models in our sector.
- 3.2 Fitness to practise frameworks are complex and vary from one regulator to the next. We know that most regulators are struggling with increasing caseloads, and as we explained in the two aforementioned publications, the current framework is expensive and overly adversarial.
- 3.3 There is an appetite for reform in the sector of professional regulation in health and care. The Department of Health, on behalf of the four UK Governments, published the consultation document *Promoting professionalism, reforming regulation* on 31 October 2017. The consultation is an opportunity for all those with an interest in the way that health professionals are regulated to play their part in influencing the future direction of policy. However, as uncertainty remains as to whether this will result in large-scale legislative reform, it is important to consider what improvements can be made through more incremental changes, with or without the need for piecemeal amendments to existing legislation.
- 3.4 There is room for improvement within the current frameworks. In particular there are two areas where more work is needed to deal with rising caseloads safely, and to ensure proportionality:

Threshold criteria and processes at the early stages: these relate to the decisions to close or progress complaints that are made at any point up to, but excluding, the investigating committee or case examiner decision.

- 3.5 We find that there are major inconsistencies in legislation, but also policy and implementation across the regulators. There is a concerning lack of clarity and transparency in this area, and the possibility of cases being closed where there is a risk to the public. We are recommending a review of the regulator's practices in

⁵¹ Professional Standards Authority, August 2015. *Rethinking regulation*. Available at <http://www.professionalstandards.org.uk/publications/detail/rethinking-regulation> [Accessed 1 November 2017].

⁵² Professional Standards Authority, October 2016. *Regulation rethought*. Available at <http://www.professionalstandards.org.uk/publications/detail/regulation-rethought> [Accessed 1 November 2017].

this area, to identify areas of risk, and to encourage greater consistency and transparency.

Consensual disposal (undertakings): increasingly, cases that meet the threshold for onward referral at the end of an investigation can be disposed of consensually through undertakings

- 3.6 We note the piecemeal development of these processes, with differences between the regulators that have these powers currently, and further variations proposed for those that do not. Even more so than with hearing proceedings, there is a need for transparency and accountability because these decisions are made ‘behind closed doors’ by members of staff, rather than independent panels. Furthermore, there is little understanding currently of what works and where the risks are in these processes. We are proposing a review across the regulators of how undertakings work in practice, to understand more about how effective they are as a form of remediation, and to identify where there may be risks to the public.
- 3.7 Looking further into the future, we believe that the purpose of fitness to practise should continue to be to protect the public, maintain public confidence, and declare and uphold professional standards. However, in this chapter, we propose a model that aims to minimise the adversarial and legalistic aspects that are prevalent in the current models.⁵³ It would do so by encouraging cooperation from registrants from the outset, and by using hearings only where the registrant disagrees with the regulator on the facts, the decision to take action, or the proposed outcome. Investigations would focus on establishing the facts, rather than building a case for the prosecution. Remediation would be encouraged, based on a better understanding of what works, and how it can fulfil the three aims of fitness to practise. Patients and service users would have a voice in the process through the provision of impact statements, to be taken into account by decision-makers. The increased power and flexibility afforded to regulators in this model would need to be balanced with greater transparency and accountability, not least through scrutiny of decisions by the Professional Standards Authority.
- 3.8 We put forward this chapter in the hope that it might stimulate debate and discussion, and help to bring about a consensus on the future of fitness to practise.

⁵³ The Scottish Social Services Council operates a model that bears some of the characteristics of our proposals in this report.

Background and purpose

- 3.9 This chapter sets out the Professional Standards Authority's (the Authority) vision for a new approach to fitness to practise (FtP) for professional regulation in the UK. In doing so, it examines the purpose and role of fitness to practise, and considers some of the key challenges and opportunities for reform presented by existing models in our sector.
- 3.10 Our vision builds on the arguments for reform in *Rethinking regulation*, and on the outline proposals we set out in *Regulation rethought*.⁵⁴ This report comes at a time when the health and care systems across the UK are under considerable strain from tightening finances and growing demand. The outcome of the EU referendum in June 2016 has implications for the workforce – for example, there has been a dramatic fall in the number of EU nurses applying for registration since the referendum.⁵⁵
- 3.11 There is an appetite for reform in the sector of professional regulation in health and care. The Department of Health, on behalf of the four UK Governments, published the consultation document *Promoting professionalism, reforming regulation* on 31 October 2017. The consultation is an opportunity for all those with an interest in the way that health professionals are regulated to play their part in influencing the future direction of policy. However, as uncertainty remains as to whether this will result in large-scale legislative reform, it is important to consider what improvements can be made through more incremental changes, with or without the need for piecemeal amendments to existing legislation.
- 3.12 In parallel, the Department for Education (DfE) is currently leading the development of a new regulator for social workers, Social Work England (SWE). The primary legislation for this regulator is very permissive,⁵⁶ and provides for the Secretary of State to make regulations setting out the shape of the fitness to practise process. There may therefore be an opportunity for SWE to pioneer new ways of working in FtP, if the timetable allows, and if its newly-appointed leaders are willing.
- 3.13 Our 2015 publication *Rethinking regulation* highlighted the expense of the current FtP frameworks, and the increasing numbers of complaints. In our follow-up paper *Regulation rethought*, the Authority called for a radical overhaul of fitness to practise, which we described as 'protracted and expensive' in its current form. We promoted a move to a less adversarial approach with more early opportunities for remediation.

Aims and approach

- 3.14 This chapter takes an in-depth look at the need and possibilities for reform of fitness to practise.

⁵⁴ Professional Standards Authority, October 2016. *Regulation rethought*. Available at <http://www.professionalstandards.org.uk/publications/detail/regulation-rethought> [Accessed 1 November 2017].

⁵⁵ See figures quoted at paragraph 1.4

⁵⁶ The Children and Social Work Act 2017 received Royal Assent on 27 April 2017. Available at <http://www.legislation.gov.uk/ukpga/2017/16/contents/enacted/data.htm> [Accessed 1 November 2017].

- 3.15 It aims to set out a clear framework and purpose for future reforms, whether incremental or radical. It examines some of the key challenges facing regulators' fitness to practise regimes at the moment, and considers ways in which they might be addressed while continuing to provide the necessary safeguards and assurances of public protection. The areas covered in depth are:
- Criteria and thresholds for referral at the initial stages of the FtP process, and
 - Consensual disposal by case examiners.
- 3.16 It also builds on our thinking in *Regulation rethought* to consider what longer-term reform could look like.
- 3.17 For any change to occur there needs to be a clear articulation of the problem it would be solving and of the tangible benefits offered by the change. Our approach to this review seeks to be both evidence-based and principles-led. Any fitness to practise model must first and foremost fulfil the three aims that have been established in case law of:
- the protection of patients
 - the maintenance of public confidence in the profession, and
 - upholding proper standards of conduct and behaviour.
- 3.18 A version of these three aims now appears in the over-arching duties of the Authority and all the regulators we oversee with the exception of the Pharmaceutical Society of Northern Ireland (PSNI).⁵⁷ In addition, they mirror the new thresholds for Authority and General Medical Council (GMC) appeals of cases to the Courts.⁵⁸
- 3.19 Furthermore, the principles of right-touch regulation⁵⁹ provide a useful framework for discriminating between different approaches. They state that regulation must be:
- proportionate
 - consistent
 - targeted
 - transparent
 - accountable
 - agile.

⁵⁷ As amended by the Health and Social Care (Safety and Quality) Act 2015 and The General Medical Council (Fitness to Practise and Over-arching Objective) and the Professional Standards Authority for Health and Social Care (References to Court) Order 2015.

⁵⁸ The General Medical Council (Fitness to Practise and Over-arching Objective) and the Professional Standards Authority for Health and Social Care (References to Court) Order 2015. Available at <http://www.legislation.gov.uk/ukxi/2015/794/contents/made> [Accessed 1 November 2017].

⁵⁹ Professional Standards Authority. 2015. *Right-touch regulation - revised*. Available at <http://www.professionalstandards.org.uk/policy-and-research/right-touch-regulation> [Accessed 1 November 2017].

- 3.20 Although these all come into play at various points in the chapter, in matters of fitness to practise in general, we have found that transparency and accountability are the most consistently relevant.
- 3.21 To these, we add two further considerations that were set out in *Regulation rethought*:
- reforms should be simple to understand and operate, and
 - they must be efficient and cost-effective.
- 3.22 For this chapter, we have drawn on the findings of major healthcare inquiries, such as Shipman⁶⁰ and Mid-Staffs⁶¹, the work of the Law Commissions to consolidate and simplify the regulators' legislation, and the growing body of research into fitness to practise and professional regulation generally. This includes research we have commissioned ourselves, but also reports published by the regulators we oversee. We have also made use of the information and data we ourselves hold as a consequence of our oversight and scrutiny of health and care professional regulation in the UK.

Terminology

- 3.23 It has not been possible within the scope of this project to consider alternative terms to describe fitness to practise. Decisions about how to describe this function cannot be made without significant involvement of the public and professionals. We are nevertheless acutely aware that the current language of fitness to practise is technical and inaccessible to professionals and the public alike. Any significant reforms of fitness to practise should consider adapting the associated terminology to make it more easily understandable, and to help disassociate the new approach from the adversarial model currently in place.

A note on future reforms and innovation

- 3.24 The Authority supports regulators innovating in fitness to practise and other areas of regulation, and thinking creatively about how to fulfil their statutory duties. We know that the current system is not fit for purpose and we are actively calling for it to be comprehensively reformed.
- 3.25 However, there are reasons why we might sometimes express reservations about innovations, even if we agree with them in principle:
- we may have concerns about how they are put into practice (for example when we have supported proposals at the consultation stage but subsequently identify issues with implementation)
 - the proposals or practice may not be in line with the current legislation or established case law (even if we believe the current legislative framework is not fit for purpose)

⁶⁰ The Shipman Inquiry, 2004. *Fifth Report - Safeguarding Patients: Lessons from the Past - Proposals for the Future*. Available at <http://webarchive.nationalarchives.gov.uk/20090808160144/http://www.the-shipman-inquiry.org.uk/fifthreport.asp> [Accessed 1 November 2017].

⁶¹ The Mid Staffordshire NHS Foundation Trust, Public Inquiry, 2013. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Volume 2*. Available at <http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/sites/default/files/report/Volume%202.pdf> [Accessed 1 November 2017].

- we may not be confident that they will protect the public, or enable transparent and accountable regulation (this is as important for individual changes as it is for comprehensive reforms).
- 3.26 This position stems from our over-arching objective to protect the public. We are empowered by our legislation to carry out a number of statutory functions, including:
- promoting the interests of patients and service users in relation to the performance of professional regulators,
 - promoting best practice in regulation, and
 - formulating principles of good regulation and encouraging regulators to conform to them.
- 3.27 We express certain views that question the appropriateness of current legislation and case law. These opinions notwithstanding, we will continue to fulfil our statutory responsibilities within and respect the principles laid down by the current framework, and we know the regulators will do the same.

Basic principles for reform

The current approach to fitness to practise

- 3.28 A clear position on the role and purpose of the fitness to practise function should underpin all thinking about how it operates and the decisions that are made about which cases to accept and progress through the different stages. It should also be driving any future reforms, however big or small.
- 3.29 The purpose of fitness to practise has evolved over time, moved on occasionally by high-profile cases and subsequent reforms – such as the Shipman Inquiry, and the White Paper *Trust, Assurance, and Safety*⁶², and subsequent legislative reforms. But also, more frequently, by case law where either the Authority, or a registrant has appealed a fitness to practise decision in the Courts, and the ensuing judgment has included statements about the purpose of this regulatory function.
- 3.30 As things stand, the purpose of fitness to practise outcomes is expressed as three limbs, helpfully encapsulated in the case of *Cohen vs GMC*:⁶³
- the protection of patients
 - the maintenance of public confidence in the profession, and
 - upholding proper standards of conduct and behaviour.
- 3.31 These three limbs of public protection are now so engrained that they have recently been written into the over-arching duty of all eight of the UK and GB regulators we oversee,⁶⁴ and into the thresholds for referral of FtP decisions to the Courts of the Authority and the GMC.
- 3.32 The landmark *Cohen* case also established the principle that FtP decisions should focus in the main on whether the registrant's fitness to practise is impaired at the time of the decision, and not simply on whether misconduct has been found.⁶⁵ This case brought to the fore considerations of remediation of the registrant's failings, insight and the risk of future repetition. It can be argued that this is a more pragmatic, less punitive approach.
- 3.33 We have seen over the last few years an increased focus among the regulators on remediation, for example this is stated explicitly in the GMC's 2011 consultation on consensual disposal.⁶⁶ This shift can be seen in the options some of the regulators are developing for disposing of cases before they reach a

⁶² HM Government, February 2007. *Trust, Assurance and Safety – the regulation of health professionals in the 21st Century*. Available at <https://www.gov.uk/government/publications/trust-assurance-and-safety-the-regulation-of-health-professionals-in-the-21st-century> [Accessed 1 November 2017].

⁶³ *Cohen v General Medical Council* [2008] EWHC 581 (Admin), [2008]. Available at <http://www.bailii.org/ew/cases/EWHC/Admin/2008/581.html> [Accessed 1 November 2017].

⁶⁴ The PSNI has yet to have its over-arching duty amended.

⁶⁵ Although the GCC and GOsC still have legislation based on misconduct rather than impairment of fitness to practise.

⁶⁶ GMC, January 2011. *Reform of the fitness to practise procedures at the GMC: Changes to the way we deal with cases at the end of an investigation. A paper for consultation*. Available at http://www.gmc-uk.org/FTP_reforms_consultation_paper.pdf_38085201.pdf [Accessed 1 November 2017].

hearing – the GMC has had undertakings in its framework for some time, and the Nursing and Midwifery Council (NMC) and General Dental Council (GDC) have also recently moved to regimes where these sorts of options are possible. The General Pharmaceutical Council (GPhC), which is the newest regulator, was set up with powers to agree undertakings at an early stage, and the PSNI has gained similar powers. We understand that other regulators are considering similar options.

- 3.34 In addition, research is emerging that suggests current fitness to practise approaches may in fact be counter-productive and even damaging. For example, research by McGivern *et al.* for the General Osteopathic Council (GOsC) highlights the negative impact on practice when information is spread around professional networks about bad experiences of hearings:

‘stories about damaging experiences of FtP hearings may produce anxiety about regulation and consequent defensive practice in the wider osteopathic population’.⁶⁷

- 3.35 A further example is the apparently high number of suicides among doctors under investigation by the GMC, that prompted the Horsfall review.⁶⁸ We look in more detail at the human impact of fitness to practise processes later in the chapter. At this stage it is simply worth noting, as we did in *Rethinking regulation and Regulation rethought*, the unintended consequences of the current incarnations of the process.

A future approach to fitness to practise

- 3.36 We argued in *Regulation rethought* that fitness to practise ought to move to a less adversarial framework focused on remediation and local resolution. The fitness to practise mechanisms employed by the regulators developed in the context of the use of criminal standards of proof and the criminal laws of evidence. They were disciplinary systems modelled on quasi-criminal processes. The emphasis was on the findings of fact, which determined whether a practitioner had committed misconduct deserving of sanction.
- 3.37 The case law establishes that the purpose of the fitness to practise (FtP) process, and the imposition of sanctions, is not punitive. Rather, its purpose reflects the statutory duty of the regulators which is now enshrined in legislation: the three limbs of public protection. What is less clear however, is how these three aims should be balanced by a fitness to practise panel in determining the case before it.
- 3.38 To what extent does the maintenance of public confidence still imply some element of the regulator being required to be seen to be ‘taking action’, even

⁶⁷ McGivern, G, et al, 2015. *Exploring and explaining the dynamics of osteopathic regulation, professionalism and compliance with standards in practice. Report to the General Osteopathic Council.* Available at <http://www.osteopathy.org.uk/news-and-resources/document-library/research-and-surveys/dynamics-of-effective-regulation-final-report/dynamics-of-osteopathic-regulation-final-report.pdf>. [Accessed 1 November 2017].

⁶⁸ General Medical Council, December 2014. *Doctors who commit suicide while under GMC fitness to practise investigation, Internal review, Sarndrah Horsfall, Independent Consultant.* Available at http://www.gmc-uk.org/Internal_review_into_suicide_in_FTP_processes.pdf_59088696.pdf [Accessed 1 November 2017].

where that registrant is considered to have remediated, and no longer poses a threat to the public? We know from research we have commissioned that members of the public sometimes disagree with assessments by FtP panels or Court Judges, that there is a threat to public confidence in particular cases.⁶⁹ How, then should it be decided that the public confidence aspect has been satisfied in a particular case? Does the need to uphold proper standards, and thereby to express the norms of the regulated community, trump the fact that the purpose of FtP proceedings has in some way already been achieved, if the registrant has sought to remediate his failings, perhaps in an effort to avoid sanction and action on his registration? These are matters that may be decided by Parliament, by the Courts, or by policy underpinned by research – certainly further clarification is needed.⁷⁰

- 3.39 Setting aside these tricky questions for the moment, we support the trend that we have seen in the case law, and across the regulators, for a greater emphasis on remediation, where it is the minimum regulatory force to achieve the desired result, namely protecting the public, maintaining confidence in the profession, and declaring and upholding professional standards. This approach to fitness to practise can be described as follows:

Fitness to practise outcomes should fulfil the three limbs of public protection through meaningful remediation where possible, and degrees of restrictions on practice where not.

- 3.40 Restrictions on practice include conditions, suspensions and erasure. Cases where remediation is not possible include if the actions of the registrant are fundamentally incompatible with continued registration, and more generally if remediation would fail to maintain public confidence and declare and uphold professional standards.

⁶⁹ Policis research for the Professional Standards Authority, June 2016. *Dishonest behaviour by health and care professionals: exploring the views of the general public and professionals*. Available at <http://www.professionalstandards.org.uk/publications/detail/research-dishonest-behaviour-by-professionals> [Accessed 1 November 2017].

⁷⁰ We touch on the matter of further research in this area later in the report.

- 3.41 Within these parameters, we would like to see a shift towards greater use of meaningful remediation in fitness to practise – whether it is achieved through incremental change or wholesale reform. The challenge, however, will be to find ways to do this that provide sufficient assurance to the public, registrants and the Authority that the public remains protected, and that regulation is working in the public interest. In this chapter, we consider ways in which this aim could be achieved.

What is meaningful remediation?

*'It must be highly relevant in determining if a doctor's fitness to practise is impaired that first his or her conduct which led to the charge **is easily remediable**, second that it **has been remedied** and third that it **is highly unlikely to be repeated**.'*

(Cohen v GMC; (2008) EWHC 581 (Admin); paragraph 65)

Where a professional has been found to be unfit to practise, their failings can sometimes be addressed by means of remediation, to try to make them fit to practise again in the future.

It is important to note that:

- In some cases, remediation may address the immediate risk to the public, but fail to uphold professional standards and/or maintain public confidence
- Not all failings can be remediated and remediation is not always successful
- Clinical failings are more likely to be successfully addressed through remediation than other types of impairment
- Remediation can only be effective if the registrant shows insight into their failings
- Evidence of meaningful remediation should include an objective element, and go beyond a reflective written piece, completion of an online course, or the mere passage of time
- Reviews are essential to check whether remediation has been effective, where remediation measures have been imposed or agreed.

Therefore, when we talk about meaningful remediation measures, we mean that:

- There is evidence of sincere insight and remorse
- Remediation measures have a realistic prospect of addressing the failings
- Remediation as an outcome fulfils all three aims of public protection as appropriate
- Review and objective assessment of whether remediation has been effective, including an assessment of the likelihood of repetition, are undertaken systematically.

Basic guidelines for FtP reform

3.42 We set out below, and in the light of what we have explained above, the basic principles that we believe should guide all reform in this area – regardless of the particular model of FtP, or of the structures in place to operate it.

- **Use fitness to practise measures only when necessary:** issues should be resolved in the place where they occur or by other bodies who are best placed to deal with them, unless or until they meet the regulator’s threshold for referral.
- **Link thresholds for accepting concerns to the professional code:** it should be clear to registrants, employers, patients and service users when a concern needs to be referred to the regulator. This should be based on the code that sets out what is expected of a registrant.
- **Seek early resolution and remediation where appropriate:** the purpose of fitness to practise is not to punish. This has implications for the way in which cases are disposed of, and for the design of the FtP process, for example the role of formal adjudication would be diminished.
- **Separate investigation and decision-making, including adjudication:** the current structures limit the extent to which this is possible for all the regulators, but it remains an important basic principle.⁷¹
- **Ensure accountability, transparency, and consistency:** this applies both to policy and to practice; there should be external scrutiny of all decisions that meet the threshold for action on registration; and there should be options to review decisions to close cases at the major decision-making points in the process. Consistency of approach across regulators is essential: there are good reasons why outcomes may be different, but any reforms should strive for greater consistency of process and thresholds where possible.

We will return to these points throughout the chapter as we examine options for reform.

⁷¹ As recommended by Dame Janet Smith’s recommendation 51 of the Shipman Inquiry, 5th Report. Available at http://webarchive.nationalarchives.gov.uk/20090808154959/http://www.the-shipman-inquiry.org.uk/images/fifthreport/SHIP05_COMPLETE_NO_APPS.pdf [Accessed 1 November 2017].

How fitness to practise works now

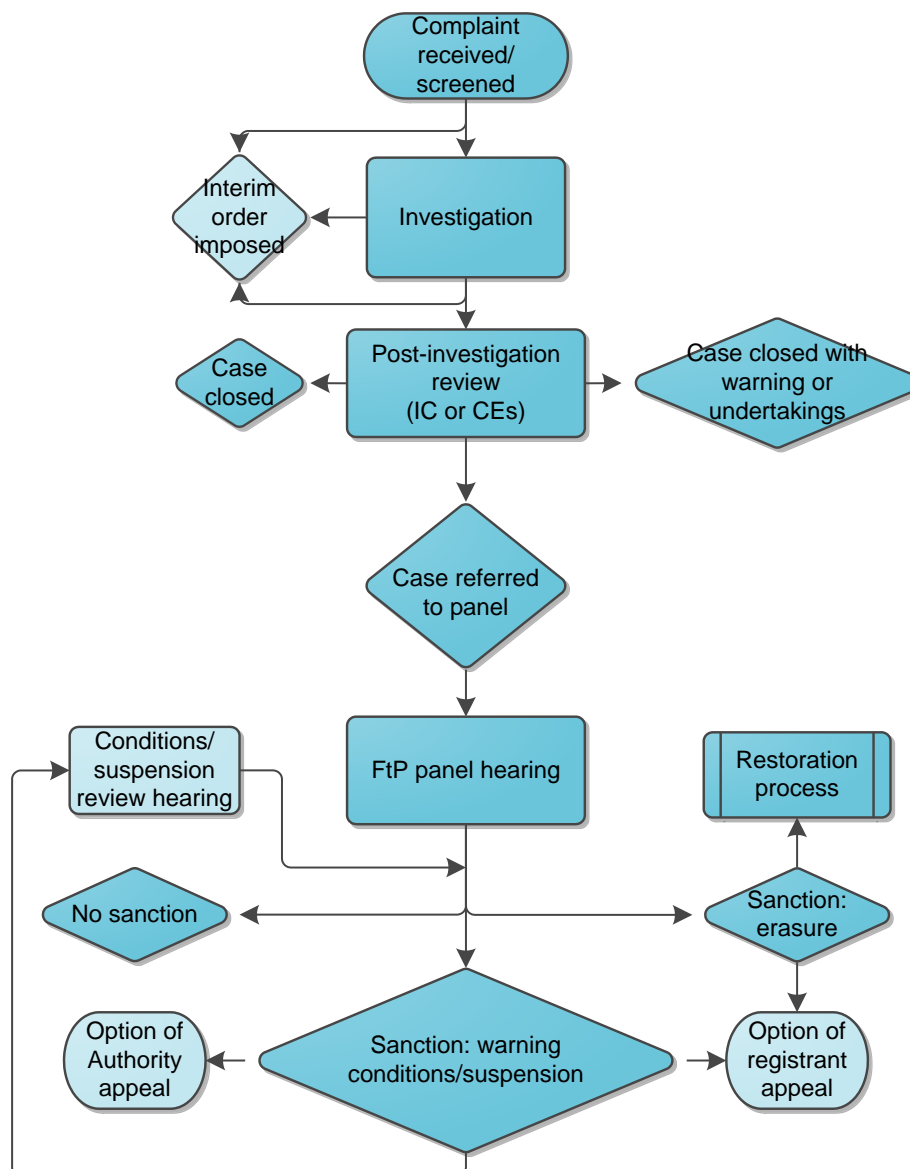
3.43 In this section, we consider the key differences and similarities between the nine regulators' fitness to practise models.

Current models – similarities

3.44 Currently, all nine of the regulators that we oversee have different legislation underpinning their fitness to practise frameworks, resulting in different processes. Some of these differences have been in the legislation from inception; others have developed over time, as the regulators have been given opportunities to amend their legislation in a piecemeal way, through Section 60 Orders.

3.45 The generic shape of the fitness to practise process, as set out in Figure 2, is nevertheless similar across all the regulators.

Figure 2: A generic fitness to practise process



- 3.46 Typically, some kind of investigation begins following receipt of a complaint or concern about a health or care professional. Once this stage is complete, or the regulator has enough information to send the case on to a decision-maker, it is referred either to an Investigating Committee (IC) or to two case examiners (CEs) to decide how it should be dealt with. For some of the regulators, the IC has a simple binary decision to make about whether there is a realistic prospect of a panel finding that the professional's fitness to practise is impaired. If there is, it is referred to a full hearing before a panel. If there is not, the case is closed (sometimes with a warning or advice for the registrant). In addition, they have the option of imposing an interim suspension (and sometimes conditions) order.
- 3.47 For other regulators, the IC or CEs can choose not to refer to a panel even if the real prospect test is met. The GMC, NMC and GDC CEs/IC have powers to agree undertakings with the registrant in any case that would not result in striking off if referred to a panel, and that can safely be disposed of in this way.
- 3.48 Once a case reaches a hearing, the Panel has to establish the following (in sequence):
- 1) that the facts/allegations are found proved
 - 2) that the facts/allegations support one or more grounds for impairment⁷²
 - 3) that impairment is found,⁷³ and
 - 4) the appropriate sanction (taking into account any mitigations).
- 3.49 The proceedings at a hearing are adversarial, with the regulator presenting its case on one side, the registrant defending on the other, and the Panel adjudicating. The Panel can decide that any of 1) to 3) above have not been established, and for most of the regulators, even where impairment has been found, can choose not to impose a sanction.
- 3.50 Sanctions at this stage vary between the regulators, but all have the option of striking a registrant off the register as the most severe, and suspension and conditions of registration as lesser sanctions. The latter two sanctions can usually be imposed with a review hearing at the end of the period for which the sanction is applied, for a panel to check whether they are fit to return to practise.
- 3.51 Once the sanction has been imposed, registrants, and the Authority (and for doctors, the GMC) can appeal the outcome. The GMC and the Authority can intervene if the decision is insufficient to protect the public. Only the Authority, however, can intervene where under-prosecution has led to an insufficient sanction (or to it being impossible to assess whether or not the sanction was sufficient). In these cases, a referral is made to the Courts (e.g. the High Court in England and Wales), where a Judge will adjudicate on a final outcome. A successful appeal can result either in a substitution of the decision, or in a remittal to the regulator's FtP panel.

⁷² Except for GOsC and GCC, where the role of the panel is to determine whether the facts amount to one or more of the statutory grounds defined in the Act, such as 'unacceptable professional conduct'.

⁷³ Except for GOsC and GCC, where the role of the panel is to determine whether the facts amount to one or more of the statutory grounds defined in the Act, such as 'unacceptable professional conduct'.

Current models – differences

- 3.52 As is already apparent from the above high-level description, there are many variations in the models across the regulators.
- 3.53 Broadly speaking, however, the regulators can be grouped as follows:
- General Chiropractic Council (GCC) and GOsC: the FtP model is based on the concept of unacceptable professional conduct, which is how the other regulators used to operate and is now regarded as outdated
 - NMC and Health and Care Professions Council (HCPC): they have virtually identical legislation but very different rules and processes
 - GMC, GDC and GPhC: they have very similar legislation and processes more comprehensively set out than the others.
- 3.54 The PSNI tends to be an outlier in part because it has not had much opportunity to update its legislation.⁷⁴ The General Optical Council (GOC) also stands out, particularly in its governance legislation (such as requirements to have advisory committees, and how they make rules). In addition, Part IV of the Opticians Act⁷⁵ is unique in setting out how optical services must be provided, and the GOC plays a role in upholding the requirements set out in this part of the legislation. The GPhC, GOC, and PSNI also have responsibility for registering and setting standards for premises or ‘bodies corporate’.
- 3.55 The GPhC’s Order⁷⁶ (its founding legislation) is the most recent – it was created in 2010 – and theoretically incorporates most of the improvements made up to that point to the GMC and GDC’s legislation. It also stands out in terms of its approach to premises regulation – it has inspection powers, meaning it can go into a pharmacy, identify a breach of its standards and take action. This is unique to the GPhC. The PSNI does not have these powers – instead they are given to the Northern Ireland Department of Health. The PSNI works with the Department’s Inspectorate through a memorandum of understanding.
- 3.56 The table that starts on the following page (Table 1) shows some of the key differences between the regulators’ fitness to practise frameworks.

⁷⁴ The PSNI is also different from the other regulators we oversee in that it has a dual role as both regulator and representative body.

⁷⁵ Opticians Act 1989. Available at <http://www.legislation.gov.uk/ukpga/1989/44/contents> [Accessed 1 November 2017].

⁷⁶ The Pharmacy Order 2010. Available at https://www.pharmacyregulation.org/sites/default/files/1116_pharmacy_order_consolidated.pdf [Accessed 1 November 2017].

Table 1: Key differences in fitness to practise models across nine regulators⁷⁷

Body	Main legislation	Initial threshold	Post-investigation review	Post-investigation powers	Criteria for post-investigation disposals	Grounds for impairment	Adjudicating panels	Adjudicating panel powers
GCC		Allegation = -unacceptable professional conduct -professional incompetence - has been convicted in the United Kingdom of a criminal offence; - their ability to practise is seriously impaired because of their physical or mental condition If = allegation – systematic referral to IC (s.20 Chiropractors Act)	IC	If case to answer, refer to Health Committee or Professional Conduct Committee If no case to answer, close. Chiropractors Act	N/A	Not defined as such, but in practice: -unacceptable professional conduct -professional incompetence - has been convicted in the United Kingdom of a criminal offence; - their ability to practise is seriously impaired because of their physical or mental condition	- Health Committee - Professional Conduct Committee	- admonishment - conditions of practice (including competence test) (w/ powers to review but not part of original decision) - suspension - removal Chiropractors Act
GDC	Dentists Act 1984	“the complaint or information amounts to an allegation” that fitness to practise is impaired	CE and IC	- close case - refer for hearing - close with advice - close with warning - agree undertakings - refer to IC for decision (CE only) (GDC s.60 2016)	Warnings: - if not referred to a practice committee - practice or behaviour represents a departure from the standards expected of the profession and should not be repeated Undertakings: - if the allegation ought to be	- misconduct; - deficient professional performance - adverse physical or mental health - conviction or caution - not having the necessary knowledge of English	- Professional Conduct Committee - Professional Performance Committee - Health Committee (GDC website)	- reprimand - conditions - suspension with or without a review - erasure (except on health grounds alone) - immediate suspension - immediate conditional registration

⁷⁷ Throughout this table we have paraphrased certain elements where we felt it was appropriate and helpful to do so in order to keep the table to a manageable size. This is particularly the case in the ‘Grounds for impairment’ column.

Body	Main legislation	Initial threshold	Post-investigation review	Post-investigation powers	Criteria for post-investigation disposals	Grounds for impairment	Adjudicating panels	Adjudicating panel powers
					considered by a practice committee - only if no real prospect of striking off (Guidance for CEs)	(CE guidance) (English language s.60)		- Refer a dental professional to another Practice Committee
GMC	Medical Act 1983 ; Fitness to Practise Rules 2004	Allegation “that the fitness to practise of a practitioner is impaired” Cannot proceed if complaint is vexatious; or older than five years and not in the public interest to proceed. Fitness to Practise Rules 2004	CE and IC	- close case - refer for hearing - close with warning - close with undertakings - refer to IC for decision (CE only) - refer to IC for warnings hearing (CE only)	Warnings: no real prospect of impairment that justifies action on registration, Undertakings: real prospect of impairment but no real prospect of erasure (IC/CE guidance)	- misconduct - deficient professional performance - conviction or caution for a criminal offence - adverse physical or mental health - not having the necessary knowledge of English - determination by another regulator. (Medical Act 35C)	Medical Practitioners Tribunal – hears all types of case (MPTS = statutory committee of the GMC)	If impairment: - conditions (with or without review) - suspension (with or without review) - erasure (if not health or language case) - undertakings (Rules [17(4)] and [22(3)] of the General Medical Council (Fitness to Practise (FTP) Rules Order of Council 2004) If no impairment: can issue warning
GOC	Opticians Act 1989	Allegation “against a registered optometrist or a registered dispensing optician that his fitness to practise is or may be impaired”; impairment must be on defined grounds for impairment Opticians Act, FtP	IC and CE Fitness to practise Rules	If the allegation ought not to be considered by a FtP Committee: close warning If it ought: refer to FtP Committee Opticians Act, FtP If competence or health assessment is needed: refer to IC (CEs only)	Warnings: must have regard to the overarching objective Opticians Act, FtP <i>No mention of real prospect or case to answer in Act</i>	- misconduct - deficient professional performance a conviction or caution - adverse physical or mental health; - a determination by another regulator	Fitness to Practise Committee Opticians Act, FtP	- erasure (except health) - suspension - conditions (+any of the above in relation to specialist registration) If no impairment: can issue warning Opticians Act, FtP

Body	Main legislation	Initial threshold	Post-investigation review	Post-investigation powers	Criteria for post-investigation disposals	Grounds for impairment	Adjudicating panels	Adjudicating panel powers
GOsC	Osteopaths Act 1993	Allegation = -unacceptable professional conduct -professional incompetence - has been convicted in the United Kingdom of a criminal offence - their ability to practise is seriously impaired because of their physical or mental condition (guidance on threshold criteria)	IC	If case to answer, refer to Health Committee or Professional Conduct Committee If no case to answer, close. Osteopaths Act	N/A	Not defined as such, but in practice: -unacceptable professional conduct -professional incompetence - has been convicted of a criminal offence - their ability to practise is seriously impaired because of their physical or mental condition	- Health Committee - Professional Conduct Committee	- Admonishment - Conditions of practice (including competence test) (w/ powers to review but not part of original decision) - Suspension - Removal Osteopaths Act
GPhC	Pharmacy Order 2010	Either: an allegation is made to the Council against a registrant that the registrant's fitness to practise is impaired Or: the Council has information that calls into question a registrant's fitness to practise, even though no allegation to that effect has been made to the Council (Pharmacy Order) Plus: - the person concerned must be identifiable; and - the allegation is capable of being referred.	Threshold criteria applied by staff, then IC decision	IC only: - Refer to FtP committee if meets the real prospect test and 'the allegation ought to be considered by the Fitness to Practise Committee' - Warnings - Advice (to registrant or other) - Undertakings (by virtue of having powers to issue rules enabling the IC to issue undertakings) Pharmacy Order 2010	U/T – if registrant admits that fitness to practise impaired, if IC sees fit, and if registrant will comply Warnings and U/T – must have regard to over-arching objective. Pharmacy Order 2010	- misconduct; - deficient professional performance (which includes competence) - adverse physical or mental health - not having the necessary knowledge of English - failure to comply with a reasonable requirement in connection with carrying out a professional performance assessment - a conviction or caution	Fitness to practise committee	- warning - conditions - suspension - removal - advice - undertakings Pharmacy Order 2010

Body	Main legislation	Initial threshold	Post-investigation review	Post-investigation powers	Criteria for post-investigation disposals	Grounds for impairment	Adjudicating panels	Adjudicating panel powers
		Also, the Registrar must not refer the allegation where— - threshold criteria are not met - more than five years have elapsed unless it is necessary for the protection of the public, or otherwise in the public interest; or (c) the allegation is made by an informant who— (i) is anonymous and the allegation is not capable of verification from an independent source; or (ii) is identifiable but does not participate in the consideration of the allegation and the allegation is not capable of verification from an independent source (FtP Rules)				- a determination by another regulator Pharmacy Order 2010		
HCPC	Health and Social Work Professions Order 2001	The allegation is made against a registrant to the effect that— (a) his fitness to practise is impaired by reason of— [grounds for impairment] Or it appears to the Council that there should be an investigation into the fitness to practise of a	IC	- close case - offer mediation - refer to Screeners for mediation (but not used) - refer to Health Committee - refer to Conduct and Competence Committee Order	If case to answer, can offer mediation or refer to committees Order	- misconduct, - lack of competence - a conviction or caution - his physical or mental health, or- a determination by another regulator - fraudulent entry incorrectly made.	Health Committee Conduct and Competence Committee	Case not well founded Or If case well founded - mediate or refer to Screeners for mediation - conditions - suspension - striking off - caution

Body	Main legislation	Initial threshold	Post-investigation review	Post-investigation powers	Criteria for post-investigation disposals	Grounds for impairment	Adjudicating panels	Adjudicating panel powers
		registrant or into his entry in the register (i.e. without an allegation)				Order		
NMC	Nursing and Midwifery Order 2001 (Consolidated)	Allegation is made against a registrant to the effect that— (a) his fitness to practise is impaired by reason of— [grounds for impairment] Or it appears to the Council that there should be an investigation into the fitness to practise of a registrant or into his entry in the register (i.e. without an allegation)	IC and CE	<ul style="list-style-type: none"> - close case - undertakings - offer mediation - refer for a hearing but Conduct and Competence and Health Committee can decide to hold a meeting (=consensual panel decision) - warning - advice(FtP Rules) 	If case to answer, can offer mediation, undertakings, or refer to committees Order	<ul style="list-style-type: none"> - misconduct, - lack of competence, - a conviction or caution - not having necessary knowledge of English - his physical or mental health, - a determination by another regulator - fraudulent entry incorrectly made. 	Fitness to Practice Committee	<p>Case not well founded</p> <p>Or</p> <p>If case well founded</p> <ul style="list-style-type: none"> - mediate or refer to Screeners for mediation - conditions - suspension - striking off - caution
PSNI	Pharmacy (NI) Order 1976 (Amendment) Order (NI) 2012	<p>Either =</p> <ul style="list-style-type: none"> - an allegation is made to the Society against a registered person that their fitness to practise is impaired; or <p>-the Society has information that calls into question a registered person's fitness to practise, even though no allegation to that effect has been made to the Society</p>	Registrar and Scrutiny Committee	<p>Refer to Statutory Committee, or</p> <ul style="list-style-type: none"> - warning - advice to the person concerned in connection with any matter arising out of, or related to, the allegation - advice to any other person or other body involved in its investigation of the allegation on any issue arising out of, or related to, the allegation - close the case 		<ul style="list-style-type: none"> - misconduct - deficient professional performance; - adverse physical or mental health; - a criminal conviction or caution; - a finding by another body 	Statutory Committee.	<p>Statutory committee:</p> <ul style="list-style-type: none"> - warning - advice to any other person or other body involved in the investigation of the allegation -conditions of practice -removal of registrant from register - suspension - removal

3.58 Although the regulators are independent bodies, legislative changes can only be made with Government backing, and parliamentary approval. Some of the regulators have been given more opportunities to update their legislation than others. To illustrate this, we have set out below the number of section 60 Orders (and Northern Ireland equivalent) by regulator, over the last ten years:^{78 79 80}

Table 2: Section 60 Order by regulator since 2007

Regulator	Number of s.60 Orders	s.60 Orders
GMC	5	<u>The Health Care and Associated Professions (Miscellaneous Amendments) Order 2008</u> , <u>The Medical Professions (Miscellaneous Amendments) Order 2008</u> , <u>The General and Specialist Medical Practice (Education, Training and Qualifications) Order 2010</u> , <u>The Medical Act 1983 (Amendment) (Knowledge of English) Order 2014</u> , <u>The General Medical Council (Fitness to Practise and Over-arching Objective) and the Professional Standards Authority for Health and Social Care (References to Court) Order 2015</u>
NMC	4	<u>The Nursing and Midwifery (Amendment) Order 2008</u> , <u>The Nursing and Midwifery (Amendment) Order 2014</u> , <u>The Health Care and Associated Professions (Knowledge of English) Order 2015</u> , <u>The Nursing and Midwifery (Amendment) Order 2017</u>
GPhC	2	<u>The Health Care and Associated Professions (Knowledge of English) Order 2015</u> , <u>The Pharmacy (Premises Standards, Information Obligations etc) Order 2016</u>
PSNI	2	<u>The Pharmacy Order (1976 Order) (Amendment) Order (Northern Ireland) 2012</u> , <u>The Health Care and Associated Professions (Knowledge of English) Order 2015</u>
GDC	2	<u>The General Dental Council (Fitness to Practise etc.) Order 2016</u> , <u>The Health Care and Associated Professions (Knowledge of English) Order 2015</u>
GOC	1	<u>The Health Care and Associated Professions (Miscellaneous Amendments) Order 2008</u>
GOsC	1	<u>The Health Care and Associated Professions (Miscellaneous Amendments) Order 2008</u>

⁷⁸ A Section 60 Order is the legislative mechanism by which the UK and GB-wide health and care regulators can amend their founding legislation. It refers to Section 60 of the Health Act 1999. Available at <http://www.legislation.gov.uk/ukpga/1999/8/contents>. [Accessed 1 November 2017].

⁷⁹ The PSNI amends its legislation by means of a similar mechanism in Section 56 of, and Schedule 4 to, The Health and Personal Social Services Act (Northern Ireland) 2001.

⁸⁰ We have excluded from these totals any UK or NI legislation transposing European legislation for all the professions, such as The Health Care and Associated Professions (Indemnity Arrangements) Order 2014, and The Council of the Pharmaceutical Society of Northern Ireland (Indemnity Arrangements), which brought about amendments in relation to indemnity requirements for all professions; and The European Qualifications (Health and Social Care Professions) Regulations 2016.

GCC	1	<u>The Health Care and Associated Professions (Miscellaneous Amendments) Order 2008</u>
HCPC	0	

- 3.59 This is not a sophisticated measure of change among the regulators, but we do believe it illustrates the lack of parity between the regulators under the current system.
- 3.60 This section has highlighted how, in spite of some key similarities, the picture across the regulators is disparate and fragmented. Some regulators can be considered more ‘modern’ than others, in part because opportunities for piecemeal reform have not been equally distributed.

Incremental change: criteria and thresholds for referral at the initial stages

- 3.61 In the next three sections we take a closer look at those aspects of the fitness to practise process where there is scope both for incremental improvement and change, and where there may be significant risks if they are not done well. Since publishing *Regulation rethought*, we have asked the regulators what issues they have with their current processes, and used this to guide our thinking in this area.
- 3.62 In this section, we consider how regulators decide which cases should proceed through the early stages of the fitness to practise process, up to but excluding the case examiner/investigating committee stage. We explore ways in which regulators can make these processes more effective while continuing to protect the public and maintain public confidence.

How it works now

- 3.63 Generally speaking, we are seeing changes to the way regulators deal with cases at the very initial stages:
- The GPhC has recently amended threshold criteria for closing cases at the initial stages⁸¹
 - The GMC is trialling a ‘provisional enquiries’ process⁸²
 - The GOsC introduced new threshold criteria in 2016⁸³
 - The HCPC made changes to its Standard of Acceptance.⁸⁴
- 3.64 This is an emerging and increasingly important aspect of professional regulation that requires more detailed examination. It has the potential to make regulation significantly more efficient, but can lead to cases where there may be a risk to the public being closed too early. We also found that there was little transparency about these stages of the process, and it is often unclear who is the decision-maker – they may be junior staff.
- 3.65 We have established over the course of this project that no two regulators operate the same processes at these early stages. The picture is hugely complex, and difficult to summarise. We have presented a picture in table 3 of the different stages and decision-points that exist among all the regulators’ processes.

⁸¹ See www.pharmacyregulation.org/news/gphc-consult-revised-threshold-criteria [Accessed 1 November 2017].

⁸² See http://www.gmc-uk.org/DC9444_QA_for_ROs_Broadening_use_of_provisional_enquiries.pdf_66751616.pdf [Accessed 1 November 2017].

⁸³ See <http://www.osteopathy.org.uk/news-and-resources/document-library/fitness-to-practise/threshold-criteria-for-upc/threshold-criteria-for-unacceptable-professional-conduct.pdf> [Accessed 1 November 2017].

⁸⁴ Available at <http://www.hpc-uk.org/publications/policy/index.asp?id=529> [Accessed 1 November 2017].

Table 3: What regulators take into account when deciding whether to progress a complaint

First-stage decision: does the case fall within jurisdiction?							Second-stage decision: does the case pass a designated threshold to progress?				Third-stage decision: does case meet threshold for referral to IC/CE?	Preparation for IC/CE consideration	
Jurisdiction		Is there any immediate reason that the regulator should not investigate the information or complaint: do any closure criteria apply?					Further information obtained	<i>NB: for those regulators with powers to close cases at the initial stages, where these decisions occur within the initial investigation is completed prior to a decision being made to refer to investigation.</i>				Assessment test	Drafting of allegations, notification of referral to registrant and referrer.
Does the concern relate to a registrant?	Does the information or complaint fall within the definition set out in legislation?	Is complaint in category of case which can be closed with guidance and need not be referred to IC/CE?	Has the referrer identified themselves?	Has the referrer provided consent?	Did the event/s giving rise to the allegation/s occur in the last five years?	Should the matter be referred to the Inspectorate?		Preliminary consideration by the Registrar	Does the case meet threshold criteria?	Does the case meet the regulator's 'standard of acceptance'?		Further information obtained	Does the information received amount to an allegation of impaired fitness to practise?
								Does the legislation give the power to deal with this concern?		Is it in the 'form required'?	Credible evidence to suggest that fitness to practise is impaired?		
IC/CE Decision													

- 3.66 The typical pattern for the initial stages of fitness to practise is a funnelling process with progressively higher thresholds to overcome, until the case reaches CE/IC. Broadly speaking, the considerations of the regulators at these early stages can be summarised as follows:
- Who is the complaint about? Is it about a registrant? Is there a reason to close it?
 - What is the complaint about? Is it something that could amount to a breach of the code, and potentially suggest that fitness to practise was impaired?
 - What evidence is or might be available?
- 3.67 There may then be a further test:
- Does the complaint meet the threshold criteria? For example, is it serious enough? Has it been resolved by other means?
- 3.68 In the section below, we describe some of main features of these different decision-making frameworks.

What do regulators take into account when deciding whether to progress a case?

- 3.69 Regulators can only proceed with a case where they have the powers to do so. Therefore, there must be an initial gateway to establish jurisdiction:
- The concern must relate to a registrant who can be identified
 - The information must also be the kind of concern that the regulator can take forward.
- 3.70 The first of these matters is relatively straightforward to settle, though even this can present some challenges, as the person bringing the concern may not know their name, or may even be unclear about their profession.
- 3.71 As for the second bullet point, under all the regulators' current legislation, any complaint or concern received by a regulator must constitute an 'allegation' in order for it to be given further consideration. However, there is wide variation between the regulators about what is involved in establishing whether a complaint constitutes an allegation, and where the investigation stage sits.
- 3.72 Two of the regulators we oversee have legislation that defines in specific terms what amounts to an allegation without reference to impairment – they are the GOsC and the GCC. Their legislation specifies that an allegation should amount to any of the following:
- unacceptable professional conduct
 - professional incompetence
 - has been convicted in the United Kingdom of a criminal offence

- their ability to practise is seriously impaired because of their physical or mental condition.⁸⁵
- 3.73 The ‘unacceptable professional conduct’ (UPC) test differs from the test of current impairment in that UPC is a backward-looking concept, and could be seen to skew the emphasis from public protection (current risk of harm) to punishment (past wrongdoing). Under this regime, panels do not consider whether the registrant has remediated.
- 3.74 The 2012 Court ruling on Spencer set out a definition of UPC which, it is felt, raised the bar for regulatory action.⁸⁶ This led to the GOsC consulting on threshold criteria setting out types of allegation that would not usually amount to UPC.⁸⁷
- 3.75 The definition of UPC in the Spencer judgment that had this impact is as follows:
- ‘Whether the finding is "misconduct" or "unacceptable professional conduct", there is in my view an implication of moral blameworthiness, and a degree of opprobrium is likely to be conveyed to the ordinary intelligent citizen’.
- 3.76 It resulted in a new test based on the precise wording of the judgment: ‘is the allegation worthy of the moral opprobrium and the publicity which flow from a finding of unacceptable professional conduct?’⁸⁸
- 3.77 This illustrates a more general point about the impact of case law on how screening decisions are made throughout the process. All models must take into account the judgments about the purpose and scope of FtP, including in the decisions made at the early stages about whether to progress a case.
- 3.78 The legislation underpinning the other seven of the nine regulators defines in only broad terms the allegations that they can consider: it must be alleged that a registrant’s fitness to practise is impaired on one or more statutory grounds for impairment. This broad definition gives the regulators greater discretion about which cases they take forward, usually set out in rules.
- 3.79 For example, the GMC can screen out cases at the initial consideration stage if they are vexatious, or older than five years. The GPhC and PSNI also have this ‘five-year rule’ that prevents them from taking forward cases where the events

⁸⁵ GOsC. 2015. *Guidance on threshold criteria*. Available at <http://www.osteopathy.org.uk/news-and-resources/document-library/fitness-to-practise/threshold-criteria-for-upc/threshold-criteria-for-unacceptable-professional-conduct.pdf> [Accessed 1 November 2017].

⁸⁶ Spencer vs GOsC [2013] 1 WLR 1307, [2012] EWHC 3147 (Admin), at paragraphs 25 and 28 of the judgment. Available at <http://www.bailii.org/ew/cases/EWHC/Admin/2012/3147.html> [Accessed 1 November 2017].

⁸⁷ GOsC, 2015. *Threshold Criteria for Unacceptable Professional Conduct*. Available at <http://www.osteopathy.org.uk/news-and-resources/document-library/fitness-to-practise/threshold-criteria-for-upc/threshold-criteria-for-unacceptable-professional-conduct.pdf> [Accessed 1 November 2017].

⁸⁸ GOsC, 2015. *Threshold Criteria for Unacceptable Professional Conduct*. Available at <http://www.osteopathy.org.uk/news-and-resources/document-library/fitness-to-practise/threshold-criteria-for-upc/threshold-criteria-for-unacceptable-professional-conduct.pdf> [Accessed 1 November 2017].

occurred more than five years ago, unless it is in the public interest to do so.^{89, 90,}
⁹¹ Several of the regulators can screen out anonymous complaints. The GDC can close certain kinds of concerns if it is the first time it has been notified of the issue and there are no aggravating circumstances, even if there is an apparent low-level breach of the Standards.

3.80 The NMC sets out the following four-step process relating to the seriousness of the allegation, the format in which it is submitted, the quality of the evidence that would be available, and whether there is a current risk to public safety and confidence:

- ‘Whether the apparent facts of the case are serious enough to raise concern that the fitness to practise of a nurse or midwife may be currently impaired, as a result of any risk to members of the public, or the public interest
- Whether the referral to us meets our formal requirements
- Whether we will be able to obtain credible evidence to support the allegation
- Whether there is evidence that the nurse or midwife has addressed the concerns involved and whether we can be confident that any risk affecting patient safety or the public interest has been met without the need for regulatory intervention.’⁹²

3.81 Although it does not have explicit powers to do so in legislation, the HCPC has a *Standard of acceptance* for cases,⁹³ which allows it to screen out those it does not consider worth taking forward. It requires the complaint to:

- be made in the appropriate form, and
- provide credible evidence suggesting the registrant’s fitness to practise is impaired.

3.82 The NMC and the HCPC, who share the same founding legislation, are the only two regulators to stipulate that the referral must be made in the form required – for the NMC, this means it must identify the registrant (with contact details and PIN if possible), describe the incidents and be ‘supported by appropriate evidence’, although there is no legal definition of that phrase.⁹⁴ The HCPC on the other hand, stipulates that a concerns should be received in writing, provide

⁸⁹ GMC, 2015. *General Medical Council (Fitness to Practise) Rules Order of Council 2004 (as amended)*. Rule 5. Available at http://www.gmc-uk.org/consolidated_version_of_FTP_Rules.dec2015.pdf_64002624.pdf [Accessed 1 November 2017].

⁹⁰ Regulation 5 (2)(b) of the PSNI Fitness to Practise regulations (No. 311)

⁹¹ We have argued that legislating for the five year rule is an unnecessary barrier to public protection – regulators have the power to close down cases where there is insufficient evidence, and including such a rigid, arbitrary time limit is likely to put some people off reporting concerns.

⁹² NMC. *Preliminary consideration of allegations guidance*. Available at https://www.nmc.org.uk/globalassets/sites/documents/ftp_information/preliminary-consideration-of-allegations-guidance.pdf [Accessed 1 November 2017].

⁹³ HCPC. *Standard of Acceptance for allegations*. Available at <http://www.hpc-uk.org/assets/documents/10004F74StandardofAcceptance.pdf> [Accessed 1 November 2017].

⁹⁴ See description in the Authority’s Audit of NMC cases, March 2014. Available at <https://www.nursingtimes.net/download?ac=1279135> [Accessed 1 November 2017].

enough information to identify the registrant the concern is about; and set out the nature of the concern and the circumstances in enough detail for the registrant to understand and respond.⁹⁵

- 3.83 The GPhC and the PSNI are the only regulators to have explicit broad powers to set criteria defining types of cases that must proceed, and types of cases that should not. In practice, they apply these threshold criteria at the end of the investigation. The GPhC consulted in early 2017 on broadening its threshold criteria, so that they should take into account both the nature of an allegation, and whether there was evidence to support it. It also considered adding a public interest test at this stage.⁹⁶
- 3.84 The GOsC has a screener role, carried out by an independent osteopath, whose responsibility is to determine whether a complaint or concern falls under the GOsC's remit. Other regulators, such as the GCC, the HCPC and the NMC, have powers to introduce them that have not been used.⁹⁷ It is of note, therefore, that the GCC came under criticism from the Authority in 2015 for taking cases forward that should not be the concern of the regulator.⁹⁸

Issues and discussion

- 3.85 Thresholds to the successive stages of fitness to practise process need to reflect its broader role, which we have argued should be primarily about remediation where possible. They also need to ensure as far as possible both that:
- those issues that warrant regulatory action come to the attention of and can be progressed by the regulator, and
 - the concerns that are received and taken forward by the regulator are those that warrant regulatory action.
- 3.86 The fitness to practise process is, generally speaking, reactive: wheels are set in motion when the regulator receives material about a registrant that calls into question his or her fitness to practise.⁹⁹ The reactive nature of the process has been identified as a barrier to professional regulators' ability to protect the public – for example in the inquiry into the failings at Mid-Staffordshire Foundation

⁹⁵ HCPC. *Factsheet: Standard of Acceptance explained*. Available at <https://www.hcpc-uk.org/assets/documents/10004E79Factsheet-Standardofacceptanceexplained.pdf> [Accessed 1 November 2017].

⁹⁶ GPhC, December 2016. *Consultation on revised threshold criteria*. Available at https://www.pharmacyregulation.org/sites/default/files/consultation_on_revised_threshold_criteria_-_december_2016.pdf [Accessed on 1 November 2017].

⁹⁷ Health and Social Work Professions Order 2001, Section 23. Available at [http://www.hcpc-uk.org/Assets/documents/10004784HCPC-ConsolidatedHealthandSocialWorkProfessionsOrder\(July2014\).pdf](http://www.hcpc-uk.org/Assets/documents/10004784HCPC-ConsolidatedHealthandSocialWorkProfessionsOrder(July2014).pdf) [Accessed on 1 November 2017].

⁹⁸ Professional Standards Authority, 2015. *Audit of the General Chiropractic Council's initial stages fitness to practise process*. Page 5. Available at http://www.ukipg.org.uk/meetings/professional_regulation_working_party/psa_adit_reort_on_gcc_2015 [Accessed 1 November 2017].

⁹⁹ The GPhC's model may be an exception to this – its powers to inspect pharmacy premises allow it to identify and help address problems in the workplace before they become fitness to practise issues.

Trust.¹⁰⁰ While regulators can in practice initiate complaints, their ability to do so is limited by their lack of genuine investigatory powers.¹⁰¹

- 3.87 But even without looking to expand on their existing powers, over-prescriptive legislation about initiating complaints may be limiting their ability to take issues forward themselves, or preventing them from dealing with concerns received from a complainant.¹⁰² When the Law Commissions consulted in 2012 on the legislation surrounding this part of the regulatory framework, they posited that the concept of the ‘allegation’ was ‘cumbersome and formulaic’, did not allow for situations where the information received fell short of an allegation, and encouraged regulators to take a passive approach to fitness to practise.
- 3.88 The second – apparently conflicting – issue concerns the upward trend seen until recently in the number of cases considered by fitness to practise panels – though we note that the numbers may have plateaued recently. This is illustrated in Figure 3 below.

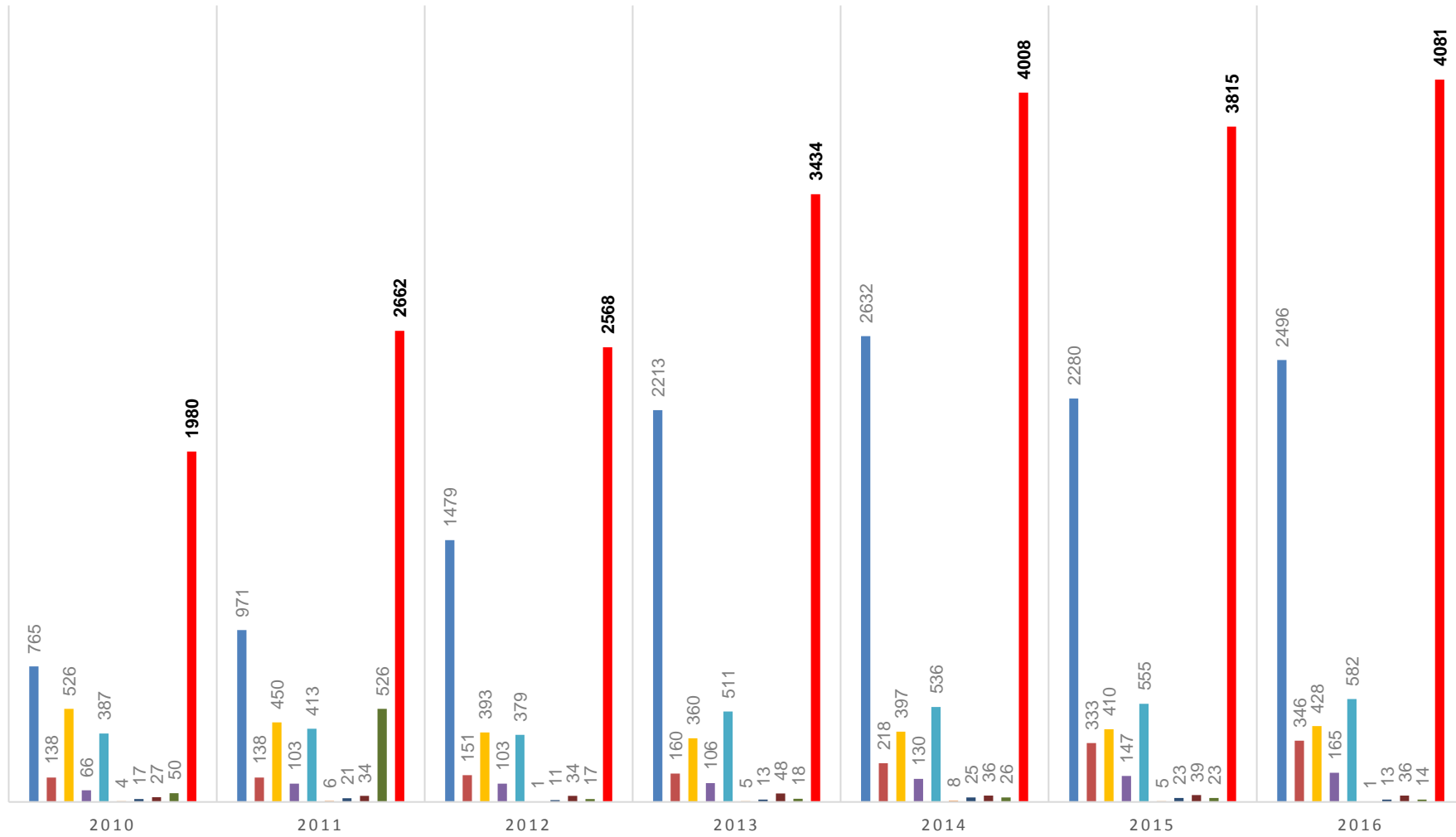
¹⁰⁰ The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Volume 2*. Available at <http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/sites/default/files/report/Volume%202.pdf> [Accessed 1 November 2017].

¹⁰¹ The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Volume 2*. Para 12.74. Available at <http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/sites/default/files/report/Volume%202.pdf> [Accessed 1 November 2017].

¹⁰² Glynn, J QC and Gomez, D, 2012. *The Regulation of Healthcare Professionals: law, principle and process*. Para 21-001. Sweet and Maxwell.

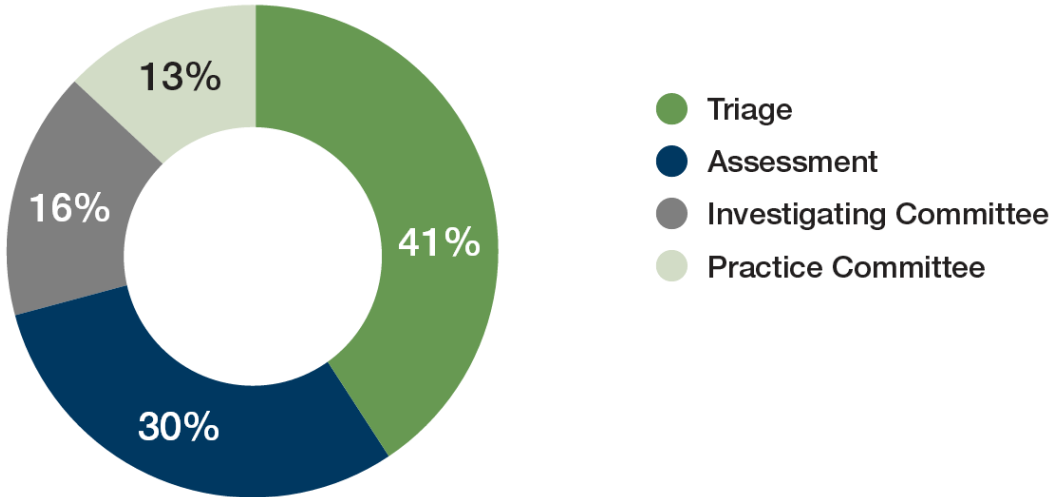
Figure 3: Total number of FtP hearings (by date received by the Authority)

■ NMC ■ GDC ■ GMC ■ GPbC ■ HCPC ■ PSNI ■ GOsC ■ GOC ■ GCC ■ Grand Total



- 3.89 Investigating cases is expensive: the GMC reported an expenditure of £49m for the year 2015 on fitness to practise activity excluding adjudication. This constituted nearly half of its overall expenditure for the year.¹⁰³ Therefore, in setting thresholds at the early stages of the process, regulators need to strike the right balance between:
- accepting that it is not possible to determine with certainty from the outset whether a complaint or concern will lead to a finding of impairment; and,
 - not diverting resources on cases that do not engage the three limbs of public protection.
- 3.90 If the threshold is too high, cases where there is a public protection risk could be missed (false negatives). If the bar is set too low, resources may be spent on cases that do not engage the three limbs (false positives). These are resources that could either be used more effectively in other ways, or passed on to registrants as savings.
- 3.91 The GDC is currently considering how to reduce the number of cases that are considered by the GDC but are then closed at an early stage.¹⁰⁴ They point out that over 70% of their cases are closed down before they reach the investigating committee (see Figure 4).

Figure 4: Chart showing the stage at which GDC fitness to practise cases were closed, 2015 (taken from GDC, *Shifting the balance: a better, fairer system of dental regulation*)



- 3.92 Part of the solution to this problem lies with bodies other than the regulator. Sharing responsibility for dealing with low-level concerns in dentistry is a central component of the reforms currently being considered by the GDC.¹⁰⁵

¹⁰³ GMC 2015 annual report and accounts. Available at http://www.gmc-uk.org/Annual_Report_2015_0816.pdf_67296034.pdf [Accessed 1 November 2017].

¹⁰⁴ GDC, 2017. *Shifting the balance: a better, fairer system of dental regulation*. Available at <https://www.gdc-uk.org/api/files/Shifting%20the%20Balance.pdf> [Accessed 1 November 2017].

¹⁰⁵ GDC, 2017. *Shifting the balance: a better, fairer system of dental regulation*. Available at <https://www.gdc-uk.org/api/files/Shifting%20the%20Balance.pdf> [Accessed 1 November 2017].

3.93 The GMC first introduced its concept of four layers of regulation in 2005 to illustrate the hierarchy of shared responsibility for quality of care. It was referenced in the 2011 command paper, *Enabling excellence*.¹⁰⁶ From the GMC's 2004/05 annual report:

'We find it helpful to think of a four layer model of regulation for healthcare professionals:

- Personal regulation, which determines the way in which individual doctors regulate themselves, based upon their commitment to a common set of ethics, values and principles which put patients first.
- Team-based regulation, which reflects the increasing importance of team working and requires health professionals to take responsibility for the performance of the team and to act if a colleague's conduct, performance or health is placing patients at risk.
- Workplace regulation, which reflects the responsibility that the NHS and other healthcare providers have for ensuring that their staff, and those who use their facilities, are fit for their roles. Workplace regulation is expressed through clinical governance and performance management systems.
- Professional regulation, which is undertaken by the GMC and other statutory health regulators.¹⁰⁷

3.94 The GMC has since introduced its Employer Liaison Service (ELS) which fulfils a number of functions, as described on the GMC website:

'The ELS creates closer working relationships between the GMC and employers. We work to:

- establish good links with Responsible Officers and their teams to support two way exchange of information about under performing doctors, therefore improving patient safety and the quality of referrals
- share our data about under performing doctors, including regional trends
- help Responsible Officers and their teams understand GMC thresholds and procedures
- provide support to Responsible Officers and employers in relation to revalidation.¹⁰⁸

3.95 We are not aware of any evaluation by the GMC of the impact of the ELS, but in principle, we agree that it seems like an effective means of ensuring that only the appropriate concerns are brought to the regulator. The role of the Responsible Officers, and of revalidation in general is no doubt also encouraging local resolution of low-level performance and competence concerns. We will not elaborate on this point here, but it will be a test of the different continuing fitness

¹⁰⁶ HM Government, 2011. *Enabling excellence: Autonomy and Accountability for Health and Social Care Staff*. Available at <https://www.gov.uk/government/publications/enabling-excellence-autonomy-and-accountability-for-health-and-social-care-staff> [Accessed 1 November 2017].

¹⁰⁷ GMC, 2005. *Annual review 2004/05*. Available at http://www.gmc-uk.org/annual_review_2004_5.pdf_25418022.pdf [Accessed 1 November 2017].

¹⁰⁸ See: <http://www.gmc-uk.org/concerns/11956.asp> [Accessed 1 November 2017].

to practise frameworks introduced by the regulators, whether the numbers of received through FtP diminish as a result.

- 3.96 The Authority demonstrated something similar to the GMC's four layers, in *Right-touch regulation*¹⁰⁹ where it sought to illustrate how responsibility for quality of care and risk management was shared across many different agents:
- 'People: self-management decisions taken or not taken by people
 - Professionals: education, training and continuing professional development
 - Providers: their policies and guidance, and local clinical governance arrangements
 - Commissioners: through contracting arrangements
 - Regulators: setting and maintaining standards, controlling entry to the profession, and taking action in response to concerns
 - Other bodies: any organisations who have an impact on standards of practice, such as accredited registers, professional organisations, royal colleges, arm's length bodies, and government departments.
 - Legislation: for example, human rights, equality, data protection, consumer protection, health and safety.'
- 3.97 Sharing the responsibility for identifying and escalating concerns with trusted partners can be seen as a solution to the challenge described in 5.28 above. It allows concerns to be dealt with, where appropriate, by other bodies, while giving the regulator confidence that those that warrant regulatory action will be brought to its attention. It also encourages local resolution, which we have argued in a number of publications, including *Right-touch regulation*, is more cost-effective than relying on the regulator. And it is a means of supporting remediation – competence issues in particular may be more appropriately and effectively dealt with by the employer.
- 3.98 However, this solution presupposes a context in which these other bodies exist – this is not necessarily the case, say, in osteopathy. It is dependent on the quality of employment practices. It also relies greatly on the quality of the relationship between the professional regulator and these other bodies, and on the clarity of the regulator's guidance about what sorts of concerns should be escalated.
- 3.99 A further, complementary, solution for the regulators is to amend the thresholds for acceptance of complaints and onward referral at the early stages of the FtP process. It is worth noting however that unlike partnership working, this option fulfils the aim of reducing the number of complaints, but in doing so could result in concerns that might warrant regulatory action being rejected by the regulator. This could create a public protection risk that would need to be addressed.

¹⁰⁹ Professional Standards Authority. 2015. *Right-touch regulation-revised*. Available at <http://www.professionalstandards.org.uk/policy-and-research/right-touch-regulation> [Accessed 1 November 2017].

- 3.100 The gateways for access to the different stages of the FtP process must be linked to the threefold purpose of fitness to practise that is now also enshrined in all the regulators' legislation¹¹⁰ as an over-arching duty. They should also be:
- transparent
 - accountable
 - agile
 - simple to understand and operate, and
 - cost-effective.
- 3.101 The Law Commissions discussed in detail whether to retain the legal concept of the allegation.¹¹¹ They initially suggested removing the concept altogether, and instead giving regulators 'broad discretion to deal with all information and complaints in such manner as they consider just'.
- 3.102 In their final report however, they dropped this proposal, perhaps convinced by the arguments from some respondents that 'removing the concept of an allegation entirely would remove the clear gateway to the fitness to practise process and produce inconsistency and uncertainty for both registrants and the public.' Concerns remained, however, about restrictive interpretations of the term 'allegation' that could limit the form in which complaints could be submitted.
- 3.103 The Law Commissions therefore proposed the following:
- 'A regulator should have the power to initiate fitness to practise proceedings where an allegation suggesting impaired fitness to practise is made to the regulator or the regulator otherwise has reason to believe that a registrant's fitness to practise is impaired.'
- 3.104 We support the Law Commissions' arguments on the use of the term allegation: it enables the regulators to establish whether a concern falls under their statutory remit, and provides some clarity for the public and for registrants about what regulators can consider. This fulfils the aims of transparency and agility.
- 3.105 The Law Commissions also proposed the following that 'there should be no set format for allegations.' We support this permissive approach to the format for allegations – in order to fulfil their role of protecting the public, regulators' must avoid erecting unnecessary barriers to the reporting of complaints. For public protection reasons, we also support the inclusion of a broad power for regulators to take forward investigations based on information that has come to their attention through means other than a complaint.
- 3.106 Giving the regulators formal discretionary powers, like those of the GPhC, to screen out cases following the initial consideration of jurisdiction could help them reduce their caseload at an early stage. The question remains, however, as to the transparency and accountability of such approaches, as they fall outside the formal decision-making stages. In addition, they cannot be challenged, other than

¹¹⁰ With the exception of the PSNI.

¹¹¹ Law Commissions, 2014. *Regulation of Health Care Professionals, Regulation of Social Care Professionals in England*. Page 120. Available at http://www.lawcom.gov.uk/wp-content/uploads/2015/03/lc345_regulation_of_healthcare_professionals.pdf [Accessed 1 November 2017].

by Judicial Review. The GPhC's legislation could also be considered rather permissive – their powers to set threshold criteria are very broad, in that they are limited only, it seems, by the GPhC's over-arching duty. We have recently expressed concerns in response to a GPhC consultation about what we felt was a broadening of the threshold criteria.¹¹² We felt that the proposals brought forward decisions that are currently made in the more formal context of the IC. Our view was driven by concerns about transparency, accountability, and lack of options for review of the decisions.

- 3.107 Nevertheless, the fact that the GPhC's powers to set thresholds are in its legislation provides greater transparency than for those regulators who introduce such screening powers with no legislative basis. The discretion the GPhC is awarded by this power also means it can be agile in responding to changes in, say, case law or in its own standards for pharmacy professionals. We assume, though this would need further examination, that this allows it to be more cost-effective.
- 3.108 There are ways in which our concerns about such approaches could be addressed without undermining the benefits of an early screening process such as this. We would support a model with clear threshold criteria for screening cases out before the IC/CE stage, provided there was:
- full transparency of policy: the regulator's policies and threshold criteria for all pre-IC stages to be consulted on and published
 - a clear demonstration of how these thresholds enable the regulator to fulfil its over-arching statutory objective relating to the three limbs of public protection
 - accountability of process and decision-making: clearly documented reasoning and decisions; formal options for challenging a decisions to close a case at key decision-points; as currently – option of scrutiny of such decisions by the Authority; and quality assurance of decisions through the publication of audits and regular reports to Council, and
 - hierarchy of decision-making: the decisions made at these early stages should not pre-empt or undermine the role of the IC/CE.
- 3.109 This is an evolving area of regulation where the risks are relatively unknown. Building on the analysis in this chapter, we plan to conduct a cross-regulator review of the processes, criteria, and decision-making on cases at the early stages. Through this exercise, we would seek to develop a more detailed picture of the different approaches, and an in-depth understanding of what sorts of cases are being closed in the stages up to but excluding CE/IC decisions, compared to those that are being referred on and why, and where we might see risks to public protection emerging.
- 3.110 We also believe there should be a national conversation about how serious an allegation should be for it to warrant regulatory action. There is little understanding and much variation across the regulators on where the

¹¹² Available at <http://www.professionalstandards.org.uk/publications/detail/the-authority's-response-to-the-general-pharmaceutical-council-consultation-on-revised-threshold-criteria>. [Accessed 1 November 2017].

seriousness threshold sits. It is our view that ultimately, this threshold should be described with reference to the professional code, because the code declares to registrants, the public, and employers the standards of conduct and competence that are expected of a professional.¹¹³

- 3.111 Linked to the previous recommendation, a common code of conduct, or *Statement of professional practice*,¹¹⁴ for all the professions would support the development of a more consistent shared understanding of when a concern should be brought to the attention of the regulators, and enable greater consistency of decision-making across the regulators.¹¹⁵
- 3.112 There is an issue with consistency of process. We cannot see a justification for one regulator turning down a case from the outset for lack of credible evidence, when other regulators would readily accept the same case based on the same information. It also does not seem acceptable that some regulators seek professional expertise on cases from an early stage to determine seriousness, when others do not. It is nevertheless our understanding that this is the case currently. There is therefore a need to harmonise the policies and processes applied by the regulators at the early stages, where they are currently resulting in unjustifiable differences in outcome. This would not necessarily require legislative change.¹¹⁶
- 3.113 Finally, we referred earlier to the Spencer Judgment. What is striking about this decision is the value-laden language that is used – “moral opprobrium”, “moral blameworthiness”. The Courts play a critical role in interpreting legislation and attempting to give definition to terms that are ambiguous – concepts such as ‘unacceptability’ and ‘reasonableness’. It is nevertheless worth considering as part of this review of fitness to practise whether case law like that of Spencer, that introduces a test based on a value-judgement, is helpful, and whether anything could be done to strive for greater objectivity.

¹¹³ Whether there is a potential breach of the code would be one of several factors used to determine whether a case meets the initial threshold.

¹¹⁴ As recommended in *Regulation rethought*.

¹¹⁵ There is already overlap between some of the professional codes produced by the regulators we oversee, particularly where they focus on high-level principles.

¹¹⁶ We note that the GCC and GOsC have more restrictive legislation, which limits their ability to screen out complaints at the early stages.

Incremental change: consensual disposal at the end of the investigation

- 3.114 We have always been supportive of consensual disposal¹¹⁷ in principle and under certain specific circumstances, but have articulated concerns about the way it has been implemented in practice.
- 3.115 Our position on consensual disposal has stemmed mainly from the fact that disposal of cases through means other than a public hearing, and by case examiners in particular, puts these decisions outside the scope of our S.29 powers, and pushes decision-making from a public forum into a private one.¹¹⁸ The current trend among those regulators that are using or in the process of gaining powers to use consensual disposal at the end of the investigation (GMC, GDC and NMC) is to exclude from consideration only those cases that are likely to result in a striking off. However, issues identified through our S.29 scrutiny give us reason to believe that it is necessary for us to have powers to appeal any decisions, and not just those that are deemed the most serious by the regulator.
- 3.116 As we explained in a letter sent to Department of Health officials in January 2017:
- ‘Our S.29 powers guard against a number of failings, such as poor quality of prosecution by the regulator, under prosecution, inappropriate or insufficient outcomes and/or sanctions and deficient or unclear reasoning by panels. Although the model is different, equivalent failings are all possible under the case examiner/undertakings model.
- [...] we are not opposed to consensual disposals, but we consider that under this model the risk of an insufficient outcome is increased, compared to the traditional hearings model.’
- 3.117 We are also aware that some of the regulators have developed other means of disposing of cases or closing investigations, that are not necessarily explicit in their legislation. Some of the regulators, particularly those that have not had opportunities to modernise their legislation, are having to push the boundaries of what is permissible.
- 3.118 The following table sets out some of the approaches across the regulators.

¹¹⁷ In this report, we use the term ‘consensual disposal’ to refer to decisions made by case examiners or, in rare circumstances, investigating committees, to dispose of a case by consent. Currently, these powers are restricted to agreeing undertakings with the registrant.

¹¹⁸ We wrote to the Department of Health outlining this point on 6 January 2017.

Table 4: Approaches to closing cases consensually across the nine regulators

Regulator	In addition to referring a case to a FtP committee, or closing a case, the IC/CE can	Other methods of consensual disposal being used
GCC	<ul style="list-style-type: none"> No other options to dispose of case 	<ul style="list-style-type: none"> None
GDC	<ul style="list-style-type: none"> Issue a warning letter Offer undertakings 	<ul style="list-style-type: none"> Voluntary removal
GMC	<ul style="list-style-type: none"> Issue a warning letter Offer undertakings 	<ul style="list-style-type: none"> Voluntary erasure
GPhC	<ul style="list-style-type: none"> Issue a warning letter Offer undertakings Issue advice 	<ul style="list-style-type: none"> Voluntary removal
GOC	<ul style="list-style-type: none"> Issue a warning letter 	<ul style="list-style-type: none"> None
GOsC	<ul style="list-style-type: none"> No other options to dispose of case 	<ul style="list-style-type: none"> Voluntary removal
HCPC	<ul style="list-style-type: none"> Discontinuance of proceedings 	<ul style="list-style-type: none"> Voluntary removal
NMC	<ul style="list-style-type: none"> No other options to dispose of case (but awaiting rule changes to introduce undertakings, warning and advice) 	<ul style="list-style-type: none"> Voluntary removal Consensual panel agreement
PSNI	<ul style="list-style-type: none"> Issue a warning letter Offer undertakings 	<ul style="list-style-type: none"> Voluntary removal

3.119 In this section of the chapter, we consider the role of the case examiners in the FtP process, and the merits and challenges associated with options to dispose of cases consensually.

The role of case examiners

How it works now

3.120 Previously, for all the regulators, it was the IC that reviewed cases at the end of the investigation, to determine whether they should go to a hearing, or be closed – with or without a warning. This model is still in place for five of the regulators, however the remaining four now use case examiners to make the majority of these decisions – the GMC, GDC, NMC, and GOC. The GMC was the first to introduce them.

3.121 Under the IC model, a panel of the IC usually consisting of three members, has to be convened in order for a meeting to take place. These meetings are not public, and neither the registrant nor the referrer is present. Decisions are made on the papers.

3.122 Under all four CE models, decisions are made in pairs consisting of one lay person and one professional. CEs, unlike committee members, are employees of the regulator, though there is usually a ‘Chinese wall’ between them and other staff to ensure a level of separation from the investigation function. There is still a

role for the IC however: if there is a disagreement, or for certain types of decision,¹¹⁹ the case will be referred to an IC panel.

Issues and discussion

- 3.123 The disadvantages for the regulator of having to use Investigating Committees appear to be mainly practical: IC panels are expensive to convene, and it is claimed that CEs are less costly; it is also simpler to convene a CE meeting than a committee meeting, meaning that in theory cases can be dealt with more quickly. In addition, the quality of decision-making is meant to improve, and decisions are meant to be more consistent. This is because the regulator has more effective means of improving the performance of CEs than it does IC members, and because there are fewer CEs than IC members.¹²⁰
- 3.124 We have said in past consultation responses that what mattered was not who was making decisions, but that the quality of the decision-making and the outcomes should not be affected. We suggested that quality-assurance of decisions took on greater importance to ensure that decisions were consistent, well-reasoned, and properly documented.¹²¹ We were concerned about the risk that CEs, as staff, might lack the independence of a committee member, and that they could be more easily influenced by the regulator. In short, they erode the separation between adjudication and investigation. That said, we have not identified this as an issue in practice as yet.¹²²
- 3.125 The use of CEs would appear to align with the principle of agility – it enables cases to be dealt with more quickly, and the regulator to be more responsive to fluctuating caseloads. Cost-effectiveness is both a legitimate, and desirable aim in this context, provided it is not to the detriment of public protection. In its most recent annual report,¹²³ the NMC reported a year-on-year decrease in FtP spending, which it attributed in part to the introduction of CEs.
- 3.126 Our scrutiny of the regulators has not identified any particular concerns about the *decisions* made by CEs as opposed to IC panels. For example, our most recent performance review of the NMC¹²⁴ found no concerns about the decisions they

¹¹⁹ E.g. fraudulent entry for the NMC.

¹²⁰ See, for example, the claims made in the 2014 Department of Health consultation on proposed changes to the NMC's legislation about the benefits of case examiners, available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/304575/nmc-governing-legislation-consult.pdf [Accessed 1 November 2017].

¹²¹ See for example, our response to the Government's and the NMC's 2014 consultation on changes to the NMC's legislation, available at <http://www.professionalstandards.org.uk/docs/default-source/publications/consultation-response/others-consultations/2014/departement-of-health-and-nmc-legislation-and-rules.pdf> [Accessed 1 November 2017].

¹²² We note nevertheless some erosion of this separation. For example the GMC guidance on its Fitness to Practise Rules allows for case examiners to provide advice on how to carry out an investigation (see para 12 of the guidance available at http://www.gmc-uk.org/DC4483_Guidance_to_the_FTP_Rules_28626691.pdf)

¹²³ NMC, 2015 *Annual Report*. Available at https://www.nmc.org.uk/globalassets/sitedocuments/annual_reports_and_accounts/annual-report-and-account-2015-2016.pdf [Accessed 1 November 2017].

¹²⁴ Professional Standards Authority, December 2016. *Annual review of performance 2015/16, Nursing and Midwifery Council*. Para 6.136. Available at <http://www.professionalstandards.org.uk/docs/default-source/publications/performance-reviews/nmc-annual-review-of-performance-2015-16.pdf?sfvrsn=15> [Accessed 1 November 2017].

made – which is important given that our primary interest is in ensuring that the outcomes protect the public, and not in the process. We also noted that the NMC had systems in place to monitor the quality and consistency of decisions made by CEs, and we support this approach.

- 3.127 However, we did suggest that to improve transparency, more information should be recorded and made available about how the CEs reach their decisions. Transparency is essential in this process, as we believe there is a greater risk of opacity with CEs than with a committee: IC decisions are made in formal proceedings, whereas CE decisions are not. This affects important aspects of the process relating to transparency, such as the way decisions are recorded, and who is present.
- 3.128 We therefore support the use of case examiners, on the grounds that they provide a more agile, cost-effective, and potentially consistent means of dealing with cases at the end of the investigation. Renewed efforts are nevertheless needed to ensure transparency of decisions and reasoning, and to allow the regulator to be held to account for these decisions. To this end, and as above, a number of conditions apply. We would want to see:
- a clear demonstration of how the decision-making framework of the CEs enables the regulator to fulfil its over-arching statutory objective relating to the three limbs of public protection
 - full transparency of policy: the regulator’s policy and decision-making framework to be consulted on and published
 - accountability of process and decision-making: clearly documented reasoning and decisions; formal options for challenging a decision to close a case; scrutiny of all decisions that meet the real prospect test by the Authority;¹²⁵ and quality assurance of decisions through the publication of audits and regular reports to council
 - hierarchy of decision-making: the decisions of the CEs should not pre-empt or undermine the role of the panel at a hearing, for example where there is a dispute about material facts
 - independence of decision-making: those making decisions about how to dispose of a case on completion of the investigation should not have been involved in the investigation.

Real prospect tests and undertakings agreed by CEs/IC

How it works now

- 3.129 At the end of the investigation, a decision must be made about whether to refer a case to a panel hearing, or to dispose of it in other ways – and there is currently a range of practices across the regulators here (see table 1 for more detail).
- 3.130 Previously, the most common approach was for the IC (or CEs) to determine whether there was a real prospect of a panel finding that the registrant was impaired on any of the statutory grounds for impairment. The nature of the test

¹²⁵ Our role in scrutinising and appealing fitness to practise decisions is discussed further later in the report.

varies from one regulator to the next, but the broad principle remains the same. Put simply, this was a binary yes/no decision that resulted in a binary outcome: case closure if no real prospect,¹²⁶ or referral to a hearing if real prospect. Some of the regulators have options, if the case is to be closed at this stage, to issue warnings or advice – these are only options if the real prospect test is not met though.¹²⁷ It is of note that the GPhC and PSNI operate a different model again: under relatively permissive legislation, their investigating committees can issue undertakings if the real prospect test is met, and occasionally also issue warnings and advice.

- 3.131 Relatively recent developments have resulted in more complex scenarios however. For the GMC, GDC, and NMC case examiners have powers to dispose of cases consensually for cases where the real prospect test is met – albeit with certain limitations. More specifically, they can agree undertakings with a registrant, if he or she is prepared to comply with them.¹²⁸ Compliance is usually monitored, and breaches can be referred to a fitness to practise hearing. All three specify that undertakings cannot be offered in cases where there is a realistic prospect of a registrant being struck off.¹²⁹
- 3.132 To illustrate the differences in the two approaches, we have set out in broad terms below in Figures 5 and 6 the old and new decision-making frameworks as exemplified by the NMC’s legislation as it stands, and the NMC’s legislation as amended by the Nursing and Midwifery (Amendment) Order 2017.¹³⁰ This is a useful example because the NMC’s current framework is among the most basic, but when its new rules come into force, it will have one of the most comprehensive.

¹²⁶ For some regulators with or without a warning.

¹²⁷ See for example, the NMC guidance on CPD, available at https://www.nmc.org.uk/globalassets/sitedocuments/ftp_information/ftp_committees/consensual-panel-determination-guidance.pdf [Accessed 1 November 2017].

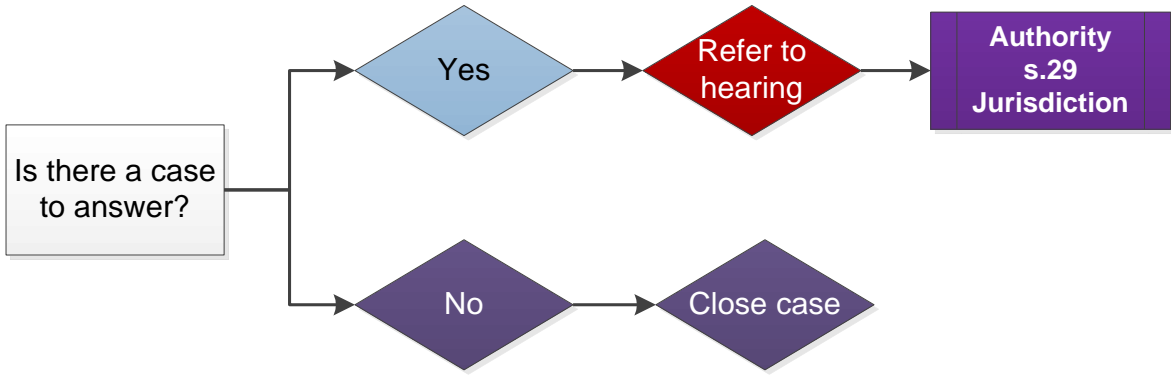
¹²⁸ See for example, the GMC guidance for case examiners on undertakings, available at http://www.gmc-uk.org/DC4595_CE_Decision_Guidance_Annex_F_Undertakings.pdf_57741459.pdf [Accessed 1 November 2017].

¹²⁹ We have argued that there is a clear rationale for using undertakings where the likely outcome is conditions because the outcome is more or less the same. It is less clear for suspension cases.

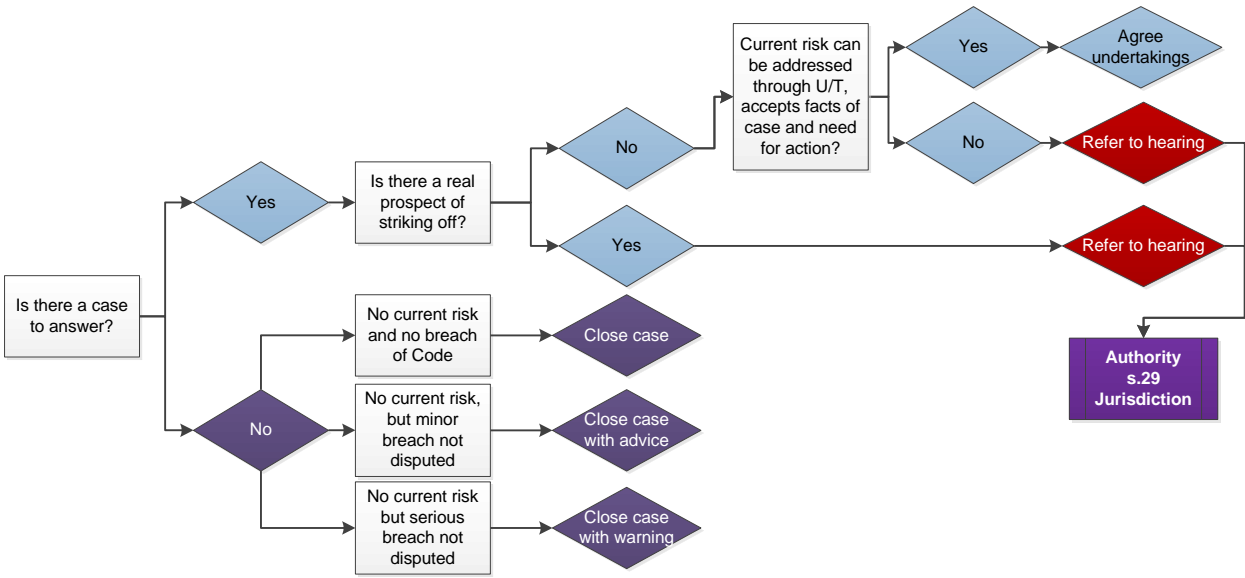
¹³⁰ The Nursing and Midwifery (Amendment) Order 2017 (Draft). Available at <http://www.legislation.gov.uk/ukdsi/2017/9780111153444/schedule/1> [Accessed 1 November 2017].

Figures 5 and 6: Case study of decision-making at the end of the investigation – the NMC¹³¹

Process under old NMC legislation¹³²



Process under NMC fitness to practise rules 2017¹³³



¹³¹ To keep the diagrams simple, we have not shown the consensual panel decision (CPD) process separately from the hearings process. As these decisions are signed off by a panel, they fall under our S.29 jurisdiction.

¹³² As set out in the *Nursing and Midwifery Council (Fitness to Practise) Rules 2004* (SI 2004/1761) at 19 January 2016. Available at <https://www.nmc.org.uk/globalassets/sitedocuments/legislation/legislation-updated/nmc-fitness-to-practise-rules-consolidated-text-effective-from-2016.01.19.pdf> [Accessed 1 November 2017].

¹³³ As set out in the *The Nursing and Midwifery (Amendment) Order 2017*. Available at <http://www.legislation.gov.uk/ukxi/2017/703/introduction/made>, and the NMC consultation document, *Modernising Fitness to Practise, Changes to the Fitness to Practise Rules 2004*. Available at <https://www.nmc.org.uk/globalassets/sitedocuments/consultations/2016/s60-ftp-consultation-rules-oct2016.pdf> [Accessed 1 November 2017].

3.133 Figures 5 and 6 serve to illustrate a trend that is emerging across a number of regulators in the decision-making at the end of the investigation:

- the powers of the decision-makers at this stage are expanding to include disposal of cases by consent
- cases that would previously have been sent to a hearing because the real prospect test was met, are being closed with undertakings by CEs without panel sign-off; this makes the process more complex and relies on greater powers of judgement.
- the powers of the decision-makers are also expanding to include action that can be taken against the registrant when the RPT is not met (though this is not new for all the regulators)
- cases that would previously have been scrutinised by the Authority under its S.29 jurisdiction now fall outside it.

Issues and discussion

The real prospect test

3.134 We note firstly that divorcing the RPT from the decision to refer to a hearing can considerably complicate decision-making, as is illustrated by Figures 5 and 6 above. Simplicity and ease of understanding are among the principles we are using in this chapter. On this occasion however, these arguments are likely to be overridden by concerns about proportionality and efficiency. We recommend only that this complexity is acknowledged, and that the training of case examiners and quality assurance mechanisms are sufficient to ensure decisions and reasoning are clearly recorded and sound.

3.135 Secondly, now may be an apt time to consider whether the RPT is fit for purpose, given these changes to the nature of decisions post-investigation, and the relatively recent introduction of an over-arching statutory duty. The real prospect test is derived from the Code for Crown Prosecutors used by the Crown Prosecution Service (CPS), in deciding whether or not to prosecute criminal offences. There are two stages to the test used by the CPS: an evidential test (“the real prospect”) and a public interest test.

3.136 In relation to the public interest, the Code states:

‘It has never been the rule that a prosecution will automatically take place once the evidential stage is met. A prosecution will usually take place unless the prosecutor is satisfied that there are public interest factors tending against prosecution which outweigh those tending in favour. In some cases the prosecutor may be satisfied that the public interest can be properly served by offering the offender the opportunity to have the matter dealt with by an out-of-court disposal rather than bringing a prosecution.’

134

¹³⁴ Crown Prosecution Service. *Code for Crown Prosecutors, The Full Code Test*. Available at https://www.cps.gov.uk/publications/code_for_crown_prosecutors/codetest.html [Accessed 1 November 2017].

- 3.137 Factors that should be weighed in assessing the public interest are set out in the Code, include the impact on the community and the seriousness of the offence. Without the counter-balance of the public interest component, the real prospect test (as interpreted by the Courts in a number of early GMC cases including *Toth*¹³⁵ and *Richards*¹³⁶) can result in cases being referred to a hearing when it is not in the public interest to do so.
- 3.138 In addition, it might be worth reviewing whether the RPT as currently constituted is consistent with the regulators' new over-arching duty.¹³⁷

Undertakings

- 3.139 We set out in *Rethinking regulation* and *Regulation rethought* a number of reasons why we felt the current fitness to practise models were no longer fit for purpose, and used these to argue for radical reform. Broadly speaking, these were the high costs and unsustainability given increasing numbers of cases, and the emotional impact on all parties of FtP cases. By and large, these are the same reasons that have been used to argue for the incremental moves towards more consensual approaches that we have seen adopted by some of the regulators.
- 3.140 We saw in figure 2 that the number of cases considered by adjudication panels has been on the rise for a number of years, across most of the regulators. We know that hearings are expensive – in its June 2016 report to the GMC Council, the MPTS estimated that its budget and staff constituted 10% of the GMC's total resources. It quoted an average per day cost of a hearing at £3,398 (down from £4,167 when the Medical Practitioners Tribunal Service (MPTS) first came into being).^{138, 139} It is not hard to see why regulators are keen to develop alternative means of disposing of cases that either reduce the number of hearing days (such as the NMC and HCPC's consensual panel decisions), or eliminate the need for hearings altogether (such as consensual disposal by case examiners).
- 3.141 In addition, the human cost of the current FtP models must be considered. The GMC has itself published a report into the apparently high number of suicides committed by doctors under investigation.¹⁴⁰ There has been some research by Professor Tom Bourne of Imperial College London, that has highlighted the emotional toll of complaints processes – including but not limited to those of the

¹³⁵ *R. v General Medical Council Ex p. Toth* [2000] 1 W.L.R. 2209 HC.

¹³⁶ *R. v General Medical Council Ex p. Richards* [2001] Lloyd's Rep. Med 47 HC.

¹³⁷ As amended by the Health and Social Care (Safety and Quality) Act 2015 for all the regulators except the PSNI.

¹³⁸ See agenda item 5, GMC Council Meeting June 2016. *Report of the Medical Practitioners Tribunal Service Committee*. Available at http://www.gmc-uk.org/05_Report_of_the_Medical_Practitioners_Tribunal_Service_Committee.pdf 66394496.pdf [Accessed 1 November 2017].

¹³⁹ We discuss in paragraph 3.223 the merits of costs orders, which can help a regulator to recoup costs, but also discourage unnecessary prolonging of the hearing process.

¹⁴⁰ General Medical Council, December 2014. *Doctors who commit suicide while under GMC fitness to practise investigation, Internal review, Sarndrah Horsfall, Independent Consultant*. Available at http://www.gmc-uk.org/Internal_review_into_suicide_in_FTP_processes.pdf 59088696.pdf [Accessed 1 November 2017].

GMC – on doctors.¹⁴¹ We have also identified the stressful nature of hearings for complainant witnesses in two pieces of our own research: *Enhancing confidence in fitness to practise adjudication - research report*¹⁴² and *Alternatives to final panel hearings for fitness to practise cases - the public perspective*.¹⁴³

- 3.142 In the latter piece of research, we sought the views of complainants and other members of the public on alternative ways of disposing of cases. We found that people were broadly supportive of disposing of cases consensually, and for the most part could not see the value in taking a case to a hearing where the registrant admitted wrongdoing, as the process was stressful for all parties. There were however concerns in relation to consensual disposals about risks of corners being cut in the investigations, plea-bargaining, lack of transparency, and the loss of the complainant's voice in the process. We can conclude from this that there is some public support for consensual disposal, but with important caveats that we would support – and could perhaps be addressed by the measures set out above about disposal by case examiners.
- 3.143 As these approaches to consensual approaches are relatively new to the regulators we oversee, there have been few opportunities to assess their effectiveness in depth. We have in the past expressed views about consensual disposal at the CE/IC stage based primarily on our understanding of the case law, and on views of the risks derived from our oversight of the regulators and their FtP decisions. This chapter is an opportunity for us to ask what evidence there is of how these decisions are working and to consider our position in more detail.
- 3.144 Regulators supportive of undertakings have argued that for some cases, even where the real prospect test is met, it is not proportionate to refer to a hearing. We prefer to use the concept of necessity rather than proportionality in this argument. The question that needs to be asked of any case that meets the RPT could be phrased as follows:

In order to fulfil the threefold purpose of fitness to practise, is it necessary for the case to be referred to a hearing?

- 3.145 It is our view that there are cases for which the answer to this question is 'no'. Of interest to us here is which factors, in addition to whether there is a need to test the evidence, might determine how the above question is answered for different cases or types of case. This is what we will examine in the remainder of this section.

- a. Will the registrant admit the facts and accept impairment?

¹⁴¹ Bourne, T, et al 2015. *The impact of complaints procedures on the welfare, health and clinical practice of 7926 doctors in the UK: a cross-sectional survey*. BMJ Open 2015;5:e006687. doi: 10.1136/bmjopen-2014-006687. Available at <http://bmjopen.bmj.com/content/5/1/e006687> [Accessed 1 November 2017].

¹⁴² Research Works report for the Professional Standards Authority, May 2011. *Enhancing confidence in fitness to practise adjudication – Research Report*. Available at <http://www.professionalstandards.org.uk/publications/detail/enhancing-confidence-in-fitness-to-practise-adjudication---research-report> [Accessed 1 November 2017].

¹⁴³ Research Works report for the Professional Standards Authority, May 2013. *Alternatives to final panel hearings for fitness to practise cases – the public perspective*. Available at <http://www.professionalstandards.org.uk/publications/detail/alternatives-to-final-panel-hearings-for-fitness-to-practise-cases-the-public-perspective> [Accessed 1 November 2017].

3.146 It is generally accepted, and we support this view, that where facts are disputed a case must be referred to a hearing for adjudication. This was stated for example by the GMC in its 2011 consultation on consensual disposal.¹⁴⁴ We have on several occasions also argued that any form of consensual disposal requires a registrant to admit to any facts, and accept that their fitness to practise is impaired. This is alluded to in the following statement from the NMC's guidance on consensual panel determination:

‘An admission of impairment demonstrates a level of insight that is essential for a case to be resolved by consent.’¹⁴⁵

3.147 In our recent response to an NMC consultation, our arguments included a similar observation on the importance of admissions, but went a step further:

- ‘these admissions contribute significantly to considerations about whether a registrant has demonstrated insight, and
- the status of any such findings needs to be clear so that they can be taken into account properly in any future investigations and proceedings against the registrant.’¹⁴⁶

3.148 We continue to hold this view – both these points pertain to important aspects of the fitness to practise decision-making process. We cannot see how without these admissions from the registrant we can be assured that such decisions are adequately protecting the public.

b. Are there public interest arguments for referring the case to a hearing?

3.149 All fitness to practise decisions must respect the legislative framework and case law that governs them. The decision-makers at the end of the investigation usually consider as part of their decision-making whether the public interest dictates that the case should be heard at a hearing. A decision made behind closed doors may protect the public in the narrowest sense, but in cases where there is a need to declare and uphold professional standards, and to maintain public confidence in the profession, it is usually considered necessary for the case to be heard in a public forum – under the current framework.¹⁴⁷ This position is inferred from the body of case law, including the cases of Cohen and Grant, which set out the three limbs of public protection – and in particular maintaining public confidence and declaring and upholding professional standards. This sits alongside compliance with Article 6 of the Human Rights Act, the principle of open justice,¹⁴⁸ and the deeply engrained position that there is a public interest in decisions being made in public hearings. This is reflected for example in the regulators' own legislation, with the presumption that hearings (aside from health)

¹⁴⁴ Available at http://www.gmc-uk.org/FTP_reforms_consultation_paper.pdf_38085201.pdf [Accessed 1 November 2017].

¹⁴⁵ NMC, October 2016. *Consensual panel determination guidance*. Available at https://www.nmc.org.uk/globalassets/sitedocuments/ftp_information/ftp_committees/consensual-panel-determination-guidance.pdf [Accessed 1 November 2017].

¹⁴⁶ Professional Standards Authority response in December 2016 to the NMC consultation *Modernising fitness to practise: changes to the Fitness to Practise Rules 2004*.

¹⁴⁷ See the section on longer-term reform for a different view on this.

¹⁴⁸ See, for example: *SRA v Spector*, [2016] EWHC 37 (Admin). Available at [http://www.bailii.org/cgi-bin/format.cgi?doc=/ew/cases/EWHC/Admin/2016/37.html&query=\(2016\)+AND+\(EWHC\)+AND+\(37\)+AND+\(Admin\)](http://www.bailii.org/cgi-bin/format.cgi?doc=/ew/cases/EWHC/Admin/2016/37.html&query=(2016)+AND+(EWHC)+AND+(37)+AND+(Admin)) [Accessed 1 November 2017].

will be held in public unless the public interest in doing so is outweighed by other factors. The legislation and case law therefore direct that cases ought to be referred to a hearing where the 'wider public interest' is engaged.

3.150 This may point to particular types of case that would be unsuitable for disposal outside a hearing, because of their relevance to the wider public interest. For example, the case law relating to dishonesty points to the fact that acts of dishonesty are likely to undermine public trust in the profession.¹⁴⁹ Where this is the case, they should therefore be heard in a public forum. When it comes to sexual boundary violations, the case of *Yeong v The General Medical Council*¹⁵⁰ suggests that maintaining public confidence in both the professional and the profession is necessary in any case.

c. Could the failings be remediated?¹⁵¹

3.151 The question of whether a registrant's failings can be remediated is also important. FtP panels typically look at the question of remediability of the failings at two points in their reasoning:

- Impairment: are the failings remediable, and has the registrant remediated to the extent that their fitness to practise could be considered no longer impaired?¹⁵²
- Sanction: (if the registrant is found to be impaired) is the impairment remediable and therefore would a remediation sanction be appropriate?

3.152 Decision-makers at the end of the investigation are therefore interested in remediation both when determining whether there is a real prospect of finding impairment (is the misconduct remediable and has it been remediated?) and when considering whether undertakings would be appropriate (are there workable undertakings that would remediate the registrant's failings?).

3.153 The extent to which failings can be remediated is likely to depend in part on the nature of these failings. In the case of *PSA v HCPC & Ghaffar*, quoting the case of *Yeong*, the judgment sets out that:

Where there has been a fundamental breach by a practitioner of a tenet of the profession and a firm declaration of standard is required to promote public confidence, the efforts of a practitioner to address his problems and reduce the risk of recurrence in the future are of far less significance than in other cases such as clinical error¹⁵³

¹⁴⁹ See, for example: *The Professional Standards Authority v The Health & Care Professions Council, Mohammed Ghaffar* [2014] EWHC 2723 (Admin), available at <http://www.professionalstandards.org.uk/docs/default-source/section-29/court-judgments/hcpc/140702-ghaffar-judgment.pdf?status=Temp&sfvrsn=0.41002320148680615> [Accessed 1 November 2017]; or *Parkinson v The Nursing and Midwifery Council*, [2010] EWHC 1898 (Admin). Available at <http://www.bailii.org/ew/cases/EWHC/Admin/2010/1898.html> [Accessed 1 November 2017].

¹⁵⁰ *Yeong v General Medical Council*, [2009] EWHC 1923 (Admin)

¹⁵¹ For a description of what we mean by 'meaningful remediation', see the box on page 106.

¹⁵² *Cohen v General Medical Council* [2008] EWHC 581 (admin). Available at <http://www.bailii.org/ew/cases/EWHC/Admin/2008/581.html> [Accessed 1 November 2017].

¹⁵³ *The Professional Standards Authority v The Health and Care Professions Council & Mohammed Ghaffar*, [2014] EWHC 2723 (Admin). Available at <http://www.professionalstandards.org.uk/docs/default-source/section-29/court-judgments/hcpc/140702-ghaffar-judgment.pdf?status=Temp&sfvrsn=0.41002320148680615> [Accessed 1 November 2017].

3.154 The Yeong judgment itself relates to a serious breach of professional and sexual boundaries. Overall we understand this judgment to suggest that remediation is of lesser significance in conduct cases than in competence cases. Dishonesty is another area where remediation is unlikely to be effective – we note, for example, from the GMC’s research into erasure cases that the majority of these outcomes relate to dishonesty, and that usually these are cases where remediation has not been possible (perhaps linked to lack of insight – see below).¹⁵⁴ We would also stress that in rare cases clinical failings may be serious enough to engage the public interest. It would follow that undertakings are less likely to be suitable for conduct cases on the basis that failings pertaining to a registrant’s conduct are less likely to be remediable.

d. Is insight an important factor?

3.155 We have identified concerns about the assessment of insight in cases being disposed of consensually in our audits. Insight is important as it links closely to the risk of repetition, and to the chances of successful remediation. We have long argued that agreeing to undertakings is not in itself evidence of insight, and we wrote to the GMC in 2013 following our audit of cases closed at the initial stages to explain our concerns about their assessment of insight.¹⁵⁵ This view was corroborated by GMC research published in November 2015, which found that ‘doctors often only agreed to undertakings to halt [the GMC] proceedings.’¹⁵⁶ We had found that in a small number of cases the evidence of insight was insufficient.

3.156 Insight is a notoriously difficult aspect of fitness to practise decision-making. The GMC’s guidance for decision-makers at the end of the investigation asks them to look for the following evidence of insight:

- ‘an indication that the doctor is likely to agree to and comply with undertakings
- the doctor accepts they should have behaved differently (showing empathy and understanding)
- the doctor has taken timely steps to remediate and apologise at an early stage of the investigation
- the doctor has demonstrated the timely development of insight during the investigation and hearing.’¹⁵⁷

3.157 It is not clear whether all of these elements need to be evidenced in order for a registrant to show insight – for example, is it plausible to say that a doctor could show insight if he or she does not accept that they should have behaved

¹⁵⁴ DJS research for the GMC, November 2015. *Analysis of cases where doctors were erased or suspended from the medical register*. Available at <http://www.gmc-uk.org/about/research/28333.asp> [Accessed 1 November 2017].

¹⁵⁵ Report available on request.

¹⁵⁶ Community Research for the GMC, November 2015. *The effects of having restrictions on practice or warnings*. Available at <http://www.gmc-uk.org/about/research/28335.asp> [Accessed 1 November 2017].

¹⁵⁷ GMC, 2013. *Guidance for decision makers on assessing insight when considering whether undertakings are appropriate*. Available at http://www.gmc-uk.org/DC4314_Guidance_for_decision_makers_on_assessing_insight_when_considering_whether_undertakings_are_appropriate.pdf_32423692.pdf [Accessed 2 November 2017].

differently? In addition, is it reasonable to expect case examiners and investigating committees to answer these questions based on documentary evidence only?

3.158 A recent Court of Appeal judgment deals with this question: the case of *The Professional Standards Authority vs. The Health and Care Professions Council and Benedict Doree*¹⁵⁸ hinged on whether it was possible for the FtP panel to judge that the registrant (Doree) was demonstrating sufficient insight based on only a written statement, and no further cross-examination:

‘Whether a registrant has shown insight into his misconduct, and how much insight he has shown, are classically matters of fact and judgment for the professional disciplinary committee in the light of the evidence before it. Some of the evidence may be matters of fact, some of it merely subjective.

In assessing a registrant's insight, a professional disciplinary committee will need to weigh all the relevant evidence, both oral and written, which provides a picture of it. This may include evidence given by other witnesses about the registrant's conduct as an employee or as a professional colleague, and, where this is also relevant, the quality of his work with patients, as well as any objective evidence, such as specific work he has done in an effort to address his failings. Of course, there will be cases in which the registrant's own evidence, given orally and tested by cross-examination, will be the best evidence that could be given, and perhaps the only convincing evidence. And such evidence may well be more convincing if given before the findings of fact are made. But this is not to say that in the absence of such evidence a professional disciplinary committee will necessarily be disabled from making the findings it needs to make on insight, or bound to find that the registrant lacks it.’

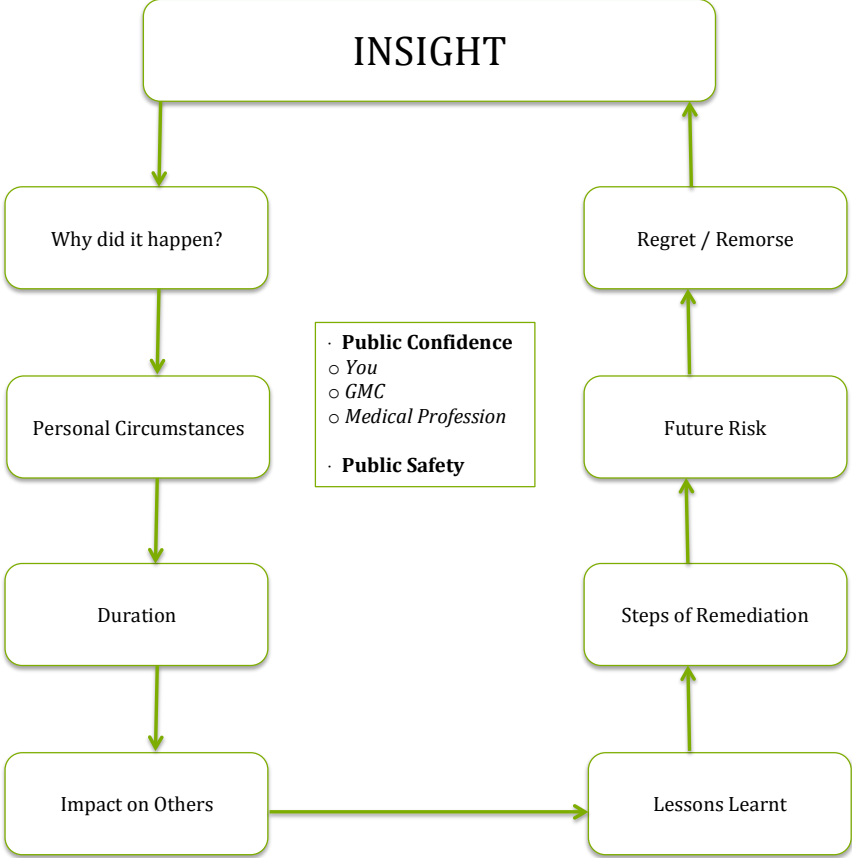
3.159 It is worth pointing out that the Judges here were considering a decision made by a fitness to practise panel at a full hearing, where the panel had had access to both written and oral evidence, including, for example, the opportunity to cross-examine witnesses. This is quite different from the situation in which case examiners operate, with only written evidence in front of them.

3.160 To illustrate the challenges faced by decision-makers here, we have copied the following guidance from Doctors Defence Service (DDS) for doctors going through FtP.¹⁵⁹

¹⁵⁸ [2017] EWCA Civ 319, Case No: C1/2015/1305. Paragraphs 35 to 40. Available at <http://www.bailii.org/ew/cases/EWCA/Civ/2017/319.html> [Accessed 2 November 2017].

¹⁵⁹ From the website of the Doctors Defence Service, at: <https://doctorsdefenceservice.com/showing-insight-in-reflective-writing-in-gmc-cases/> [Accessed 2 November 2017].

Figure 7: Doctors Defence Service – Showing insight in reflective writing in GMC cases



3.161 There is a legitimate need for registrants to be guided through all the stages of what is a hugely stressful and often alien process, and for organisations like the DDS to support doctors and help them understand what is required or expected of them. However, if it is possible for such organisations to provide detailed guidance on what the GMC is looking for in a demonstration of insight, this suggests that written statements may not be reliable evidence of insight.

3.162 We therefore argue that undertakings are unlikely to be an appropriate outcome for cases where insight is a major factor in determining impairment or where it may be difficult to establish whether insight is genuine, because we question the reliability of written statements as evidence of insight.

3.163 This suggests that cases where the main concerns relate to clinical competence may be more suitable for consensual disposal by case examiners and ICs than conduct cases, because of the lesser importance of insight. More generally, it seems that certain *types* of case may be unsuitable for undertakings because they require a more sophisticated examination of evidence of insight than is possible on paper. We would welcome further exploration of this question.

e. How serious are the allegations?

3.164 In addition to considering types of case, there are arguments for excluding cases on the basis of their severity, as measured by the sanction that a panel would be likely to impose. For the GMC, GDC and NMC, striking-off cases are excluded from consideration for undertakings. We see a number of reasons for this:

- Testing the evidence: this is both to ensure fairness to the registrant by allowing them and the panel to test the robustness of the regulator's case, and to ensure public protection by examining and challenging aspects of the registrant's account. Both these aims take on greater importance with more serious allegations.
- Using 'independent' adjudicators: although not entirely independent of the regulators, panel members are separate from the investigation function. The more serious the allegations, the more important it is to all parties and the public should have confidence that decision-makers are impartial.¹⁶⁰
- Airing the issues in a public forum: this is one of the ways in which the process can fulfil the wider public interest aims of maintaining public confidence and upholding the standards of the profession. The importance of fulfilling these aims is greater the more serious the allegation.

3.165 Arguably, this reasoning could also apply to suspension cases, which are usually serious, particularly where there is a significant patient safety issue, and/or the public interest is otherwise engaged. In addition, there is a clear rationale for using undertakings in cases that are likely to result in conditions, because the outcomes are more or less the same – this is not the case for suspension cases. However, there are also cases, such as serious health cases, where it would not be necessary to refer to a hearing, and undertakings might be the most appropriate outcome. Decisions about whether to refer a suspension case to a hearing should therefore be made on an assessment of whether this is required in order for the threefold purpose of fitness to practice to be fulfilled.

How is consensual disposal working in practice?

3.166 Setting aside the in-principle and case-law based arguments outlined in the previous section, what evidence do we have of the effectiveness of consensual disposal as a means of fulfilling the threefold purpose of FtP, or of the risks of these approaches in practice?

3.167 There is limited value in looking at evidence from regulators outside the UK jurisdiction, as our concerns here are whether the specific regimes operated by the GMC, GDC, and NMC are protecting the public and working in the wider public interest. We do not have powers systematically to review and appeal consensual disposal decisions that are signed off by CEs or ICs,¹⁶¹ however, we have amassed some evidence of our own about the quality of the decision-

¹⁶⁰ It is for this reason that Dame Janet Smith recommended the creation of an independent adjudication body, that became the Office of the Health Professions Adjudicator (OHPA). *The Shipman Inquiry. 2004. Fifth Report - Safeguarding Patients: Lessons from the Past - Proposals for the Future.* paragraph 25.352. Available at http://webarchive.nationalarchives.gov.uk/20090808154959/http://www.the-shipman-inquiry.org.uk/images/fifthreport/SHIP05_COMPLETE_NO_APPS.pdf [Accessed 1 November 2017].

¹⁶¹ Although we may see a sample of such decisions if we decide to audit initial stage decisions in our Performance Reviews. In addition, previously, we also carried out and published initial stage audits separately from the performance review.

making in these processes, and identified some key risks through our audits and targeted Performance Reviews.

- 3.168 But we do not feel that we are yet able to establish whether undertakings are generally being used for the right sorts of cases (i.e. in a way that fulfils the three limbs of public protection), or whether there are any risks attached to the way they are being used. The Authority therefore considers that a cross-regulator audit and research project is needed in this area. Such an evidence-base would build a picture of what sorts of cases are being disposed of in this way, whether these approaches present any risks, and how they could be improved.
- 3.169 We put forward some provisional views in this section about the considerations that may be brought to bear in determining whether a case should be referred to a hearing or disposed of consensually by CEs/IC. These views are based on our interpretation of the case law and experiences of scrutinising FtP decisions. However, using the evidence-base generated by a cross-regulator research piece, we wish to initiate discussion and reflection in our sector on the factors that should be taken into account when considering whether a case needs to be referred to a hearing, in order for the three limbs of public protection to be fulfilled.
- 3.170 This reflection should consider arguments, evidence and case law relating to the public interest, remediation, insight, and severity of cases. The outcomes of these reflections could be incorporated into guidance for decision-makers at the end of the investigation.
- 3.171 We would also like to see explored Dame Janet Smith's recommendation¹⁶² for guideline cases to be developed to help decision-makers, registrants, the public and employers understand how different types of case should be disposed of. These cases would need to be underpinned by extensive research, including evidence on how to satisfy the public interest aspects of the three limbs. Such guidelines could be a valuable means of bringing greater clarity and consistency to decision-making at the end of the investigation and beyond.¹⁶³
- 3.172 This is in addition to the measures we set out above which, if properly implemented, should provide some assurance that consensual disposal decisions are transparent, accountable, and protecting the public (three limbs). By way of a reminder, these measures are:
- a clear demonstration of how the decision-making framework for consensual disposal enables the regulator to fulfil its over-arching statutory objective relating to the three limbs of public protection
 - full transparency of policy: the regulator's policy and decision-making framework to be consulted on and published

¹⁶² As recommended by Dame Janet Smith's recommendation 51 of the Shipman Inquiry, 5th Report. Available at http://webarchive.nationalarchives.gov.uk/20090808154959/http://www.the-shipman-inquiry.org.uk/images/fifthreport/SHIP05_COMPLETE_NO_APPS.pdf [Accessed 2 November 2017].

¹⁶³ It is also worth noting that the benefits of such decision-making guidance can be lost if it is enforced too rigidly, as was the case at the General Dental Council when we conducted a special review of the workings of the Investigating Committee. The report is available at <http://www.professionalstandards.org.uk/docs/default-source/publications/special-review-report/investigation-report---general-dental-council.pdf?sfvrsn=4> [Accessed 2 November 2017].

- accountability of process and decision-making: clearly documented reasoning and decisions; formal options for challenging a decision to close a case; scrutiny of all decisions by the Authority; and quality assurance of decisions through the publication of audits and regular reports to council
- hierarchy of decision-making: the decisions of the CEs/IC should not preempt or undermine the role of the panel at a hearing, for example where there is a dispute about material facts
- independence of decision-making: those making decisions about how to dispose of a case on completion of the investigation should not have been involved in the investigation.

Involvement of the referrer at the investigation stage

3.173 Consensual disposal mechanisms, unlike hearings, do not provide a formal mechanism for the complainant/referrer/witness¹⁶⁴ to put across their side of the story. Our research with members of the public on alternatives to hearings identified concerns about the voice of the complainant getting lost in the process.¹⁶⁵

3.174 If consensual means of disposing of cases are to be used more and more across all regulators, one area in which there will need to be improvements is the involvement of the complainant or referrer at the screening and investigation stages. Such involvement is necessary to:

- help to establish the facts of a case
- keep them informed of progress
- enable their views to be taken into account, if appropriate when the decision is made about how to dispose of the case
- explain to referrers what to expect from the FtP process and outcomes.

3.175 Meaningful and respectful involvement helps to maintain the public confidence in regulation that is essential if complainants are to come forward with their concerns. It demonstrates a degree of respect for the people on whom the FtP system is largely dependent. We know from our research with complainants for the *Modern and efficient fitness to practise adjudication* project that referrers often feel they are kept in the dark throughout the FtP process, and feel disenfranchised as a result.¹⁶⁶ An additional benefit of greater involvement of referrers is that it gives the regulator a ready source of feedback on their experiences of the process.

¹⁶⁴ Terminology on this varies – the person referring the concern, or bringing the complaint is not a party in the FtP proceedings, but may become a witness at the hearing.

¹⁶⁵ Research Works for the Professional Standards Authority. May 2013. *Alternatives to final panel hearings for fitness to practise cases – the public perspective*. Available at <http://www.professionalstandards.org.uk/publications/detail/alternatives-to-final-panel-hearings-for-fitness-to-practise-cases-the-public-perspective> [Accessed 2 November 2017].

¹⁶⁶ Research Works for the Professional Standards Authority. 2011. *Enhancing confidence in fitness to practise adjudication - research report*. Available at <http://www.professionalstandards.org.uk/publications/detail/enhancing-confidence-in-fitness-to-practise-adjudication---research-report> [Accessed 2 November 2017].

3.176 In addition, in 2009, we published a report on sharing the registrant's response to allegations with the complainant or referrer.¹⁶⁷ Our conclusions remain relevant:

'CHRE understands that the regulators' fitness to practise processes are not established as a complaints process. However there are certain principles common in complaints processes that the public would expect a fitness to practise process to follow. Health professionals, and the regulators that oversee them, have a duty to act openly and transparently in their dealings with patients and the public. It seems only right, therefore, that there should be an opportunity to exchange correspondence between the registrant and complainant, facilitated by the regulator, to establish an accurate record of events. These facts form the basis for decisions made by investigating committees. We agree with the Henshall judgment, that panels should not consider a registrant's statement which the complainant has not had the opportunity to comment on'¹⁶⁸

3.177 There remain huge variations in how and the extent to which referrers/complainants/witnesses are involved or kept informed throughout the process. For some of the regulators, this activity remains very limited – aside from informing them of whether their case is proceeding they may only follow up with the referrer if they need further information, and do not share the registrant's response. At the other end of the spectrum, the GMC has launched a patient liaison service that offers two different meetings with complainants: one after someone has made a complaint, and one after they have finished investigating and decided what action, if any, they need to take to protect the public. Although we support these meetings in principle, we understand that are being used primarily for the GMC to impart information to the referrer about the process, and in our 2015-16 review of the GMC's performance, we highlighted concerns about how these meetings were being carried out in practice.¹⁶⁹

3.178 It remains unacceptable that some of the regulators still do not, at a minimum, share the registrant's response with the referrer. We would like to see this process adopted by all. Further work is also needed to clarify the role of the referrer or patient in the fitness to practise process generally, and specifically to consider their involvement in the processes leading to consensual disposals.

¹⁶⁷ Professional Standards Authority (formerly CHRE), December 2009. *Handling complaints: Sharing the registrant's response with the complainant*. Available at [http://www.professionalstandards.org.uk/docs/default-source/publications/handling-complaints---sharing-the-registrant-39-s-response-with-the-complainant-\(chre-2009\).pdf](http://www.professionalstandards.org.uk/docs/default-source/publications/handling-complaints---sharing-the-registrant-39-s-response-with-the-complainant-(chre-2009).pdf) [Accessed 2 November 2017].

¹⁶⁸ The case of *Henshall v General Medical Council (Henshall v General Medical Council [2005] EWCA Civ 1520)* was a Court of Appeal decision where the registrant had refused to consent to disclosure of his written response. The registrant believed that his response could be used for other, improper purposes. The judgment concluded that panels should generally not consider evidence where fairness dictates that complainants should have had the opportunity to respond but have not been provided with that opportunity.

¹⁶⁹ See paragraph 6.47 to 6.54 of our 2015-16 performance review of the GMC, available at <http://www.professionalstandards.org.uk/docs/default-source/publications/performance-reviews/performance-review-2015-16-gmc.pdf?sfvrsn=8> [Accessed 2 November 2017].

Other means of disposal

- 3.179 As mentioned above, there are a number of other means for the regulators to close cases that have been developed through, perhaps, permissive interpretations of their legislation. These include, for example, the HCPC's discontinuance process. Following the referral of a case to a final hearing by the IC, where the HCPC considers that an 'objective appraisal of the evidence' subsequently gathered suggests there is no longer a realistic prospect of the Conduct and Competence Conduct or Health Committee (as appropriate) upholding the allegation, it will apply to discontinue the case, in full or in part (i.e. the totality of the allegation or parts of the allegation).
- 3.180 This is done by way of an application to the Conduct and Competence Committee or the Health Committee to discontinue the case. The HCPC must give an explanation for seeking to discontinue, and the Committee has to consider whether the application is justified. If it agrees the application, the panel is invited to record that the allegation is not well founded.¹⁷⁰ Another example is the HCPC and NMC consensual panel determinations, which allow cases to be heard on the papers where the registrant has accepted a sanction proposal made by the regulator beforehand.¹⁷¹ The panel's role is to accept or reject the proposal. This approach may have merits – it avoids the need for a full panel hearing when the registrant does not wish to dispute the case, but still falls under our S.29 scrutiny (see below). However, it has no explicit statutory basis.
- 3.181 This situation is far from ideal: because these approaches are not in legislation, they lack the transparency and accountability we would expect for processes of this type. The legislation should be brought up-to-date so that it provides the regulators with the transparent legal basis to do what is needed to deal with their caseload effectively, in line with their statutory duty to protect the public. This should involve consideration of whether it is, or would be, appropriate or necessary for the Authority to scrutinise in the interests of public protection any decisions to close cases.

External scrutiny of consensual decisions (S.29)

- 3.182 In her report on the role of regulation in the Shipman case, Dame Janet Smith stated that 'everything a regulator does must (subject to confidentiality) be capable of scrutiny, i.e. it must be transparent.'¹⁷²

¹⁷⁰ Some regulators also use the practice of offering no evidence at the hearing, where there has been a change to the case since the decision by the IC/CE. For example, the NMC can offer no evidence:

- "When the particular allegations add nothing to the overall seriousness of the case.
- When there is no longer a realistic prospect of some or all of the factual allegations being proved.
- When there is no longer a realistic prospect of a panel finding that the nurse's or midwife's fitness to practise is currently impaired."

See the NMC guidance on offering no evidence, Available at <https://www.nmc.org.uk/ftp-library/hearings/offering-no-evidence/when-will-we-offer-no-evidence/> [Accessed 2 November 2017].

¹⁷¹ In addition, the NMC and HCPC have a process through which the registrant can provisionally agree to a sanction proposed by the regulator, that is subsequently either signed off or rejected by a fitness to practise panel. This process is known as a consensual panel determination (CPD), and is discussed in a later section.

¹⁷² The Shipman Inquiry, 2004. *Fifth Report - Safeguarding Patients: Lessons from the Past - Proposals for the Future*. paragraph 25.352. Available at

3.183 Our powers under Section 29 of the National Health Service Reform and Health Care Professions Act 2002 enable us to review all final FtP panel decisions and challenge them in the Courts if we believe them to be insufficient to protect the public. As is illustrated in Figures 4 and 5 showing the changes to the NMC process, consensual disposal of cases by case examiners or investigating committees removes cases from our S.29 scrutiny. Like the regulators it oversees,¹⁷³ the Authority's over-arching objective is to protect the public by pursuing the following objectives in relation to the regulation of health and care professionals:

- (a) to protect, promote and maintain the health, safety and wellbeing of the public;
- (b) to promote and maintain public confidence in the professions regulated by the regulatory bodies;
- (c) to promote and maintain proper professional standards and conduct for members of those professions.¹⁷⁴

3.184 Our S.29 oversight provides a means for FtP decisions to be challenged in the public interest. Removing this power – which is effectively what is happening when decisions are taken out of our remit – means that there is no equivalent to the registrant's right of appeal in the public interest. The following statement by the Minister during the second reading debate of the National Health Service Reform and Health Care Professions Bill (our founding legislation), clearly sets out the purpose of our powers:

'At present, the only appeal that exists against the decision of a regulator on someone's fitness to practise belongs to the registrant himself. No other remedy is available, either to the regulatory body or anyone else, to query whether those decisions have been in the public interest and properly protect members of the public.¹⁷⁵ The fundamental question for members of the Committee is whether they are content for there to be no such ultimate last-ditch power of review. Our view is clear the present situation is not satisfactory. That sentiment is shared by the regulatory bodies. [...]

No one should interpret clause 27 as calling into question the professionalism or competence of the disciplinary bodies who currently discharge this function. They are doing a good job and protecting the public very effectively. There is no argument about that. The clause is simply an attempt to remedy what is generally perceived to be a loophole, not a subliminal criticism of the work of the regulatory bodies.¹⁷⁶

http://webarchive.nationalarchives.gov.uk/20090808154959/http://www.the-shipman-inquiry.org.uk/images/fifthreport/SHIP05_COMPLETE_NO_APPS.pdf [Accessed 1 November 2017].

¹⁷³ With the exception of the PSNI.

¹⁷⁴ Sub-section 2(B), Section 25 of *the National Health Service Reform and Health Care Professions Act 2002*, as amended by the *Health and Social Care (Safety and Quality) Act 2015*. Available at <http://www.legislation.gov.uk/ukpga/2015/28/section/5> [Accessed 2 November 2017].

¹⁷⁵ The GMC has since acquired a right of appeal – however unlike the Authority, it cannot appeal on grounds of under-prosecution.

¹⁷⁶ Available at

<https://www.publications.parliament.uk/pa/cm200102/cmstand/a/st011213/am/11213s03.htm> [Accessed 2 November 2017]. To note - Section 29 of our legislation was 'clause 27' in the draft Bill being debated.

3.185 The report by the Law Commissions on reforming professional regulation recommended that the Authority have oversight of any consensual disposal decisions, particularly if there was to be no formal approval of the decision by a panel:

‘On balance we think that a requirement of formal approval in every case is unnecessary, although this would continue to be an option for the regulators. There should be some additional checks on the use of consensual disposals. First, the power of the Professional Standards Authority to refer fitness or practise decisions to the higher courts should be extended to include consensual disposals. This would ensure that all individual decisions to dispose of cases consensually would be subject to review by the Authority.’¹⁷⁷

3.186 We agree that this is essential if we are to continue to protect the public effectively. The following table showing some of the outcomes we have achieved from this process demonstrates the direct public protection impact of our work.

Table 5: FtP decisions that the Authority successfully appealed between March 2014 and April 2016¹⁷⁸

Regulator	Original panel decision	Outcome post-Authority intervention
HCPC	Caution – one year	Striking off
NMC	Suspension – nine months with review	Striking off
NMC	Caution – three years	Suspension – two months with review
HCPC	Suspension – one year with review	Striking off
NMC	Suspension – 12 months with review	Striking off
NMC	Caution – four years	Suspension – six months with review
NMC	Conditions – 12 months with review	Striking off
NMC	Suspension – four months with review	Striking off
HCPC	Caution	Suspension – three months
GMC	Suspension – 12 months	Striking off
HCPC	Suspension – 12 months	Striking off
NMC	Suspension – 12 months	Striking off
NMC	Conditions – 18 months	Suspension

¹⁷⁷ Law Commissions, 2014. *Regulation of Health Care Professionals, Regulation of Social Care Professionals in England*. Paragraph 8.67 and recommendation 68. Available at http://www.lawcom.gov.uk/wp-content/uploads/2015/03/lc345_regulation_of_healthcare_professionals.pdf [Accessed 1 November 2017].

¹⁷⁸ Based on the date of the original panel decision. This table shows those interventions that resulted in a significantly higher sanction against the registrant than the original sanction imposed by the FtP committee.

3.187 The above table illustrates the impact that our interventions can have. Every case that is taken out of our S.29 jurisdiction represents a decision that can go unchallenged even if it is insufficient to protect the public.

3.188 However, the positive impact of our appeals goes far beyond the direct impact it can have on the practice or behaviour of the individual practitioner in question. The cases we bring to Court have enabled the clarification in case law of the purpose and scope of fitness to practise, and of the power and responsibilities of the regulator, FtP panels, and bodies with power to appeal insufficient decisions.¹⁷⁹ The following list is a selection of the judgments we consider the most significant:

- The failure to include an express allegation of sexual motivation in the context of an inappropriate breast examination amounted to under-prosecution and a serious procedural error. (R (on the application of the Council for the Regulation of Healthcare Professionals) v (1) General Medical Council (2) Dr Mahesh Rajeshwar [2005] EWHC 2973 (Admin), see Bailii: <http://www.bailii.org/ew/cases/EWHC/Admin/2005/2973.html>)
- The question of whether charges found proved amount to misconduct is one of judgement and not fact. (Council for the Regulation of Healthcare Professionals v (1) General Medical Council (2) Dr Tarun Kumar Biswas [2006] EWHC 464 (Admin), see Bailii: <http://www.bailii.org/ew/cases/EWHC/Admin/2006/464.html>)
- Sets out the relevant principles when considering a stay of proceedings in the context of health care professional regulation. (Council for the Regulation of Healthcare Professionals v (1) General Medical Council (2) Gurpinder Saluja [2006] EWHC 2784 (Admin), not on Bailii)
- Sets out the approach to be taken when determining the issue of impairment and the need to include consideration of the wider public interest. (Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant [2011] EWHC 927 (Admin), see Bailii: <http://www.bailii.org/ew/cases/EWHC/Admin/2011/927.html>)
- Where a registrant is convicted of serious criminal offence, they should not be permitted to resume practice until the criminal sentence is satisfactorily completed. (Council for Healthcare Regulatory Excellence v (1) General Dental Council (2) Alexander Fleischmann [2005] EWHC 87 (Admin), see Bailii: <http://www.bailii.org/ew/cases/EWHC/Admin/2005/87.html>)
- The failure to provide sufficient reasons in relation to sanction can amount to a serious procedural or other irregularity where it is not possible to be satisfied that the sanction was appropriate in the case. (Council for the Regulation of Healthcare Professionals v (1) General Dental Council (2) Iain Ralph Marshall [2006] EWHC 1870 (Admin), see Bailii: <http://www.bailii.org/ew/cases/EWHC/Admin/2006/1870.html>)
- Sets out the approach the courts should take to a referral under S.29 and confirms that an acquittal may be referred to the courts. Also that a

¹⁷⁹ Currently only the GMC and the Authority.

disciplinary tribunal should play a more proactive role than a judge presiding over a criminal trial in making sure that the case is properly presented and the relevant evidence is placed before it. (Dr Giuseppe Ruscillo v (1) Council for the Regulation of Health Care Professionals (2) General Medical Council, Council for the Regulation of Health Care Professionals v (1) Nursing and Midwifery Council (2) Steven Truscott [2004] EWCA Civ 1356, see Bailii: <http://www.bailii.org/ew/cases/EWCA/Civ/2004/1356.html>)

- The failure to bring allegations that were relevant to a registrant having a serious underlying attitudinal problem was a serious procedural error where it prevented a panel from properly addressing the issue of impairment. (Professional Standards Authority v (1) Nursing and Midwifery Council (2) Joselo Silva [2016] EWHC 754 (Admin), see Bailii: <http://www.bailii.org/ew/cases/EWHC/Admin/2016/754.html>)
- Sets out the two questions to be considered when analysing possible under-charging, being whether on the evidence and applying its own rules should have included the further allegations and if so, whether the failure to include those allegations mean the Court is unable to determine whether the sanction was unduly lenient or not. (Professional Standards Authority v (1) General Chiropractic Council (2) Cameron Briggs [2014] EWHC 2190 (Admin), see Bailii: <http://www.bailii.org/ew/cases/EWHC/Admin/2014/2190.html>)

3.189 It is clear is that our oversight and powers of appeal for decisions that do not protect the public will take on greater importance as more decisions are taken out of the public hearing forum. It is therefore essential that they should be extended to decisions that are made outside the hearings forum.

Action when the real prospect test is not met – warnings and advice

3.190 Increasingly, the regulators we oversee are obtaining powers to issue warnings and/or advice when they close a case that does not meet the real prospect test: the GMC, GDC, GOC, GPhC, PSNI and NMC all have some version of these powers.¹⁸⁰ We do not see this as a particularly contentious aspect of the fitness to practise process, however we feel it is important to mention it as a potentially effective means of dealing with issues early before they become serious.

3.191 Warnings and advice can be a helpful response from the regulator where the issues with the registrant's practice or behaviour are not so serious as to warrant action on registration, but where they could be remedied by the issuing of advice or a warning. If published, they can also raise awareness among other registrants, employers and patients of the boundaries of acceptable behaviour.

3.192 We would not however view warnings and advice as appropriate responses where there is a real prospect of a panel finding impairment. These actions should be available only where the misconduct is not serious, because unlike conditions and suspension there is no option for a review by the regulator or panel, to establish whether the registrant's fitness to practise continues to be impaired. We also know from GMC research that employers are unclear about

¹⁸⁰ The GPhC IC can also issue warnings and advice in cases where there is a real prospect of the alleged facts being proven, but there is no real prospect of a finding of current impairment.

the status of decisions to issue warnings against doctors.¹⁸¹ This kind of confusion is likely to be exacerbated if a minority of regulators have powers to issue warnings and advice when there is a real prospect of finding impairment.

3.193 We consider it essential however that there is clarity about when advice and warnings can and are likely to be used. This would help registrants, the public, and employers understand the status of such decisions. We were critical in our response to the NMC's consultation in December 2016, because it did not explain clearly when CEs should issue warnings or advice, or agree undertakings.

3.194 It is also important that decisions to use these alternatives are made only once an investigation is complete and the regulator has sufficient information to put the case before an IC/CEs for a decision about the real prospect of finding impairment. This is to ensure that the established decision-making process is respected, and to prevent the decision-makers at the early stages from pre-judging the IC/CE decision.

¹⁸¹ Community Research for the GMC, November 2015. *The effects of having restrictions on practice or warnings*. Available at <http://www.gmc-uk.org/about/research/28335.asp> [Accessed 2 November 2017].

Incremental change: additional issues

3.195 In this final section on incremental change, we consider some further aspects of fitness to practise where minor reforms could be beneficial.

Powers to make costs orders

3.196 One consequence of the adversarial, legalistic approach that has developed in FtP over the years is that registrants may be encouraged by their defence bodies, or even their indemnity insurance provider to contest whatever case is presented to them by the regulator, or to delay proceedings. This can cause significant delays in proceedings, and is expensive for the regulators. We do not, by this, mean to suggest that these registrants are doing anything wrong. However, we do believe there are insufficient incentives or disincentives being used in the current system to discourage this sort of behaviour.

3.197 As we understand it, the GDC,¹⁸² GPhC,¹⁸³ PSNI and the GOC¹⁸⁴ FtP committees, and committees of the MPTS¹⁸⁵ all have powers to order that costs be paid by either party, but we believe that they are rarely used.

3.198 It is our view that reasonable and appropriate use of cost orders could provide an important disincentive to registrants and their defence bodies to obstruct the smooth running of proceedings. These powers are already in place for some of the regulators – we see no reason why they should not be extended to all, and perhaps used more readily, provided doing so was deemed cost-effective. This proposal would provide an incentive to all parties to engage in proper and timely case management.

Automatic erasure offences

3.199 Currently none of the regulators have powers to remove registrants automatically for a particular criminal conviction. The GMC consulted on this question in 2011, and found there was strong support in principle (83%) for the proposal that certain criminal convictions are so serious that they are incompatible with continued registration as a doctor and that there should be a presumption that the doctor be erased.¹⁸⁶

3.200 It explained in its consultation document that:

‘Unless representations made by the doctor raise matters which need to be considered by a fitness to practise panel we would proceed to erase the doctor’s name from the register. This would enable the GMC to take swift and

¹⁸² Paragraph 6 of schedule 3 to the Dentists Act 1984.

¹⁸³ Part 7 of the Pharmacy Order at 61 (rules in respect of proceedings).

¹⁸⁴ GOC, Fitness to Practise Rules 2005 Part 8.

¹⁸⁵ GMC FtP Rules, Rule 16B. Available at http://www.mpts-uk.org/consolidated_version_of_FTP_Rules.dec2015.pdf_64002624.pdf [Accessed 2 November 2017].

¹⁸⁶ GMC, January 2011. *Reform of the fitness to practise procedures at the GMC: Changes to the way we deal with cases at the end of an investigation. A paper for consultation.* Available at http://www.gmc-uk.org/FTP_reforms_consultation_paper.pdf_38085201.pdf [Accessed 2 November 2017].

robust action in the most serious cases and could well boost public confidence in the regulatory process.’¹⁸⁷

3.201 However, for the GMC to take such swift action it would need changes to its primary legislation. It had hoped that this would form part of the new regulatory bill following work undertaken by the Law Commissions but as that has still not gone ahead, we understand that the GMC still waits for confirmation of when this change might be implemented.

3.202 The Law Commissions were supportive of this policy:

‘We are persuaded that the draft Bill should introduce a new provision for automatic removal for certain serious criminal convictions. From the regulators’ perspective, being able to act quickly against registrants convicted of serious offences will have benefits in terms of public confidence and costs. We also agree that some criminal convictions are so serious they are incompatible with continued registration. We think that automatic removal should apply in cases of murder, trafficking people for exploitation, blackmail (where a custodial sentence is imposed), rape and sexual assault (where a custodial sentence is imposed), and certain sexual offences against children. [...]’¹⁸⁸

3.203 For the most serious offences, it is in the public interest to remove registrants as quickly as possible – not only does it provide swifter public protection, it also removes the unnecessary costs of a hearing. We therefore support this view, provided the process is compliant with article 6 of the European Convention of Human Rights. The Law Commissions argued for the registrant’s ability to make representations to the regulator and a limited right to appeal to the higher courts on the factual basis of an error in law or finding of fact.

3.204 Furthermore, we do not see any reason why there should be variation across regulators and professions on this matter. We therefore consider that such a reform across all the regulators could be a straightforward means of reducing the costs of fitness to practise while continuing to protect the public.

Consistency, cooperation, autonomy and flexibility

3.205 The importance of consistency has been a recurring theme throughout the chapter so far. This is not the place for a discussion on how permissive the regulators’ legislation should be – though we note that many of the regulators brought up the need for more flexible legislation when we asked them what issues they experienced with their current FtP framework. We are interested in outcomes, and what we have established in this chapter is that there remains an unacceptable level of variation across the regulators – unacceptable because we believe it is leading to differences in outcome for which there is no justification. This is hardly revelatory – Francis identified this issue in his report on Mid-

¹⁸⁷ GMC, January 2011. *Reform of the fitness to practise procedures at the GMC: Changes to the way we deal with cases at the end of an investigation. A paper for consultation*. Available at http://www.gmc-uk.org/FTP_reforms_consultation_paper.pdf_38085201.pdf [Accessed 2 November 2017].

¹⁸⁸ Law Commissions, 2014. *Regulation of Health Care Professionals, Regulation of Social Care Professionals in England*. paragraph 8.28. Available at http://www.lawcom.gov.uk/wp-content/uploads/2015/03/lc345_regulation_of_healthcare_professionals.pdf [Accessed 2 November 2017].

Staffs;¹⁸⁹ the Law Commissions were tasked with bringing greater consistency across the regulatory framework by creating a single statute to govern all nine regulators.¹⁹⁰

- 3.206 What is interesting however, is that much of the variation we have identified in this chapter, and particularly in the way cases are screened out at the early stages, does not appear to be a result of the legislation – it is either down to different interpretations of the same or similar legislation, or differences in implementation and organisational culture.
- 3.207 This is both helpful, and potentially challenging – changing statute takes time and resources but there is at least a clear mechanism for doing so. Changing the way organisations work, their policies and practice, is a far greater challenge. It also suggests that the consistency vs. autonomy argument in relation to legislation could be something of a red herring – there may be huge scope for harmonising the operational processes of the regulators without the need to amend legislation.
- 3.208 Over time, we would therefore like to see the regulators renew their efforts to understand the different practices that exist where there is scope for greater consistency without the need for legislative change. As discussed earlier in the chapter, decision-making at the early stages would be an example of this, and could go some way towards reducing the sorts of unjustifiable differences in outcome that Sir Robert Francis identified in his Inquiry.
- 3.209 This still leaves the question of how a system that is set up to hold individuals to account should deal more effectively and efficiently with issues and incidents that occur across teams, as the use of multi-disciplinary teams becomes increasingly prevalent across health and care. This is not a problem that can be solved by fitness to practise alone – standards and education can both play a role in bringing different professions together. As we proposed in *Regulation rethought*, a single regulator could be the ultimate solution.
- 3.210 The concern in fitness to practise is twofold – as we have already discussed, inconsistency of process and outcome can be problematic. But there is also an issue of inefficiency and burden on those involved, with each regulator having to carry out its own investigation on the same incident. We know that the regulators

¹⁸⁹ Excerpt from recommendation 235 of the Francis Inquiry: ‘*The Professional Standards Authority for Health and Social Care (PSA) (formerly the Council for Healthcare Regulatory Excellence), together with the regulators under its supervision, should seek to devise procedures for dealing consistently and in the public interest with cases arising out of the same event or series of events but involving professionals regulated by more than one body.*’

The Mid Staffordshire NHS Foundation Trust

Public Inquiry, 2013. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Volume 2.*

Available at

<http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/sites/default/files/report/Volume%202.pdf> [Accessed 1 November 2017].

¹⁹⁰ Law Commissions, 2014. *Regulation of Health Care Professionals, Regulation of Social Care Professionals in England*. Page 120. Available at http://www.lawcom.gov.uk/wp-content/uploads/2015/03/lc345_regulation_of_healthcare_professionals.pdf [Accessed 1 November 2017].

are already working together, particularly with system regulators, to share intelligence and information on individual cases, and to reduce duplication.¹⁹¹ ¹⁹²

- 3.211 We also believe, however, that more could be done to encourage and enable joint working across the professional regulators in our sector. Some of this might require legislative change – for example to allow one regulator to accept the findings of an investigation carried out by another, and only have to make a decision on impairment and sanction.¹⁹³ This reform would need to be supported by a more inquiring approach to investigations that focused on identifying the facts of the case, rather than on building a case against a specific registrant – a proposal we made in *Regulation rethought*, and reiterate in our proposals for longer-term reform in the section that follows. A more inquiring approach could also support the use of joint investigations among professional regulators.
- 3.212 In addition, we would encourage the regulators we oversee to continue to explore ways in which they could collaborate amongst themselves, both on specific incidents and cases, and on intelligence-sharing.

¹⁹¹ See for example, the Joint Operating Protocol between the GMC and the CQC, available at <http://www.cqc.org.uk/news/stories/regulators-share-information-improve-patient-care> [Accessed 2 November 2017]. The work of the Regulation of Dental Services Programme Board, available at http://www.cqc.org.uk/sites/default/files/20170411_working_together_delivering_change.pdf [Accessed 2 November 2017].

¹⁹² The PSNI is part of the Pharmacy Network Group (PNG), which facilitates the sharing of information with different agencies of the Northern Ireland Department of Health concerning ongoing and overlapping investigations. The aim is to avoid duplication, delay, and jurisdictional issues.

¹⁹³ This echoes a proposal made in response to our questionnaire to regulators.

Longer-term solutions

3.213 At the time of writing, the Department of Health, on behalf of the four UK Governments, has published the consultation document *Promoting professionalism, reforming regulation*. However there remains uncertainty as to whether this will lead to the opportunity for large-scale legislative reform. It remains essential, therefore, that we come to a shared understanding across the sector of what might be achieved in the long-term, so that we may move closer to this ideal, in stages if necessary. We do not claim to be putting forward a definitive solution to the problems encountered in the current system. We wish simply to share our thinking, and stimulate further discussion and debate. We have nevertheless endeavoured to make our proposals realistic as well as ambitious.

A future approach to fitness to practise

3.214 We set out in the opening sections of this chapter the role of fitness to practise as we see it:

Fitness to practise outcomes should fulfil the three limbs of public protection by means of meaningful remediation where possible, and degrees of restrictions on practice where not.

3.215 We also listed a number of guiding principles for reform of fitness to practise:

- **Use fitness to practise measures only when necessary:** issues should be resolved in the place where they occur or by other bodies who are best placed to deal with them, unless they meet the regulator's threshold for referral.
- **Link thresholds for accepting concerns to the professional code:** it should be clear to registrants, employers, patients and service users when a concern needs to be referred to the regulator. This should be based on the code that sets out what is expected of a registrant.
- **Seek early resolution and remediation where appropriate:** the purpose of fitness to practise is not to punish. This has implications for the way in which cases are disposed of, and for the design of the FtP process, for example the role of formal adjudication would be diminished.
- **Separate investigation and decision-making, including adjudication:** the current structures limit the extent to which this is possible for all the regulators, but it remains an important basic principle.¹⁹⁴
- **Ensure accountability, transparency, and consistency:** this applies both to policy and to practice; there should be external scrutiny of all decisions to take action on registration; there should be options to review decisions to

¹⁹⁴ As recommended by Dame Janet Smith's recommendation 51 of the Shipman Inquiry, 5th Report. Available at http://webarchive.nationalarchives.gov.uk/20090808154959/http://www.the-shipman-inquiry.org.uk/images/fifthreport/SHIP05_COMPLETE_NO_APPS.pdf [Accessed 2 November 2017].

close cases at the major decision-making points in the process. There are good reasons why outcomes may be different, but any reforms should strive for greater consistency of process and thresholds where possible.

3.216 We would like to add to the above a more radical principle that would not be applicable under the current system because it challenges the case law:

- **Use formal adjudication only when the registrant disputes the case:** only when there is a dispute between the regulator and the registrant (on material facts, the decision that regulatory action is needed, or the specific action recommended by the regulator) is it necessary to use an independent means of adjudicating.

3.217 The case law suggests that a public hearing may be necessary to maintain public confidence in certain cases, for example where there is a strong public interest element. In our view, there would be value in re-evaluating this assertion.

3.218 We find it helpful here to distinguish between outcome and process. In our view, fitness to practise *processes* must be worthy of public trust through transparency, accountability, consistency, and fairness; but it is primarily the *outcomes*, (which for us would include the decision to publish information about the case) that protect the public, maintain public confidence and declare and uphold professional standards. We are not aware of any evidence that public hearings are the most effective means of maintaining public confidence and declaring and upholding professional standards – indeed research commissioned by the Authority with members of the public suggests alternatives to public hearings would be well received, provided that they did not impact negatively on the fairness or integrity of the process.¹⁹⁵

3.219 It would be worth exploring how alternatives to public hearings would most effectively fulfil the aims of maintaining public confidence and declaring and upholding professional standards, for example by finding digital options for the recording of proceedings and publicising of outcomes. Any such shift would need to be accompanied by assurances that independence of decision-making was retained, and that there would be opportunities for a decision to close a case to be challenged by the complainant, as well as the Authority.

3.220 In addition, we would need to know more about the impact of taking decisions out of a public forum in the traditional sense, on the psychology of decision-makers. The presence in the room of external observers is likely to have a positive effect on the quality of the proceedings and subsequent reasoning and outcome. It would be worth exploring how this real-time scrutiny could be replicated in proceedings that were not open to the public.

¹⁹⁵ Research Works report for the Professional Standards Authority, May 2013. *Alternatives to final panel hearings for fitness to practise cases – the public perspective*. Available at <http://www.professionalstandards.org.uk/publications/detail/alternatives-to-final-panel-hearings-for-fitness-to-practise-cases-the-public-perspective> [Accessed 2 November 2017].

Terminology

- 3.221 As mentioned at the start of this chapter, it has not been possible within the scope of this project to consider alternative terms to describe fitness to practise. We are acutely aware that the current jargon is technical and inaccessible to professionals and the public alike. Any significant reforms of fitness to practise should consider adapting the associated terminology to make it more easily understandable, and to help disassociate the new approaches from the adversarial model currently in place.
- 3.222 We have nevertheless in this section avoided the use of terms such as ‘sanction’ and ‘impairment’ that are so closely associated with the current framework.

Towards a new model for dealing with concerns about healthcare professionals

- 3.223 We set out the main problems with the current fitness to practise models earlier in this document, and in our publication *Regulation rethought*, where we also proposed a number of radical reforms. In addition, colleagues from the regulators we oversee have had the opportunity to explain to us what they see as the main issues in FtP and possible radical solutions (see Annex).¹⁹⁶ We have used this feedback to inform the development of this model.
- 3.224 The broad lines of our proposed approach are as follows:
- a distinction between remediable and non-remediable cases
 - early agreed outcomes (including remediation) would be encouraged for all cases, except where the registrant did not accept the facts, the decision to take action, or the outcome proposed by the regulator, and
 - only cases where there was such a dispute would be dealt with through formal adjudication
 - all decisions relating to cases that were pursued by the regulator post-investigation to be subject to scrutiny by the Authority, which could appeal if it felt a decision did not protect the public.
- 3.225 We have tried to develop a simple model that would reduce the friction between regulator and registrant, and move away from the legalistic, adversarial system we have today. It is designed to encourage full cooperation from the registrant from the outset, and to deploy the minimum regulatory force to achieve the desired result. Any concrete proposals would of course need to be carefully costed. The regulator of social workers and social care workers in Scotland, the Scottish Social Services Council already runs a fitness to practise model that bears some resemblance to our proposals in this chapter.¹⁹⁷ We understand that they view its introduction as a success, based in part on the high proportion of cases that are now disposed of by consent without a hearing.

¹⁹⁶ Some of this feedback was provided on an informal basis.

¹⁹⁷ More information is available at <http://www.sssc.uk.com/fitness-to-practise/what-is-fitness-to-practise/fitness-to-practise-documents> [Accessed 2 November 2017].

- 3.226 This approach is compatible with, but not dependent on, the creation of a single register and a licensing system for healthcare professionals, which was a proposal in *Regulation rethought*. For the remainder of this section however, we have worked with the assumption that the current *structure* of professional regulation in our sector will remain more or less the same, potential mergers of regulators notwithstanding.
- 3.227 What we set out below is not a recipe for structural reform. Instead, we describe how the fitness to practise process could work differently, without opining on which bodies or institutions should deliver it. Our proposals are therefore not dependent on structural change, although they would no doubt also require some legislative reform, and greater collaboration between regulators than we have seen until now. We understand from the regulators' responses to the questionnaire we circulated that, for the most part, regulators would like their legislation to give them greater flexibility to evolve and modernise. We would support this, provided that collaboration and consistency of approach could – and would – be achieved through other means.
- 3.228 Much of what we said in our sections on incremental change is relevant here. In particular, the recommendations for clear and transparent threshold criteria, and accountability of decision-making for the initial stages would continue to apply.

Basic concept

- 3.229 Our approach centres on the decision that is made at the end of the investigation. At this point, all cases that are found to warrant regulatory action fall into one of the following categories, based on whether the misconduct can be remediated, and whether the registrant accepts the outcomes of the regulator's investigation, including the proposed outcome.

Table 6: Longer-term reform – disposal of cases beyond the end of the investigation

Is it remediable?	Findings and proposed outcome accepted?	Disposal route	Outcome options ¹⁹⁸
Yes	Yes	Accepted outcome	Conditions Suspension
Yes	No	Adjudication	Advice Warning Conditions Suspension Striking off
No	Yes	Accepted outcome	Advice Warning Conditions Suspension Striking off
No	No	Adjudication	Advice Warning Conditions Suspension Striking off

3.230 After the investigation, the FtP function would therefore operate two distinct processes:

- **Accepted outcome, including remediation:** for cases where the facts, decision to take action, and proposed outcome were accepted by the registrant
- **Referral to adjudication:** for cases where the findings and outcome were not accepted by the registrant.

3.231 A case would default to the adjudication route at any point where the registrant either did not comply with the process, or chose to dispute any aspects of the regulator’s case.

¹⁹⁸ The outcomes listed in this table could be combined, where appropriate – for example conditions could be issued with a warning; a suspension could be issued with conditions.

The process in more detail

3.232 In order for these decisions to be reached at the end of the investigation, a number of elements would need to change in the early parts of the process. There would need to be an early decision point for determining whether the allegations were, on the face it, remediable. Cases that involved both remediable and non-remediable allegations would ultimately have to be considered through the non-remediation route. Cases where the registrant was found to have remediated by this point, to the extent that they were no longer a threat to public safety, would only be pursued if there was a need to take further action in the wider public interest.

3.233 Investigations would take on a more inquiring nature. Rather than building a case against a registrant, they would seek to uncover the facts. Investigation of allegations relating to competence, English language and health for example would be likely to involve an assessment. All other types of investigation would involve both the registrant and the referrer (and/or those affected by the misconduct if different from the referrer). As previously discussed, such an approach could facilitate joint investigations or the adoption by one regulator of the findings of an investigation by another, for incidents where more than one profession was involved.

What is meaningful remediation?

*'It must be highly relevant in determining if a doctor's fitness to practise is impaired that first his or her conduct which led to the charge **is easily remediable**, second that it **has been remedied** and third that it **is highly unlikely to be repeated**.'*

(Cohen v GMC; (2008) EWHC 581 (Admin); paragraph 65)

Where a professional has been found to be unfit to practise, their failings can sometimes be addressed by means of remediation, to try to make them fit to practise again in the future.

It is important to note that:

- In some cases, remediation may address the immediate risk to the public, but fail to uphold professional standards and/or maintain public confidence
- Not all failings can be remediated and remediation is not always successful
- Clinical failings are more likely to be successfully addressed through remediation than other types of impairment
- Remediation can only be effective if the registrant shows insight into their failings
- Evidence of meaningful remediation should include an objective element, and go beyond a reflective written piece, completion of an online course, or the mere passage of time
- Reviews are essential to check whether remediation has been effective, where remediation measures have been imposed or agreed.

Therefore, when we talk about meaningful remediation measures, we mean that:

- There is evidence of sincere insight and remorse
- Remediation measures have a realistic prospect of addressing the failings
- Remediation as an outcome fulfils all three aims of public protection as appropriate
- Review and objective assessment of whether remediation has been effective, including an assessment of the likelihood of repetition, are undertaken systematically.

- 3.234 The quality of the investigations would be key, as the decision-maker at the end of the investigation would need to be furnished with sufficient evidence to make a decision about whether the case warranted regulatory action (this could be the RPT or a different test), whether the misconduct was remediable and how, and the most appropriate outcome to protect the public. The definition of what is remediable would take into account not only the need to protect the public, but also seriousness and the need to maintain public confidence and declare and uphold professional standards.
- 3.235 Insight would be an important consideration: acceptance of the proposed outcome should not be taken in itself as proof of insight. The investigation and decision-making processes would need to include opportunities to assess insight, for example through face-to-face discussions with the registrant. The final bundle presented to the decision-maker could also include a statement from the referrer about the impact of the registrant's actions,¹⁹⁹ to inform the outcome proposal.
- 3.236 If the misconduct was remediable, two options would be available to decision-makers at this point: conditions or suspension. In both scenarios, the outcome would be published, though we believe there would be value in exploring the imposition of shorter durations of publication (with a minimum of the duration of the conditions or suspension order) to reflect the fact that failings have been remediated and the registrant has cooperated with the process. This would encourage compliance and remove the unintentionally punitive effect of publication where there is no longer a public protection or public interest imperative to keep the information public. If the registrant disputed any aspects of the case, or turned down the outcome proposal at this point, the case would automatically be referred to adjudication, where all sanctions would be available to the panel, including striking off, and the outcome would be published. Cost orders would also be available to the panel.
- 3.237 All remediation outcomes would need to be subject to systematic monitoring and review, to assess the success of the chosen remediation measures, and the likelihood of repetition.²⁰⁰
- 3.238 If the misconduct involved any non-remediable element, the full range of outcomes would be available at the end of the investigation. If accepted by the registrant, the proposed outcome would be published, but a hearing would not be necessary. If disputed by the registrant, the case would automatically be referred to a hearing, and as above, all sanctions would be available, the outcome would be published and the registrant could be ordered to pay costs to the regulator.
- 3.239 There would be options for review of all decisions made at the end of the investigation, i.e. whether to close a case or to pursue it, which disposal route to adopt, and the final outcome. As part of that, all decisions relating to cases that were pursued by the regulator post-investigation would be subject to scrutiny by the Authority, and could be appealed if we felt they did not protect the public. All decisions to close cases with no further action, or with advice or a warning could be scrutinised by the Authority if it deemed there was a performance issue or a

¹⁹⁹ Similar to a 'victim impact statement' as used in the criminal courts.

²⁰⁰ See the box on the previous page.

risk associated with these decisions, as we have audited cases closed at the initial stages in the past.

3.240 As we explained in the previous section, our role is important not only in protecting the public in the cases we appeal successfully, but also in clarifying the purpose and scope of fitness to practise more generally. This latter role could become all the more important if fitness to practise were to evolve as we have described as new principles would need to be established.

Potential risks and issues to be addressed with this approach

3.241 Our proposals above would of course need to be considered in more depth, costed, and assessed for unintended consequences. Below we set out a few of the potential issues that would need to be either addressed in order for the scheme to work, or further examined to understand the overall viability and desirability of these changes.

- As we ascertained in the earlier sections of this chapter, moving disposal options further upstream in the FtP process means that the investigation of cases that meet the initial threshold has to be thorough, and complete before a decision is made about how they should be disposed of. The quality of the investigation is therefore key to this model.
- Our understanding of what can be remediated would need to improve. Clearly, some types of case are more likely to fall into the 'remediable' category – clinical failings, for example. Other types of case, particularly attitudinal issues such as dishonesty, perhaps would never be considered remediable. This could form part of work already recommended in this chapter to develop a more sophisticated understanding of how to dispose of different types of misconduct most effectively to protect the public.
- This approach places much responsibility on the role of the post-investigation decision-maker(s), and we would expect the quality assurance, transparency, and accountability of decision-making to be bolstered accordingly. This would be a senior role, and would need to have a degree of separation from the investigation, as CEs and ICs do now.
- This system works in part on the assumption that hearings are not necessarily needed to maintain public confidence and declare and uphold professional standards. As our proposals would result in many decisions being taken outside FtP hearings, further thinking and research would need to be applied to the question of how to maintain the trust of the public, professionals, and employers in the system as a whole, and how to ensure that individual decisions were maintaining public confidence in regulation and declaring professional standards.
- We have said this above, but it is worth repeating: this approach places a great deal of trust in the regulatory bodies, by removing potentially large numbers of decisions from the public forum that is a hearing. This would need to be counter-balanced with improved accountability and transparency of decision-making.

3.242 No doubt further, more detailed issues would emerge and need to be addressed over time. We nevertheless consider this proposal to demonstrate our full commitment to rethinking fitness to practise, both to give it greater clarity of purpose, and for that purpose to be clearly reflected in its design.

Conclusion

- 3.243 The health and care sectors are evolving at a fast pace. New ways of working, such as greater use of multi-disciplinary teams and the development of technology to support the delivery of healthcare, call for changes in the way regulators deal with registrants who have fallen below the required standard. The strain on the NHS of increased demand and tightening resources, and the potential for even greater workforce shortages as the UK leaves the EU, suggest that a change of approach to fitness to practise may be needed. This has provided an opportunity to examine, in the current context, the role of fitness to practise, how it is working in practice, how the current framework could be improved, and what more radical reform might look like.
- 3.244 What is needed now is a flexible model that enables regulation to keep pace with and adapt to these external developments. The three limbs of public protection must remain the core purpose of fitness to practise. However, both in the short and the longer-term, greater use of remediation and consensual disposal, for cases that are suitable, could allow regulators to fulfil these aims with less reliance on expensive and legalistic hearings.
- 3.245 We recognise that regulators need to be able to discriminate at an early point in the FtP process between allegations that are capable of amounting to a breach of the regulators' standards, and those that are not. However we are also clear that there are risks associated with giving the regulators more powers to close cases at the initial stages (whether at the end of the investigation or before), that must be counterbalanced with greater transparency and accountability. There also needs to be a more developed evidence-base to ensure that decisions to dispose of cases are protecting the public as far as possible.
- 3.246 For the time being, hearings must remain a key part of the fitness to practise process, in part because the legislative framework points to their being needed in certain cases, to maintain public confidence and uphold professional standards. But also because as things stand, they are more effective at performing certain functions than the regulators' processes for closing cases at the end of the investigation – such as assessing insight, and bringing in the perspective of the patient (as a witness).
- 3.247 In the event of substantial reform, we would see formal adjudication as an option reserved for cases where there was a dispute between regulator and registrant over material facts, the decision by the regulator to take action, or the outcome proposed by the regulator. All other cases would be disposed of consensually, including cases where remediation was considered the most effective means of protecting the public. Investigations would take on a more inquiring role, focused on establishing the facts rather than building a case against the registrant. The process would seek to be less adversarial, and elicit greater cooperation from the registrant. The views of the patient or service user would be sought as a matter of course, and if the impact of the professional's action on them would be taken into account in the decision about the outcome.

- 3.248 These reforms would need to be accompanied by increased transparency and accountability, to counter the effects of moving FtP decisions into a less public forum. The Authority would need to have powers of scrutiny and appeal of all final decisions whether made consensually or in a hearing. The reforms would incorporate new ways of putting proceedings and decisions into the public domain. We believe that these proposals could ultimately help to deal with the increasing costs of fitness to practise and the toll that the current ways of working take on both registrants and complainants. They chime with much of the feedback we received from regulators on how to fix the current problems they are experiencing.
- 3.249 We have highlighted in this chapter the huge variation in the legislation as well as in policy and practice across the regulators. Consistency of approach is as important as ever, though it is also right that outcomes may be different. There are ways in which greater consistency could be achieved – and this is something we would like to see, for example, in thresholds and criteria for closing cases before the investigating committee/case examiner stage. A common code of conduct across professions would support this consistency. There is also more that could be done to enable regulators to work together on specific cases and share intelligence, though we recognise the efforts that the regulators have made on this challenging agenda to date.
- 3.250 We put forward this chapter to stimulate debate and discussion, and help to bring about a consensus on the future of fitness to practise.