

Right-touch reform

A new framework for assurance of professions

November 2017

Right-touch reform: summary

This report aims to influence the debate about the future direction of regulatory policy and improvement. We hope that it will support stakeholders in engaging with and responding to the current UK-wide Government consultation *Promoting professionalism, reforming regulation*¹.

The report covers in detail four main areas: the role of regulators in prevention of harm; the future of fitness to practise; professional regulators' role in education and training; and modernising registers. We also discuss our proposal for a single assurance body, an idea we first set out last year in *Regulation rethought*,² and which we now strongly encourage stakeholders to consider in the light of the recent consultation.

As well as making proposals for future development and improvement, both incremental and more radical, the report provides detailed summary and analysis of current arrangements in these areas in order to help stakeholders in understanding existing arrangements and to act as a platform for future discussions towards reform.

The discussions in the report focus on statutory regulation in many respects but development work is envisaged as being across the sector and inclusive of accredited registers and other assurance arrangements. This inclusivity is central to our proposal for a single assurance body as described in Chapter 6 and previously proposed in *Regulation rethought*.

Harm prevention (Chapter 2, pages 11-35)

In this chapter, we describe how the existing regulatory functions already contribute to the prevention of harm, setting out existing continuing fitness to practise provisions. We discuss some key research ideas offering insights into support for registrants to stay compliant with standards. We explain why we think there is more that can be achieved towards harm prevention through better data capture and analysis, and make specific recommendations for further development work and research. We propose work to explore further the role of patients in contributing to the safety and effectiveness of the care they receive.

Fitness to practise (Chapter 3, pages 36-111)

In this chapter, we describe the law and practice in fitness to practise (FtP) across regulators, recent reform through Section 60 orders, and recent contextual trends such as in the number of cases. We also discuss the problems with current arrangements, recognising where regulators are already working to achieve improvements. We go on to propose principles for FtP reform, with a focus on early resolution and remediation, insight and engagement, separation of investigation and

¹ Department of Health, 2017. *Promoting professionalism, reforming regulation*. Available at <https://www.gov.uk/government/consultations/promoting-professionalism-reforming-regulation> [Accessed 1 November 2017].

² Professional Standards Authority, 2016. *Regulation rethought*. Available at <https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/regulation-rethought.pdf?sfvrsn=14&sfvrsn=14> [Accessed 1 November 2017].

decision-making, transparency and accountability, and linking case acceptance to the professional code of conduct. We describe the potential for both incremental and radical reform of this function, making a number of specific recommendations for change to achieve either.

Quality assurance of higher education (Chapter 4, pages 112-160)

Here, we describe the range of regulators' responsibilities and approaches to education, and the multiple agencies involved in this area. We assess the progress that has been made within the existing legislation to reduce burden and streamline processes. We set out how higher education regulation is going through a period of substantial change, and discuss the potential impact of leaving the European Union. We propose a series of principles to guide further change or wider reform and propose further review of approaches, roles and responsibilities in this area. We make specific recommendations about how change might proceed, focusing on reduction of duplication, and the potential impacts of changes of regulatory approach in other areas, such as shared functions and standards.

Registers (Chapter 5, pages 161-187)

In this chapter we describe how registers currently work, including the differences for example in information that is displayed, duration of information, and search functionality. We discuss various policy areas in relation to registers, such as the use of non-practising lists, and set out our positions. We review progress since our last report in this area in 2010, and make some recommendations for improvement and consistency in the way that information is made available and accessible. We also discuss potential areas for reform.

A single assurance body (Chapter 6, pages 188-191)

We set out our earlier proposal for a single assurance body for health and care occupations, a set of common standards, shared functions and a system of licensing, underpinned by a consistent approach to the assessment of risk. We argue that a single assurance body would be the model best suited to delivering regulation which is proportionate, simple to understand, effective and efficient. We recommend therefore that this proposal is given serious consideration by stakeholders in light of the current UK-wide consultation Promoting professionalism, reforming regulation.

About the Professional Standards Authority

The Professional Standards Authority for Health and Social Care³ promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and voluntary registration of people working in health and care. We are an independent body, accountable to the UK Parliament.

We oversee the work of nine statutory bodies that regulate health professionals in the UK and social workers in England. We review the regulators' performance and audit and scrutinise their decisions about whether people on their registers are fit to practise.

We also set standards for organisations holding voluntary registers for people in unregulated health and care occupations and accredit those organisations that meet our standards.

To encourage improvement we share good practice and knowledge, conduct research and introduce new ideas including our concept of right-touch regulation.⁴ We monitor policy developments in the UK and internationally and provide advice to governments and others on matters relating to people working in health and care. We also undertake some international commissions to extend our understanding of regulation and to promote safety in the mobility of the health and care workforce.

We are committed to being independent, impartial, fair, accessible and consistent. More information about our work and the approach we take is available at www.professionalstandards.org.uk.

³ The Professional Standards Authority for Health and Social Care was previously known as the Council for Healthcare Regulatory Excellence

⁴ 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].

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1. Right-touch reform: a new framework for assurance of professions

- 1.1 In this report, we bring together research and set out views on a future direction for regulatory reform, looking at four distinct but closely related areas: the role of regulators in harm prevention, fitness to practise, quality assurance of higher education, and registration. We have built on ideas that we set out in previous papers, such as *Asymmetry of influence*⁵, *Rethinking regulation*⁶, *Regulation rethought*⁷, *Right-touch regulation*⁸ and *Right-touch assurance*⁹, and have also taken into account the work of others, such as the Law Commissions, the Departments of Health, regulators, accredited registers and other stakeholders, including international colleagues.
- 1.2 We are publishing this report at an interesting time for UK regulatory policy in the health and care sector. There remains an appetite for reform; the Department of Health, on behalf of the four UK Governments, published the consultation document *Promoting professionalism, reforming regulation*¹⁰ 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. While it is currently unclear whether this will lead to an opportunity for new legislation, as we said in *Regulation rethought* ‘with cooperation, imagination, innovation and determination much may be achieved’.
- 1.3 We are facing great uncertainty in the health sector more generally. The Health Foundation predicts continuing and worsening staffing shortages in the NHS, and highlights the ‘combination of piecemeal workforce planning, a long period of capped NHS pay increases, and a lack of attention to longstanding morale issues’. Like our own previous observations in *Asymmetry of influence* about the complexity of professional regulatory arrangements, the Foundation identifies that ‘in England, workforce policy and planning involves a constellation of 40

⁵ Bilton, D and Cayton, H, 2013. *Asymmetry of influence: the role of regulators in patient safety*. The Health Foundation. Available at <http://www.health.org.uk/publication/asymmetry-influence-role-regulators-patient-safety> [Accessed 1 November 2017].

⁶ Professional Standards Authority, 2015. *Rethinking regulation*. Available at <https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/rethinking-regulation-2015.pdf> [Accessed 1 November 2017].

⁷ Professional Standards Authority, 2016. *Regulation rethought*. Available at <https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/regulation-rethought.pdf?sfvrsn=14&sfvrsn=14> [Accessed 1 November 2017].

⁸ Professional Standards Authority, 2015. *Right-touch regulation - revised*. Available at <https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-regulation-2015.pdf> [Accessed 1 November 2017].

⁹ Professional Standards Authority, 2016. *Right-touch assurance: a methodology for assessing and assuring occupational risk of harm*. © Available at [https://www.professionalstandards.org.uk/docs/default-source/publications/right-touch-assurance---a-methodology-for-assessing-and-assuring-occupational-risk-of-harm-\(october-2016\).pdf?sfvrsn=0&sfvrsn=0](https://www.professionalstandards.org.uk/docs/default-source/publications/right-touch-assurance---a-methodology-for-assessing-and-assuring-occupational-risk-of-harm-(october-2016).pdf?sfvrsn=0&sfvrsn=0) [Accessed 1 November 2017].

¹⁰ Department of Health, 2017. *Promoting professionalism, reforming regulation*. Available at <https://www.gov.uk/government/consultations/promoting-professionalism-reforming-regulation> [Accessed 1 November 2017].

national-level statutory bodies, a further 15 royal colleges, 18 trade unions and over 100 professional and specialist institutions'.¹¹

- 1.4 We also know that since the referendum on membership of European Union on 23 June 2016, applications from nurses in the EU to register to practise in the UK were reported in June 2017 to be down 96%, from a high of 1,304 in July 2016 to 46 in April 2017.¹² In November 2017 the NMC reported that 'between September 2016 and September 2017 'the number of people joining the register from the EEA decreased sharply' (an 89% decrease from 10,178 to 1,107 in the previous year) and that 'the number of EEA nurses and midwives leaving the register increased by 67% from 2,345 last year to 4,067 this year'.¹³ The full impact of leaving the EU and consequent new immigration policies on health services throughout the UK has yet to be seen. The adequacy of funding for the NHS and the cap on pay increases for NHS staff continue to be heavily contested.
- 1.5 This being the case, we stand by our earlier observation in *Rethinking regulation* that 'ahead are the massive challenges of a healthcare system creaking under the strain of an aging population, long-term conditions, comorbidities, the rising cost of health technologies and a global shortage of health and care workers. If health and care services are to be reformed in the way envisaged in many a forward-thinking plan for service delivery...then UK health and care regulation must also be reformed'. It will also be important that through difficult times regulators seek to understand the new ways in which the risk of harm to patients may also evolve, either through an overstretched and depleted workforce, through a lack of resources for training and development, through a loss of focus on monitoring, development and appraisal, or for any other changes in the working environment that may result. Regulators must listen to the challenges being faced by their registrants during difficult times, and help them understand where their professional responsibilities lie, and how they should discharge them.
- 1.6 In this report, we have set out our thoughts across a number of policy areas, which we intend to be a contribution to a renewed discussion about how reform is taken forward in the sector. The report has been written for a wide audience of stakeholders including those outside the regulatory world, and so has been written in part to establish a clear account of how things are now. We hope that this will serve as a useful reference point for future discussions about how we move forward most effectively. In each of the areas we have covered, we have provided an account of current arrangements, and an analysis and discussion of a range of policy issues that arise in each. In the chapters on harm prevention, fitness to practise and registration, we have provided some specific recommendations for improvement or reform; in the chapter on quality assurance

¹¹ The Health Foundation, 2017. *Election briefing: a sustainable workforce – the lifeblood of the NHS and social care*. Available at <http://www.health.org.uk/publication/election-briefing-sustainable-workforce> [Accessed 1 November 2017].

¹² The Health Foundation, June 2017. *New data show 96% drop in nurses from EU since July last year*. [Online]. Available at <http://www.health.org.uk/news/new-data-show-96-drop-nurses-eu-july-last-year> [Accessed 1 November 2017].

¹³ Nursing and Midwifery Council, 2017. *The NMC register*. Available at <https://www.nmc.org.uk/globalassets/sitedocuments/other-publications/the-nmc-register-30-september-2017.pdf> [Accessed 2 November 2017].

of education we suggest some principles to guide how we might take forward discussion and improvement. The chapters have been written with the intention that they can be read separately as well as in the context of the report as a whole.

- 1.7 We intend that the discussion in this report will help set a new direction for future policy work which will encompass both statutory regulation, accredited registers, and other forms of assurance in relation to the health and care workforce, even though in some areas the focus of the discussion is principally the statutory regulators. Many policy areas apply equally – for example, understanding the nature of the relationship between a register holder and its registrants and how it might be more fruitfully managed – and we shall continue to seek to build collaboration and co-operation, both within our sector, across the four UK countries, with regulators outside health and care, and internationally.
- 1.8 In setting out these ideas, we look forward to discussion with stakeholders on how they can be further developed, refined and implemented in the context of the current consultation. In taking forward new developments, it will be important to strike the right balance between on one hand, the proper pursuit of creative innovation and exploratory thinking, and on the other, establishing an evidence base for development work and guarding against the risk of confusing responsibilities or creating unnecessary duplication. We must be clear about both the potential and the limitations of regulation and other forms of assurance to keep the public safe from harm.
- 1.9 We hope that this report, coming shortly after the publication of the consultation document, will be helpful in engaging as wide a range of stakeholders as possible in responding to the consultation questions and in the ongoing and future dialogue around how regulation can be reformed for the benefit of the public.

A note on future reforms and innovation

- 1.10 In this context it seems helpful to be clear about the Authority's position on innovation and public protection. The Professional Standards Authority supports regulators in innovating and thinking creatively about how to fulfil their statutory duties. We know that the current system is not fit for purpose, and we will continue to call for it to be comprehensively reformed.
- 1.11 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 weaknesses in implementation)
 - The proposals or practice may not be compliant with the current legislation or established case law (even if we believe the current legislative framework is not fit for purpose)
 - We may not be confident that changes will protect the public, or enable transparent and accountable regulation (this is as important for small changes as it is for comprehensive reforms).

1.12 In this report, in particular in the chapter on fitness to practise, we express certain views that question the appropriateness of current legislation and case law. The opinions notwithstanding, we will continue to fulfil our statutory responsibilities and respect the principles laid down by the current legal framework, and we know the regulators will do the same.

2. Harm prevention: can we reduce the amount of harm?

Chapter summary

- 2.1 In *Regulation rethought*¹⁴ the Authority recommended that ‘protecting patients and reducing harms’ should be one part of the shared purpose of the regulatory system. This is a growing area of interest in research and policy development, and the Authority is keen to progress and clarify thinking in the sector about what is the proper place of regulation in this respect.
- 2.2 In this chapter, we start by identifying some of the kinds of harm that can occur, and how the core regulatory functions are by their nature preventative. We outline in some detail how regulators are taking forward, through their continuing fitness to practise programmes, ways to prevent harm to patients by supporting and encouraging registrants to remain compliant with regulatory standards throughout their careers.
- 2.3 We discuss the policy questions that arise from thinking about how regulators might try to do more to prevent harm, setting out some relevant theoretical perspectives, and discuss some of the key ideas in the academic literature about how this might be achieved. While much of the focus in this section is on fitness to practise and the data associated with it, it is important to stress that all regulatory functions contribute to harm prevention.
- 2.4 We have made a number of recommendations for future work, building on that which is already underway by the Authority and regulators. The chapter is intended as a contribution to the ongoing discussion about the role of regulators in preventing harm to patients. It is not a literature review of this subject, but references some recent thinking which we believe is particularly salient and useful for future policy development.
- 2.5 As we wrote in *Rethinking regulation*,¹⁵ we understand the challenge of harm prevention to mean ‘how can regulators, through their interventions and influence, reduce the prevalence of instances of noncompliance with their standards?’ Another way to put the question might be, how and to what extent can regulators shrink the amount of harm, both through their own interventions and those which are achieved through collaboration?

¹⁴ Professional Standards Authority, 2016. *Regulation rethought*. Available at <https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/regulation-rethought.pdf?sfvrsn=14&sfvrsn=14> [Accessed 1 November 2017].

¹⁵ Professional Standards Authority, 2015. *Rethinking regulation*. Available at <https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/rethinking-regulation-2015.pdf> [Accessed 1 November 2017].

Background and purpose

- 2.6 The standards of competence and conduct set by the regulators address a wide range of aspects of professional practice. Conversely, the fitness to practise cases that result when it is alleged to the regulator that these standards have not been met encompass a wide range of unprofessional behaviours. These can result in many different kinds of harm including, but not limited to:
- Harm to the physical and/or mental health of patients and those close to them, their career, financial status and family life, sometimes irrevocable
 - Harm to the physical and/or mental health of the registrant, their career, financial status and family life, sometimes irrevocable
 - Harm to the reputation of an organisation delivering care – thus damaging the trust of future patients in the safety of care
 - Disruption to the ongoing work of teams, and thus potentially to the quality of patient care in the future
 - Damage to the relationship between a registrant's colleagues and their regulator, register-holder and/or employer.
- 2.7 When referring to harm in this chapter, we use the term harm to mean the harmful impact of the kinds described above that can result from a particular situation or set of circumstances. In *Right-touch regulation*¹⁶ we defined harm as 'physical injury or psychological distress experienced by people through interaction with health or social care practitioners'. We use the term risk to mean 'the likelihood of harm occurring'¹⁷ or the probability of a particular situation or set of circumstances resulting in harm. Many of the fitness to practise cases that are reviewed by the Authority include situations where a health or care professional has exposed a patient, colleague or other to increased risk of harm where they would be expected to have acted otherwise, even where the potential harm has not materialised. The approaches we discuss in this section to harm reduction should be taken also to refer to preventing situations occurring where patients and others are exposed to elevated risk in this way.
- 2.8 The specific types of misconduct or failures of competence which can result in harm are also wide-ranging – by way of demonstration, we list at Appendix I the categories of misconduct that are used on the Authority's database of final fitness to practise hearing determinations. These categories, while not to be confused with the harm they cause, illustrate the different kinds of event and behaviour to which patients and those close to them can be subject, and of which any of the types of harm listed above can be the consequence. We recognise that harm

¹⁶ Professional Standards Authority, 2015. *Right-touch regulation - revised*. Available at <https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-regulation-2015.pdf> [Accessed 1 November 2017].

¹⁷ Professional Standards Authority, 2015. *The role of risk in regulatory policy*. Available at <https://www.professionalstandards.org.uk/docs/default-source/publications/research-paper/risk-in-regulatory-policy-2015> [Accessed 1 November 2017].

occurs in ways other than in consequence of those matters which come before regulators' fitness to practise proceedings, which are concerned with the most serious matters, and do not profess that these form a comprehensive account of all harm that is caused to patients.

- 2.9 Fitness to practise and complaint processes occur after the fact – after the alleged harm has occurred. An emerging area of interest in regulatory policy in recent years however has been the potential of regulators to contribute to harm prevention. This has also been referred to as regulators becoming more upstream of problems before they occur. As we said in *Rethinking regulation*, 'how can regulators, through their interventions and influence, reduce the prevalence of instances of non-compliance with their standards?' Another way to put the question might be, how can regulators reduce the volume of harm, both through their own interventions, and through those which are achieved through collaboration?
- 2.10 Seeking to answer this question results in a number of interesting regulatory policy challenges. First, as analysis of fitness to practise cases shows, every such case turns on its own unique circumstances, a combination of personal, environmental and other factors. How can learning be drawn from such specific incidents, in such a way as to change the sequence of distant and future events to a different outcome? Regulators (and the Authority) hold a huge body of data on previous fitness to practise cases, but how capable is this data of supporting retrospective analysis, having been collected in fulfilment of a legal process, not a descriptive one? How can regulators best use their data or share their knowledge with other agencies optimally placed to intervene? How can they encourage potential informants to take prompt action when they think that a registrant is increasing the risk of harm to patients, and bring relevant information to the regulator's attention? How can they encourage and support the public in particular to ask questions or raise concerns when they think that something just isn't right?
- 2.11 These are just some of the issues that arise from trying to elucidate the potential opportunities, but also to define the boundaries, of how regulators might refashion their approaches to be more preventative of harm. Yet, to address and overcome these challenges and translate these insights into regulatory interventions would have many benefits – principally of course improvement to safety through the reduction of harm caused to patients and those close to them.
- 2.12 An example of an approach to harm, taken by the Australian Health Practitioner Regulation Agency, places it in the context of risk-based regulation, with the aim to 'collect information on harm in a systematic manner, and then identify hotspots of risk that are amenable to a regulatory response'. This approach entails:
- 'A focus on identifying and reducing risks and harms
 - Selective action based on identified risks
 - Evidence based regulatory action and policy
 - Using a wider range of practice to prevent harm

- Reducing unneeded regulatory interventions'.¹⁸
- 2.13 It is tempting to draw the conclusion that the successful implementation of further preventative strategies might result in a reduction in the volume and thus costs of fitness to practise cases, and thus the costs of regulating overall, even despite the resources required to do so, through a reduction in harmful incidents. As the saying goes, 'if you think safety is expensive, try an accident'¹⁹. The ideas that we discuss in this chapter might also have the potential to reduce the number of allegations being made inappropriately to regulators, which it could also be assumed would have a positive impact on costs. However, we recognise that the cost of fitness to practise as a regulatory function has a number of contributory factors; it is not yet possible to offer any kind of cost-benefit analysis to these questions. We hope in time that it will be.
- 2.14 We are mindful of the challenge that was given to the General Medical Council (GMC), which we believe applies to all regulators, by the *Report of the Morecambe Bay Investigation*²⁰: 'the GMC must use its wealth of knowledge, experience and its capacity as a regulator to approach patient safety from a wider, more holistic perspective to ensure that it maintains its focus on protecting the public while continuing to maintain standards within the medical profession', which we believe applies to the ambition of aiming to be more preventative. The challenge is how regulators can use their position within the architecture of care to do more, and to make their interventions more effective and influential. Can they use their insight, data, knowledge and relationship with registrants and with the public to further shrink the amount of harm?
- 2.15 At the same time we are cautious to strike the right balance between, on one hand the proper pursuit of creative innovation and exploratory thinking, and on the other, the risk of creating unnecessary and unhelpful duplication or ambiguity of responsibility. Regulators are geographically, and probably psychologically, distant from harmful situations; they are only one of a number of influences on practice. They must avoid blurring their responsibilities with those who are closer, and take care to make their contribution complementary to those others guiding practice. As Quick observed, 'if a number of sources of influence all nudge practitioners in the same direction (eg, terms of employment contracts, clinical guidelines, professional regulation, professional leadership, law and financial incentives) regulatory goals stand a better chance of being realised'²¹.

¹⁸ AHPRA working definition of risk-based regulation, and following bullet points, were presented to the International Society for Quality in Healthcare International Conference, London, October 2017, by Martin Fletcher, Chief Executive. Quoted here with permission.

¹⁹ As quoted for example by Sir Stelios Haji-Iannou in *Management Today*, 1 June 2010. Available at <https://www.managementtoday.co.uk/mt-interview-sir-stelios-haji-ioannou-easyjet/article/1004499> [Accessed 1 November 2017].

²⁰ Kirkup, B, 2015. *The Report of the Morecambe Bay Investigation*. The Stationery Office. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf [Accessed 1 November 2017].

²¹ Quick, O, 2011. *A scoping study on the effects of health professional regulation on those regulated. Final report submitted to the Council for Healthcare Regulatory Excellence*. Available at <http://www.professionalstandards.org.uk/docs/default-source/publications/research-paper/study-on-the-effects-of-health-professional-regulation-on-those-regulated-2011.pdf> [Accessed 1 November 2017].

2.16 Regulators must also be careful to ensure that their primary focus remains on registrants meeting standards, rather than seeking to improve quality across the board. As we have previously observed, ‘inspection, regulation and quality improvement are different things. The role of regulation is primarily to control quality and ensure minimum standards rather than to improve quality’²² although it may have that effect over time. We recognise that many of the interventions described in this chapter and beyond may have a positive impact on quality, but that is not the primary role of the regulator.

²² Professional Standards Authority, 2017. *Comments on the Welsh Government consultation ‘Services fit for the future’*. Available at <https://www.professionalstandards.org.uk/docs/default-source/publications/consultation-response/others-consultations/2017/professional-standards-authority-response---welsh-government-services-fit-for-the-future-consultation.pdf> [Accessed 1 November 2017].

The contribution to prevention of the core regulatory functions

- 2.17 All of the existing core regulatory functions can be seen as contributing to the prevention of harm. In fact, they are all inherently preventative. Regulators apply controls to entry to their registers and quality assure higher education courses to ensure that registered professionals hold the correct, and appropriate qualifications and are fit to practise. Regulators' standards set out the professional behaviour to which registrants should adhere, and registrants are aware that they may be subject to regulatory scrutiny through fitness to practise processes if it is alleged to the regulator that these standards have not been met. The standards include that registrants must take action if they believe that a colleague is placing patients at risk of harm, thus in theory establishing a mechanism whereby problems, or potential problems, are intercepted at an early stage. Fitness to practise processes can remove a registrant from practice entirely or temporarily to prevent future harm.
- 2.18 Yet we know that in some respects, the underlying logic and intention of these interventions does not translate to their fulfilment in the realities of daily practice. For example, we know from the work that we commissioned from Quick in 2011 that there is little evidence of the impacts of regulators' standards on behaviour in practice; few researchers have directly addressed this question, possibly a reflection of the difficulty of establishing a methodology which is able to discern the impact of regulation from the many other behavioural influences that affect professionals. We also know from inquiries into instances of the most serious, concerted and long-lasting harm to patients that there are always people close to the situation who know what is happening, but who do not take action, whether or not they are subject to a professional responsibility to do so.
- 2.19 One area in which considerable progress has been made has been in the regulators' developing mechanisms to require registrants to demonstrate their continuing fitness to practise. This has increasingly elided with their work to set and promote standards. We discuss this in more detail in the next section of the chapter.

Compliance with standards and continuing fitness to practise

- 2.20 Seeking to ensure that registrants remain compliant with regulatory standards, and harm prevention, are very closely-aligned objectives. In 2012, in our paper *An approach to assuring continuing fitness to practise based on right-touch regulation principles*,²³ the Authority proposed that:

²³ Council for Healthcare Regulatory Excellence, 2012. *An approach to assuring continuing fitness to practise based on right-touch regulation principles*. Available at <https://www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/continuing-fitness-to-practise-based-on-right-touch-regulation-2012.pdf?sfvrsn=6> [Accessed 1 November 2017].

- In developing continuing fitness to practise schemes, the regulator's role should be focused on ensuring that registrants continue to meet the standards of conduct and competence rather than a narrower focus on measurement of inputs such as hours of continuing professional development (CPD) activity
- The task of seeking to ensure continuing fitness to practise (CFtP) is supported by the regulatory functions of education, standard setting, registration and fitness to practise
- Regulators should take a proportionate approach when developing appropriate continuing fitness to practise mechanisms, based on a clear assessment of the level of risk of harm in the practice of the regulated group, where and why the risk occurs and the context in which the regulated group operates
- Continuing fitness to practise measures should be clearly targeted at areas of risk in performance but regulators should also utilise any existing mechanisms which can help to ensure ongoing compliance with the standards
- Regulators should assess the reliability of different levels of assurance provided by different CFtP measures pursued by assessing how accurately it helps them identify those who continue to meet the standards. The level of risk should determine how reliable a response needs to be
- There should be transparency to the public on the level of assurance provided by different mechanisms and on how decisions are made on what level of assurance is needed.

2.21 The arguments were made in the context of the then ongoing overhaul of medical revalidation by the GMC following the recommendations made by the Shipman Inquiry, and following a steer from the Government in *Enabling Excellence*²⁴ that any revalidation scheme proposed by the other regulators must be proportionate and demonstrate 'significant added value in terms of increased safety or quality of care for users of health care services'.

2.22 Work in this area has developed in different ways but generally there has been a significant shift from purely input-based systems such as hours-based CPD requirements to much broader frameworks of activity based on assessment of registrants' ongoing fitness to practise and consideration of more innovative measures seeking to ensure that registrants understand and continue to comply with the standards throughout their professional life. Our 2012 paper outlined a continuum of different frameworks for ongoing assurance, based on the level of risk to be addressed. However, since then, a wider spectrum of different approaches has emerged. Key differences include how centralised or

²⁴ Secretary of State for Health, 2011. *Enabling Excellence Autonomy and Accountability for Health care workers, Social Workers and Social Care Workers*. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216580/dh_124374.pdf [Accessed 1 November 2017].

decentralised the systems in place are, the evidence needed to demonstrate compliance carried out by the regulator and the frequency/intensity of reporting.

- 2.23 Examples of the approaches range from the GMC system of revalidation which requires doctors to participate in local systems of appraisal and receive sign-off from a local Responsible Officer who confirms their ongoing participation in revalidation activity to the Health and Care Professions Council (HCPC), which outlines a set of CPD criteria with which registrants should comply and asks that individuals reflect on their own practice. The GMC is ultimately responsible for making decisions on a doctor's revalidation activity based on a recommendation from a Responsible Officer along with any other information available to them. The Nursing and Midwifery Council (NMC) process of revalidation is similar to the GMC's with the regulator responsible for making decisions about registrant renewal. Some of the other regulators require submission of a CPD portfolio centrally, however most will only audit a sample of submissions to check compliance.
- 2.24 There are a number of common themes across the different arrangements. Peer review and feedback come through as key areas, with almost all of the regulators including this as a continuing fitness to practise requirement. Similarly, the importance of individual reflection on practice comes through in most systems, with requirements for registrants to participate in reflective discussions or complete reflective writing examining how the standards of conduct and competence have been relevant to specific area of their practice. The use of patient and peer feedback is also a common feature, as is a move to base requirements closely around the standards set by the regulator, although some of the regulators including the General Osteopathic Council (GOsC) and the HCPC have specific standards which registrants must meet to demonstrate continuing fitness to practise.
- 2.25 Several of the regulators are consulting on changes to their CFtP requirements currently or are due to shortly. The General Pharmaceutical Council (GPhC) has published a consultation on a three-stage model looking at a required element of CPD covering issues of particular relevance to pharmacy professionals, a peer discussion element, and a reflective case study based on an event from practice which has benefited patients or service users. The General Chiropractic Council (GCC) is shortly due to consult on an enhanced CPD scheme covering an objective activity such as case based discussion, CPD based on an area identified as important to the profession as a whole, and a structured discussion with a peer about CPD. The General Dental Council (GDC) in *Shifting the balance*,²⁵ its discussion paper on reform of its regulatory processes, laid out proposals to work more closely with partners to embed the standards into registrants' practice. This included proposals to work with employers to ensure that the standards for the dental team are reinforced through performance management and appraisal mechanisms and work to strengthen data-sharing

²⁵ General Dental Council, 2017. *Shifting the balance: a better, fairer system of dental regulation*. Available at <https://www.gdc-uk.org/about/what-we-do/regulatory-reform> [Accessed 1 November 2017].

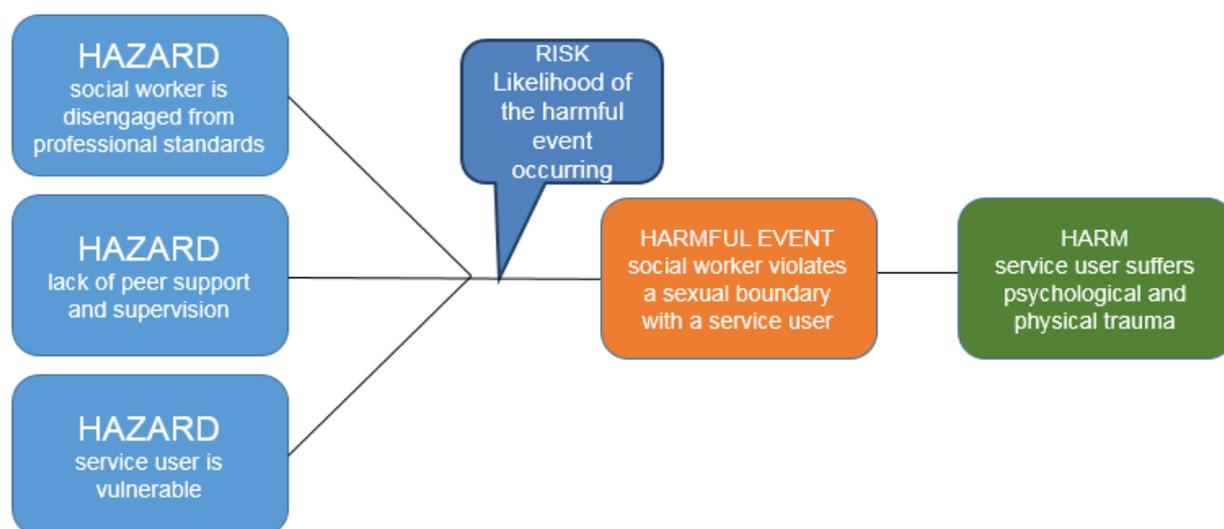
with partners including system regulators, to allow more effective use of complaints data to inform a range of interventions to address potential causes of harm at an early stage.

2.26 At Appendix II we set out a summary of current and planned activity across the statutory regulators.

Hazards and harms – thinking on prevention

- 2.27 The work of Professor Malcolm Sparrow²⁶ provides one conceptual framework for discussing how regulators might develop further innovative approaches to the deployment of their knowledge and insights towards prevention. It has been influential in developing thinking in the sector in recent years. Sparrow introduced the idea that regulators should place greater focus on actual and specific serious harms and their ‘sabotage’. This way of thinking about harm prevention involves an analysis and identification of the ‘hazards’, the contributory factors that convene and result in harm occurring. In the context of health and care professional regulation these hazards could include those relating to the competence, health, or wellbeing, individuals involved when such harms occur; to the vulnerability of a patient or patient group; to the state of professional relationships within a team; or to features of the working environment or employing organisation, amongst others.
- 2.28 In *Right-touch regulation* by way of example we applied this model of thinking to a situation where a health professional violates a sexual boundary with a patient. This is illustrated below in Figure 1.

Figure 1: Hazards, risk and harm



- 2.29 In this example we give three potential hazards, all of which in this example must be present in order for matters to proceed to the harmful event. We separate ‘harmful event’ from ‘harm’ to distinguish the event from the effects that it causes. Risk increases as more of the hazards align in time and place.

²⁶ For example Sparrow, M, 2000. *The Regulatory Craft*. Brookings Institution Press.

Intervention, context, and agency

- 2.30 In *Right-touch regulation and Right-touch assurance*²⁷, we developed the idea of categories of hazard. This was in the context of putting forward our methodology for assessing the most appropriate form of regulation or assurance for any particular professional group. However, they are also helpful in this context in illustrating the range of different factors which could be considered a hazard:
- **Intervention:** hazards which arise from the complexity and inherent dangers of the activity
 - **Context:** hazards which arise from the environment in which care takes place
 - **Agency/vulnerability:** hazards which arises from service user vulnerability.

Harm 'sabotage'

- 2.31 The next stage of analysis, having identified the hazards which combine to result in a particular harm, is to identify ways in which the progress of these factors to the harmful outcome could have been prevented. Could one or some of those hazards have been thwarted to prevent the harmful outcome that was the product of all of them? The process of seeking to intercept particular hazards or factors is what Sparrow refers to as 'sabotaging' harms.
- 2.32 In (at least) two specific ways efficiency is embedded in this approach to thinking about the regulatory task. In any potentially harmful situation, several hazards might be present together and result in harm occurring. However, it is probably not necessary to thwart all of the hazards individually, but only as many as is necessary to impede the evolution of a situation to a harmful point. The approach is also efficient in that it encourages regulators to focus their resources on the areas of highest priority, those areas where actual harm is known to occur, taking into account their impact and prevalence. To quote *Right-touch regulation*, it is about 'the minimum regulatory force required to achieve the desired result'.

What do we need to know to prevent harms in this way?

- 2.33 To apply Sparrow's concept successfully, we would first want to know the answer to a series of questions. These questions are to differing degrees already being answered through the research and policy programmes of the Authority and the regulators. They relate to the circumstances in which harm occurs involving health and care professionals, and each relates to the possibility of the risk of harm being elevated in any given situation:
- What are the factors which could negatively influence behaviour, including but not limited to health and wellbeing, or environmental or other factors bearing on individuals' behaviour?

²⁷ Professional Standards Authority, 2016. *Right-touch assurance: a methodology for assessing and assuring occupational risk of harm* © Available at [https://www.professionalstandards.org.uk/docs/default-source/publications/right-touch-assurance---a-methodology-for-assessing-and-assuring-occupational-risk-of-harm-\(october-2016\).pdf?sfvrsn=0&sfvrsn=0](https://www.professionalstandards.org.uk/docs/default-source/publications/right-touch-assurance---a-methodology-for-assessing-and-assuring-occupational-risk-of-harm-(october-2016).pdf?sfvrsn=0&sfvrsn=0) [Accessed 2 November 2017].

- What are the traits of relationships between professionals which might result in harmful outcomes for patients?
- What are the team dynamics which might result in elevated risk of harm?
- What are the organisational features or factors which might result in elevated risk of harm?
- What are the factors at play when registrants, patients and the public decide whether or not to raise concerns about elevated risk of harm?

Preventing harm – what is the regulator’s responsibility?

- 2.34 Even where it is possible for analysis to demonstrate the salient hazards in any given situation, it is clearly not always or even often the regulator who is best placed to take preventing action in situations that are current and evolving, from which it is distant. The regulator’s insights from analysis of fitness to practise data and intelligence derived from the fulfilment of its other functions could for example, indicate ways that standards could be more effectively communicated; identify gaps in higher education curricula; or indicate patient or professional groups that are at higher risk of involvement in harmful situations. However, the regulator will often not be well placed to frustrate an emerging specific harmful situation, since it does not ‘own’ the hazards in question. These probably more often belong to employers, managers, teams, or individual professionals or patients. A more realistic aspiration for regulators might be seen as the indirect frustration of harm – providing those close to emerging and potentially harmful situations with knowledge to contribute to prevention. There is increasing proactive engagement at the boundary between professional regulators, system regulators and employers, helping to create the conditions in which effective frustration of harm might better be achieved.
- 2.35 An effective flow of information of course relies on those close to the scene to be willing, able and supported to act when things are going wrong. That they often will not and are not is demonstrated by many cases of serious failings in care, including recently by the recent report into the actions of the surgeon Ian Paterson at Solihull Hospital.²⁸ The report lists all those close to problems whose intervention might have effectively prevented the harm, or whose contribution might have been acted on to better effect – these include the Senior Management Team, the Board, clinical colleagues of Mr Paterson, the National Cancer Peer Review, and the West Midlands Cancer Intelligence Unit. The report also notes that Mr Paterson’s oncology colleague and team members should have reported their concerns to the GMC but did not do so.

²⁸ Kennedy, 2017. *Review of the response of Heart of England NHS Foundation Trust to Concerns about Mr Ian Paterson’s Surgical Practice: Lessons to be Learned; and Recommendations*. Solihull Hospital Kennedy Breast Care Review. Available at <http://www.heartofengland.nhs.uk/wp-content/uploads/Kennedy-Report-Final.pdf> [Accessed 1 November 2017].

Retrospective analysis of fitness to practise cases

- 2.36 Retrospective analysis of fitness to practise cases has great potential to generate the insights, knowledge and understanding of patterns which can be used prospectively. Since 2010 the Authority has reviewed 22,548 final hearing decisions by regulators' fitness to practise panels.²⁹ Records are kept by the regulators and by the Authority in fulfilment of their statutory duties. On the Authority's database, each case has its own record (in the form of the regulator's determination document) which usually includes details of the allegations or charges, and an account of the circumstances in which misconduct has occurred, and of the panel's reasoning in coming to a final decision on sanction. Therefore, a huge body of data about fitness to practise cases has grown; the database currently in use by the Authority which it might be reasonably assumed would help us to address at least some of the questions that arise from seeking to adopt a preventative approach.
- 2.37 A number of projects have looked retrospectively at fitness to practise cases, including work commissioned by both the regulators and by the Authority. For example, in 2014 the HCPC commissioned Picker Institute Europe to research engagement and disengagement in health and care professionals, which included a review of documentation associated with 27 fitness to practise cases,³⁰ as well as other methods. More recently, the University of Surrey has published a report on complaints against paramedics and social workers to the HCPC,³¹ which, amongst other methods, analysed 284 cases (52 paramedics and 232 social workers). The analysis 'identified a higher number of older, male practitioners in the overall sample relative to their numbers on the registers in both professions', and recommends a range of preventative strategies.
- 2.38 Gallagher and Jago were commissioned by the Authority to analyse a sample of cases of dishonesty using the Authority's Section 29 database of cases across the professions it oversees. The method included analysis of a sample of 151 cases involving dishonesty. Their report³² sets out a typology of dishonesty which contributes to our understanding of this particular area of professional misconduct, and which demonstrates common features that apply across all

²⁹ See Chapter 3, Figure 3.

³⁰ Health and Care Professions Council, 2015. *Preventing small problems from becoming big problems in health and care*. Available at <http://www.hpc-uk.org/assets/documents/10004A7EPreventingsmallproblemsfrombecomingbigproblemsinhealthandcare.pdf> [Accessed 1 November 2017].

³¹ Van der Gaag, A, et al, 2017. *People like us? Understanding complaints about paramedics and social workers*. University of Surrey. Available at http://www.hcpc-uk.org/assets/documents/10005590Peoplelikeus_Surreyresearchsummary.pdf [Accessed 1 November 2017].

³² Gallagher, A, and Jago, R, 2017. *A typology of dishonesty illustrations from the Section 29 database*. Professional Standards Authority. Available at <https://www.professionalstandards.org.uk/docs/default-source/conferences/presentation/2017-conference/gallagher-and-jago.pdf?sfvrsn=2&sfvrsn=2> [Accessed 1 November 2017].

professions. This will be complemented by the publication of work in the near future by the Authority on how cases are categorised by regulators, and how case categorisation might be more harmonised. Given that care is increasingly delivered by teams, greater harmonisation of the categories that are applied to this dataset should facilitate comparison and analysis on a multi-professional basis.

- 2.39 A recent report by Searle et al,³³ funded by the Authority, piloted the application of a cluster analysis methodology to 6,714 cases on the Authority's database of final hearing determinations and seeking to identify both typical profiles of the registrants involved and trends in the appearance of different charges together. Three different types emerge from the analysis: the self-serving 'bad apple'; the individual who is corrupted by the falling standards of their workplace; and the depleted perpetrator struggling to cope with the pressures of life. Searle's analysis of these types places our understanding of misconduct within the academic literature on counterproductive work behaviour, and suggests a range of preventative and supportive approaches for each. The GDC has recently published a report on trends within its fitness to practise cases, based on retrospective analysis of fitness to practise data commissioned from the Peninsula School of Medicine and Dentistry.³⁴
- 2.40 The Authority will support and encourage further work to continue to develop our understanding either of traits of perpetrators of misconduct, of patterns of misconduct, or other such analysis which will further our understanding of the circumstances in which misconduct occurs, using both fitness to practise records and any other data, research and insight which can contribute to developing and enriching our understanding of the circumstances where things go wrong. We recognise that there are limitations to this data, not least that it does not capture concerns that have not been raised with the regulator for whatever reason; as we say elsewhere, we do not profess that it captures the sum of all harm. Nevertheless it is a wealth of data with much potential for further exploitation.
- 2.41 Another concern which has been expressed about using data analysis in this way concerns the potential for unlawful discrimination. The potential for unlawful discrimination has been said to arise where a particular group is identified through analysis to be at higher risk of involvement in patient harm than others; how might any regulatory interventions subsequent to that analysis be conducted without being discriminatory towards those registrants who are part of that group? This demonstrates one of the key weaknesses in the way that fitness to practise data can be analysed. Any particular case will be entered onto a database and will be allocated to a number of predetermined categories including

³³ Searle, R et al, 2017. *Bad apples? Bad barrels? Or bad cellars? Antecedents and processes of professional misconduct in UK Health and Social Care: specific insights into sexual misconduct and dishonesty/theft and qualifications dishonesty*. Available at <https://www.professionalstandards.org.uk/latest-news/latest-news/detail/2017/11/03/trust-in-healthcare-undermined-by-bad-apples-ground-breaking-research-reveals> [Accessed 3 November 2017].

³⁴ General Dental Council, November 2017. Available at www.gdc-uk.org/about/what-we-do/research [Accessed 20 November 2017].

those relating to characteristics of the registrant. Analysis which attaches for example personal characteristics to particular categories of misconduct risks generating the appearance of causal links which are in fact only correlations. This may in turn result in the risk of inappropriately discriminatory conclusions being drawn where these are protected characteristics. Further analysis is needed to understand the hazards present, and how they might or might not be associated with any characteristics of the registrant, the context of practice, or any other factor with bearing on the situation. The Authority would support and encourage further research and discussion to explore how this challenge to effective use of data analysis might be overcome. We discuss further below potential improvements to the way that data on fitness to practise is collected and structured.

Improving fitness to practise data

- 2.42 Despite the obvious potential of fitness to practise data, which we and others are seeking to exploit, there are inherent shortcomings in the data, one of which is summarised in the HCPC's report mentioned in the previous section: 'the documents reviewed included final decision bundles, a summary decision form and the evidence contained in registrant bundles. It is worth noting the context within which the registrants were responding, which has a bearing on the evidence within the registrant bundle. Registrants were defending themselves against an allegation and as such, the evidence presented tended to be set out in order to show themselves in the best possible light'.
- 2.43 In order to provide the basis for objective analysis therefore the data that accrues in the process of fitness to practise proceedings is at best imperfect. Currently, its purpose is not to furnish the regulator with a comprehensive and unbiased account of what went wrong and why in each case, but is collected in fulfilment of a legal process. The cases are categorised (in the Authority's database) by charges in any given case. Yet not all of the misconduct that features in a case is necessarily included in the charges, making it extremely laborious for researchers to compile or assess a complete picture of what is going on. There are other issues making cross-regulator comparison difficult, such as differences of terminology, and differences of categorisation of allegations. At Appendix I, by way of demonstration of the range of misconduct that occurs within the sector, we reproduced the list of categories that we at the Authority apply to cases when we upload them on our database. However, each of the regulators will also have their own approach to categorisation and data management. As previously mentioned, we have been working in recent months to develop proposals around the use of a shared category set, which we hope will begin a dialogue about how this data can be harmonised and therefore analysed more readily on a cross-professional basis.
- 2.44 It may be the case that salient hazards which are highly influential in many cases are simply not being captured in the way that the fitness to practise processes are currently operated and documented – resulting in a dataset which is critically flawed for the purpose of recognising those hazards and identifying preventative

strategies relating to particular kinds of harm. The less adversarial approach to fitness to practise that we describe in the following chapter might to some extent address this, since such an approach would involve seeking to establish a more holistic understanding of the circumstances in which alleged misconduct has occurred, which might then result in a fuller dataset capturing a fuller range of hazards more effectively.

- 2.45 Another issue in using this data, as currently organised, is that it is focused on the registrant, and not those harmed. Just as through Searle's research it has proved possible to describe trends in relation to the perpetration of misconduct, it might also be possible to trace patterns, for example, in the kinds of harm caused in different situations, or in the specific kinds of vulnerability involved. These may be features that are currently out of sight, because they may not currently be recorded or noticed as important in the way that cases are investigated. We recognise that collecting such data in a systematic way will present challenges, and must be done in such a way as to avoid appearing in any way to blame complainants or victims for what has occurred.
- 2.46 We would support work to address these limitations. For cases that have occurred in the past, this might involve seeking to engage with registrants and/or patients or other victims of harm, who have been involved in fitness to practise cases and complaints, to explore with them the hazards that were present when things went wrong in an open way, and to seek to uncover hazards that may not have been visible in the case as investigated and heard. Clearly such a study would require extremely careful design to be successful, not least to avoid a detrimental impact on the individual participating, but we believe that if this could be overcome, it could yield extremely rich insights into hazards and their sabotage.
- 2.47 To address these limitations as they apply to recording data on cases that occur in future, we recommend that regulators and register holders review how they can better enable future analysis, including for example through agreement on the collection of a common data set, and building on work that has already been done, to better support a preventative approach. Although the emphasis in this discussion has been on fitness to practise data, such review should have regard to other datasets, arising from other regulatory functions, with preventative potential. Further discussions will need to take into account the observation, quoted in our earlier work on the role of risk in regulatory policy, that 'pro-active tailor-made methods of data collection are time-consuming, and costly to the data provider. On the other hand, reactive methods that piggy back on other collections may not provide the data in usable form. Both require a thorough assessment of the quality and reliability of the data, and an understanding of the 'social and organisational processes whereby it enters the database'.³⁵

³⁵ Lloyd-Bostock, SM, and Hutter, BM, quoted in Professional Standards Authority, 2015, *The role of risk in regulatory policy*. Available at <https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/regulation-rethought.pdf?sfvrsn=14&sfvrsn=14> [Accessed 1 November 2017].

Encouraging reflective engagement with regulatory standards

- 2.48 In this section we discuss three specific ideas that have emerged from the academic literature which we believe are particularly useful and helpful as reference points for further discussion on how registrants can be encouraged to engage constructively with regulators' and register holders' standards. A common theme through all of them is that they demonstrate the value for compliance with standards of reflective discussion, involvement, engagement and debate. They recognise the personal and social dynamics that are a feature of professional practice. The authors who have developed and discussed these concepts often refer to each other's work in doing so; they form a coherent and compelling set of ideas which we think should be valuable in future discussions.

Formative spaces

- 2.49 An element of harm reduction is to seek to encourage registrants to discuss problematic situations openly and at an early stage. One way in which it has been proposed to achieve this is through the creation of 'formative spaces', or regulator-sanctioned confidential discussions between colleagues about problematic areas of practice, even though these discussions may be outside the direct control of regulators. The term³⁶ appeared in 2012 in work by Fischer in an analysis of organisational turbulence, and the possible result being either a creative 'formative space' or destructive 'perverse space'.³⁷ In a paper of the same year McGivern and Fischer further advanced the idea of the formative space.³⁸ This was in the context of a discussion of the potentially counterproductive reactions that might be provoked by regulatory interventions, and the innate tensions between the regulator's desire for transparency and information, and the risks that regulatory interventions might result in registrants either hiding the truth from regulators, or presenting a falsely positive impression. A further result of this might be registrants practising (and representing their practice) defensively at the expense of patient care. To address this risk, the formative space as conceived by McGivern and Fischer provides a regulator-sanctioned but informal context for the early exploration and resolution of potential problems, before risks are elevated, and away from the fear of regulatory scrutiny.

³⁶ We also recognise earlier ideas that provide a format for open discussion between colleagues, such as Schwartz rounds and Balint groups, which have been supported by regulators.

³⁷Fischer, M, 2012. *Organisational turbulence, trouble and trauma: Theorising the collapse of a mental health setting*. Organization Studies, Vol 33, Issue 9. Available at <http://journals.sagepub.com/doi/abs/10.1177/0170840612448155> [Accessed 1 November 2017].

³⁸ McGivern, G, and Fischer, M, 2012. *Reactivity and reactions to regulatory transparency in medicine, psychotherapy and counselling*. Social Science and Medicine Vol 74 Issue 3. Available at <http://www.sciencedirect.com/science/article/pii/S0277953611006319?via%3Dihub> [Accessed 1 November 2017].

- 2.50 McGivern, Fischer et al in 2015³⁹ recommended in work for the GOsC that informal discussion of practice with another osteopath be part of the recognised process to assure osteopaths' continuing fitness practise. They found that osteopaths would feel more able to raise 'tough issues' in an informal than in a formal discussion. In other words, the confidentiality of an informal discussion would allow for the open and constructive discussion of more uncomfortable material than a recorded formal discussion. This is potentially an uncomfortable finding for regulators, for whom the pursuit of transparency in professional practice has been an important element of regulatory policy; formative spaces if poorly managed may risk important information not reaching the regulator.
- 2.51 The Authority recommends further work to explore how the idea of formative spaces could be applied to different professional groups and appropriately supported by regulators, balancing the benefits of the formative space as described with the need for regulators to be alerted to serious concerns, and to avoid unnecessary and confusing duplication with other initiatives by other agencies. There may be further opportunity to develop this idea in order to identify and resolve problematic practice issues at an early stage and before risks to patient safety have arisen. We recognise that the intent of formative spaces is already reflected in a number of regulatory initiatives and approaches, such as the safe space provided by the GMC's employer liaison service for early conversations about potential problems, and the emphasis on reflection in revalidation and other continuing fitness to practise schemes. It has also been adopted as part of the GOsC's continuing fitness to practise arrangements.

Relational regulation

- 2.52 The concept of relational regulation has becoming of increasing interest to regulators internationally. In 2011 Huising and Silbey⁴⁰ defined relational regulation when they identified a gap within the prevailing logic of regulation, between 'law on the books' and 'law in action'. In other words a gap emerges when a regulator aims to set standards which guide registrants on how to act in particular situations 'because the exigencies of practical action exceed the capacity of system prescriptions to anticipate and contain them'. The perceived lack of applicability of regulatory standards to everyday work is inherent in Christmas' and Cribb's⁴¹ recent work for the Authority on professional identity, in which participants reported that they thought of standards as 'what you would expect of yourself anyhow', and said that in times of uncertainty of how to act in a

³⁹ McGivern, G, et al, 2015. *Exploring and explaining the dynamics of osteopathic regulation, professionalism and compliance with standards in practice*. General Osteopathic Council. Available at <http://www.osteopathy.org.uk/news-and-resources/document-library/research-and-surveys/dynamics-of-effective-regulation-final-report/> [Accessed 1 November 2017].

⁴⁰ Huising, R and Silbey, SS, 2011. *Governing the gap: Forging safe science through relational regulation*. Regulation and Governance Vol 5 Issue 1. Available at <http://onlinelibrary.wiley.com/doi/10.1111/j.1748-5991.2010.01100.x/full> [Accessed 1 November 2017].

⁴¹ Christmas, S and Cribb, A, 2017. *How does professional regulation affect the identity of health and care professionals: exploring the views of professionals*. Professional Standards Authority. Available at <https://www.professionalstandards.org.uk/docs/default-source/publications/research-paper/regulation-and-professional-identity-july-2017-final.pdf?sfvrsn=4&sfvrsn=4> [Accessed 1 November 2017].

particular situation, they would turn not to the standards but to ‘a range of other actors – first and foremost colleagues, but also supervisors/superintendents, managers, helplines provided by employers and training bodies’. These observations are also consistent with the findings of the earlier work that the Authority commissioned from Quick, that found limited evidence of influence of regulators standards on behaviour, and many other influences that were closer to home.

- 2.53 Relational regulation as defined by Huising and Silbey addresses ‘the insufficiency of formalized, prescribed processes to handle the complex, situated demands faced in daily compliance work’, and focuses on ‘governing rather than erasing the gap between regulation and performance. We call this relational regulation’. They set out four stages which they argue are implicit in governing the gap: narrating the gap, inquiring without constraint, integrating pluralistic accounts, and crafting pragmatic accommodation. They use the example of a University science department and its regulations on disposing of hazardous waste as an example of working meticulously through these stages, resulting in guidance being placed over the sinks on what can and cannot be poured down them, but acknowledging that this guidance ‘is not a final answer, but a moment in a continuing process of achieving environmental sustainability, or more narrowly producing compliance’.
- 2.54 Relational regulation as defined by Huising and Silbey provides an accessible conceptual relationship between regulatory standards, which are relatively fixed in time, with the working world as everyone knows it: a ‘complex web of interactions and processes’ and ‘a set of interdependent yet malleable relationships’. In the process of governing the gap, it is also by necessity bridged – the process requires thoughtful reflection on what the standards mean. Christmas and Cribb’s findings as reported above and our other work, reflect on the potential risks that might arise from registrants becoming disengaged from professional standards. For example we wrote in *Asymmetry of Influence* of the danger of the proliferation of different standards for a given situation ‘alienating professionals and [causing] them to disengage from the ethical decisions in front of them’. The dynamic process of enquiry, reflection and problem-solving described by Huising and Silbey requires engagement with standards.
- 2.55 Relational regulation has been adopted by a number of regulators as part of their approach and regulatory philosophy, such as the College of Registered Nurses of British Columbia (CRNBC), which states that:⁴²
- ‘Relational regulation means that we believe that it is possible to build genuine relationships with nurses and other stakeholders, while at the same time, regulate effectively in the public interest. Public protection and safety is our utmost concern, and we believe we can best achieve this through collaborative approaches with nurses and the health care community’.

⁴² College of Registered Nurses of British Columbia. 2017-18. *Strategic Plan*. Available at <https://www.crnbc.ca/crnbc/StrategicPlan/Pages/Default.aspx> [Accessed 1 November 2017].

- 2.56 The CRNBC continue that ‘relational regulation implies:
- We build strong relationships with nurses, the public and other stakeholders
 - We keep things simple and communicate in easy-to-understand language
 - We accept that mistakes happen and believe that open conversations with nurses and the health care community assists us in finding ways to promote safety and reduce risks
 - We use the right amount of regulation needed and only use it when necessary
 - We use principles, rather than rules, to guide nursing regulation’.
- 2.57 This is one regulator’s interpretation of what relational regulation means for regulatory practice. The Authority recommends that within the sector we continue to consider and discuss relational regulation, its potential for engaging registrants with professional standards and its relationship to right-touch regulation. Further, the Authority recommends that we consider and discuss how the process of bridging the gap described by Huising and Silbey in the context of environmental regulation applies in the context of the exercise of professionalism.

Interpretive vigilance

- 2.58 Meleyal⁴³ found perverse behavioural consequences when statutory registration was introduced for social workers in England. This finding was consistent with other work, such as McGivern and Fischer, cited above, on how enforced transparency might result in defensive or secretive practice. In more recent work Meleyal⁴⁴ has summarised this and other authors who found that ‘the same types of rules governing behavioural expectations fail to achieve the requisite outcomes over and over again’, and cites regulatory theorists who show that ‘regulation assumes individuals are uniformly interested and capable of modifying their own behaviours in line with imposed rules, and does not take account of those who respond strategically or perversely to regulatory requirements’. The analysis she undertook in her research showed the impact in particular of conduct (ie fitness to practise) cases on other registrants, where ‘the publicity about the outcomes of registration conduct cases triggered a negative allegiance to registration with respondents passively avoiding engagement with conduct matters in the workplace’.
- 2.59 Again, the problem of disengagement from standards is identified, this time with the trigger not of cognitive overload from different standards, nor from a view that the standards fail to add value, but because of anecdotal evidence of how other registrants have fared who have been subject to fitness to practise proceedings.

⁴³ Meleyal, LF, 2011. *Reframing conduct: a critical analysis of the statutory requirement for registration of the social work workforce* (doctoral thesis). University of Sussex. Available at <http://sro.sussex.ac.uk/7665/> [Accessed 1 November 2017].

⁴⁴ Meleyal, LF, 2017. *Nudging workers towards interpretive vigilance: approaches supporting management of conduct in the workplace*. *European Journal of Social Work*. ISSN: 1369-1457 (print) 1468-2664 (online). Available at <http://www.tandfonline.com/doi/abs/10.1080/13691457.2017.1320526> [Accessed 1 November 2017].

It is particularly interesting how disengagement from one area of regulatory activity results from the publicity surrounding another – a point discussed further under trust, as below.

- 2.60 Melejal's first study had shown how 'environments that had a positive approach to engaging with regulatory rules and conduct expectations in the workplace were also those that had clear systems and processes in place that encouraged identification of places where risks may occur (eg log books)', and in the second paper she defines this from Macrae's work⁴⁵ in the context of aviation as 'interpretive vigilance'. Melejal shows how the idea of interpretive vigilance speaks to Sparrow's model of harm sabotage in that through such straightforward and practical measures since 'emerging risk can and should be identified by piecing together cues in apparently inconsequential, minor, 'small events', and that interpretive vigilance can protect against 'small mishaps that can combine to create a major catastrophe'.
- 2.61 Melejal also shows how a mutually complementary set of ideas is formed with McGivern et al's formative spaces within which 'social workers have the opportunity to actively engage in consideration of regulatory policy, conduct, competence and their values in relation to practice'. Emerging from these different domains of research – harm sabotage, relational regulation, formative spaces, and interpretive vigilance – is a mutually complementary set of ideas spanning both the abstract and the practical, which we recommend are further developed to encourage registrant engagement with regulatory standards in the workplace. We propose further work to explore how, through different ways and through different models, local action at the level of the employer or workplace can assist in clarifying the purposes and meaning of regulatory requirements, and can promote constructive and mature engagement with registrants.

Trust and legitimacy

- 2.62 In *Regulation rethought*, the Authority called for a 'rebuilding of trust between professionals, the public and regulators'. In so far as this related to the relationship between professionals and regulators, this was in part because of some emerging research evidence that suggested that the relationship between registrants and regulators may not be one firmly underpinned by trust. An example of this is work by Bourne et al^{46,47} on the impact on doctors of the GMC's fitness to practise proceedings and other complaints procedures, in which 7,926 doctors submitted responses. The authors found, amongst other things, that 'complaints seriously impact on doctors' psychological wellbeing', and that 'doctors with recent/current complaints have significant risks of moderate/severe

⁴⁵ Macrae, C, 2014. *Close Calls – Managing Risk and Resilience in Airline Flight Safety*. Palgrave Macmillan.

⁴⁶ Bourne, T, et al. *The impact of complaints procedures on the welfare, health and clinical practice of 7926 doctors in the UK: a cross-sectional survey*. BMJ Open. Vol 5 Issue 1. Available at <http://bmjopen.bmj.com/content/5/1/e006687> [Accessed 1 November 2017].

⁴⁷ Bourne, T, et al. *Doctors' experiences and their perception of the most stressful aspects of complaints processes in the UK: an analysis of qualitative survey data*. BMJ Open 2016 011711. Available at <http://bmjopen.bmj.com/content/6/7/e011711> [Accessed 1 November 2017].

depression'. The research also found an increased incidence of defensive behaviours in those with direct experience or, specifically hedging and avoidance.⁴⁸ It is important of course to distinguish these behaviours from careful adherence to standards.

- 2.63 The authors also found that the behavioural impact was not limited to the doctor who was the subject of the complaint or fitness to practise process, but by extension, to colleagues who were witnessing the experiences of the direct subject. This mirrors McGivern's observation (2012) that certain stories that circulate among professionals have the power to stick, and thus to profoundly influence how the regulator's purpose and interventions are understood. Misunderstanding of the purposes of regulation may threaten registrants' acceptance of its legitimacy. Quick identified in 2011 the importance of acceptance of legitimacy, in that this was more likely to result in compliance with standards. He observed, 'the clear message to emerge from a number of studies is that regulation (however well intentioned) is far more likely to be complied with when accepted as legitimate by practitioners'.
- 2.64 We are cautious about making any prescriptions that are either too simplistic or too 'heroically rational' (to paraphrase Christmas and Cribb, in their work for us on professional identity) about how misunderstanding or misperception of the role of the regulator might be addressed. However, we recommend that this is taken into account in future policy and communications work, and that the sector continues to seek to understand how the regulator is apprehended by registrants, and to address any misunderstandings while working with the grain of the social dynamics of organisations and social psychology. We think that a greater understanding of the dynamics of these relationships will be vital to the rebuilding of trust that we recommended in *Regulation rethought*.
- 2.65 Our earlier discussion of the use of fitness to practise data notwithstanding, the ideas of 'stories that stick' could be put to better use by regulators, particularly in relation to key messages about standards and fitness to practise. Greater use could be made of the 'stories' in fitness to practise cases for regulators to explain what it means to stay compliant with standards, to deter registrants from breaching standards, and to explain why it is important for the profession that effective action is taken when standards are breached.

⁴⁸ The study defines hedging as 'when doctors are overcautious, leading for example to overprescribing, referring too many patients or over investigation'. Avoidance is defined as including 'not taking on complicated patients and avoiding certain procedures or more difficult cases'.

The role of patients in safe care

- 2.66 In *Right-touch regulation*, the Authority argued for the importance of people when they use services acting as one of the agents of their own safety. We have also, as mentioned above, called for a rebuilding of trust between professionals, the public and regulators. There are two specific ways in which we propose now that further work is done to respond to these proposals.
- 2.67 The first relates to what is known about patients involved in fitness to practise cases and has been mentioned above in relation to fitness to practise data. We have discussed both the potential and the inherent problems with using this data for retrospective analysis and future risk management. A further consideration is that because the process is one which assesses the registrant's fitness to practise, the registrant is the protagonist of the story, not the patient who may have been harmed. This of course is at the heart of the frustration experienced by many members of the public who refer problems to regulators. We have also discussed above work which is being taken forward by Searle et al to use fitness to practise data to a number of ends including identifying types or typical circumstances of registrants involved in fitness to practise cases. As we discussed previously, we propose that as part of a review of how data about fitness to practise is gathered and categorised, we also look at how data about trends in harm are captured, and whether there are measures that could be taken by regulators or others to mitigate vulnerabilities in particular situations.
- 2.68 A second area for further work relates to trust. Trust is an area of growing interest in research in healthcare and in regulatory policy. Recent work by Peters and Bilton⁴⁹ has discussed the importance of trust for patients, not least because patients 'have limited information (about their illness or treatments); they delegate responsibility for making decisions about their care to professionals; they rely in turn on professionals' professionalism to ensure the care they receive is appropriate; and in this way their trust addresses the inherent uncertainty underlying medical care'. A loss of trust in either a specific individual, in an organisation or in the arrangements for the delivery of care at a higher level has consequences beyond the individual, such as deterring patients from seeking needed care. Trust transfer can be seen, in that trust in an individual can invoke trust in a wider organisation or system, and vice versa; distrust or loss of trust can also transfer between patients and those close to them because of stories that stick, to use McGivern's phrase.
- 2.69 Peters and Bilton also describe the dangers of excessive or blind trust, and show how unscrupulous professionals can manipulate perceptions to induce a sense of trust where it is not justified. They describe the importance of patients being actively distrustful – listening to their instincts when they feel that something is not right, asking questions when they feel uncertain, and taking action including reporting or escalating concerns. It is here in particular that we feel patients have

⁴⁹ Peters, S, and Bilton, D. *Right-touch trust: thoughts on trust in healthcare* in *Routledge Companion to Trust* (in press). Routledge.

a part to play in helping to mitigate their vulnerability and protecting themselves from harm. In evidence given recently to the Independent Inquiry into Child Sexual Abuse it was described as empowering people on 'what to do and how to speak out if people behave in ways that aren't that which you expect'.⁵⁰ We believe that further work should be done to model ways in which patients can be supported and encouraged to be constructively distrustful.

- 2.70 We recognise that the concept of promoting patients being 'distrustful' may be problematic, and would need to be carefully expressed to avoid in itself provoking a loss of confidence. As a starting point however, the Authority intends to undertake a piece of work to understand better how patients currently contribute to the safety and effectiveness of the care they receive, to develop our understanding of their role in this respect. We propose as a second stage to then develop ideas and proposals around the mutual roles of the patient and of the regulator in this respect, encouraging a conversation which extends beyond the professional regulators and which encompasses a wider range of issues relating to developing innovative ways to support public engagement with regulators.

⁵⁰ Christine Braithwaite, Director of Standards and Policy, Professional Standards Authority. Quote from transcript of IICSA seminar 26 September 2017. Available at www.iicsa.org.uk/key-documents/2646/view/26%20September%202017%20IICSA%20Health%20Sector%20seminar%20transcript%20.pdf [Accessed 1 November 2017].

Conclusion

2.71 In conclusion we recommend the following:

- That we continue to develop approaches focused on the avoidance of harms within the sector
- That we continue to seek new ways to use data to support insights into trends and patterns in the circumstances in which misconduct occurs
- That we identify the range of potential targeted regulatory action subsequent to identification of 'high-risk' groups, and identify ways in which these could be made non-discriminatory
- That we work to develop a methodology to engage retrospectively with those involved in fitness to practise cases, to discuss the hazards that were present when things went wrong in an open and exploratory way
- That we review of the way in which regulators collect data about fitness to practise, and how within available resources a common data set might be developed
- That we explore how 'formative spaces' could add further value for different professional groups
- That there is further work to understand the nature of the relationship between regulators and their registrants and how (it is constructed, and to identify strategies by which misperceptions might effectively be addressed
- That we explore how, through different ways and through different models (formative spaces, relational regulation, interpretive vigilance, or others) local action at the level of the employer or workplace can assist in clarifying the purposes and meaning of regulatory requirements, and can promote constructive and mature engagement with registrants
- That we further explore the role of the patient in the safety of care, and the role of the regulator in supporting patients in this respect.

2.72 The Authority will look to support and encourage this work within the sector, particularly where this is on the basis of collaboration and shared commissioning to address common issues and research questions.

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

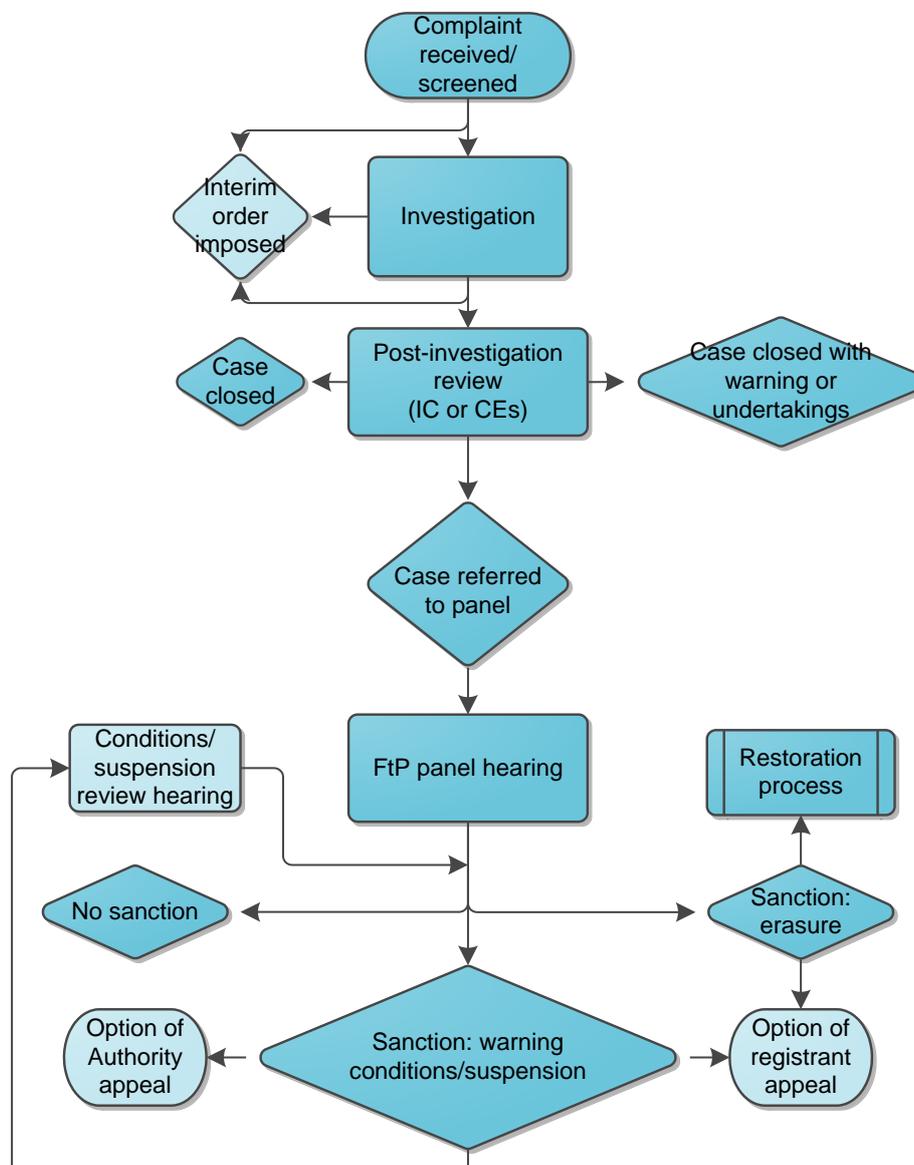
3.43 In this section, we consider the key differences and similarities between the nine regulators' fitness to practise models.

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.

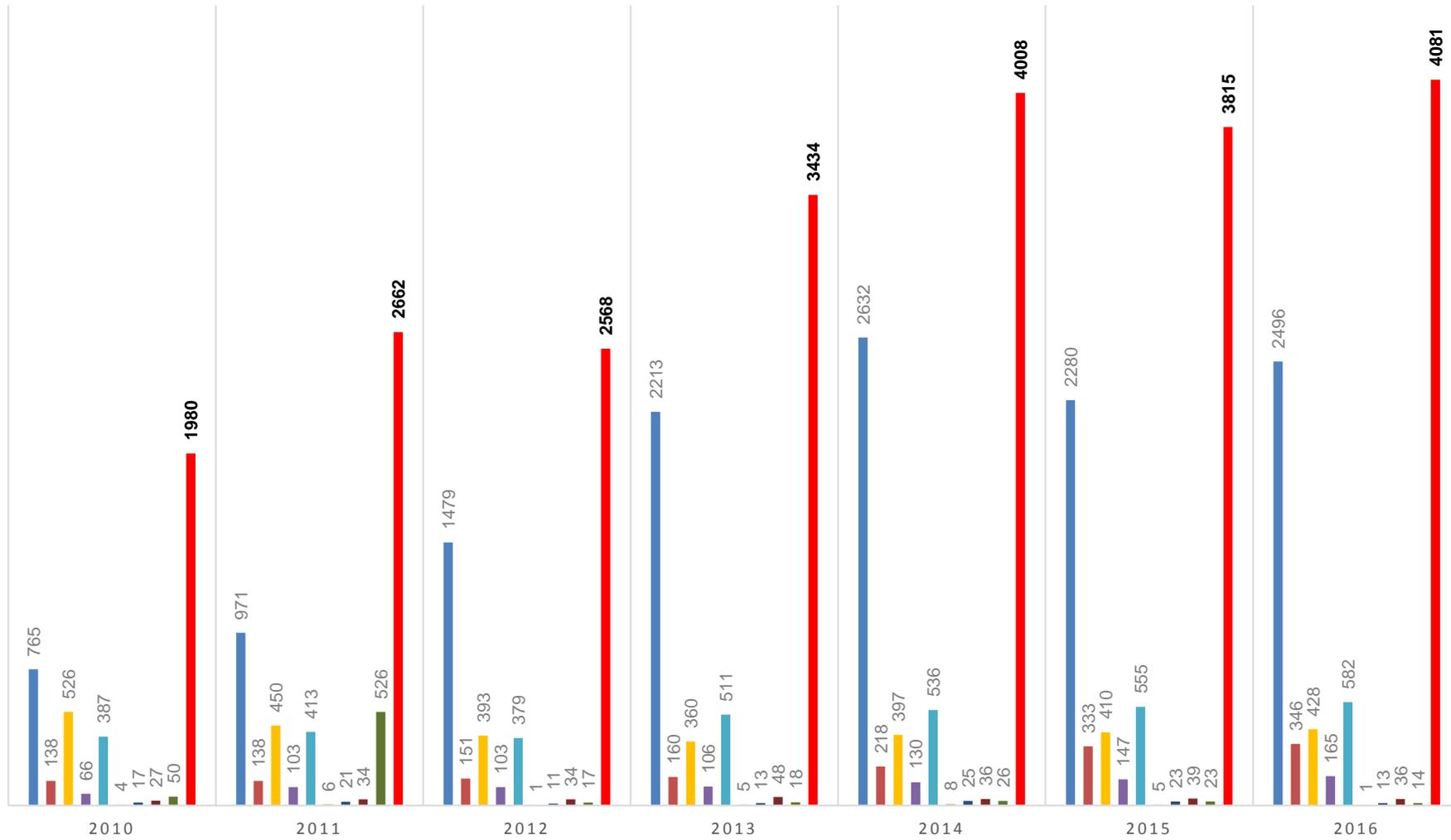
¹⁰⁰ The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Volume 2*. Available at <http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/sites/default/files/report/Volume%202.pdf>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

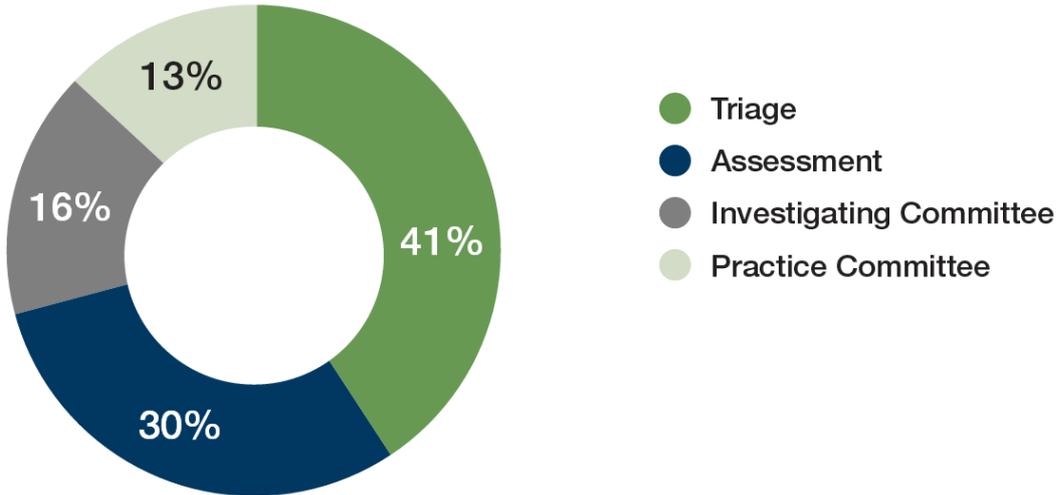
Figure 3: Total number of FtP hearings (by date received by the Authority)

■ NMC ■ GDC ■ GMC ■ GPhC ■ 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].

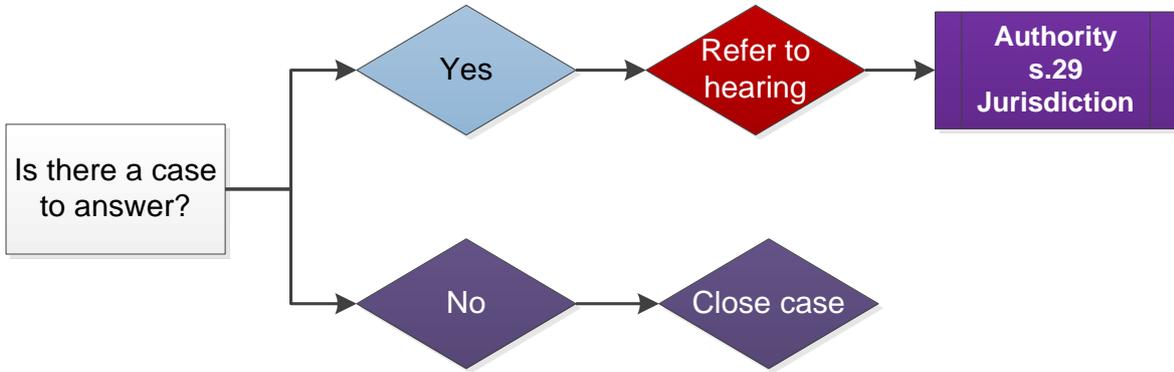
¹²⁸ See for example, the GMC guidance for case examiners on undertakings, available at http://www.gmc-uk.org/DC4595_CE_Decision_Guidance_Annex_F_Undertakings.pdf_57741459.pdf [Accessed 1 November 2017].

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.

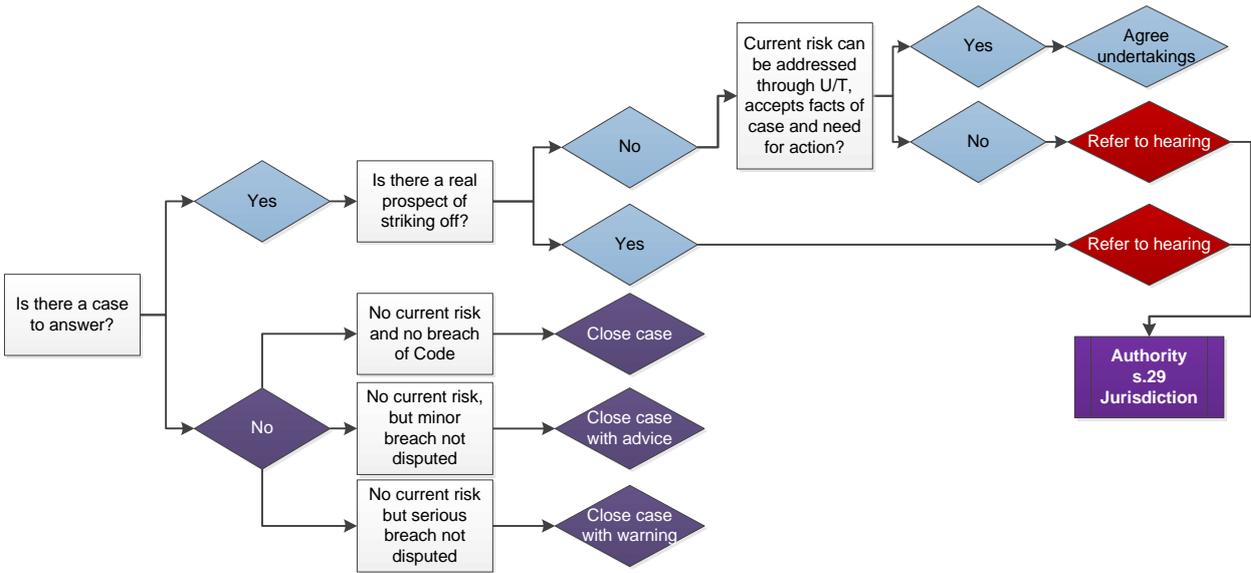
¹³⁰ The Nursing and Midwifery (Amendment) Order 2017 (Draft). Available at <http://www.legislation.gov.uk/ukdsi/2017/9780111153444/schedule/1> [Accessed 1 November 2017].

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.’

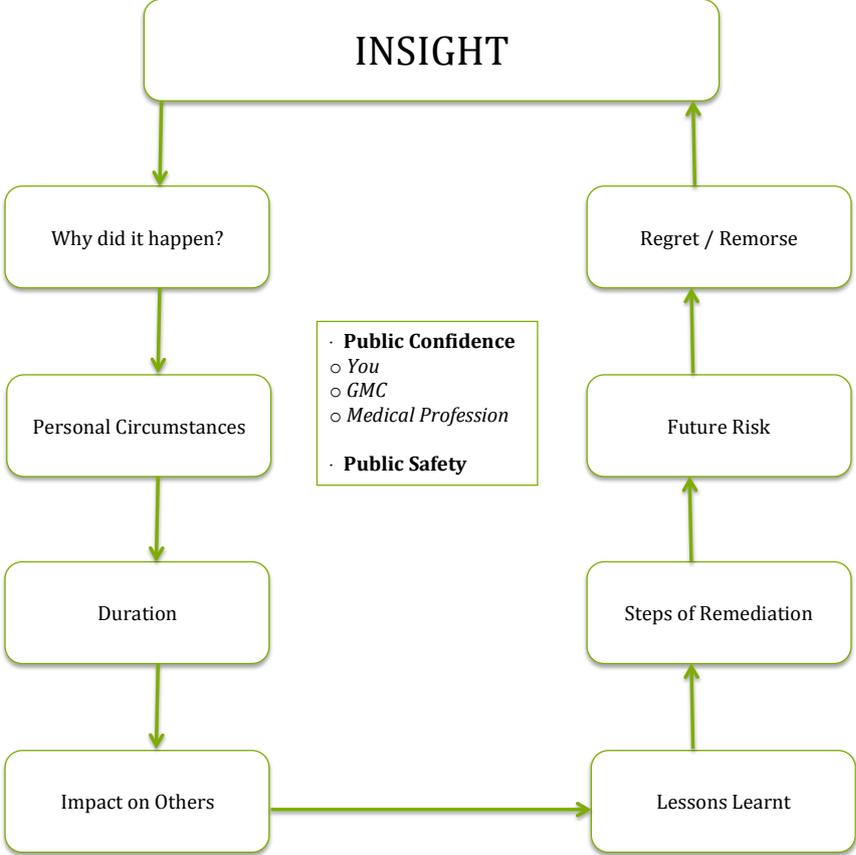
3.159 It is worth pointing out that the Judges here were considering a decision made by a fitness to practise panel at a full hearing, where the panel had had access to both written and oral evidence, including, for example, the opportunity to cross-examine witnesses. This is quite different from the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

4. The professional regulators' role in education and training

Chapter summary

- 4.1 This chapter looks at the regulators' role in education and training. Our work has included reviewing similarities and differences in approach across the regulators, examining a range of current and emerging issues within health and higher education and considering how these may affect the regulators' role in education and training in the future.
- 4.2 Key findings include:
- There is variation between the regulators' responsibilities and approaches to education and training
 - There are multiple agencies with regulatory influence over higher and further education, some with overlapping remits and data requirements and the evolving roles of different bodies is likely to complicate this picture
 - Workforce pressures and Government policies pose a number of challenges to regulators, including in relation to the way that they assure the competence of those joining the register
 - A significant amount of progress has been made within the current legislation to reduce burden, streamline processes and pursue a more risk-based approach
 - The regulatory structure of higher education in England is going through a period of substantial change alongside increasing divergence in approach to education and training across the four countries which may have implications for quality assurance of education and training
 - Any agreement reached when leaving the EU may have an impact on how the regulators assure competence of EU/EEA staff or wider objectives around increased training of UK staff.
- 4.3 Building on the characteristics of good practice which we identified in our previous 2009 review of the regulators' role in quality assuring undergraduate education, we have laid out some principles. We hope these will be helpful in guiding changes in this area across the regulators in the short term and also in the event of more long term legislative change in this area. These principles are detailed in the paragraph below.
- 4.4 The approach:
- Is underpinned by a legislative framework which is based on the duty to protect the public and is sufficiently flexible to allow a risk-based approach to assuring different professional groups and to meet future challenges

- Builds on other quality assurance activities and seeks to actively review and, where appropriate, withdraw activity where other agencies can provide sufficient assurance
- Promotes the benefits of Interprofessional education and supports the development of shared values across professional groups to ensure a consistent approach to patient safety
- Actively involves and seeks perspectives of students, patients and other members of the public in quality assurance processes and the development of training courses
- Ensures processes, criteria and procedures are consistently applied and, along with outcomes and rationale, are publicly available and clearly explained
- Actively encourages the sharing and use of data to ensure that education and training programmes are fit for purpose
- Supports flexibility in training and allows development of new roles where required to address wider workforce challenges.

4.5 Our recommendations for the professional regulators, other bodies involved in health and care education and training and those in a position to make changes to the system include:

- Any changes to quality assurance processes should be considered against the principles we have outlined
- Further opportunities to share best practice and reduce duplication of requirements should be explored
- An exercise to clarify the regulatory approach and responsibilities amongst the bodies involved in the quality assurance of education and training should be carried out
- Opportunities should be explored to simplify and improve regulators' legislation in this area with reference to the 2014 recommendations from the Law Commissions to allow a more streamlined and coordinated approach. This would enable regulators to reduce activity or stop carrying out specific tasks where unnecessary or where other bodies are carrying out similar activity
- There should be consideration of the implications for the regulators' approach to education and training of a move towards shared regulatory functions and/or the impact of an introduction of a common statement of professional practice across all professions on the development of learning outcomes.

Background and purpose

- 4.7 It is one of the core statutory responsibilities of the health professional regulators to ensure that those qualifying from education and training courses are fit to practise and join the register for their profession. Quality assuring the courses that prospective registrants undertake to ensure that they adequately prepare them for practice is one of the primary ways that regulators ensure they meet this statutory requirement.
- 4.8 This chapter focuses mainly on the regulators' quality assurance activities in education and training that leads to initial registration as a healthcare professional. We recognise that regulators also undertake additional roles in relation to education and training. These include among others: the quality assurance of postgraduate specialty training; the accreditation of independent prescriber programmes; oversight of pre-registration training periods for certain healthcare professionals; assessment of overseas healthcare professionals; and guidance for, and interaction with, students and trainees on professionalism and fitness to practise matters.
- 4.9 The Authority assesses the performance of the regulators against the *Standards of Good Regulation*.²⁰¹ There are 24 standards divided between four different areas: guidance and standards; education and training; registration; and fitness to practise. The standards for education and training include:
- Standards for education and training are linked to standards for registrants. They prioritise patient and service user safety and patient and service user centred care. The process for reviewing or developing standards for education and training should incorporate the views and experiences of key stakeholders, external events and the learning from the quality assurance process
 - The process for quality assuring education programmes is proportionate and takes account of the views of patients, service users, students and trainees. It is also focused on ensuring the education providers can develop students and trainees so that they meet the regulator's standards for registration
 - Action is taken if the quality assurance process identifies concerns about education and training establishments
 - Information on approved programmes and the approval process is publicly available.²⁰²
- 4.10 Our role also includes setting standards for registers of occupations that are not regulated by law and accrediting the registers that meet these standards. We do this so that the public, employers and commissioners can choose practitioners

²⁰¹ The Authority is currently reviewing the *Standards of Good Regulation* and anticipates publishing revised standards in 2018.

²⁰² Professional Standards Authority, *Standards of Good Regulation*. Available at <http://www.professionalstandards.org.uk/publications/detail/standards-of-good-regulation> [Accessed 2 November 2017]. The Authority is currently carrying out a review of the Standards of Good Regulation and learnings from this report may be reflected in any changes made in the future.

from voluntary registers that we have independently vetted and approved. Accredited registers must meet our demanding standards, which includes commitment to protecting the public, governance, education and training, risk management and complaints-handling. Practitioners on accredited registers meet requirements set by the register including approved levels of education and training, engagement in continuing professional development and commitment to codes of conduct. They are also subject to disciplinary processes if something goes wrong.²⁰³

- 4.11 As highlighted in Chapter 1, ongoing discussion on the need for reform to the system for professional regulation has led to reflection about the way that statutory regulators carry out their statutory functions and how these methods contribute to the overall objective of public protection.
- 4.12 In *Regulation rethought*, where the Authority laid out proposals for reform, we commented: ‘We consider ... that the current arrangements for the regulation of undergraduate and other pre-registration training tend to duplication of regulatory responsibilities between professional regulators and other regulators in education, and this may be resulting in unnecessary expense and regulatory burden on higher education and training institutions’, and called for ‘a review of regulatory approach and responsibilities in this area.’^{204 205}
- 4.13 The Authority last carried out a review on this topic in 2009 when we published the report *Quality assurance of undergraduate education by the healthcare professional regulators*²⁰⁶ following a commission from the Department of Health. In that report, we outlined the approach taken by the regulators to quality assurance, the differences and similarities, outlined characteristics of good practice and made some recommendations.
- 4.14 For this chapter, we have sought to carry out an initial review of the current arrangements in place for quality assurance of education and training and provide a snapshot of the range of current and emerging issues which are driving change. Whilst we do not seek to lay out firm recommendations for what a future approach to education and training might look like, the principles of right-touch regulation have been a useful framework to keep in mind when considering regulatory approach in this area. They state that regulation must be:
- proportionate
 - consistent
 - targeted

²⁰³ Professional Standards Authority. *Accredited Registers - Our Standards*. Available at <http://www.professionalstandards.org.uk/publications/detail/accredited-registers---our-standards> [Accessed 2 November 2017].

²⁰⁴ Professional Standards Authority 2016, *Regulation rethought*. Available at <http://www.professionalstandards.org.uk/docs/default-source/publications/regulation-rethoughtd6c718f761926971a151ff000072e7a6.pdf?sfvrsn=0> [Accessed 2 November 2017].

²⁰⁵ We recognise that this is not the case for all professions, for example osteopathy where the GOsC are the only regulator or body that visits osteopathic educational institution patient clinics.

²⁰⁶ Professional Standards Authority, 2009. *Quality assurance of undergraduate education by the healthcare professional regulators*. Available at <http://www.professionalstandards.org.uk/docs/default-source/publications/advice-to-ministers/quality-assurance-of-undergraduate-education-2009.pdf> [Accessed 2 November 2017].

- transparent
 - accountable
 - agile.²⁰⁷
- 4.15 In addition, in *Regulation rethought*, when laying out our proposals for wider reform, we highlighted that reforms should also be:
- simple to understand and operate, and
 - efficient and cost-effective.²⁰⁸
- 4.16 Paragraphs 4.19-4.93 of this chapter cover:
- The purpose of quality assurance of education and training, the regulators' role in this area and the differences and similarities in approach
 - Progress made against the recommendations from the Authority's last report
 - Key themes around quality assurance emerging from the Performance Reviews.
- 4.17 In paragraphs 4.94-4.180 we look at current and emerging issues relating to education and training, challenges these may present for the regulators and how these may affect the future development of the regulators' role in this area.
- 4.18 We are grateful to all of those who we have spoken to as part of this project or who have contributed advice and expertise. We would welcome feedback on this chapter and the issues we have highlighted to feed into any further review of the work of regulators in education and training that takes place in the future.

The professional regulators' role in quality assurance

- 4.19 As highlighted, the role of statutory professional regulators in this area is to ensure that those qualifying from education and training courses are fit to practise and join the register for their profession. They do this by quality assuring the institutions providing education and training and/or the courses themselves to ensure that prospective registrants are fit to practise and join the register. For regulators, being able to control access to the register is fundamental to being able to ensure public protection.
- 4.20 The different regulators' approaches to education and training are influenced by a number of factors. Some regulatory bodies such as the General Medical Council (GMC), General Chiropractic Council (GCC), and General Osteopathic Council

²⁰⁷ Professional Standards Authority, 2015. *Right-touch regulation*. Available at <http://www.professionalstandards.org.uk/what-we-do/improving-regulation/right-touch-regulation> [Accessed 2 November 2017].

²⁰⁸ Professional Standards Authority, 2016, *Regulation rethought*. Available at <http://www.professionalstandards.org.uk/docs/default-source/publications/regulation-rethoughtd6c718f761926971a151ff000072e7a6.pdf?sfvrsn=0> [Accessed 2 November 2017].

(GOsC) regulate only one profession whilst others like the General Dental Council (GDC) and General Optical Council (GOC) regulate different professions within the same field of healthcare. The Health and Care Professions Council (HCPC) currently regulates 16 professions including some of the allied health professions, practitioner psychologists and hearing aid technicians.

- 4.21 In addition, whilst some professions enter the register after a prescribed period of undergraduate study, this is not the case for all and many professions require a postgraduate level qualification or further training to specialise or pursue specific areas of practice before being permitted to join the register, or to broaden their scope of practice if already registered. Quality assurance activity therefore may cover undergraduate and postgraduate qualifications as well as further training such as specialty training and prescribing courses.

Example: Once medical students have successfully completed an undergraduate degree they will receive provisional registration whilst completing the foundation training. Full registration is granted after successful completion of the first year of this two-year programme. During foundation training, individuals will be working within the clinical environment in hospital, GP and community settings but are closely supervised. After foundation training, most junior doctors enter specialty training or train to become a GP.

- 4.22 Nevertheless, whilst the range of activities which the different regulatory bodies are required to assure varies due to their legislation, there are three main aspects of quality assurance activity which all regulatory bodies fulfil:

- Setting the outcomes for students²⁰⁹ to be achieved by those who complete the relevant training
- Setting the standards for education and training providers to meet when designing and delivering courses to ensure that students will achieve the relevant outcomes and will be prepared to join the register
- Assessing the performance of the institution against the standards for education and training providers and/or specific courses and ensuring that the quality management system of the institution has processes in place to identify, manage and monitor issues that may impact on quality.

- 4.23 The standards for education and training and the outcomes for students developed by the regulators provide a framework against which they can assess the delivery of education and training to ensure it will produce prospective registrants who are safe and adequately prepared to join the register for their profession.

Other organisations involved in quality assurance and regulatory oversight of higher and further education

- 4.24 For the majority of professions, the professional regulators are one group amongst a range of organisations that have a role in the quality assurance of

²⁰⁹ Outcomes describe the knowledge, skills and attitudes/behaviours that prospective registrants should have to ensure they are fit to join the register. These may also be referred to as learning outcomes or standards of proficiency but in this report we will refer to 'outcomes for students'.

education and training provision.²¹⁰ These organisations include bodies such as the Royal Colleges and professional associations as well as the Skills Councils and system regulators such as the Care Quality Commission (CQC) alongside the education institutions themselves.

- 4.25 In addition, there are a number of other bodies which, whilst they may not all be regulators in the formal sense, have some form of regulatory oversight of higher or further education institutions or gather data or information from institutions. Whilst we have not sought to identify every organisation with involvement in this area, in relation to the higher and further education sector in England, the key bodies and their general remit and responsibilities are outlined below, along with alternative or equivalent bodies in the other countries of the UK where they exist:²¹¹

Table 7: Key oversight bodies

Area	Organisations	Further information
Funding	The Higher Education Funding Council for England (HEFCE), ²¹² the Department for the Economy in Northern Ireland, ²¹³ the Scottish Funding Council ²¹⁴ and the Higher Education Funding Council for Wales. ²¹⁵	HEFCE has been responsible for the distribution of government funding to higher education institutions since 1992. As part of this role it is responsible for assessing the financial health of publicly funded institutions. It also contracts the QAA to assure the quality of education provision within the higher and further education providers that it funds. The Charities Act 2010 also makes HEFCE the 'principal regulator' of HEIs that are exempt charities. (Some HEIs are registered charities and are therefore regulated directly by the Charity Commission.)
Academic standards and education quality	The Quality Assurance Agency (QAA) ²¹⁶ works across all four nations. The QAA tailors its approach across the four countries and includes a dedicated team for Scotland: QAA Scotland.	The QAA is responsible for producing and maintaining the UK Quality Code, which sets out the standards that higher education providers are required to meet. It no longer carries out subject level reviews but carries out a range of

²¹⁰ It should be noted that whilst this is the case for many professions it is not for all. For example, for some areas of osteopathic training, the professional regulator is the only organisation with regulatory oversight.

²¹¹ Higher Education Funding Council, *Roles and responsibilities of organisations in the operating framework*. [Online] Available at <http://www.hefce.ac.uk/reg/of/organisations/> [Accessed 2 November 2017].

²¹² Higher Education Funding Council, *Our role*. [Online] Available at <http://www.hefce.ac.uk/reg/of/organisations/> [Accessed 2 November 2017].

²¹³ Department for the Economy, *Higher Education Division*. [Online] Available at <https://www.economy-ni.gov.uk/articles/higher-education-division> [Accessed 2 November 2017].

²¹⁴ The Scottish Funding Council, *About us*. [Online] Available at <http://www.sfc.ac.uk/about-sfc/about-us/about-us.aspx> [Accessed 27 October 2017].

²¹⁵ The Higher Education Funding Council for Wales. [Online] Available at http://www.hefcw.ac.uk/about_he_in_wales/higher_education_institutions/he_institutions.aspx [Accessed 27 October 2017].

²¹⁶ The Quality Assurance Agency, *About us*. [Online] Available at <http://www.qaa.ac.uk/about-us> [Accessed 2 November 2017].

		institution level reviews of higher education institutions (HEIs) where contracted to by other organisations in the sector, including HEFCE.
NHS education and training	Health Education England (HEE), the Department of Health in Northern Ireland, ²¹⁷ NHS Education for Scotland ²¹⁸ and a new body, Health Education and Improvement Wales (HEIW) which is due to come into being in April 2018 and which will lead on strategic workforce planning, workforce design and education commissioning. ²¹⁹	HEE was set up in 2012 and is responsible for ensuring ongoing improvement in the quality of health education and training in England, primarily in the NHS. The organisation has been responsible for publishing an education outcomes framework for the healthcare workforce and in 2016 published a Quality Framework for education and training which sets standards for education providers and work placement providers and seeks to ensure the creation of a flexible workforce, excellence in training and a better educational experience for all staff. ²²⁰
Access to education	The Office for Fair Access (England) (OFFA). ²²¹	Promoting and safeguarding access to higher education for under-represented groups. The position regarding tuition fees is different for home students in the other nations which did not implement the 2012 increase meaning there is not the same imperative to ensure that fair access is monitored.
Complaints handling	The Office of the Independent Adjudicator (England and Wales), ²²² the Northern Ireland Public Services Ombudsman ²²³ and the Scottish Public Services Ombudsman. ²²⁴	The OIA's role is to promote good practice in complaints handling and to review individual and group complaints against HEIs which are required by law to join the OIA scheme. Whilst the OIA doesn't have powers to implement fines or sanctions they will gather information and review whether the HEI properly applied its internal procedures and

²¹⁷ Northern Ireland Department of Health. [Online] Available at <https://www.health-ni.gov.uk/topics/health-workforce-policy-and-management> [Accessed 2 November 2017].

²¹⁸ NHS Education for Scotland. [Online] Available at <http://www.nes.scot.nhs.uk/> [Accessed 2 November 2017].

²¹⁹ Health Secretary announces plans for new organisation - Health Education Wales (HEW). [Online] Available at <http://gov.wales/newsroom/health-and-social-services/2016/161111hew/?lang=en> [Accessed 2 November 2017].

²²⁰ Health Education England, *Commissioning for Quality*. [Online] Available at <https://www.hee.nhs.uk/our-work/planning-commissioning/commissioning-quality> [Accessed 2 November 2017].

²²¹ Office for Fair Access. *About OFFA*. [Online] Available at <https://www.offa.org.uk/about/> [Accessed 2 November 2017].

²²² Office of the Independent Adjudicator. *About us*. [Online] Available at <http://www.oiahe.org.uk/about-us.aspx> [Accessed 2 November 2017].

²²³ The Office of Northern Ireland Public Services Ombudsman. *Who we are*. [Online] Available at <https://nipso.org.uk/nipso/> [Accessed 2 November 2017].

²²⁴ The Scottish Public Services Ombudsman. [Online] Available at <https://www.spsso.org.uk/> [Accessed 2 November 2017].

		<p>whether the outcome was reasonable and will make recommendations on remedies which may include compensation to students who have been disadvantaged or suffered stress or inconvenience.</p> <p>A similar role is carried out by the Public Service Ombudsman in Scotland and Northern Ireland.</p>
Other	<p>Education and training providers may also need to provide information to, and meet the regulatory requirements of, a range of other bodies, such as the Universities and Colleges Admissions Service (UCAS), UK Visas and Immigration, the Higher Education Statistics Agency, the Student Loans Company and Research Councils UK in relation to the funding they receive for research projects.</p>	
Further education	<p>The bodies relevant to further education differ across the UK.^{225 226 227}</p> <p>Funding: The majority of colleges in England fall under the requirements of the Charities Act. Further education and sixth form colleges are classified as 'exempt' charities so are regulated by the Department for Education (DfE) rather than by the Charity Commissioners. The majority of further education in England is publicly funded through the Education and Skills Funding Agency (ESFA).</p> <p>In Scotland funding of further education falls to the Scottish Funding Council, alongside Higher Education, in Wales from the Welsh Government and the Department for the Economy in Northern Ireland.</p> <p>Academic standards and quality:</p>	<p>Funding bodies undertake regular audits to satisfy themselves that funds have been properly applied.</p> <p>Ofsted is an independent inspectorate reports directly to Parliament and inspects all colleges on a cyclical basis.</p>

²²⁵ The Association of Colleges. *The national framework*. [Online] Available at <https://www.aoc.co.uk/funding-and-corporate-services/governance/induction-governors/the-national-framework> [Accessed 2 November 2017].

²²⁶ Department for the Economy Northern Ireland, *DfE's role in further education*. [Online] Available at <https://www.economy-ni.gov.uk/topics/further-education/dfes-role-further-education> [Accessed 2 November 2017].

²²⁷ Welsh Government, Further Education. [Online] Available at <http://gov.wales/topics/educationandskills/learningproviders/further-education/?lang=en> [Accessed 2 November 2017].

	<p>Colleges in England are inspected by the Office for Standards in Education (Ofsted).²²⁸</p> <p>Colleges that provide courses of higher education are also inspected by the Quality Assurance Agency for Higher Education (QAA).</p> <p>Qualifications: The Office of Qualifications and Examinations Regulation (Ofqual) regulates qualifications, examinations and assessments in England.²²⁹</p> <p>Scotland has its own regulatory and qualifications development body, the Scottish Qualifications Authority (SQA)²³⁰ as does Wales, Qualifications Wales.²³¹ In Northern Ireland the Council for the Curriculum, Examinations and Assessment carries out this role.²³²</p>	
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- 4.26 Table 7 is intended to demonstrate the range of bodies who place requirements on education and training providers, and to demonstrate the different roles and purposes in the regulatory activity that these bodies carry out.
- 4.27 Due to the passing of the Higher Education and Research Act in April 2017, the soon to be created body, the Office for Students (OfS), will take on most of the functions of HEFCE and OFFA alongside a new focus and responsibility for overseeing the regulatory landscape for higher education in England. UK Research and Innovation will take over HEFCE’s research and knowledge exchange functions. The implications of these changes will be assessed in paragraphs 4.94-4.180 of the chapter.

²²⁸ Ofsted, *About us*. [Online] Available at <https://www.gov.uk/government/organisations/ofsted/about> [Accessed 2 November 2017].

²²⁹ Ofqual, *What we do*. [Online] Available at <https://www.gov.uk/government/organisations/ofqual> [Accessed 2 November 2017].

²³⁰ Scottish Qualifications Authority, *About us*. [Online] Available at <http://www.sqa.org.uk/sqa/5656.html> [Accessed 2 November 2017].

²³¹ Qualifications Wales, *About us*. [Online] Available at <http://qualificationswales.org/about-us/?lang=en> [Accessed 2 November 2017].

²³² Council for the Curriculum, Examinations and Assessment, *What we do*. [Online] Available at http://ccea.org.uk/about_us/what_we_do [Accessed 2 November 2017].

Comparing the professional regulators' approaches to quality assurance

4.28 As highlighted, there are many variations between the regulators' systems for quality assurance. This is based both on differences between the number and variety of professions they regulate, the threshold for entry to the profession and also the different educational environments within which pre-registration training is offered. There are also differences in the regulators' legislation and how they interpret their responsibilities in this area. This chapter is intended to give an overview of some of these differences; further detail is available in the table at Appendix III.

Scale of quality assurance operations and range of education and training in scope

- 4.29 There is wide variation in the scale of the regulators' quality assurance operations. At one end of the scale, the Pharmaceutical Society of Northern Ireland (PSNI) in conjunction with the General Pharmaceutical Council (GPhC) under a Memorandum of Understanding accredits pharmacy courses in the two Northern Ireland Universities and accepts the GPhC accreditation of Universities in GB.²³³
- 4.30 At the other end of the scale, the HCPC quality assures courses from around 145 different providers.²³⁴ This is partly related to the number of professions covered by the regulator in question but also the complexity of the training route for each profession and the type of provider. For example, the HCPC and GOsC and some of the other regulators work with a range of providers which are predominantly higher education institutions but an increasing number are collaborative, professional body, employer or private provider led, some of which fall outside the broader regulatory framework around education.
- 4.31 As highlighted, quality assurance activities pursued by the regulators also depend on the variety and complexity of different kinds of training under their remit. For example, the GMC is responsible for quality assuring the full range of medical training for doctors from undergraduate study through to the foundation and specialty or GP training which follows.²³⁵
- 4.32 In contrast, students in professions such as dental nursing carry out training on the job whilst completing an approved training programme.²³⁶ Most courses involve some element of practical training but the risks to be managed, and therefore the requirements of the quality assurance process, may vary depending on how much of the training this constitutes or where it falls within the course. Within dentistry, hygiene and therapy, the student undertakes procedures on a

²³³ Pharmaceutical Society of Northern Ireland. *Accredited MPharm degrees (website)*. [Online] Available at <http://www.psni.org.uk/education-2/> [Accessed 2 November 2017].

²³⁴ Available at <http://www.hcpc-uk.org/education/programmes/> [Accessed 2 November 2017].

²³⁵ General Pharmaceutical Council. *Our role in education and training*. [Online] Available at <https://www.pharmacyregulation.org/education/approval-courses> [Accessed 2 November 17].

²³⁶ General Dental Council. *What defines a student/trainee dental nurse or dental technician?* [Online] Available at <https://gdc-uk.org/newsarticle?id=263> [Accessed 2 November 2017].

patient, some of which will be irreversible, in the pre-registration environment. This makes supervision key, as is assessment within a simulated environment. Trainee pharmacy technicians will work in a pharmacy under the supervision of a registered pharmacist or pharmacy technician whilst completing their training. The GPhC's standards for providers of initial training for pharmacy technicians therefore also emphasise the importance of supervision to ensure adequate public protection.²³⁷ Pharmacists are also required to complete a pre-registration training year and pass an exam with the GPhC or PSNI before they are able to practise unsupervised.

- 4.33 For regulators with more than one profession in their remit their powers in relation to education and training for the different groups may vary significantly, for example the GDC has very different requirements under its legislation for dentists than it has for dental care professionals (DCPs).

Length and complexity of approval process

- 4.34 All regulators have mechanisms to review and approve the undergraduate level education and training that will lead to registration but there are also differences in the way that they carry out this process. A specific difference, driven largely by legislative variations, is that some of the regulators, including the Nursing and Midwifery Council (NMC), have the powers to approve both the education provider as well as courses.²³⁸ Others, including the GOsC and GCC only have powers to approve courses.^{239 240} For those regulators that do not approve the education provider it is usual to have a more in-depth process for initial approval of a course than for subsequent re-approval. Both the HCPC²⁴¹ and the GPhC²⁴² have the flexibility under their legislation to approve institutions as well as courses but both choose to structure their process to carry out just programme approval and incorporate requirements for the education and training provider into this process.
- 4.35 The GMC, in contrast only has the powers to decide which organisations can award UK primary medical qualifications (PMQs). While it will monitor how courses are run and ensure that medical schools are meeting standards, approval covers all of the programmes which a medical school may offer,

²³⁷ General Pharmaceutical Council. *Standards for the initial education and training of pharmacy technicians*. Available at

<http://www.pharmacyregulation.org/sites/default/files/Standards%20for%20the%20initial%20education%20and%20training%20of%20pharmacy%20technicians.pdf> [Accessed 2 November 2017].

²³⁸ Nursing and Midwifery Council. *Our role in education*. [Online] Available at

<https://www.nmc.org.uk/education/our-role-in-education/> [Accessed 2 November 2017].

²³⁹ General Chiropractic Council. *Approvals Undergraduate Education*. [Online] Available at

<https://www.gcc-uk.org/education/assuring-quality-in-chiropractic-education/approvals-undergraduate-education.aspx> [Accessed 2 November 2017].

²⁴⁰ General Osteopathic Council. *Recognition of osteopathy qualifications*. [Online] Available at

<http://www.osteopathy.org.uk/training-and-registration/information-for-education-providers/> [Accessed 2 November 2017].

²⁴¹ Health and Care Professions Council. *Approval process*. [Online] Available at <http://www.hcpc-uk.org/education/processes/approval/> [Accessed 2 November 2017].

²⁴² General Pharmaceutical Council. *Approval process for education and training providers (website)*. [Online] Available at

<https://www.pharmacyregulation.org/education/approval-courses> [Accessed 2 November 2017].

potentially including undergraduate programmes run in other countries.²⁴³ This has similarities with the system which the GDC operates under although they are not able to decide which organisations are designated dental authorities which is a decision reserved to the Privy Council. As noted, there is different legal standing for dentistry and DCPs. For DCPs the course is approved not the provider.

- 4.36 The duration of the approval process is another area of difference. Whilst some regulators carry out approval over a relatively condensed period, for example the HCPC generally approves new programmes within nine months,²⁴⁴ a number of the other regulators, including the GMC, GPhC, and GDC will not grant approval/accreditation of new courses until the first cohort of students have graduated. The GOC and the NMC will grant provisional approval for new programmes until the first cohort has graduated, following which full approval will be granted provided the standards and requirements are met.
- 4.37 It should also be noted that the time taken may be dependent on the ‘readiness’ of the proposed programme submission documentation. For example, the NMC generally requires requests for an approval event at least 12 weeks before the proposed date of the event, however in practice they often have to accommodate a shorter lead in time, for example when commissioning models are in place.

Example: *The GMC aims to engage with potential new medical schools or undergraduate programmes run by existing medical schools at least two to three years before the course will start. Approval isn't granted until the GMC is happy that the standards have been met once the first cohort of students graduate, usually after four to six years.*

Following an application from a new medical school, if the GMC decides that the new school is on track to meet standards, it will enter the quality assurance review, a process of annual visits from GMC visitors and staff will begin. The aim is to assess whether the new school is meeting the GMC standards for medical education and training.

Once the first cohort of students has graduated, if the provider has been successful in meeting the requirements of the standards, then the institution will be added to the GMC list of bodies entitled to award a UK medical degree.

- 4.38 As part of the approval process most regulators will request information from the education provider in advance to demonstrate how the course they wish to run meets the regulator's standards of education and to demonstrate how students completing the relevant programme will meet the outcomes for students required. They will then carry out a visit to the institution to compare the evidence received from the education provider with information gathered on the ground from staff, students and members of the public. To carry out visits, regulators put together a

²⁴³ General Medical Council. *Approvals*. [Online] Available at <http://www.gmc-uk.org/education/approvals.asp> [Accessed 2 November 2017].

²⁴⁴ Health and Care Professions Council. *Approval process: Supplementary information for education providers*. [Online] Available at <http://www.hcpc-uk.org/education/processes/approval/> [Accessed 2 November 2017].

panel usually including individuals with academic expertise of the qualification being approved, lay members and sometimes current registrants in the profession.

- 4.39 The size and composition of visitor panels varies widely. The HCPC has three visitors on their panels, accompanied by a member of staff. The GDC in general has panels of around four to five visitors/inspectors for the dentistry programmes, accompanied by a relevant member of GDC staff,²⁴⁵ whereas GMC visit panels can include up to eight people, depending on the size of the institution under review. The HCPC's legislation requires the inclusion of a registrant, and it also chooses to include someone with academic expertise on all visit panels.

Example: *The accreditation or recognition of pharmacy qualifications and/or providers is undertaken by an accreditation team drawn from the GPhC's accreditation and recognition panel.*

The size and composition of the team varies depending on the type of course being approved but generally includes qualified professionals e.g. pharmacist or pharmacy technician, those with academic expertise and includes recently registered members of the pharmacy team to ensure a viewpoint from the perspective of someone who has recently gone through the education system. It also includes lay members who represent the views of patients and the public.

- 4.40 The average length of approval visits also varies from one regulator to another but averages around two days. This is subject to a range of factors and, along with panel size, is not always down to the complexity of the process alone. Depending on the composition of the course in question, it may be necessary for the visit panel to observe exams or practical assessments and this may have an impact on when visits are held or the length of the visit. Although there is variation between regulators on the type of panel and length of visit, this also depends on the scale or complexity of the visit, for example a wider range of expertise may be needed when reviewing more than one course or a larger institution.

Example: *Where possible or where requested by education institutions in line with their own academic regulations the NMC seeks to carry out re-approval of multiple courses. For example, pre-registration nursing and midwifery courses may wish to be assessed at the same time to demonstrate the inter-professional aspects of their curricular design.*

Where this occurs, this may involve longer visits and larger panels with a more diverse range of expertise to ensure specialist knowledge of all the courses under review. This may also be the case where joint visits are carried out e.g. for programmes that are seeking approval with more than one regulator – for example non-medical prescribing programmes.

²⁴⁵ General Dental Council. *Quality Assurance Process BDS - A guide for providers of education and training programmes of dental students*. Available at <https://gdc-uk.org/professionals/education> [Accessed 2 November 2017].

Example: The HCPC works closely with the professional bodies for each of the professions that it regulates through its quality assurance processes. Whilst the HCPC is responsible for ensuring that those graduating from approved courses are fit and eligible to join the register, professional bodies take more of a development and improvement role. This can include setting curriculum guidance and frameworks which may go beyond the HCPC's threshold standards and include new areas of practice as well as examples and expectations of best practice.

The HCPC standards of education and training aim to tie in with the frameworks and documentation produced by the profession and may require education providers to declare how they fit in with any other frameworks or curriculum guidance. Whilst the regulator has the role of officially approving the course, a professional body may also accredit the course as being in line with their requirements.

Ongoing monitoring and re-approval

- 4.41 Following approval of a provider or undergraduate course, the regulators have a range of different processes to monitor ongoing compliance with the standards and ensure that students qualifying from the relevant courses continue to achieve the necessary outcomes for students to join the register.
- 4.42 The majority of regulators currently carry out re-approval of approved courses or institutions either to a fixed or flexible timetable. The periods for re-approval vary with the NMC,²⁴⁶ the GPhC²⁴⁷ and the PSNI reaccrediting courses every six years (for the MPharm degree, other pharmacy courses every three years) and re-approval every five years for the GOsC unless it is a new course, or there is a particular concern in which case it can be a shorter period.²⁴⁸ The NMC will permit one year deferral of re-approval for valid reasons or may delay if there is any change due to the standards which would require reassessment of curricula.²⁴⁹ The HCPC provides open ended approval²⁵⁰ and the GCC is moving to an open-ended approval system for existing programmes. This is also an option which the GOsC is exploring. The HCPC carries out visits to institutions based on any issues or concerns arising from their scrutiny of annual monitoring reports submitted, or through issues identified through their major change and concerns processes.²⁵¹ They can suspend or withdraw approval if they are

²⁴⁶ Nursing and Midwifery Council. *Quality assurance of education*. [Online] Available at <https://www.nmc.org.uk/education/our-role-in-education/> [Accessed 2 November 2017].

²⁴⁷ General Pharmaceutical Council. *Approval process for education and training providers*. [Online] Available at <https://www.pharmacyregulation.org/education/approval-courses> [Accessed 2 November 2017].

²⁴⁸ General Osteopathic Council. *Policy Advisory Committee papers, 9 March 2017 - Quality assurance review*. Available at <http://www.osteopathy.org.uk/news-and-resources/document-library/about-the-gosc/pac-march-2017-item-5-quality-assurance-review/?preview=true> [Accessed 2 November 2017].

²⁴⁹ http://www.nmc.mottmac.com/Portals/0/Rebranding%20documents_March%202017/QA_Handbook_A4%20version_2016-17_rebranded_Final.pdf?ver=2017-03-31-085124-287 [Accessed 2 November 2017].

²⁵⁰ Health and Care Professions Council. *Approval process*. [Online] Available at <http://www.hcpc-uk.org/education/processes/approval/> [Accessed 2 November 2017].

²⁵¹ Health and Care Professions Council. *Major change process*. Available at <http://www.hcpc-uk.org/education/processes/majorchange/> *Raising a concern about an approved education and training*

concerned that a course is no longer meeting the relevant standards or there is a risk to patient safety.²⁵² The GDC is required under their legislation to offer open-ended approval to dentistry programmes and have adopted the same approach for DCP programmes. They carry out inspections every five to six years and can remove approval if they have serious concerns on petition the Privy Council to do so where necessary.

- 4.43 All regulators require institutions to submit an annual paper based monitoring report. This is intended to provide an update on how the course is being delivered against the regulator's standards, and provide any supporting evidence along with information about any relevant changes. Evidence and information submitted may include documentation from internal quality assurance processes and any external examiners reports along with the institution's response to these reports.
- 4.44 Outside of visits carried out for approval or re-approval purposes the regulators have varied patterns of visits to monitor institutions and courses. In between their six yearly approval visits, the GPhC and the PSNI carry out interim three yearly monitoring visits to check up on delivery of the course and talk to students and patient groups involved in the design and/or delivery of courses. Both the GMC and the NMC carry out a schedule of thematic and regional visits to educational institutions and healthcare providers that deliver education and training and also carry out risk-based monitoring visits to those where issues of concern have been identified through monitoring.

Example: Thematic and regional reviews

The GMC carries out cyclical reviews of medical education institutions on a regional basis. This means that it visits all medical schools in a particular geographic area as well as the organisations responsible for postgraduate training and some NHS trusts or boards which provide training in a region. The aim of a regional review is to pick up on key challenges for medical education and training institutions across the region as a whole. Visits to each organisation will aim to identify and share good practice as well as identifying and managing areas of risk.

Alongside regional reviews, the GMC also carries out thematic reviews including of medical specialties, risk based checks and reviews based on areas requiring further exploration such as bullying and undermining in medical education and training.

The NMC and GOsC have also made use of thematic reviews. The NMC asks accredited institutions to report on key themes and publish their findings on specific themes in their annual report. The GOsC has carried out a thematic review relating to professional boundaries as part of their quality assurance process and have made the recommendations available to

programme. [Online] Available at <http://www.hcpc-uk.org/education/processes/concerns/> [Accessed 2 November 2017].

²⁵² Health and Care Professions Council. *Approval process: Supplementary information for education providers.* [Online] Available at <http://www.hcpc-uk.org/education/processes/approval/> [Accessed 2 November 2017].

osteopathic education institutions to enable sharing of good practice.

Assuring the competence of non-UK students

- 4.45 Under the Mutual Recognition of Professional Qualifications Directive (MRPQ), the UK automatically recognises equivalent qualifications from the EEA/EU/Switzerland for nurses, midwives, doctors (including general practitioners and specialists), dental practitioners and pharmacists wishing to come and practise in the UK. This means that beyond English language checks permitted for doctors, nurses, dentists and pharmacists, regulators are unable to implement any additional initial training requirements for EEA professionals from these groups. All other health and care professionals fall under a separate provision which enables those qualifying in the EU/EEA/Switzerland to have evidence of their qualifications, training and experience taken into account for registration in the relevant profession. In this case, where there is a substantial difference between training and experience and UK standards, compensation measures (which could include a period of adaptation, for example) may be required.
- 4.46 For professionals wishing to join the register from countries outside of the EU/EEA, the regulators have a range of approaches to assuring the competence of applicants. Some regulators like the NMC require professionals trained outside the EU/EEA to take a test of competence which includes both a written element and a structured clinical examination.²⁵³ Others, such as the GPhC, carry out quality assurance of Overseas Pharmacist Assessment programmes (OSPAP) designed to ensure that those who have qualified overseas receive the appropriate education and training to prepare them for UK practice and entry to pre-registration training. All providers are universities already accredited to deliver the MPharm degree. With a view to avoiding duplication, the PSNI cooperates with the GPhC in this area and make use of their system of accreditation for overseas pharmacists.²⁵⁴
- 4.47 The HCPC runs separate processes for EU/EEA and international applicants which generally means that applicants are assessed on a case by case basis and may be required to undertake further training or workplace experience before being admitted to the register. Where appropriate to do so, they also run tests of competence as part of the applications process.²⁵⁵
- 4.48 The GMC has a range of different routes for international medical graduates (IMGs) to become registered and gain a licence to practise in the UK. These include taking a test to demonstrate that they have the necessary skills and knowledge, providing evidence of an acceptable postgraduate qualification abroad or receiving assurance from a UK sponsoring body that they possess the

²⁵³ Nursing and Midwifery Council. *Trained outside the EU/EEA*. [Online] Available at <https://www.nmc.org.uk/registration/joining-the-register/trained-outside-the-eueea/> [Accessed 16 May 2017].

²⁵⁴ General Pharmaceutical Council. *Overseas pharmacists' assessment programme*. [Online] Available at <https://www.pharmacyregulation.org/education/pharmacist/overseas-pharmacists-assessment-programme> [Accessed 2 November 2017].

²⁵⁵ Health and Care Professions Council, International. [Online] Available at <http://www.hcpc-uk.org/apply/international/>, <http://www.hcpc-uk.org/apply/emr/> [Accessed 27 October 2017].

knowledge, skills and experience for practising as a fully registered medical practitioner in the UK.²⁵⁶

Differences in legislation

- 4.49 The legislative framework which governs each regulator's involvement in education and training varies according to the piecemeal development of the legislative frameworks and the different roles fulfilled by the regulators in this area historically. There are further differences due to the way that the regulators interpret their respective legislation, for example the NMC and the HCPC have broadly the same legislative framework but have different approaches to processes followed. Variations in interpretation may be based on the specific risks related to the different professional groups each body regulates.
- 4.50 The GOsC legislation requires Privy Council approval of decisions made by the GOsC Council to approve or withdraw Recognised Qualification status from any osteopathic courses.²⁵⁷ The same is true for the GDC for dental qualifications. In contrast, GPhC legislation is more flexible and through power delegated from Council the Registrar alone can sign off approval/accreditation of qualifications, however withdrawal of approval is reserved to the GPhC Council.²⁵⁸ This is the same system that the GDC has in place for DCPs.
- 4.51 The NMC's legislation has considerable detail on the process of withdrawing approval from institutions and programmes but comparatively little on granting approval. In addition, it is relatively prescriptive on the process for appointing visitors to participate in review panel events, due to efforts when the Order was drafted which attempted to mitigate against conflicts of interest occurring.²⁵⁹
- 4.52 In relation to the cost of quality assurance activity, the GPhC is currently the only regulator which carries out cost recovery for certain quality assurance activities carried out for GB-based courses. The GPhC also has powers to recover costs of quality assurance for courses for overseas. Although the GMC carries out significant monitoring of programmes abroad run by UK medical schools that issue UK degrees, they have no specific powers to charge for this activity and also limited powers to enforce decisions on compliance with the standards as the only action would be to withdraw approval from the entire institution; this would be a major step and has never been done. This is an issue that has also arisen for the GDC and could also arise if a dental authority franchised their degree awarding powers to another institution, for example a private provider.

²⁵⁶ General Medical Council, *Registration with a licence to practise for international medical graduates*. [Online] Available at http://www.gmc-uk.org/doctors/registration_applications/routeG.asp [Accessed 2 November 2017].

²⁵⁷ General Osteopathic Council, *Information for education providers (website)*. [Online] Available at <http://www.osteopathy.org.uk/training-and-registration/information-for-education-providers/> [Accessed 2 November 2017].

²⁵⁸ General Pharmaceutical Council. *The accreditation of foundation degrees leading to direct entry into Year 2 of an accredited MPharm degree*. Available at <https://www.pharmacyregulation.org/sites/default/files/GPhC%20Accreditation%20Methodology%20-%20UK%20MPharm%20+%20FD.pdf> [Accessed 2 November 2017].

²⁵⁹ Nursing and Midwifery Council, *The Nursing and Midwifery Order 2001 (SI 2002/253) Unofficial consolidated text*. [Online] Available at <https://www.nmc.org.uk/globalassets/sitedocuments/legislation/the-nursing-and-midwifery-order-2001-consolidated-text.pdf> [Accessed 2 November 2017].

Other variations and rationale for differences in approach

- 4.53 Alongside the differences in the structure of the regulators' processes for quality assurance of relevant courses, there are a number of other variations across the regulatory bodies. The GOsC and the NMC are the only regulators who currently contract out operational delivery of quality assurance activities to external bodies, the GOsC to the QAA²⁶⁰ and the NMC to contractor Mott McDonald.²⁶¹ In practice this means that approval and monitoring visits and most liaison with education providers is organised and carried out by the external bodies on behalf of the regulators.

Example: *The QAA has been carrying out quality assurance on behalf of the GOsC for over 10 years. Reviews of osteopathic courses and course providers, are conducted by the QAA using a panel of visitors which includes lay governance and management experts as well as osteopathic expertise.*

Visitors are appointed by the GOsC but the QAA trains individuals and plans and executes the visits and provide a report to the GOsC Education Committee with a recommendation on the granting, maintenance or renewal of Recognised Qualification status. The Education Committee may endorse the report as it is presented, add or remove conditions or make a different judgement entirely based on the panel's findings.

The recommendations of the Education Committee will go to the GOsC Council, which is required to recognise the qualification and to recommend approval to the Privy Council. The report for the programme will then be published on the GOsC's website.

- 4.54 The GPhC primarily accredits education programmes for pharmacist training which are then delivered by Universities who must meet the GPhC standards for education and training. In relation to training for pharmacy technicians, they have taken a flexible approach for the different training routes on offer. As well as accrediting certain providers to offer knowledge based training they also recognise national qualifications delivered country wide by EdExcel, City and Guilds and the Scottish Qualifications Authority (SQA). These courses are mapped to the quality credit framework and to agreed national occupational standards. This means that GPhC recognises the quality assurance activity carried out by these awarding bodies and do not directly accredit the specific providers.²⁶² The GDC has a similar approach to approval of training for DCPs.
- 4.55 As highlighted at the beginning of this chapter, it is the regulators' duty to assure the competence of those they allow onto the register. However, it is clear that the legislative framework across the regulators ensures that this is carried out in a

²⁶⁰ Quality Assurance Agency. *General Osteopathic Council Review*. [Online] Available at <http://www.qaa.ac.uk/reviews-and-reports/how-we-review-higher-education/general-osteopathic-council-review> [Accessed 2 November 2017].

²⁶¹ Mott McDonald website. [Online] Available at <http://www.nmc.mottmac.com/> [Accessed 2 November 2017].

²⁶² General Pharmaceutical Council. *Approval process for education and training providers*. [Online] Available at <https://www.pharmacyregulation.org/education/approval-courses> [Accessed 2 November 2017].

specific way which is reflected by the processes in place across the regulators which have broad similarities as well as differences.

- 4.56 With reference to the variation in approach across the regulatory bodies, whilst this is often driven by differences in legislation, it is also related to the range of professions that are regulated and the different risks associated with practice. It would be helpful to establish where key differences are related to the risks of different professions or legislative or historic variation. Regulation being proportionate to risk is a key element of right-touch regulation and therefore must be a key consideration in any approach to assuring education and training.

Progress made since 2009

- 4.57 In 2008, we were commissioned by the Department of Health to provide advice on the approaches to quality assurance of undergraduate education and training taken by the health professional regulators. In the report produced and published in 2009 we reached several conclusions and recommendations which included:
- Different approaches are inevitable given the current legislative framework for healthcare professional regulation
 - As programmes are subject to scrutiny by the different agencies, including the NHS, greater clarity and understanding is needed about their respective roles, including regulatory bodies
 - All regulators must be willing and able to demonstrate how their processes link proportionately to patient safety and public protection, maintaining the focus on being fit to join the register. Demonstrating the contribution of quality assurance to the main duty to protect the public would be valuable, both in continuing improvements in education and in assuring the public of the competency of newly qualified healthcare professionals.²⁶³
- 4.58 We also highlighted some key characteristics of good practice. Whilst these primarily related to quality assurance of undergraduate education, they have wider relevance and our conclusions, recommendations and findings from the 2009 report helped to inform changes to our *Standards of Good Regulation* in relation to education and training. We are aware that a number of the regulators have made significant changes to their processes in the intervening period or are currently reviewing their approach to education and training. It therefore seemed sensible to review developments made during this time, under the areas identified in our previous report.
- 4.59 The Authority's performance reviews carried out since 2009 have provided information on some of the changes that have taken place and we have had helpful conversations with those involved in quality assurance at the regulators. We have also referred to published materials on the regulatory bodies' websites including consultation documents, press releases, revised standards, quality assurance framework documents, guidance and monitoring and thematic reports.
- 4.60 This section is not an exhaustive list of all the changes made by the different regulators but to illustrate progress in certain areas and highlights significant change and good practice in the area of quality assurance. The characteristics of good practice are highlighted in grey, followed by examples of where changes have occurred.

Builds on other quality assurance activities, including the processes adopted internally by the education provider, and other external interests to

²⁶³ Professional Standards Authority, 2009. *Quality assurance of undergraduate education by the healthcare professional regulators*. Available at <http://www.professionalstandards.org.uk/docs/default-source/publications/advice-to-ministers/quality-assurance-of-undergraduate-education-2009.pdf> [Accessed 2 November 2017].

minimise impact, and works to coordinate visits with other bodies with an interest wherever possible

- 4.61 One of the key areas identified in relation to the regulators' role in education and training was the potential for duplication with the other agencies and organisations active in this area. Whilst the regulators have a specific remit to ensure public safety and ensure that those qualifying from approved courses are fit to join the register, as highlighted in 4.24-4.27 there are many others who also set requirements for, and collect, data and information from education and training providers. These include amongst others, external examiners, the Quality Assurance Agency and also professional bodies who may have an interest in the content or delivery of courses. Education providers will also have their own internal quality assurance processes.
- 4.62 Following concerns that the large number of bodies involved in the regulation of health and care programmes could be a burden on some education providers, there have been a range of developments in this area with the majority of regulators reviewing their processes and seeking to streamline where possible. The GOC has worked with education providers to carry out joint visits as part of the internal review process where possible and to ensure that they are using other agencies' reports and action plans as evidence of compliance with standards to avoid duplication. To aid this collaboration they have agreed and implemented Memoranda of Understanding with the QAA and the Office of Qualification and Examinations Regulation to enable these organisations to share information and reports with the GOC.
- 4.63 When implementing their new standards for education, the GDC carried out workshops with educators and awarding bodies to ensure a shared understanding of the requirements of the outcomes and the timeframe for implementation and also to provide support on how to assess difficult learning outcomes and discuss how to ensure a risk based approach to QA. In their recently published discussion document on a new approach to dental regulation, *Shifting the Balance*, the GDC is proposing to review its QA methods to identify risk areas and use them to target its QA activity in 2018-19.²⁶⁴
- 4.64 Following an assessment that their previous system of quality assurance had the potential to duplicate other quality monitoring systems the NMC carried out work in 2012/13 to ensure their standards for education providers were more outcomes focused and to seek to collaborate with other regulators on approval where possible. They have more recently commissioned an independent review of their education quality assurance function, which commenced in May 2016. This will look at options for shaping the quality assurance process to meet the future challenges.²⁶⁵
- 4.65 In relation to post-graduate training, the GMC has worked to develop better engagement and cooperation with the wide range of other bodies involved in medical education, including the Royal Colleges and Faculties, and better utilise

²⁶⁴ General Dental Council, 2017. *Shifting the Balance*. Available at <https://gdc-uk.org/about/what-we-do/regulatory-reform> [Accessed 2 November 2017].

²⁶⁵ Professional Standards Authority, *Annual Review of Performance 2015/16 – Nursing and Midwifery Council*. Available at <http://www.professionalstandards.org.uk/publications/performance-review-detail/nmc-annual-review-of-performance-2015-16> [Accessed 2 November 2017].

the information they all produce. This has included the use of risk-profiling to assist with quality assurance of medical education institutions by collating risks associated with each education provider's performance that have been identified through means such as the National Training Survey, monitoring reports from Postgraduate Deans, Royal College annual specialty reports, and information shared with the GMC by individuals within or associated with the institutions themselves. It has also developed a data-sharing agreement with CQC and other healthcare service regulators to identify risks from training environments.

- 4.66 The GOsC has also carried out work to streamline their quality assurance process and reduce the burden. As part of a review of quality assurance activity, the GOsC is also looking at introducing more flexibility in visit dates to enable them to coordinate with institutions' internal assessment where possible and desirable. Currently their process is tied to a fixed re-approval timetable.
- 4.67 The HCPC worked with The British Psychological Society and The College of Social Work when those professions came onto their register to streamline and coordinate requirements, for example by creating joint mapping documents, aiming for joint approval visits, and in the case of social work, holding joint seminars for education providers in the lead up to the opening of the Register.

Actively involves and seeks perspectives of students, patients and other members of the public

- 4.68 The involvement of students, patients and members of the public in education and training is an area which has seen significant change and development in recent years. Alongside the direct involvement of patients and the public in the regulators' quality assurance visits, there has also been an increase in the requirements on education providers to actively involve patients and members of the public in the design and delivery of courses.
- 4.69 All regulators have made progress in ensuring patient and public involvement in the quality assurance process. It is now standard to include lay members on panels visiting education and training providers. The regulators have also sought to use the feedback from these visits to ensure that the criteria for providers they use are fit for purpose. For the GOsC, the annual monitoring report requires an analysis of feedback from patients, students and staff and to see this form a part of the annual quality management process of the institution.²⁶⁶
- 4.70 There has also been a renewed focus on ensuring that there are robust systems in place to allow both students and members of the public to raise concerns about institutions or courses and in publicising these mechanisms better. This can help the regulators to identify issues with the delivery of courses or potential risks to patient safety. The GMC has also developed their capability to respond quickly to concerns raised in relation to training environments to ensure they can fully ensure the safety of trainees and the patients.
- 4.71 The NMC has worked to develop good practice on service user involvement in curriculum design to support the requirements for education and training

²⁶⁶ General Osteopathic Council. Annual report template. Available at <http://www.osteopathy.org.uk/news-and-resources/document-library/about-the-gosc/pac-june-2017-item-7-quality-assurance-annual-reports-template/?preview=true> [Accessed 1 November 2017].

providers.²⁶⁷ They distributed this to all approved educational institutions to make use of and also to their reviewers attending visits so they know what evidence to request from the education provider for this standard.

- 4.72 The HCPC has also introduced a new standard making it mandatory for education and training providers to involve service users and carers in the design and delivery of courses and they now meet with groups of service users and carers at visits. They have also introduced lay visitors for all approval visits to bring a service user and carer perspective to their own decision-making and included a student and service user member on the group reviewing their standards of education and training to ensure a diversity of perspectives in the review of these standards.²⁶⁸
- 4.73 The GOC has developed a self-assessment tool for education providers to help them report on how patient perspectives are shaping the development and delivery of education and training.
- 4.74 In relation to the involvement of students and trainees in the quality assurance process, a number of the regulators have improved their systems to allow current students and trainees to raise concerns and provide feedback on their training. The GMC has led the way with their National Training Survey which now provides an invaluable source of data on the views and experiences of doctors in training and trainers across the UK, but all the regulators now seek to include trainee views in the process in a variety of ways. There has also been work to ensure that the perspective of recently qualified registrants is reflected, for example, the GPhC now includes a recently registered member of the pharmacy team on all visit panels. They also carry out pharmacist pre-registration training surveys as well as tutor surveys.

Builds from duty to protect the public that underpins all regulatory activity and this objective drives the process

- 4.75 With a number of bodies active in the quality assurance space, the need for regulators to focus on their core duty of public protection is key. One way in which this has manifested itself has been an increased focus on an outcome based approach in relation to the knowledge and skills they expect students to have when they qualify. This allows education providers flexibility over the detail of course delivery alongside compliance with any other frameworks that might be in place such as those from professional bodies, or subject benchmark statements from the QAA.
- 4.76 Whilst there remains a range amongst the regulators in relation to the amount of detail included both in outcomes for students and standards for education and training providers, the majority have taken steps to ensure their approach is more clearly focused on ensuring public protection and doesn't seek to be over

²⁶⁷ Nursing and Midwifery Council. *Supporting information for implementing NMC standards for pre-registration nursing education*. [Online] Available at <https://www.nmc.org.uk/globalassets/sitedocuments/registration/supporting-information-of-spne-20120629.pdf> [Accessed 2 November 2017].

²⁶⁸ Health and Care Professions Council. *Service user and carer involvement in education and training programmes*. [Online] Available at <http://www.hcpc-uk.co.uk/education/providers/sucinvolvement/> [Accessed 2 November 2017].

prescriptive on the content or composition of courses. Areas of development include taking a risk-based approach to monitoring to ensure that public safety issues are adequately addressed and ensuring that outcomes and criteria are closely based on standards for registered professionals to ensure consistency and a clear focus on public safety.

- 4.77 As part of their work reviewing their quality assurance system the NMC concluded that it was not sufficiently outcomes focused and activity should also should be directed more towards practice environments where students have direct contact with patients, leading to the introduction of a more targeted and risk-based approach. The NMC also took a leading role in an extraordinary review of education programmes and midwifery supervision in North Wales bringing together the relevant organisations and working collaboratively to address the problems identified to ensure public and patient safety.²⁶⁹
- 4.78 The GMC has also carried out a number of targeted reviews of emergency medicine departments when concerns were raised about conditions for trainees and taken action when required. It has also carried out work to ensure that doctors who trained overseas have a full understanding of the UK cultural context when joining the register to mitigate any risks to public protection.
- 4.79 The GDC investigated the risks to the public from newly-qualified and registered dentists and dental care professionals. Although it concluded that there was not enough evidence to support a pre-registration training period it has carried out work to address the gap in responsibility for who is supporting new registrants in the transition to independent practice.
- 4.80 The HCPC carried out a review of social work programmes following the completion of a three-year schedule of approval visits after becoming the regulator for social work in August 2012. The report focused on the outcomes reached, and how comparable they are as a profession to the others the organisation regulates using the same quality assurance approaches. This work reinforced the focus on outcomes and setting standards for public protection which are flexible enough to accommodate different models of education delivery.²⁷⁰
- 4.81 A number of the regulators have also sought to provide additional guidance to education and training providers on student fitness to practise processes and to raise awareness of the requirements for students ahead of qualification and registration.
- 4.82 Annual monitoring returns are used by all regulators to identify potential risks to public safety. Education and training providers are also required to notify the regulators of any major changes to the delivery of approved programmes which may have an impact on public safety. This information is used by the regulators to seek to identify any public protection risk and ensure that they are effectively targeting visits.

²⁶⁹ Nursing and Midwifery Council. *NMC reports on extraordinary review visit to North Wales*. [Online] Available at <https://www.nmc.org.uk/news/press-releases/2015/nmc-reports-on-extraordinary-review-visit-to-north-wales/> [Accessed 2 November 2017].

²⁷⁰ <http://www.hcpc-uk.org/assets/documents/10004ED2SocialworkinEnglandreport-FINAL.pdf> [Accessed 2 November 2017].

All processes, criteria and procedures are predetermined and publicly available, and decision-making is based on criteria that are consistently applied; reports are publicly available and narratives clearly support decisions taken and subsequent actions; all elements within quality assurance are fit for purpose and subject to review including visitor/reviewer recruitment, training and appraisal

- 4.83 The above characteristics of good practice are grouped as there is overlap in how these areas have been dealt with across the regulators and therefore the following progress updates cover all three areas.
- 4.84 A clear and transparent quality assurance process, and ensuring that reports and results from visits are clearly and prominently available are important elements in ensuring confidence in the system of quality assurance used by the regulators. This includes confidence from:
- the public, that risks are being controlled and that those joining the register are safe and fit to practise
 - from registrants, that the education and training they receive will make them competent to join the register
 - and from education providers that the requirements they must meet are justified and proportionate.
- 4.85 All regulators have information available on their quality assurance process but there remains variation in the detail provided and the level of clarity to anyone looking to understand the process. All regulators now also publish reports from quality assurance visits which is progress from 2009 when only some made these reports publicly available. However, there remains variation in the information included in these reports and the detail available, in particular the explanation of the findings and the decision taken or the conditions imposed. Some regulators also publish the responses received from the education or training provider alongside the report which is helpful in understanding the context of the reports. It is worth noting that there may be challenges for some regulators in publishing further detail on their website such as the importance of not affecting commercial competitiveness or the need for open dialogue between the regulator and an institution.
- 4.86 There have been a variety of developments aimed at ensuring that visitors/reviewers are appropriately selected and prepared for the job they undertake. The NMC, as one of the two regulators who contract out the delivery of quality assurance activity, delegates this area to their contractors, Mott McDonald, which follows the NMC's requirements.
- 4.87 The GPhC aims to use their education associates, who form the lay membership of their visit panels, on a regular basis to ensure that their knowledge and skills remain up to date and that they can provide effective input to the quality assurance process. To minimise the regulatory burden on educational establishments associated with two regulators accepting qualifications in the UK, they carry out quality assurance visits on behalf of the PSNI in GB and with the PSNI in Northern Ireland. To ensure that those education associates who participate in the Northern Ireland visits remain qualified, it also takes part in visits across GB to ensure maintenance of their overall level of experience.

- 4.88 To manage the process internally and ensure accountability, most regulators have oversight from their Education Committees some of whom are required to formally make decisions on approval of courses or removal of approved status. Others such as the GOsC are required by their legislation to seek Privy Council approval for decisions made by their Council following a recommendation from the Education Committee. A number of regulators, including the GMC and the NMC, have also established internal groups specifically to oversee the quality assurance process and ensure that it remains fit for purpose. Following revision of their standards the GDC also made use of an expert group to advise on how best to incorporate the changes into its quality assurance process. The HCPC published its revised education standards in June 2017²⁷¹ and the review involved commissioned research and convening a liaison group made up of employer, education provider and service user representatives.²⁷²

Summary reports providing analysis of trends and general findings produced on a periodic basis demonstrating the value of quality assurance and facilitating the sharing of good practice in education and training

- 4.89 The GMC introduced the use of regional and thematic reviews relatively early to identify key issues and share good practice and it also publishes an annual report *The State of Medical Education and Practice in the UK* which provides an overview of data and findings from their involvement in medical education and training. Other regulators including the HCPC, NMC, GOsC and the GDC have also begun to take this approach and produce annual, thematic, regional and summary reports to highlight key findings from their work and share good practice. The GOsC has recently published a thematic report analysis of boundaries education and training within the UK's osteopathic educational institutions²⁷³.
- 4.90 There has generally been significant progress by the regulators on sharing information gathered from the process with the education and training providers they work with, both through written reports as well as workshops, round tables and meetings. The GPhC holds a pre-meet with providers to help prepare them for the approval/re-approval process and workshops at the start of the academic year to go through the outcomes and previous learnings with them. They also carry out evaluations of all events to pick up on learnings and feedback from education and training providers on how it went and how they are managing the process.
- 4.91 In order to facilitate the sharing of best practice and learning, the GCC invites all of their education providers to meet with the Education Committee as a group

²⁷¹ Health and Care Professions Council. *Standards of education and training guidance*. Available at <http://www.hpc-uk.org/assets/documents/10001A9DStandardsofeducationandtrainingguidanceforeducationproviders.pdf> [Accessed 2 November 2017].

²⁷² Health and Care Professions Council. *Results of the consultation on revised standards of education and training and supporting guidance*. Available at <http://www.hcpc-uk.org/assets/documents/10005312Enc03-RevisedSETsandguidanceconsultationanalysis.pdf> [Accessed 2 November 2017].

²⁷³ General Osteopathic Council. *Thematic Analysis of Boundaries Education and Training*. Available at <http://www.osteopathy.org.uk/news-and-resources/research-surveys/gosc-research/boundaries/> [Accessed 2 November 2017].

and discuss their annual monitoring and any issues arising. The GOC also meets with all its education providers to get feedback on their quality assurance and accreditation processes. The HCPC delivers seminars each year across the UK to facilitate discussion and engagement with education providers across a range of topics.

Summary

- 4.92 We consider that there is evidence that the regulators have made significant progress in addressing the areas identified in our last report on quality assurance of undergraduate education. As the above themes demonstrate, there is a clear direction of travel across the regulatory bodies in seeking to build on existing activity, share data and learning effectively, involving patients, the public and students in quality assurance activity, improving clarity and transparency of processes and decision-making and undertaking regular reviews of whether processes are fit for purpose.
- 4.93 It is however clear that the changes occurring are within the confines of the existing legislative framework which shapes the approach to education and training currently taken by the regulators. This is entirely understandable and the regulators' actions must be in line with their statutory responsibilities; however, as highlighted previously, the current legislative framework is prescriptive to a greater or lesser degree across the regulators. It is worth reflecting on whether the processes that have been developed to quality assure education and training would be the same if there was more flexibility about how to assure the competence of those coming onto the register.
- 4.94 In the following sections of the chapter we have sought to highlight some of the current and emerging issues driving change in the provision of education and training. Whilst for some of these issues the direct implications for quality assurance are not yet fully clear, these changes may well require a wider evaluation of the regulators' role in education and training. We have therefore sought to take a broad view and identify challenges in addressing these issues whilst continuing to ensure that the public are sufficiently protected by ensuring the ongoing integrity of the register.

Current and future issues in education and training

- 4.95 As we have seen in the previous section, there has been considerable change across the regulators in their approaches to the quality assurance of education and training in recent years and significant progress made in streamlining and focusing regulatory approach, within the current legislative framework. These developments appear likely to continue given the range of external issues arising which will impact on the regulators' role in education and training and we are aware that a number of the regulators have recently or are currently carrying out further work.
- 4.96 For some of the regulators, decisions to review their approach in this area have been directly related to some of these external changes. For example, the NMC's review of its approach to education and training and of its quality assurance processes has been driven in part by the changing requirements on nurses and midwives who are being asked to take on more complex roles across a wider range of care settings and different responsibilities.²⁷⁴
- 4.97 Similarly, the GOC's strategic review of education has been carried out in the face of rapid technological developments which is changing the roles of optical professionals. This has led to a need to ensure that education programmes and qualifications leading to registration will provide students with the skills to adapt to new technology and meet patients' future needs.²⁷⁵
- 4.98 Others have been driven by an ongoing focus on ensuring a risk-based and proportionate approach. For example, the GDC states in *Shifting the Balance*, their recent discussion document, that the purpose of their review is to enable them to 'identify risk areas and target... quality assurance activity accordingly'.²⁷⁶ The HCPC is commissioning research on its quality assurance process as part of a review to consider the suitability of their current process to manage risk as well as explore opportunities to reduce burden and make better use of data held.²⁷⁷
- 4.99 The GOsC's proposal to remove the expiry dates from Recognised Qualification status for education providers is partly due to perceived benefits of having more flexibility to tie in with key changes to curricula or assessment or the closing or opening of clinical provision but also to allow alignment with internal quality assurance processes, where appropriate, to reduce burden on institutions.²⁷⁸

²⁷⁴ Nursing and Midwifery Council. <https://www.nmc.org.uk/education/programme-of-change-for-education/programme-change-education/> [Accessed 2 November 2017].

²⁷⁵ General Optical Council. *Education Strategic Review Call for Evidence: Preparing optical professionals for the roles of the future* <https://www.optical.org/en/get-involved/consultations/past-consultations.cfm> [Accessed 2 November 2017].

²⁷⁶ General Dental Council, 2017. *Shifting the Balance*. Available at <https://gdc-uk.org/about/what-we-do/regulatory-reform> [Accessed 2 November 2017].

²⁷⁷ HCPC reference – Education and Training Committee minutes - <http://www.hcpc-uk.org/assets/documents/10005419Enc03-Educationresearchapproachtoeducationqualityassurance.pdf> [Accessed 2 November 2017].

²⁷⁸ General Osteopathic Council. *Policy Advisory Committee - 9 March 2017 - Quality assurance review*. [Online] Available at <http://www.osteopathy.org.uk/about-us/the-organisation/meetings/policy-advisory-committee-past-papers/> [Accessed 1 November 2017].

- 4.100 The GCC cites the introduction of their new code for registrants along with issues identified with the current approach, the potential for reform of professional regulation and new training models amongst other reasons for the review of their education standards and quality assurance policies and processes. Their recent move to open ended approval for existing programmes reflects a focus on a risk-based approach and an attempt to reduce the burden on training providers.²⁷⁹
- 4.101 The GMC has made significant progress in moving to a largely decentralised approach to quality assurance with extensive use of data utilisation to strengthen ongoing monitoring and continuous interaction with those on the ground. Their recent consultation and ongoing work on a proposed Medical Licensing Assessment (MLA) for all UK and international medical graduates has been driven by a desire ‘to create a single, objective demonstration that those applying for registration with a licence to practise medicine in the UK can meet a common threshold for safe practice.’²⁸⁰ The GMC has long expressed their wish to bring EU and EEA doctors within the scope of such an assessment if the UK were to review its involvement in the Mutual Recognition of Professional Qualifications Directive.
- 4.102 However, other changes occurring in UK medical education and Government policy are also having an impact on the GMC approach in this area. This includes the Government announcement that there will be 1,500 additional medical school places each year and a new graduate entry programme in Scotland which will also increase places. There are also new medical schools being set up in the context of the changes to higher education regulation and the prospect of more being created to manage the additional number of students. The GMC believes that the MLA will help to demonstrate that doctors entering UK practice meet a common threshold, no matter where they obtained their medical degree.²⁸¹

Workforce pressures

- 4.103 The issue of workforce continues to dominate both the agenda of many organisations in the health and care sector as well as the headlines. Nurse and GP shortages present a key challenge for those involved in workforce planning in the UK, particularly in the light of ongoing uncertainty over the status of EU nationals after the UK leaves the EU.
- 4.104 This area presents a number of challenges to professional regulation. These include: possible pressure on regulators to lower standards required for registration in the face of workforce shortages; ensuring that regulation can adapt to allow the development of new roles; an increased focus on flexibility of roles, including allowing movement of students and trainees between courses; promoting flexible training opportunities and finding ways of accrediting prior experience and learning in a robust way.

²⁷⁹ General Chiropractic Council. *Education Standards*. Available at www.gcc-uk.org/education/education-standards/ [Accessed 2 November 2017].

²⁸⁰ General Medical Council. *Medical Licensing Assessment*. [Online] Available at www.gmc-uk.org/education/29000.asp [Accessed 2 November 17].

²⁸¹ General Medical Council, *Securing the licence to practise: introducing a Medical Licensing Assessment a public consultation*. Available at http://www.gmc-uk.org/MLA_consultation_document_English_writeable_distributed.pdf_69151379.pdf [Accessed 2 November 2017].

- 4.105 In relation to new roles, the recent development and debate around regulation of the Nursing Associate role²⁸² and calls for regulation of Physician Associates²⁸³ to help address the GP shortage highlight the perception that regulation is necessary to allow roles to develop. However, new roles may not fit with traditional approaches to professional regulation and may need to be broad enough in scope to meet a range of different needs and work in diverse settings. Regulators therefore face the challenge of setting learning outcomes that are high level enough to allow flexibility in professional scope, but also enable education and training providers to be clear on what they need to cover to ensure patient safety. There may also be challenges if training for new roles is delivered through different models, for example more workplace-based training and apprenticeships. Whilst more flexible routes into education and training are to be welcomed, these may require new approaches to quality assurance, which will be covered in more detail in the next section.
- 4.106 With regard to flexibility of training, a GMC flexible training review earlier in the year identified barriers to switching between specialties based on the way in which training is currently developed and organised. The GMC has therefore recently published new standards to improve the flexibility of postgraduate training which will allow doctors in training to more easily switch between specialties based on their own areas of interest or to adapt to the changing health needs of patients.²⁸⁴
- 4.107 Another pressure on those employing health and social care professionals is to ensure that their staff have the right values to undertake these roles. To this end, HEE has developed a values-based recruitment framework (values covering, for example, 'respect and dignity' and 'compassion'). There has been discussion about whether or not it is the role of the regulator to set standards in relation to entry requirements for education and training programmes. A number of the regulators are, however, focusing on entry requirements for students. If values-based recruitment exercises meet their aims, then those in training (many of whom may be learning in the workplace from the beginning of their courses) and subsequently joining the registers should have the right values for the roles.
- 4.108 It is worth noting that there remain challenges around the potential for differences between those of the patient and the practitioner that may arise in shared decision-making, an area which has been explored particularly in relation to mental health services by the Collaborating Centre for Values-Based Practice at Oxford University. However, the case law in this area, based on the Supreme Court judgment in the *Montgomery v Lanarkshire Health Board* case in March

²⁸² Health Education England. *Nursing Associate - a new support role for nursing*. [Online] Available at <https://www.hee.nhs.uk/our-work/developing-our-workforce/nursing/nursing-associate-new-support-role-nursing> [Accessed 2 November 2017].

²⁸³ Health Select Committee. Primary Care Enquiry. [Online] Available at <https://www.publications.parliament.uk/pa/cm201516/cmselect/cmhealth/408/40806.htm> [Accessed 2 November 2017].

²⁸⁴ General Medical Council. *GMC unveils new standards to boost flexibility of doctors' training*. [Online] Available at <http://www.gmc-uk.org/news/29707.asp> [Accessed 2 November 2017].

2015 makes it clear that the patient choice is key and that professionals must provide patients with the information to provide informed consent to treatment.²⁸⁵

Government policy

- 4.109 New models of training are becoming increasingly prevalent in health and care. This has partly been driven by Government policy in this area and partly by the changing shape of health and care provision. The Apprenticeship Levy, which came into force in April of this year, will allow employers²⁸⁶ who are required to contribute to the levy to access funds to spend on apprenticeship training. The first nursing apprenticeships are due to be advertised in September 2017 and apprenticeships are also being developed for other roles including nursing associate, dental technician, paramedic, social worker and biomedical scientists.
- 4.110 Apprenticeships present an opportunity to open up professional roles to new candidates including those who may be unable to take time out from work to study, and may provide a way of addressing some of the challenges in funding available for other forms of training. However, they also pose some different or heightened challenges in ensuring a safe and effective learning environment for trainees. These may include ensuring that employers meet the need for varied experience for trainees across different clinical settings, ensuring effective assessment of trainees and providing sufficient supervision. There may also be a conflict of interest as employers will want to ensure that apprentices who they are employing qualify from the training. This is a conflict which may also be reflected within educational institutions.
- 4.111 Some of these challenges apply in some degree to more traditional forms of education as they all involve practical experience. In addition, training on the job is not a new concept in health and care. Dental nursing is a profession where this has been common for some time as many choose to start as a trainee with a dental practice and work towards an approved qualification such as an NVQ or National Diploma rather than going down the route of a foundation degree. Similar challenges apply in relation to ensuring appropriate supervision and the dual role of the employer in both assessing the competence of a trainee and relying on them to fulfil a role. However, the rapid expansion of apprenticeships for a wider range of roles and in different contexts may make some of these issues more acute, in particular the availability of adequate supervision.
- 4.112 Other Government policies relevant to this area include the announcement of 1,500 new medical places in England and new medical schools to take some of these places.²⁸⁷ This will require the GMC to carry out considerable additional

²⁸⁵ The Supreme Court March 2015, *Montgomery (Appellant) v Lanarkshire Health Board (Respondent)*. Available at https://www.supremecourt.uk/decided-cases/docs/UKSC_2013_0136_PressSummary.pdf [Accessed 2 November 2017].

²⁸⁶ The Apprenticeship Levy applies to all employers with an annual pay bill of over £3 million. Non-levy paying employers will be able to share the cost of training and assessing their apprentices with government - this is called 'co-investment'. Department for Education, *Apprenticeship funding: how it will work*. [Online]. Available at <https://www.gov.uk/government/publications/apprenticeship-levy-how-it-will-work/apprenticeship-levy-how-it-will-work#pay-apprenticeship-levy> [Accessed 2 November 2017].

²⁸⁷ Up to 1,500 extra medical training places announced. [Online] Available at <https://www.gov.uk/government/news/up-to-1500-extra-medical-training-places-announced> [Accessed 2 November 2017].

quality assurance activity in approving new schools and courses which will have resource implications as well as highlighting the challenge of finding enough medical training places with sufficient supervision available.

Education across the four nations and regions of the UK

- 4.113 Education policy is devolved across the four nations of the UK and variations have begun to emerge, particularly in relation to funding. Whilst the training bursary in nursing and allied health professions is longer available in England from 2017, Scotland, Wales and Northern Ireland all retain it. The requirement for certain employers to pay the apprenticeship levy is UK wide, but, while the devolved nations will receive a proportion of the funds, they will not be required to ring-fence the money for apprenticeships. The Scottish Government has said it will put the funding towards general employment issues, and any money used on apprenticeships will be in the engineering and IT sectors, rather than in health and care. In Wales and Northern Ireland, funds may go towards other spending.²⁸⁸
- 4.114 We have highlighted later on the significant changes taking place in HEE, however it is worth noting that whilst further education has remained more uniform across the four countries, policy differences here are also starting to emerge in response to national issues and skills priorities.²⁸⁹
- 4.115 In the case of Wales, a major development is the establishment of Health Education Improvement Wales (HEIW), whose remit will be to oversee strategic workforce planning, workforce design and education commissioning for NHS Wales. HEIW will, of course, be focused on the specific demographic needs of Wales. However, some of the issues that it will be tackling are also relevant to the four countries. These include the removal of boundaries between medical and non-medical workforce planning, providing new opportunities for multi-professional approaches, widening access, raising awareness of the different roles in the NHS and opening up more flexible career pathways. The Welsh Government currently expects the body to be in place by 1 April 2018.
- 4.116 The difference in approach to the development of apprenticeship schemes across the four countries and separate bodies setting standards for the quality of environments in which health and care professionals are training, may lead to challenges for the professional regulators. As highlighted in the previous section, although the quality assurance of training in the workplace is not new to regulators, those with responsibility for apprenticeship training will need to ensure that the experience of trainees is broad enough to cover the entire curriculum and that assessment is robust and impartial. If apprenticeship schemes in England correlate with the health needs of local populations, there may be variations

²⁸⁸ Nursing and Midwifery Council. *Council Papers May 2015 - Item 5: Annex 1 - Briefing: Apprenticeship arrangements in the four countries*.p.31 [Online] Available at <https://www.nmc.org.uk/globalassets/sitedocuments/councilpapersanddocuments/council-2017/may-2017-council-papers.pdf> [Accessed 2 November 2017].

²⁸⁹ Institute for Education, 2017. *Policy and policy learning across the four countries of the UK: The case of further education and skills - An initial scoping paper*. [Online] Available at <http://www.ucl.ac.uk/ioe/departments-centres/centres/centre-for-post14-education-and-work/projects/fe-skills-four-countries-uk/pdf/fe-skills-across-uk-scoping-paper> [Accessed 2 November 2017].

between regions, as well as countries and this may also have implications for how quality assurance of education and training is carried out in the future.

- 4.117 The development of new roles in one country rather than UK-wide, such as the Nursing Associate role, may also raise issues around whether education and training can or should be delivered outside of England given the difficulty of providing appropriate placements and possible tensions over funding implications.

Focus on a proportionate risk-based approach

- 4.118 An increased focus on a proportionate, risk-based approach by the regulators is leading to changes to quality assurance processes along with other areas. There is no single driver of this change but the national profile of the better regulation principles and the need to improve regulatory efficiency are likely to have played a role. The Authority published *Right-touch regulation*²⁹⁰ in 2010 and has encouraged the use of a right-touch approach, therefore it has been positive to see these developments. As highlighted in the first half of the chapter, considerable work has been carried out to ensure that the focus of activity in this area is on assuring student suitability to join the register and that processes are focused on areas of highest risk and do not place undue burden on education and training providers.
- 4.119 A number of the regulators have carried out reviews of their standards for education and training and their learning outcomes for students to ensure a clear focus on patient safety and managing risks associated with training. Professional regulators already draw upon documentation provided by other regulators to assess the quality of education and training programmes to avoid duplicating data requests to institutions.
- 4.120 Regulators also seek to make use of other relevant frameworks and standards where appropriate – for example the NMC has recently proposed aligning with the Royal Pharmaceutical Society’s (RPS) Competency Framework for All Prescribers. Joint approvals with other regulators are also used where possible, for example the NMC and HCPC carry out joint approval for courses qualifying students as a nurse and a social worker. Others seek to align with the institutions’ internal quality assurance activity.
- 4.121 Whilst progress has been made it seems likely that the focus on this area will continue and there may be further scope to review the necessity of certain requirements placed on educational institutions, align requirements between the different bodies setting standards and reduce duplication of regulatory activity where possible.

Reforms in Higher Education

- 4.122 Alongside the developments occurring within the health and care setting, the higher education sphere is undergoing a significant period of change. The Higher

²⁹⁰ Professional Standards Authority 2015, *Right-touch regulation - revised*. Available at <http://www.professionalstandards.org.uk/what-we-do/improving-regulation/right-touch-regulation> [Accessed 2 November 2017].

Education and Research Bill²⁹¹ received Royal Assent in April and will bring into law a new body, the Office for Students (OfS). This will take on the regulatory functions of HEFCE and the Office for Fair Access (OFFA). The Act also gives the Secretary of State the powers to appoint designated bodies to carry out the quality assessment and data collection functions.

- 4.123 The powers of the OfS are yet to be confirmed through secondary legislation. However the White Paper, *Success as a Knowledge Economy: Teaching Excellence, Social Mobility and Student Choice* outlines the OfS's role to: 'form the basis of all the regulatory requirements on higher education providers, such as quality assurance, widening participation, data and information requirements'.²⁹² Additionally, the Government is currently consulting on the OfS's remit.²⁹³ It seems likely that the OfS will have a remit to consider the overall regulatory burden on the higher education sector.
- 4.124 The OfS will also take on the role, currently reserved to the Privy Council, of granting degree awarding powers through its powers to hold and maintain a register of approved higher education providers. This will require providers to meet minimum requirements of sustainability, management and corporate governance, and quality thresholds. This is largely an administrative change as in practice HEFCE and the QAA already advise the Privy Council on decisions on degree awarding powers. However, there may still be implications for the future process for the creation of new education providers, for example the new medical schools that will be required to provide the additional places pledged by Government.
- 4.125 In addition, the introduction of the Teaching Excellence Framework, which will provide subject level ratings for participating higher education providers, will bring in a new layer of assessment for participating institutions which will need to fit with existing requirements from professional regulators and other bodies with regulatory oversight.²⁹⁴
- 4.126 It will be important to continue to monitor the development of the new structures for the regulation of higher education and ensure involvement with any activities designed to rationalise the regulatory landscape in higher education and which may have implications for the regulators' role in quality assurance.

Redesigning the Higher Education information landscape

- 4.127 Another area of activity within the higher education sector is the work being done by the HESA following on from the Higher Education Data & Information

²⁹¹ Higher Education and Research Act 2017. Available at <http://www.legislation.gov.uk/ukpga/2017/29/contents/enacted/data.htm> [Accessed 2 November 2017].

²⁹² Department for Business, Innovation and Skills, 2015. *Success as a Knowledge Economy: Teaching Excellence, Social Mobility and Student Choice*. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/523396/bis-16-265-success-as-a-knowledge-economy.pdf [Accessed 2 November 2017].

²⁹³ Department for Education, 2017. *Securing student success: risk-based regulation for teaching excellence, social mobility and informed choice in higher education*. Available at <https://consult.education.gov.uk/higher-education/higher-education-regulatory-framework> [Accessed 17 November 2017].

²⁹⁴ Higher Education Funding Council. *About the TEF*. [Online]. Available at <http://www.hefce.ac.uk/lt/tef/> [Accessed 17 November 2017].

Improvement Programme (HEDIP). This work stems from the White Paper *Students at the Heart of the System* which was published under the coalition government. The paper called for the HE data and information landscape to be redesigned 'in order to arrive at a new system that meets the needs of a wider group of users; reduces the duplication that currently exists, and results in timelier and more relevant data'.²⁹⁵

4.128 Although the white paper never made it into legislation, the work continued in a number of areas to rationalise and reduce the data burden on higher education institutions with oversight from a steering group on which the GMC sits alongside HEE, UCAS, HEFCE, the Student Loans Company and Research Councils UK, as well as representatives from a number of higher education institutions. Work streams include:

- Collective governance and oversight of the data landscape, underpinned by common data principles to enable a joined-up approach to managing data requirements across the sector and minimise the scope for duplication of data requests
- Development of a standard higher education data set through developing a set of common data definitions that can be used by all those requesting or using data to make reporting more efficient and make published information more comparable
- Rationalisation of data collections through a transformed HESA collection process to address the need for higher education providers to provide the same or very similar data multiple times
- Improved data capability to increase the quality and efficiency of data processes resulting in better information and lower risk.

4.129 In relation to the first work stream, a specific output will be a code of conduct for data collectors which will require those seeking information from higher education providers to abide by the principles of good practice around data management. Whilst the code will be voluntary to sign up to, involvement may require changes in the way that regulators currently gather the information that they need. HESA intends to consult on the draft code later in the year.

4.130 The newly passed Higher Education and Research Act, provides legislative underpinning to much of the work that HESA has been doing in this area. The requirement for the appointment of a designated data body which will be required to 'have regard to the desirability of reducing the burdens on such providers relating to the collection of information'.²⁹⁶ This is therefore likely to be an area of development and ongoing monitoring of the implications for the regulators will be important.

²⁹⁵ Department for Business, Innovation and Skills, 2011. *Students at the Heart of the System*. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/32409/11-944-higher-education-students-at-heart-of-system.pdf [Accessed 2 November 2017].

²⁹⁶ *Higher Education and Research Act* 2017, S.64, C.8(b). Available at <http://www.legislation.gov.uk/ukpga/2017/29/contents/enacted/data.htm> [Accessed 2 November 2017].

Evolving roles and responsibilities

- 4.131 The first section of this chapter highlighted the wide range of bodies with regulatory influence over the higher and further education sector, ranging from the funding councils, bodies regulating student access and finance through to skills and research councils and professional bodies, as well as the statutory regulators. Quality assurance activity is therefore carried out for a range of different purposes.
- 4.132 Students qualifying from health and care programmes must meet requirements in at least three distinct areas: being deemed competent to join the professional register by the regulator, fit to join the workforce and meet the needs of an employer and adequately trained to receive the relevant qualification from the education provider. Some organisations carry out activities which span several of these areas, for example the QAA are responsible for carrying out reviews to ensure academic standards are maintained against the Quality Code but are also contracted by the GOsC to carry out their quality assurance of osteopathic educational institutions. In relation to medical education there is a historic arrangement that the QAA does not carry out reviews of medical schools but the GMC has regular engagement with them, and use its QAA reports on higher education institutions to inform the evidence base for medical schools, and QAA similarly makes use of GMC quality assurance reports. The same arrangement applies with the GDC.
- 4.133 Within higher education Professional, Statutory and Regulatory Bodies (PSRBs) are generally grouped together in relation to the requirements they place on institutions. Whilst they are broadly regarded as fulfilling an important role in relation to the independent, objective assurance that they provide, there is a large number of diverse bodies that fall within this group. A 2011 report from the Higher Education Better Regulation Group (HEBRG) highlighted around 130 PSRBs (across a range of different sectors including health) which engage most frequently with institutions and made a number of recommendations seeking to improve regulatory efficiency and reduce burden, some of which have been taken forward by HESA through the work streamlining data requirements.²⁹⁷
- 4.134 Whilst it is important to note the specific statutory role of the professional regulators amongst this wider group, it is worth highlighting that institutions may not differentiate between the requirements they face in the same way. The Law Commissions in their 2015 proposals for reform of professional regulation also highlighted the large number of bodies involved in setting standards for education and training and suggested that there was ‘considerable overlap’.²⁹⁸
- 4.135 Elsewhere, in health education commissioning, the role of HEE in ensuring high quality learning environments for all healthcare learners may have implications for roles and responsibilities in quality assurance. HEE’s role has developed

²⁹⁷ Higher Education Better Regulation Group, 2011. *Professional, statutory and regulatory bodies: an exploration of their engagement with higher education*. Available at <http://www.universitiesuk.ac.uk/policy-and-analysis/reports/Documents/2011/hebrg-professional-bodies.pdf> [Accessed 2 November 2017].

²⁹⁸ Law Commissions, 2014. *Regulation of Health Care Professionals, Regulation of Social Care Professionals in England*. Available at http://www.lawcom.gov.uk/wp-content/uploads/2015/03/lc345_regulation_of_healthcare_professionals.pdf [Accessed 2 November 2017].

since its creation in 2012 and the launch in 2016 of the single HEE Quality Framework for education and training appears to have significant crossover with elements of existing frameworks, including those of the professional regulators. HEE's remit is multi-professional and relates to training commissioned on behalf of the NHS in England, however in practice this means that there is more than one set of standards covering very similar areas which numerous training providers are subject to.

- 4.136 Other frameworks which may also overlap with other requirements include those required for the Skills for Health Quality Mark,²⁹⁹ which is administered by the National Skills Academy on behalf of Skills for Health. This accreditation for employers and training providers seeks to reward excellence and defines and endorses superior learning and training standards. The assessment involves both submission and review of documentary evidence, as well as on-site visits and stakeholder surveys, in reaching a decision on the award of the quality mark. Although a voluntary rather than a mandatory accreditation, this constitutes another set of requirements which training providers may be subject to and as with similar optional accreditations, whilst this may initially be seen as the gold standard, training providers may ultimately feel obliged to hold such a quality mark to ensure they are seen as a provider of high quality training.
- 4.137 There is also work ongoing by the regulators themselves which may add an extra layer of complexity such as the development by the GMC of a system of credentialing to recognise those working at an advanced level of practice.³⁰⁰ Credentialing would provide formal accreditation of competence in a defined area of practice. In the case of the GMC, it could be particularly relevant for doctors who work in areas of practice that are not covered by existing standards for training and in new and emerging areas of medical practice. These areas of practice would not constitute medical specialties - these are already regulated.

Reform of professional regulation

- 4.138 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.
- 4.139 The Law Commissions' 2014 proposals recommended a duty of cooperation and greater autonomy for regulators over what areas they focus on and greater flexibility to make rules in this area and how they carry out the process of assuring education and training. They highlighted the potential 'for a regulator to reduce its regulatory activity or withdraw from specific tasks, especially where the impact is marginal and other agencies are undertaking similar tasks.'³⁰¹ Whilst

²⁹⁹ Skills for Health, *Skills for Health Quality Mark – FAQs*. [Online] Available at <http://www.skillsforhealth.org.uk/news/blog/item/92-skills-for-health-quality-mark-faqs> [Accessed 2 November 2017].

³⁰⁰ General Medical Council, 2015. *Introducing regulated credentials: consultation on proposed framework*. Available out: <http://www.gmc-uk.org/education/27299.asp> [Accessed 27 October 2017].

³⁰¹ Law Commissions, 2014. *Regulation of Health Care Professionals, Regulation of Social Care Professionals in England*. Available at <http://www.lawcom.gov.uk/wp->

there would be merit to more flexibility to respond to key challenges it would also be important to ensure a consistent approach where possible with differences based on a clear assessment of risk. We note that the Conservative Party manifesto included a commitment to ‘reform medical education, including helping universities and local health systems work closer together to develop the roles and skills needed to serve patients’.

- 4.140 Whilst it is unclear what form any changes under this Government may take, and whether this will involve primary legislation, any changes to the roles or responsibilities of regulators may make changes to the current system of quality assurance necessary. For example, a move towards sharing of functions could mean consideration of a shared service for quality assurance of education and training.
- 4.141 The GMC in its 2013 review of quality assurance highlighted the option of ‘a system of pooled sovereignty which would have the effect of creating a single, multi-professional approvals framework covering both the provision of patient care and education’ although the review suggested that this was unlikely to have support or be achievable in the near future. It suggested instead that: ‘A more realisable goal would be to work towards more co-ordinated regulatory action with the aim of securing collective assurance. This may require regulators to sacrifice some independence of action and it would be important to avoid the blurring of regulatory roles and responsibilities’. The review also highlighted the Law Commissions’ recommendations and suggested that this pointed to ‘the need for a better fit between professional and systems regulation’.³⁰² The GMC has made significant progress in this area with their approach to data-sharing and cooperation with a range of partners in carrying out quality assurance activity.
- 4.142 It is worth noting that the Council of Australian Governments is currently consulting on proposals for the development of a cross-profession National Health Education Accreditation Board with profession specific Accreditation committees reporting into it. This follows concerns expressed that despite the creation of the Australian Health Practitioner Regulation Agency (AHPRA) the body which oversees registers in Australia, operating under one national piece of legislation, a complex picture remains for education and training with multiple overlapping regulators, including 14 authorities responsible for accrediting health professional education and training many other entities having accreditation functions.³⁰³

[content/uploads/2015/03/lc345_regulation_of_healthcare_professionals.pdf](#) [Accessed 2 November 2017].

³⁰² General Medical Council, 2014. *Report of the Review of Quality Assurance of Medical Education and Training*. Available at http://www.gmc-uk.org/06_Report_of_the_Review_of_Quality_Assurance_of_Medical_Education_and_Training.pdf_55154276.pdf [Accessed 27 October 2017].

³⁰³ Woods, M, 2017. *Australia’s Health Workforce: strengthening the education foundation - Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions – draft report*. Available at <http://www.coaghealthcouncil.gov.au/Portals/0/Accreditation%20Review%20Draft%20Report.pdf> [Accessed 27 October 2017].

- 4.143 Whilst the Authority does not make a firm recommendation in *Regulation rethought* about the form that quality assurance should take in the future, we do propose that there should be a more unified approach to professional standards, including a single statement of professional practice which all professionals would be required to commit to.
- 4.144 Previously the regulators have collaborated on key issues of relevance to all health professionals, for example the production of a joint statement on the duty of candour and work to include the duty of candour in all of their different sets of standards.³⁰⁴ There is also ongoing cross-regulator collaboration in this area, for example following the development of their new standards for medical education and training, the GMC has been working with the NMC which is currently reviewing standards for nurse education and training to ensure consistency of approach within healthcare teams.
- 4.145 A single statement of professional practice for all professions may suggest the need for even greater alignment over education and training outcomes across the professions, where desirable, an area we will touch on in more detail shortly.

Changes arising from the UK leaving the EU

- 4.146 Whilst the implications for professional regulation of the UK's exit from the EU are not yet clear, there is the potential for this to impact on how the regulators assure the competence of those who trained in the EU/EEA or Switzerland and seek to work in the UK. As highlighted in paragraphs 4.43-4.46 of the chapter, under the MRPQ, the UK automatically recognises equivalent EU/EEA and Swiss qualifications for nurses, midwives, doctors (including general practitioners and some specialists), dental practitioners and pharmacists wishing to come and practise in the UK. This means that only limited additional checks, such as English language checking, are carried out. Other health and care professionals fall under a separate provision which enables those qualifying in the EU/EEA/Switzerland to have evidence of their qualifications, training and experience taken into account for registration in the relevant profession.
- 4.147 The UK Government has stated its wish to ensure that professional qualifications obtained prior to the date of the UK's withdrawal from the EU continue to be recognised after the UK's exit from the EU.³⁰⁵ However, its long-term position on the MRPQ is as yet unclear, as is the European Union's, and therefore continued participation in the mutual recognition agreement as well as related initiatives such as the European Alerts system is currently under discussion as part of the negotiations. However, concerns over health and care workforce shortages following the UK's exit from the EU have received considerable media attention. Statistics from the Nursing and Midwifery Council show a significant reduction in

³⁰⁴ Chief Executives of statutory regulators. *Joint statement from the Chief Executives of statutory regulators of healthcare professionals - Openness and honesty - the professional duty of candour*. Available at http://www.gmc-uk.org/Joint_statement_on_the_professional_duty_of_candour_FINAL.pdf_58140142.pdf [Accessed 2 November 2017].

³⁰⁵ Department for Exiting the European Union, 2017. *Policy paper: The United Kingdom's Exit from the European Union - Safeguarding the Position of EU Citizens Living in the UK and UK Nationals Living in the EU*. Available at <https://www.gov.uk/government/publications/safeguarding-the-position-of-eu-citizens-in-the-uk-and-uk-nationals-in-the-eu> [Accessed 2 November 2017].

the number of EU and EEA nurses applying to work in the UK³⁰⁶ although it is unclear how much of this is attributable to the referendum result or to the introduction of English language checking for applicants early in 2016. The NMC has recently announced amendments to the English language requirements for applicants trained outside the UK.³⁰⁷ Workforce concerns are likely to be a significant factor in influencing government policy around future involvement in the MRPQ.

- 4.148 On the other hand, some of the regulators, in particular the GMC and the NMC have raised concerns about the MRPQ. They see the Directive as posing a risk to patient safety as it prevents them from considering an applicant's competence prior to registration. GMC statistics show that EEA and international medical graduates doctors are more likely than UK doctors to receive a sanction or a warning.³⁰⁸
- 4.149 The GMC and the NMC have called for the right to test all European doctors and nurses along with other overseas medical graduates following the UK's exit from the EU.³⁰⁹ For the GMC this would involve bringing EU doctors within the MLA which it is proposing for all medical graduates seeking a place on the register from the UK and abroad. Whilst the timeline for such proposals being realised is far from clear, a move towards a greater focus on pre-registration assessment for overseas and UK graduates could be a significant change for the way in which the regulators assure those who apply to join their registers.
- 4.150 If the UK does withdraw from the MRPQ, there is potential for the professional regulators to have increased control and flexibility over their standards for education and training. The current standards for pre-registration nursing education are aligned with Article 31 of the MRPQ; this includes specific requirements on programme length, content and ratio of theory to practice, and the nature of practice learning and range of experience for nursing education. On the other hand, under Article 35 of the MRPQ, training in the dental specialties is required to be a minimum of three years. Increased flexibility of training and increasing numbers of UK trained health and care staff is a key priority of Government, however this may conflict with the need to retain the MRPQ to stabilise workforce supply from the EU.

Increased focus on multi-professional and inter-professional education

- 4.151 Alongside the focus on new roles to meet workforce challenges, some of which bridge more than one professional group, there is also a growing recognition of the value of instilling a shared understanding and shared values within the

³⁰⁶ Nursing and Midwifery Council, 2017. *NMC releases new data on EU nurses and midwives*. Available at <https://www.nmc.org.uk/news/press-releases/nmc-releases-new-data-on-eu-nurses-and-midwives/> [Accessed 2 November 2017].

³⁰⁷ Nursing and Midwifery Council, 2017. *NMC to amend English language requirements for applicants trained outside the UK*. Available at <https://www.nmc.org.uk/news/news-and-updates/nmc-to-amend-english-language-requirements-for-applicants-trained-outside-the-uk/> [Accessed 30 October 2017].

³⁰⁸ General Medical Council, 2016. *The State of Medical Practice - Chapter four: Groups of doctors at higher risk of complaints and investigations*. Available at http://www.gmc-uk.org/SoMEP_2016_Chapter_four.pdf_68139310.pdf [Accessed 2 November 2017].

³⁰⁹ Health Committee, 2017. *Brexit and health and social care - Health & social care workforce*. Available at <https://www.publications.parliament.uk/pa/cm201617/cmselect/cmhealth/640/64006.htm> [Accessed 2 November 2017].

healthcare team on how to protect patients and ensure quality care through more focus on a multi-professional approach to certain areas or more inter-professional learning.

- 4.152 This is partly driven by a view that the multiple and complex challenges facing the health service today including an ageing population, an increase in chronic conditions and co-morbidity, the rising cost of health technologies and changing consumer demands and expectations which require a collaborative approach as no one profession holds the key to addressing these alone. In addition, recommendations from reviews such as those from the Francis report on the Mid-Staffordshire NHS Foundation Trust, put a great deal of emphasis on the creation of a common culture throughout the system, in relation to openness, transparency and candour.³¹⁰
- 4.153 Whilst this is not a new idea and regulators already assess team-based practice as part of their quality assurance activity, there are calls for a more coordinated approach from organisations such as the Centre for the Advancement of Inter-Professional Education (CAIPE).³¹¹ Their 2016 guidelines highlight the variations in requirements and procedures that remain between university departments internally and regulatory bodies which can obstruct opportunities for closer alignment between professional courses. It welcomes efforts made by regulatory bodies to conduct reviews jointly to allow comparisons and includes recommendations for regulators to review their approach to ensure more consistency including a more explicit focus on encouraging inter-professional learning where possible, for example through use of a common template for recording inter-professional learning identified during reviews and the use of review panel members with direct inter-professional education experience.³¹²
- 4.154 Regulators have sought to embed a focus on inter-professional learning where possible. As previously highlighted, the NMC's recently published draft standards for nurse education include a commitment to align with the Royal Pharmaceutical Society's approach to prescribing: 'As part of our commitment to inter-professional learning and in recognition of a multi-professional approach to prescribing proficiency, we have decided that in future all NMC approved prescribing programmes must deliver outcomes which meet the Royal Pharmaceutical Society's (RPS) Competency Framework for All Prescribers.'³¹³ The HCPC has now made inter-professional education a requirement within their standards of education and training: 'The programme must ensure that learners are able to learn with, and from, professionals and learners in other

³¹⁰ *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, 2013. Available at <http://webarchive.nationalarchives.gov.uk/20150407084231/http://www.midstaffspublicinquiry.com/report> [Accessed 2 November 2017].

³¹¹ The Centre for the Advancement of Interprofessional Education. <https://www.caipe.org/> [Accessed 2 November 2017].

³¹² Prepared for CAIPE by Barr, H., Ford, J., Gray, R., Helme, M. & Reeves, S. *Continuing Interprofessional Development: Guidelines 2017*. Available at <https://www.caipe.org/resources/publications/barr-h-grayr-helme-m-low-h-reeves-2016-interprofessional-education-guidelines> [Accessed 30 October 2017].

³¹³ Nursing and Midwifery Council, Council 24th May 2017, *Item 7 – Future Nurse Standards and Education Framework: Consultation*. Available at <https://www.nmc.org.uk/globalassets/sites/default/files/councilpapersanddocuments/council-2017/council-item-7-may-2017.pdf> [Accessed 30 October 2017].

professions'.³¹⁴ It is important to note that promoting interprofessional learning may be challenging for professions where training takes place outside of an NHS environment.

- 4.155 Given how important it is for those working in health and social care to have the right values to undertake the roles, HEE has developed a values-based recruitment framework (values covering, for example, 'Respect and Dignity' and 'Compassion'). There has been discussion about whether or not it is the role of the regulator to set standards in relation to entry requirements for education and training programmes. A number of the regulators are, however, focusing on entry requirements for students. If values-based recruitment exercises meet their aims, then those in training (many of whom may be learning in the workplace from the beginning of their courses) and subsequently joining the registers should have the right values for the roles.
- 4.156 Further focus on the merits of this approach in this area and the Authority's proposals for a core set of standards for health and care professionals may strengthen the case for a more integrated approach to inter-professional education on core areas and may lead to a case for greater rationalisation of quality assurance approaches as a result.

Conclusion

Challenges

- 4.157 As the previous section highlights, the future of the education and quality assurance landscape is far from clear with a range of issues that are likely to have an impact on how this area develops in the future. Whilst it is evident that the regulatory bodies are alive to these issues and have taken steps to address them through reviewing and updating their quality assurance processes where possible, a number of specific challenges remain.
- 4.158 One key area is the contradiction that may be developing for regulatory bodies who, on the one hand, should focus their work on assuring the competence of those who they allow on the register and on the other hand, are facing calls to use their regulatory levers across education and more broadly to address issues which, at least at first glance, may not appear to be directly related to public protection. These may include meeting changing workforce needs or encouraging greater inter-professional learning.
- 4.159 There is evidence to suggest that inter-professional education may have a beneficial effect in relation to improving collaborative practice and ensuring a consistent approach to patient care and safety. Therefore, challenges in this area may be around how to practically incorporate this into quality assurance processes. However, pressure to consider workforce needs may pose a conflict

³¹⁴ Health and Care Professions Council. Standard 4.9, *Standards of education and training guidance*. Available at <http://www.hpc-uk.org/assets/documents/10001A9DStandardsofeducationandtrainingguidanceforeducationproviders.pdf> [Accessed 2 November 2017].

of interest for regulators in encouraging them to consider lowering the standards required before allowing people onto the register.

- 4.160 It is interesting to note that elsewhere in the world, the AHPRA has a specific statutory responsibility to assist with workforce planning and to facilitate workforce mobility.³¹⁵ This is not the case for UK professional regulators whose statutory responsibilities are focused on standards of professional practice not with the supply of professions. However, regulators may hold data that can provide some insight into the workforce for planners and other organisations. Maintaining a balance in this area is an issue for professional regulation more broadly, however, concerns may arise if there is pressure to compromise the approach to education and training. For example, there has recently been much focus on the NMC's decision to introduce English language checking for EU/EEA nurses seeking to work in the UK which may have contributed to a decline in nurses applying for registration from the EU/EEA, an issue of concern in the face of overall nursing shortages.³¹⁶
- 4.161 Whilst these pressures come from different places and some are more aligned with the regulators' core purpose in quality assurance than others, the need to incorporate such requirements in quality assurance processes still poses a challenge to regulators seeking to be as targeted and proportionate as possible. For example, inclusion of an individual experienced in inter-professional education on review panels with a specific remit to monitor this area as part of the review process may mean a larger panel and a more complex process. These sometimes contradictory pressures are likely to continue to occur, however it will be important to have ongoing scrutiny of the different requirements which could form part of the quality assurance processes across the regulatory bodies and ensure that they are sufficiently important or relevant to statutory objectives.
- 4.162 A key question to ask when assessing where health professional regulators fit within quality assurance of education and training is, what do the professional regulators do that other regulators don't? As highlighted previously, the focus of PSRBs is seen as providing an important objective oversight of courses within higher education. Professional regulators have made efforts to reduce duplication by making use of information gathered by other bodies where possible, and aligning with internal or external quality assurance activities where practical. However, as noted through the evolving role of organisations such as HEE, the difficulty of separating other definitions of quality from patient safety considerations makes some overlap inevitable across many professions.
- 4.163 With the GMC and potentially the NMC considering the merits of a pre-registration assessment for graduates, there may need to be further review of the risk of duplication in this area. The GMC's quality assurance process for post-graduate training is very different from the other regulators' processes in this

³¹⁵ Health Practitioner Regulation National Law Act 2009. Available at <https://www.legislation.qld.gov.au/LEGISLTN/CURRENT/H/HealthPracRNA09.pdf> [Accessed 2 November 2017].

³¹⁶ The Guardian, 2017. *More nurses and midwives leaving UK profession than joining, figures reveal*. [Online] Available at <https://www.theguardian.com/society/2017/jul/03/more-nurses-and-midwives-leaving-uk-profession-than-joining-figures-reveal> [Accessed 2 November 2017].

respect, as it has already made significant progress in localising quality assurance mechanisms. However, in relation to undergraduate medical education, GMC proposals for an MLA state that it 'will supplement our existing systems for quality assurance'³¹⁷ therefore this may raise questions around whether the existing systems for quality assuring undergraduate programmes remain proportionate and appropriate.

- 4.164 Another ongoing challenge for regulators in seeking to ensure robust quality assurance of education and training environments is the dependence that certain health and care services may have on trainees. This is particularly the case for the medical profession where trainee doctors completing their foundation training often form a significant part of the workforce and also dental nurses in training. With the challenges facing the NHS, funding being under pressure and a significant strain on resources, regulators such as the GMC often have to consider the safety of both trainees and patients if hospitals do not meet the standards required.
- 4.165 Whilst the GMC does have powers to withdraw approval from training environments resulting in the removal of doctors in training, this is very much seen as a 'nuclear option' since taking doctors in training out of a hospital could potentially prevent it operating at full capacity. A recent example of a situation of this nature was in 2016 when concerns were raised about care provided at the emergency department at North Middlesex Hospital and the lack of proper support for, and supervision of, doctors in training. Following a series of improvements made by the hospital in response to conditions placed on it by the GMC working with HEE, further action to remove trainees was avoided. However, in the recent case of the Canterbury Urgent Care Centre, it was agreed that trainees should be moved from some medicine specialties at Kent and Canterbury Hospital to other sites within the trust.
- 4.166 With the rising focus on the apprenticeship model of training as a flexible and accessible route into training, there may be implications for professions where apprentices are needed to fulfil a role in a hospital or other workplace, but employers and those overseeing their training will have an additional duty of care to their welfare and safety as a trainee. There may be additional issues where trainees are based in small practices rather than large hospitals where they may feel less able to raise concerns with their employer and also in situations where the employer is a private company with additional considerations.

Future direction

- 4.167 Whilst significant progress has been made by the regulators in seeking to ensure that their approach to education and training is effective and proportionate, the landscape of quality assurance remains complex with a number of actors fulfilling distinct but sometimes overlapping responsibilities. In addition, the current legislative framework limits what the regulators can do to adapt their approach to a changing environment and new challenges. Whilst there is recognition of the importance of the role that professional regulators carry out and their specific focus on patient safety, the potential overlap identified with other quality

³¹⁷ General Medical Council, *Medical Licensing Assessment*. [Online] Available at www.gmc-uk.org/education/29000.asp [Accessed 2 November 2017].

frameworks including HEE and the development of HEIW demonstrates that there may be further scope to review approaches in certain areas. Work being carried out by HESA on rationalising the data landscape reinforces this.

- 4.168 As highlighted, the higher education landscape is going through a significant period of change at the moment with potential implications for quality assurance of education. If the Government decides to proceed with reforms to professional regulation then, along with the other challenges and issues identified, this could set the scene for a protracted period of change which is likely to pose a range of challenges to the regulators in a variety of areas, including their approach to education and training.
- 4.169 As it remains difficult to anticipate the pace or scale of any legislative changes taking place we would suggest that some of the characteristics of good practice which we identified in our 2009 report remain relevant to guide future developments in the short as well as the long term. With this in mind we have outlined a set of principles which we hope will offer some guidance both for further changes within the current framework or wider reform in this area. These are detailed in the paragraph below:
- 4.170 The approach:
- Is underpinned by a legislative framework which is based on the duty to protect the public and sufficiently flexible to allow a risk-based approach to assuring different professional groups and to meet future challenges
 - Builds on other quality assurance activities and seeks to actively review and, where appropriate, withdraw activity where other agencies can provide sufficient assurance
 - Promotes the benefits of inter-professional education and supports the development of shared values across professional groups to ensure a consistent approach to patient safety
 - Actively involves and seeks perspectives of students, patients and other members of the public in quality assurance processes and the development of training courses
 - Ensures processes, criteria and procedures are consistently applied and, along with outcomes and rationale, are publicly available and clearly explained
 - Actively encourages the sharing and use of data to ensure that education and training programmes are fit for purpose
 - Supports flexibility in training and allows development of new roles where required to address wider workforce challenges.
- 4.171 Ahead of any broader legislative change we suggest that regulators continue to consider the aims and impact of quality assurance activity in line with the principles we have laid out above. We would also suggest further exploration of the opportunities to participate in activity to share best practice and reduce duplication of data requirements on higher education institutions, for example through the work being pursued by HESA.

- 4.172 For certain professions, the professional regulator may be the only body with regulatory oversight of certain training environments and for others it may be the best placed to take the lead on regulatory oversight. We also note that further rationalisation in this area may be reliant on cooperation and data sharing with other bodies active in this space. With this in mind, we would suggest that the above principles and our observations in this chapter will be of relevance to systems regulators and others involved in any way with education and training in the health and care sector who may also wish to review their involvement with education and training providers and ensure they are not duplicating existing arrangements.
- 4.173 Looking further ahead, much will depend on the appetite and scale for wider legislative reform, however we believe that with the changes coming down the line and issues highlighted, our recommendation in *Regulation rethought* for a review of regulatory approach and responsibilities amongst the bodies involved in the quality assurance of education and training remains appropriate. However, it will be important to be alive to the changes taking place within higher education, in particular the development of the OfS and any activity that may be pursued by this body in relation to reviewing or rationalising the regulatory landscape for higher education.
- 4.174 We suggest that such an exercise could build on the findings of this chapter looking particularly at mapping the roles and specific requirements from the different bodies both in the higher and further education and health sector, including those highlighted in the table at 4.26 and considering how these interact. This could include further exploration of any other frameworks for courses produced by other bodies, where relevant and how these fit in with regulators' standards, as well as the requirements developed by bodies involved in workforce planning and commissioning education and training.
- 4.175 We need to be mindful of the range of education and training providers both in higher and further education. It is important to recognise that not all regulated professions require a degree level qualification. Different challenges that may face those training in services which are outside of the NHS and the regulatory landscape also varies in relation to the number of bodies with oversight in certain areas.
- 4.176 It would also be important to look at approaches to quality assurance of education and training in other countries, drawing on research already carried out by the regulators and others. As noted Australia is exploring the potential of developing a multi-professional system of accreditation for education and training.
- 4.177 We believe it is also necessary to consider the restrictions currently placed on the regulators by the legislative framework and review the Law Commissions' proposals for changes to make the legislation in this area simpler and more flexible. A single, simplified legislative framework would promote consistency where possible and encourage a unified approach where desirable on key areas whilst allowing the flexibility to adapt to the specific needs and risks of the profession. It would also allow a more streamlined and coordinated approach, for example, as proposed, it could allow a regulator to reduce activity or stop carrying out specific tasks where unnecessary or where other bodies are carrying

out similar activity. There is an arrangement currently in place between the GMC and the QAA whereby the QAA accepts GMC assurance for medical schools rather than carrying out any further review. It may be useful to explore lessons that could be learnt from the Primary Authority scheme which operates to simplify business interaction with local authorities.³¹⁸ In the future, there may be the potential for the development of a 'lead regulator' scheme where certain bodies take the lead in carrying out quality assurance activity for different institutions and other organisations accept assurance from the lead body rather than duplicating activity/requirements. This is also an arrangement that currently operates within higher education where HEFCE takes on the role of principal regulator for education providers which hold charitable status.

- 4.178 It will be important for any change following a review to take account of, and respond to, any wider changes which might be pursued as part of a reform agenda, with or without legislation. For example, the introduction of a shared statement of professional practice across the different professions could be pursued without the need for primary legislation. If this was to be introduced, then there would also be merit in the regulators collaborating on consistent outcomes for students to ensure that these joint values are also translated into the approach to education and training for all professionals, whilst also reflecting the specific needs of the different professions. It is worth noting the work carried out by the GMC and the NMC, which has effectively established common standards for education across nursing and medical education with profession specific variation where required. This has also enabled providers locally to start to join up quality frameworks across professions.
- 4.179 Finally, the concept of a shared multi-professional function for quality assurance across the regulators has been raised both by the Authority in *Regulation rethought* and by the GMC in its 2013 review of their quality assurance processes and also the Scottish Government in the Law Commissions' report which called for a single body to be responsible for assurance of education which would have representation from individual regulators 'a 'hub and spoke' model'.³¹⁹ This would be a much larger change, and further work would be required to establish whether such a move would be necessary or desirable, and develop an evidence base. However, it is important to be aware of these options which have been raised and explore as appropriate. We discuss our proposal for how the regulatory system should be structured in the final chapter of this report. As highlighted a multi-professional system of accreditation for education and training is currently being explored in Australia with the aim of increasing consistency, cost-effectiveness and collaboration across professions and promoting innovation to ensure that education and training supports national workforce and health priorities.

³¹⁸ The Primary Authority scheme was established by the Regulatory Enforcement and Sanctions Act 2008. It enables a business to form a partnership with a single local authority, which is called its 'primary authority' and enforcement activity including checks and inspections by other local authorities must then be in line with policies and plans agreed with the primary authority.

³¹⁹ Law Commissions, 2014. *Regulation of Health Care Professionals, Regulation of Social Care Professionals in England*. Available at http://www.lawcom.gov.uk/wp-content/uploads/2015/03/lc345_regulation_of_healthcare_professionals.pdf [Accessed 2 November 2017].

4.180 Work is ongoing within the Authority to review the *Standards of good regulation* and any learning from this chapter will feed into this project as it progresses. Ultimately, we would reiterate that we believe the professional regulators play an important role in this area and that significant progress has been made in improving quality assurance within the current structures, but that external events are likely to make further change inevitable. Any reform should take account of the principles we have laid out in this chapter and, whilst recognising that there are many stakeholders with responsibilities in this area, a new system should ideally be focused not on what has evolved either historically or organically, but consider the most right-touch approach to ensuring that those qualifying from education and training are competent to join the register.

5. Modernising registers: a review of UK health and care professional regulators' registers

Chapter summary

- 5.1 The public registers of professional regulators display all practitioners statutorily approved or qualified to practise in UK health and care. Relatedly, there are also registers of practitioners who voluntarily sign up to the register-holder's requirements.³²⁰ As such, registers are valuable tools for employers, the public and other practitioners.³²¹ They are accessible online and constantly updated to provide details of health and care practitioners across the UK. One of the regulators we oversee describes the register as a 'basis for proportionate and progressive regulation and protecting the public'.³²² Registers are an easily accessible and highly visible face of regulatory activities and although not often the subject of policy discussion, have the ability to spark debate when alterations are made. Last year, the General Medical Council's (GMC) consultation on proposed changes to the register had the largest response rate of any consultation the organisation had conducted.³²³ Meanwhile, developments such as the Department of Health's 2011 *Enabling Excellence* report and the *Health and Social Care Act of 2012* enshrined innovative role of the Professional Standards Authority (the Authority) in accrediting non-statutory registers.^{324,325}
- 5.2 We last explored the subject of registers at length in 2009 and 2010 through a mixture of consumer research and our own thinking on the issues. Since then the professional regulators' registers have developed to cater for expanding online audiences. Relatedly, the number of registers we oversee by virtue of our role has increased from nine to over 30 as a result of our new role in setting standards for organisations that hold registers of practitioners in unregulated occupations. More broadly, information-sharing has become a point of focus in UK healthcare; health and care organisations are expected now more than ever to display transparently and accessibly information for a variety of groups across the health and care economy. The likes of NHS Choices, NHS Inform, Health in

³²⁰ Voluntary registers approved by the Professional Standards Authority are known as Accredited Registers.

³²¹ The Professional Standards Authority accredits registers of health and care practitioners working in occupations not regulated by law.

³²² Pharmaceutical Society of Northern Ireland, 2016. *Annual Report and Accounts 2015-16: For the year ended 31 May 2016*, pg. 10. Available at <http://www.psnri.org.uk/wp-content/uploads/2012/10/Pharmaceutical-Society-NI-Annual-Report-Master-2015-16-16-09-16-Final-approved-by-Council.1.pdf> [Accessed 2 November 2017].

³²³ General Medical Council, 2017. *M6 – Developing the UK medical register*, pg. 1. Available at http://www.gmc-uk.org/M06_Developing_the_UK_medical_register.pdf 69417294.pdf [Accessed 2 November 2017].

³²⁴ Department of Health, 2011. *Enabling Excellence Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers*. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216580/dh_124374.pdf [Accessed 2 November 2017].

³²⁵ Health and Social Care Act, 2012. Available at <http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted> [Accessed 2 November 2017].

Wales, and Health and Social Care Online Northern Ireland are all examples of new ways in which information is being put into the public domain. As registers are primarily tools for public protection, through being accessible and easily comprehensible information sources, they may need to adapt to these trends.

5.3 This chapter provides an overview and discussion of the different ways and means that a register-holder can run a register. Some of these are in use by the regulators we oversee, such as registering non-practising practitioners, whilst other ways to run a register have not been implemented, for example the tiered register (a mixture of voluntary and mandatory information on a register entry). Our consideration of the merits and disadvantages of these tools has led us to make a number of key recommendations:

- Regulators should continue in the trajectory of keeping a pared down approach to registers. We believe only details necessary for the purposes of public protection should be on the register. If a register user wishes to find information which is unrelated to public protection, they should use other resources (such as a professional's practice's website or a directory).
- When a register-user searches for an individual who has been erased by a regulator, the individual should be immediately viewable. It is important that if a user searches for a practitioner they can clearly see if the practitioner is registered, erased or not registered. Currently, only four of the nine regulators offer this functionality.
- We recommend that the General Chiropractic Council (GCC) and the General Osteopathic Council (GOsC) should not continue to register non-practising registrants. This would require alterations to the relevant regulators' legislation.
- We consider specialist lists and registers should only be used by regulators if a potential harm to the public in the specialist practice is identified and can be mitigated by using such instruments. This applies to annotations too.
- There needs to be more consistency in the length of time sanctions are published on registers. At the moment, there is disparity between regulators in how long sanctions such as suspensions are displayed on the register.

Background and purpose

- 5.5 This chapter will explore the variations in the UK professional health and care regulators' operation of registers. It will also identify elements of best practice and areas which may require review by some or all regulators. Additionally, this chapter will review proposals and ideas for reforming registers, and assess whether they are appropriate for the regulators we oversee. In 2010, we articulated some of our thinking on registers and different proposals to improve them in *Health professional regulators' registers: Maximising their contribution to public protection and patient safety*.³²⁶ The work was informed by research we commissioned into public attitudes towards registers in 2009.³²⁷
- 5.6 For the purposes of this work, we define register as a publicly available list of practitioners held by a regulatory body, which is maintained by the regulator to reflect registrants' ongoing compliance with the regulator's requirements. This chapter considers information published by regulatory bodies on their registers.³²⁸ Although it touches on issues that have the capability of expanding beyond simply being about registers, for example student registration, it will focus on the public-facing register aspects of such issues and not on wider discussion points. In addition, some of the professional regulators we oversee run registers of locations of practice or bodies corporate: General Optical Council (GOC), General Pharmaceutical Council (GPhC), and the Pharmaceutical Society of Northern Ireland (PSNI). This chapter will be exclusively looking at register issues related to professionals and not places or companies.
- 5.7 UK health and social care professional regulators have four main functions: setting standards, maintaining the register, quality assuring higher education courses, and investigating fitness to practise allegations and taking appropriate action. The maintenance of the register is a critical part of their role to protect the public. Registers are used by employers, patients, the general public and other stakeholders for various reasons. Those reasons range from checking a registrant's qualifications to finding out if a registrant is subject to FtP conditions. There is variation in the scale of registers held by regulators, ranging from the PSNI overseeing 2,360 practitioners, to larger ones like the Nursing and Midwifery Council (NMC) which registers 692,550 individuals.³²⁹ ³³⁰ Accredited

³²⁶ Professional Standards Authority, 2010. *Health professional regulators' registers Maximising their contribution to public protection and patient safety*. Available at <http://www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/health-professional-regulators-registers-2010.pdf?sfvrsn=8> [Accessed 2 November 2017].

³²⁷ Synovate, 2009. *Review of online health professionals registers*. Professional Standards Authority. Available at <http://www.professionalstandards.org.uk/docs/default-source/publications/research-paper/review-of-online-health-professionals-registers-2009.pdf?sfvrsn=4> [Accessed 2 November 2017].

³²⁸ Regulatory bodies provide further information to employers and other entities, but this report will not examine that content.

³²⁹ Professional Standards Authority, 2017. *Annual review of performance 2015/16: Pharmaceutical Society Northern Ireland*, pg.1. Available at <http://www.professionalstandards.org.uk/docs/default-source/publications/performance-review---psni-2015-16.pdf?sfvrsn=0> [Accessed 2 November 2017].

³³⁰ Professional Standards Authority, 2016. *Annual review of performance 2015/16: Nursing and Midwifery Council*. Available at <http://www.professionalstandards.org.uk/docs/default-source/publications/performance-reviews/nmc-annual-review-of-performance-2015-16.pdf> [Accessed 2 November 2017].

registers cover approximately 80,000 practitioners working in a variety of non-statutory health and care occupations. The statutorily regulated bodies overseen by the Authority will be the major focus of this chapter. However, there is also potential learning for register-holders accredited by us, system regulators, complaints bodies, providers and other stakeholders of the wider health and care economy.

- 5.8 Over the years there have been proposals to change and improve regulators' registers. For example, in *Regulation rethought* we proposed the idea of a single register for all the regulators we oversee, on the basis that a single register would make a simpler route for the public to access information about practitioners and support multi-disciplinary working.³³¹ This is discussed in the following chapter. The GMC and the General Dental Council (GDC) have also put forward ideas to improve their registers. The former regulator recently considered bringing in a 'tiered approach', which would have made some data on the register mandatory, whilst other parts would have been voluntary; the latter has revised address details displayed for practitioners on the dental registers.
- 5.9 For the purposes of writing this chapter, information was gathered from UK health and care professional regulators' websites, comparing and contrasting the register functions and layouts. The chapter's focus and recommendations are orientated towards the nine health and care professional regulators we oversee, but there may be potential learning points for accredited registers too.
- 5.10 We have identified good practice and points of contrast in regulators beyond our remit. For example, although professional regulation of social care is a devolved matter, we have looked not just at the Health and Care Professions Council's register (HCPC) but also the corresponding regulators in Northern Ireland, Scotland and Wales.³³² We have also reviewed and included registers from beyond the UK in other countries including Australia, Finland and USA, and analysed the registers of different industries such as the legal and veterinary professions.
- 5.11 Due to the generic nature of the word 'register', there were challenges in searching for useful secondary literature on the subject. We found little secondary literature focusing on the concept of registers. However, we have assembled evidence from commentary and analysis from trade press, regulatory policy documents, think-tank reports, parliamentary documents and our own previous research.

³³¹ Professional Standards Authority, 2016, *Regulation rethought*, pg. 7. Available at <http://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/regulation-rethought.pdf?sfvrsn=10> [Accessed 2 November 2017].

³³² Northern Ireland Social Care Council, Scottish Social Services Council and Social Care Wales.

Functionality of the registers

The purposes of the register

- 5.12 The primary purpose of the register is to act as a record of practitioners who have met a regulator's standards in a defined scope of practice. An individual can apply to join the register if they have the required qualification and experience, gained either in the UK or abroad.³³³ Once on the register, registrants will have to meet continuing professional development, revalidation or other requirements to remain on the register and renew registration, for as long as they wish to practise.
- 5.13 If a practitioner fails to comply with registration requirements, they may be removed administratively, or may not be allowed to renew registration. If a complaint is raised about a practitioner, and through the fitness to practise process, a practitioner's ability to practise is found to be impaired, they may have to practise with conditions, or be suspended from the register. Another outcome is erasure or being struck off from the register. A registrant may also request voluntary removal. An up-to-date register enables a person searching the register to know if an individual is fit to practise to the minimum standards of the regulator. A further important role of the regulators is to maintain the 'integrity' of the register by identifying and prosecuting individuals practising without registration.³³⁴ Non-statutory registers accredited by us do not have this power to prosecute, and instead check to see if the watermark (provided by us, which can be used by registrants of accredited registers) is being misused by individuals not on their registers.
- 5.14 When reviewing regulatory arrangements, the Law Commissions believed 'a key aim' of registers was 'to reduce the risk posed by unqualified and/or incompetent practitioners to the public'.³³⁵ In our *Standards of Good Regulation* for statutory regulators, we make clear that a register:
- 'Assures the public that professionals are regulated and are required to meet certain standards before they are able to provide care, treatment or services to them
 - Informs the public of any limits imposed on the way a registrant is allowed to practise

³³³ Some regulators also assess good character when an individual applies for registration.

³³⁴ General Osteopathic Council, 2016. *General Osteopathic Council Annual Report and Accounts 2015-16*, pg. 11.

³³⁵ Law Commissions, 2012. *Regulation Of Health Care Professionals Regulation Of Social Care Professionals In England A Joint Consultation Paper*, pg.68. Available at http://www.lawcom.gov.uk/wp-content/uploads/2015/03/cp202_regulation_of_healthcare_professionals_consultation.pdf [Accessed 2 November 2017].

- Helps the public and others to identify and report those who practise illegally'.³³⁶
- 5.15 We also make clear in our standards for non-statutory registers accredited by us that a register holder must focus on 'promoting the health, safety and wellbeing of service users and the public and generating confidence in its register'.³³⁷
- 5.16 By finding out information about who is and is not qualified to undertake a role, a visitor to the register is able to mitigate (but not prevent) the risk of harm. In 2010, we outlined four ways in which a register contributes to public protection:
- 'Assuring the public that professionals are regulated and are required to meet certain standards
 - Helping the public and employers to identify registered professionals from those practising illegally
 - Informing the public of any limits imposed on the way a registered professional is allowed to practise
 - Providing information about special areas of practice that a professional may be qualified to work in'.³³⁸
- 5.17 However, the purposes of registers are not always clear to the public. We noted in our previous research that despite the public being 'reassured by the existence of registers', the public had 'low' awareness of registers and their purposes. There were also some misconceptions, such as that registers held patient records and that registers provided advice about health issues.³³⁹ Greater awareness of the purpose and benefits of registers are important for public protection as it means there is less chance a person may receive treatment from an unregulated individual.

Who uses registers?

- 5.18 Professional regulators' registers are used by patients, health professionals, employers and other groups. In 2014, researchers asked 3,351 visitors to the GMC's register what they identified as. The visitors were split up into the following bands:

³³⁶ Professional Standards Authority, 2016. *The Performance Review Standards: Standards of Good Regulation*. Available at <http://www.professionalstandards.org.uk/docs/default-source/publications/standards/standards-of-good-regulation.pdf?sfvrsn=4> [Accessed 2 November 2017].

³³⁷ Professional Standards Authority, 2016. *Standards for Accredited Registers*, Pg. 12. Available at <http://www.professionalstandards.org.uk/docs/default-source/publications/standards/standards-for-accredited-registers.pdf?sfvrsn=4> [Accessed 2 November 2017].

³³⁸ Professional Standards Authority, 2010. *Health professional regulators' registers Maximising their contribution to public protection and patient safety*, 2010, pg. 3. Available at <http://www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/health-professional-regulators-registers-2010.pdf?sfvrsn=8> [Accessed 2 November 2017].

³³⁹ Professional Standards Authority, 2010. *Health professional regulators' registers Maximising their contribution to public protection and patient safety*, pg. 10. Available at <http://www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/health-professional-regulators-registers-2010.pdf?sfvrsn=8> [Accessed 2 November 2017].

- Patient looking for information about a doctor(s) – 11%
- A parent/carer looking for information about a doctor(s) – 1%
- A doctor looking for information about a colleague – 18%
- A health service provider looking for information about a doctor – 21%
- A representative of a professional body looking for information about a doctor(s) – 6%
- An employee looking for information about a doctor(s) – 23%
- None of these – 19%.³⁴⁰

5.19 The results show a diversity of visitors and purposes for using the register. It is worth noting though that this data only relates to the GMC and that different regulators may have different proportions of viewing figures for the bands above. For example, professions where registrants operate largely in the private sector (rather than NHS care) could count insurers amongst register viewing figures.

5.20 In addition to professional regulators, another mode of professional assurance are performers lists. Each of the four UK countries has three national lists: Medical (GPs only), Dental and Ophthalmic performers. Each country's publicly available lists are held by their respective NHS counterparts (NHS England, NHS Scotland, NHS Wales and Health and Social Care in Northern Ireland). According to NHS England, lists 'provide an extra layer of reassurance for the public' that primary care performers are 'suitably qualified, have up to date training, have appropriate English language skills and have passed other relevant checks such as with the Disclosure and Barring Service and the NHS Litigation Authority'.³⁴¹ On page 25, we describe how differing and overlapping authorities such as in the case of the national performers list can cause confusion and the need to consider simplifying or at least clarifying the UK regulatory systems.

What do registers look like?

- 5.21 All of the registers are accessible online with options to tailor searching for a practitioner. The options differ from regulator to regulator – later in this chapter, we discuss the merits of search functions used by one or a minority of regulators.
- 5.22 There are three different approaches to holding registers. The simplest method is for a regulator to hold a single register for a given profession. Another way is a single register that is divided into different parts, like that of the HCPC, which has a part devoted to each profession it regulates. The final model involves a regulator holding multiple and separate registers. The GMC does this with its main register, the General Practitioner register and the register of specialist medical practitioners.

³⁴⁰ Trajectory, 2015. *Reviewing the LRMP: Options for Development*, General Medical Council, Pg. 19. Available at http://www.gmc-uk.org/Reviewing_the_LRMP_Options_for_Development_research_report.pdf_60686256.pdf [Accessed 2 November 2017].

³⁴¹ NHS England, National Performers List. Available at <https://www.performer.england.nhs.uk/> [Accessed 2 November 2017].

- 5.23 Of the nine regulators, only the GMC uses a licence and registration model. This means that in order to practise medicine an individual needs to be listed on the register as being both registered and holding a licence. An individual may be listed as being registered but not having a licence to practise – and in this case, they cannot practise as a doctor in the UK.
- 5.24 The register entries of practitioners are intended to contain enough detail to identify and describe a practitioner’s capacity to practise. Regulators have different specifications for public register entries, but generally include name, registration date, registration number and fitness to practise information. Appendix V at the end of this chapter shows in detail the differences between regulators.
- 5.25 In 2010 we asked members of the public what should be included on a register entry. The findings are described below:

Table 8: Public views on what should be included on a register entry

Essential information	Nice-to-have information
Full name	Areas of specialism (where applicable)
Registration number	Practice opening hours
Fitness to practise details (including brief explanation for any disciplinary actions)	Telephone numbers
Formal qualifications	Last updated date
Address of practice (so that users can be sure they are checking the right professional if several registrants share the same name).	Google maps function
	Registration expiry date. ³⁴²

- 5.26 The list above shows there is a large pool of potential information that a regulator could collect to include on the register. However, regulators must make sure that all information is accurate, and is necessary for public protection purposes. Regulators must also ensure that information presented on a register entry is clear and understandable to different users.
- 5.27 Statutory regulators have the power to hold voluntary registers of practitioners in addition to their statutorily-held registers, although at the time of writing, no regulators had yet exercised that power. In our response to the Law Commissions review, we argued that statutory regulators should not hold voluntary registers and voluntary registers should be clearly distinguishable from

³⁴² Professional Standards Authority, 2010. *Health professional regulators’ registers Maximising their contribution to public protection and patient safety*, pg. 14. Available at <http://www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/health-professional-regulators-registers-2010.pdf?sfvrsn=8> [Accessed 2 November 2017].

statutory registers.³⁴³ Although both offer levels of assurance, it is important for the public to be aware of the differences. Confusion could be avoided by an accredited register being distinctly branded. This could involve voluntary registers joining the Authority's Accredited Registers programme and display the Accredited Registers Quality Mark on the register's page.

- 5.28 Registers beyond the health and social care sector can provide interesting comparisons. For example, the Bar Standards Board (BSB) of England and Wales lists details such as 'Practising Status' (employment status), 'Registered Pupil Supervisor' and 'Authorised to conduct litigation' next to a barrister's registration entry. The BSB also has a 'Disciplinary findings' heading which says, 'There are no findings on our website in relation to this barrister' if the registrant has no disciplinary history.³⁴⁴ The regulator of UK architects, the Architects Registration Board (ARB), includes contact details like email and telephone number in a registrant's entry.³⁴⁵
- 5.29 In the United States of America, large multi-professional registers can be found in many states. They combine professions as diverse as midwives and plumbers. In addition, in Colorado, register entries may show a 'supervision' section in a registrant's entry which shows a registrant's supervisor and details.³⁴⁶ There are of course examples of multi-occupational registers in the UK too, both statutory (HCPC) and non-statutory (Academy for Healthcare Science). Unlike statutory registers, accredited registers can add occupations to their register, provided the register continues to meet the *Standards for Accredited Registers as held by the Authority*.³⁴⁷
- 5.30 An approach in the mould of a shared register can be found in Australia. The Australian Health Practitioner Regulation Agency (AHPRA) has a professional search portal prominently displayed on the its website's front page. On searching for a health practitioner (along with occupation), fitness to practise results are displayed. Unlike the Singaporean search, the register searcher is not directed to another website.³⁴⁸ Similar to the AHPRA model, Finland's National Supervisory Authority for Welfare and Health (Valvira) is a national agency operating under the Ministry of Social Affairs and Health, charged with the supervision of the

³⁴³ Law Commissions, 2012. *Regulation Of Health Care Professionals Regulation Of Social Care Professionals In England A Joint Consultation Paper*, pp.65-6. Available at http://www.lawcom.gov.uk/wp-content/uploads/2015/03/cp202_regulation_of_healthcare_professionals_consultation.pdf [Accessed 2 November 2017].

³⁴⁴ Bar Standards Board. *The Barristers' Register*. Available at <https://www.barstandardsboard.org.uk/regulatory-requirements/the-barristers'-register/> [Accessed 2 November 2017].

³⁴⁵ Architects Registration Board, *Architects' Register*. Available at <http://architects-register.org.uk/> [Accessed 2 November 2017].

³⁴⁶ Colorado Department of Regulatory Agencies. *Verify a Colorado Professional or Business License*. Available at <https://apps.colorado.gov/dora/licensing/Lookup/LicenseLookup.aspx> [Accessed 2 November 2017].

³⁴⁷ Professional Standards Authority Standards. *Our Standards*. Available at <http://www.professionalstandards.org.uk/what-we-do/accredited-registers/about-accredited-registers/our-standards> [Accessed 2 November 2017].

³⁴⁸ Australian Health Practitioner Regulation Agency. *Home*. Available at <https://www.ahpra.gov.au/> [Accessed 2 November 2017].

social and health care, alcohol and environmental health sectors. Valvira licenses 17 professions (from physicians to physiotherapists) and authorises professionals to use 13 occupational titles nationwide in Finland. Licensed and authorised professionals can be found by the public on its single register called the 'Terhikki'.³⁴⁹ In the Netherlands, the BIG-register lists more than 350,000 healthcare professionals on one register. It is administered on behalf of the Ministry of Health, Welfare and Sport by CIBG which manages other products such as a veterinary register.³⁵⁰

- 5.31 Centralised sites can direct users to search for the correct site for regulatory details about a professional. This operates in Singapore, where a page hosted by the Ministry of Health lists both healthcare establishments and healthcare professionals. A user clicks on the relevant link and is taken directly to the relevant regulator's page to search the regulator's registrants.³⁵¹ Similarly, the Federation of Health Regulatory Colleges of Ontario (OHR) webpage acts as a 'one-stop gateway' to websites of 26 healthcare regulators in the Canadian province of Ontario. One of the purposes of collecting registers on the OHR website is to service the 'public's need for easy-to-access information and resources on regulated health professionals in a single place'.³⁵² This kind of accessibility to register links in one place is similar to the 'Find a practitioner' function on our website. This functionality allows visitors to Authority's site to choose the type of practitioner they want to know more details about and then follow links to the corresponding register.³⁵³

³⁴⁹ Valvira. *Professional Practice Rights*. Available at

http://www.valvira.fi/web/en/healthcare/professional_practice_rights [Accessed 31 May 2017].

³⁵⁰ BIG-register. *About the BIG-register*. Available at <https://english.bigregister.nl/about-the-big-register> [Accessed 2 November 2017].

³⁵¹ Singapore Ministry of Health. *Medical Directory*. Available at https://www.moh.gov.sg/content/moh_web/home/medical-directory.html [Accessed 2 November 2017].

³⁵² College of Optometrists of Ontario, 2017. *Announcing the new Ontario Health Regulators website*. Available at <https://www.collegeoptom.on.ca/resources/news/announcing-the-new-ontario-health-regulators-website/> [Accessed 2 November 2017].

³⁵³ The creation of a portal to access different regulators' registers has also been explored in the UK. The GMC led a technical analysis, involving each of the health and care regulators, exploring the options for delivering a combined register portal.

Merits of the registers

5.32 This section focuses on register functions that are not used by all the UK health and care professional regulators we oversee. It includes analysis of whether these functions, unique to a few or one regulator, enhance or hinder public protection.

Search Functions

5.33 In order to find a register entry of a practitioner, a visitor to the register is required to input search terms. The criteria for searching varies by regulator. In 2010, we stated that the following criteria were useful for good searching:

Table 9: Search criteria

Essential criteria	Nice-to-have criteria
Registration number	First name
Surname	Search by area/postcode. ³⁵⁴
'Sounds like' box or softer search filtering (to accommodate spelling mistakes).	

5.34 Presently, all regulators feature 'Surname' and 'Registration number' as potential search criteria. Five of the nine regulators offer a 'sounds like' function or softer search filtering when searching (this helps to accommodate spelling mistakes and inaccuracies).

5.35 A comprehensive list of the current search functions of regulators can be found in Appendix IV. Some regulators offer additional means for tailoring searches of registrants:

- Under 'Advanced Search Options', GOsC's register users can check if a registrant conducts home visits to patients, whether a registrant's practice has disabled access, and if a registrant speaks Welsh.
- Only the GMC and the GOC offer the option of searching for a professional by gender. This may be useful for filtering results when searching for professionals with unisex names.
- Visitors to the GDC's register can search for registrants by choosing to filter results by a specific type of register (such as the Temporary Registrant Dentist register) or can select 'All Registers' to search for a registrant across all the GDC's registers. Similarly, the GMC's List of Registered

³⁵⁴ Professional Standards Authority, 2010. *Health professional regulators' registers Maximising their contribution to public protection and patient safety*, pg. 11. Available at <http://www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/health-professional-regulators-registers-2010.pdf?sfvrsn=8> [Accessed 2 November 2017].

Medical Practitioners allows users to search for practitioners only on the GP Register.

- The HCPC offers a multiple registrant search function, which it added in response to queries from employers and managers.³⁵⁵ A visitor to the HCPC register is able to search up to 100 professionals per search simply using the registrants' HCPC profession code and registration number. The GMC also has a multiple registrant search function, allowing a register visitor to search up to 10 doctors.

5.36 In our 2010 registers report, public research participants considered 'sounds like' search functionality to be an essential criterion. Five of the regulators under our remit have developed this functionality: GCC (is not an option but is automatically applied when searching), GDC, GMC, GOC and GPhC. We therefore recommend that the other four regulators look at including similar soft searching.

5.37 An interesting point of comparison is accredited registers. Accredited registers rely to a greater extent on searching by area. It is also of note that six of the 23 accredited registers offer the option to search by specialty or therapy. One also offers the option to search by language spoken, gender of therapist, the types of client therapists work with, and the types of session available.

Annotations on the register

5.38 A means for adding extra information to a register entry is by annotation. The HCPC has stated that generally, it only annotates the Register where it is 'legally required to do so or in exceptional circumstances where there is evidence that [the HCPC] can improve public protection in a specific area by annotating a qualification'.³⁵⁶ The HCPC puts this theory into practice as it annotates register entries when registrants have completed additional medicines training that allow them to supply, administer or prescribe medicines. The HCPC also makes annotations for podiatric surgery: chiropodists and podiatrists who had undertaken approved qualifications in podiatric surgery should have their register entries annotated. The HCPC considered there to be the following benefits:

- 'annotation will enable specific standards to be set for podiatric surgery training and practice
- training programmes in podiatric surgery will be approved, providing independent oversight and quality assurance
- annotating the Register will provide information to members of the public about chiropodists / podiatrists who have completed recognised, approved

³⁵⁵ Health and Care Professions Council, Multiple registrant search. Available at <http://www.hcpc-uk.co.uk/aboutregistration/theregister/multiple/> [Accessed 2 November 2017].

³⁵⁶ Health and Care Professions Council. *Policy statement on annotation of the register*, pg. 2. Available at <http://www.hpc-uk.org/Assets/documents/10003C96PolicystatementonannotationoftheRegister.pdf> [Accessed 2 November 2017].

training in this area, supporting patients to make informed choices about the services they use.³⁵⁷

- 5.39 Annotation has been by non-regulatory bodies for its ability to highlight risks to the public. Last year, the Royal College of Surgeons (RCS) called for the GMC to gain powers of annotation to mention if a registrant has been certified by the RCS. It claimed this would give its certification system for cosmetic surgery 'extra teeth and regulatory backing' if surgeons who were certified were highlighted to patients and the public.³⁵⁸
- 5.40 The GMC records information relating to doctors approved as GP trainers on their register entries believing that it would 'help to enhance the profile, standing and visibility of training as a clear statement of the importance we attach to the responsibilities of trainers'.³⁵⁹ Alongside this, the GMC publishes a separate list (on its website) of doctors approved as a GP trainer as 'it raises the profile of these doctors and emphasises the importance of good training'.³⁶⁰
- 5.41 In 2009 we wrote of the potential risks of annotation:
- 'It is important that any additional steps taken by regulatory bodies, such as annotating registers, are not seen by employers as providing all the necessary information on a professional's practice. If it were, and employers abdicated their responsibility in determining an applicant's fitness for a particular job, either wholly or in part, statutory regulation would do more to jeopardise than uphold patient safety'.³⁶¹
- 5.42 The Authority has previously endorsed the idea of using annotations but 'only in situations where a risk has been identified that is best addressed by the regulator, and there is a clear benefit in terms of public protection in publishing information about specialist practice. It must not be used simply as tool for career development or a means for the regulator to charge additional fees'.³⁶² We continue to hold this viewpoint.

³⁵⁷ Health and Care Professions Council. *Podiatric Surgery FAQs*, pg. 2. Available at <http://www.hcpc-uk.org/Assets/documents/100048E0PodiatricSurgeryFAQs.pdf> [Accessed 2 November 2017].

³⁵⁸ Royal College of Surgeons, 2016, Change in the law 'urgently needed' to protect patients undergoing cosmetic surgery. Available at <https://www.rcseng.ac.uk/news-and-events/media-centre/press-releases/rcs-calls-for-change-in-the-law-to-protect-patients-undergoing-cosmetic-surgery/> [Accessed 2 November 2017].

³⁵⁹ General Medical Council, 2012, *Recognising and approving trainers: the implementation plan*, pg. 37. Available at http://www.gmc-uk.org/Approving_trainers_implementation_plan_Aug_12.pdf_56452109.pdf [Accessed 2 November 2017].

³⁶⁰ General Medical Council, Recognition and approval of GP trainers. Available at http://www.gmc-uk.org/education/approval_trainers.asp [Accessed 2 November 2017].

³⁶¹ Council for Healthcare Regulatory Excellence, 2009. *Advanced Practice: Report to the four UK Health Departments*, pg. 10. Available at <http://www.professionalstandards.org.uk/docs/default-source/publications/advice-to-ministers/advanced-practice-2009.pdf> [Accessed 2 November 2017].

³⁶² Law Commissions, 2013. *Regulation of health care professionals Regulation of social care professionals in England Consultation Analysis*, pg. 89. Available at http://www.lawcom.gov.uk/wp-content/uploads/2015/03/lc345_regulation_of_healthcare_professionals.pdf [Accessed 2 November 2017].

Specialist lists and registers

- 5.43 To become a medical consultant, a practitioner must be on the GMC's Specialist Register.³⁶³ The GMC also holds a General Practitioner Register, on which all UK doctors working in general practice in the health service must be registered (except for doctors in training such as GP registrars).³⁶⁴ There have been proposals to unify the GP and Specialist Registers, the British Medical Association's (BMA) General Practice Committee chairman Dr Chaand Nagpaul in early 2017 said "placing GPs on the specialist register would make their expertise clearer and put them on a deserved equal footing with other specialists, such as hospital consultants".³⁶⁵ The Department of Health subsequently stated it had no plans immediate to implement the idea.³⁶⁶
- 5.44 The GDC holds specialist lists in 13 areas of dentistry, for dentists wishing to call themselves a 'specialist' in one of the 13 areas. Practitioners on these lists must comply with certain requirements and pay a fee in addition to the annual retention fee they would already pay to the GDC as a non-specialist dentist. The GDC's 2014 research found that 36% of respondents it surveyed considered it was 'very important' for the GDC to hold a separate list of specialists, and a further 46% stated that it is 'quite important'; only 8% stated that they feel it is 'not that important'.³⁶⁷ Respondents were asked 'how important do you feel it is for the GDC to have this separate list of specialists as opposed to being regulated in the same way as general dentists?' and then asked 'why do you think it is important?'. The responses to the second question were coded and are listed below:
- To confirm the ability of the dentist and their qualifications – 15%
 - It's important information – 13%
 - For public research – 9%
 - It maintains high standards – 5%
 - Because they offer different services – 5%
 - To improve confidence – 4%
 - To highlight the difference between qualified dentists – 4%
 - For health and safety purposes – 3%
 - Other – 1%

³⁶³ General Medical Council. Information on the Specialist Register. Available at http://www.gmc-uk.org/doctors/register/information_on_the_specialist_register.asp [Accessed 2 November 2017].

³⁶⁴ General Medical Council, Information on the General Practitioner (GP) Register. Available at http://www.gmc-uk.org/doctors/register/gp_register.asp [Accessed 2 November 2017].

³⁶⁵ GP Online, 2017. *GMC backs call to give GPs equal status to consultants*. Available at <http://www.gponline.com/gmc-backs-call-give-gps-equal-status-consultants/article/1422127> [Accessed 2 November 2017].

³⁶⁶ GP Online, 2017. *DH has no immediate plans to unify medical register despite GMC backing*. Available at <http://www.gponline.com/dh-no-immediate-plans-unify-medical-register-despite-gmc-backing/article/1422383> [Accessed 2 November 2017].

³⁶⁷ DJS Research, 2014. *Reviewing the Dental Specialities*, General Dental Council, pg. 6.

- Don't know – 41%³⁶⁸

- 5.45 In the same year, the GDC noted that specialist listing can act as an 'assurance' to patients and registrants that a specialist has undergone the required training and able to perform complex treatments safely. However, the GDC also noted that lists do not 'appear to help patients make informed choices about their care, although it may be helpful for referring professionals'.³⁶⁹
- 5.46 Specialist lists and registers can be perceived to be an extra mode of assurance and act as a means for the public and patients to differentiate between practitioners who are sanctioned by the regulator to practise in different areas. It can be useful for practitioners referring a patient to other practitioners to make sure they are sending their patient to an appropriate practitioner. Our view on specialist lists and registers is in accordance with our view on annotating registers: regulatory tools such as specialty lists and registers should only be applied where potential harm to the public is identified and such a tool is required to mitigate risk; they should not be used for career progression or advertisement of credentials.

Non-practising registrants

- 5.47 Three of the regulators we oversee display non-practising registrants on their registers, this is as a result of the regulators' legislation. Non-practising registrants are practitioners who are registered with a regulator but choose not to practise. On taking on the status of a non-practising registrant, an individual is not permitted to practise by the regulator. In response to the Law Commissions' review of non-practising registrants, a 'slim majority' of respondents thought that the idea of registering non-practising practitioners should be abolished.³⁷⁰ Listed below at Table 10 are some of the reasons given by the three statutory regulators for featuring non-practising registrants on their registers.

³⁶⁸ DJS Research, 2014. *Reviewing the Dental Specialities*. General Dental Council, pg. 39.

³⁶⁹ General Dental Council, 2014. *Item 4 Council September 2014 Reviewing the Regulation of the Specialities*, pg. 16.

³⁷⁰ Law Commissions, 2014. *Regulation of Health Care Professionals Regulation of Social Care Professionals in England*, pg. 63. Available at http://www.lawcom.gov.uk/wp-content/uploads/2015/03/lc345_regulation_of_healthcare_professionals.pdf [Accessed 2 November 2017].

Table 10: Reasons for appearing on non-practising registers

Regulator	Reasons for being a non-practising registrant
General Chiropractic Council	A period of illness Maternity/paternity Full-time education Sabbatical. ^{371,372}
General Medical Council ³⁷³	Allows doctors to show to employers, overseas regulators and others that they remain in good standing with the GMC An acknowledgement that the doctor’s primary medical qualification allowed them to gain entry to the medical register in the UK ³⁷⁴
General Osteopathic Council	Maternity/paternity Sabbatical Travelling Health Other. ³⁷⁵

5.48 The GMC’s view that registration can be a mark of good standing is shared by Baroness Gardener of Parkes, who criticised the absence of non-practising dentists from the GDC register: “There is a public interest in non-practising dentists remaining on the list, as many non-practising dentists continue to work on boards, trusts, charities and other bodies, public and private. If they claim to

³⁷¹ General Chiropractic Council, *The non-practising registration fee*. Available at <https://www.gcc-uk.org/registration/information-for-chiropractors-who-are-on-the-register/non-practising.aspx> [Accessed 2 November 2017].

³⁷² The General Chiropractic Council has a more comprehensive breakdown reasons (14) given for the 272 registrants that pay the non-practising fee in 2016. 75% joined the non-practising list because they were working overseas or taking a career break for maternity or child care reasons. It is available on page 23 at <http://www.gcc-uk.org/UserFiles/Docs/Registrations/Report%20on%20the%202016%20registration%20year.pdf> [Accessed 2 November 2017].

³⁷³ Of the nine regulators we oversee, the General Medical Council has a unique model of registration and licences. This means that in order for an individual to practise they need to be both registered and licensed. This also means an individual can be registered but not allowed to practise as they do not have a licence.

³⁷⁴ General Medical Council. *Frequently asked questions about licensing*. Available at http://www.gmc-uk.org/doctors/licensing/faq_licence_to_practise.asp [Accessed 2 November 2017].

³⁷⁵ General Osteopathic Council, 2014. *Registration non-practising form*. Available at <http://www.osteopathy.org.uk/news-and-resources/document-library/registration/registration-non-practising-form/> [Accessed 2 November 2017].

have been dentists with an honourable record, it should be verifiable”.³⁷⁶ Interestingly, although the GCC has non-practising registrants it does not agree with the idea of individuals becoming non-practising registrants if they do not intend to return to practice in the UK. The GCC explains that as its role is to protect UK patients and the public, there is no purpose to remaining registered of an individual is not practising.³⁷⁷ Additionally, a non-practising practitioner registered with the GCC, GMC and GOSc can be subject to fitness to practise proceedings if they are found to be practising.

- 5.49 Two of the regulators in the table above (GCC and GOSc) allow non-practising professionals on their registers for ‘maternity/paternity’ reasons. In contrast, the HCPC (which does not have a non-practising list) allows registrants to take a break from practice of up to two years but remain on the register. A registrant will need to have practised their profession at least once in that period to ensure HCPC renewal at the end of the two years. The HCPC recommends practitioners should leave the register if they have not practised for more than two years (and then re-apply to the register when they wish to work again).³⁷⁸ Meanwhile, the GPhC allows registrants on maternity leave 12 months during which they do not have to meet CPD requirements, despite being registered.³⁷⁹ The PSNI has the power to allow registrants on maternity leave for a period to remain registered during which they do not have to meet CPD requirements.
- 5.50 Other forms of non-practising registration include the Royal College of Veterinary Surgeons’ registration category of ‘Non Practising 70+’ for a ‘veterinary surgeon who is not practising or engaging in any veterinary activity, which in the opinion of Council is veterinary related, anywhere in the world and is aged 70 years or over’.³⁸⁰ Teachers in Scotland wishing to retire but remain on the register of the General Teaching Council for Scotland (GTCS) can assume associate membership. This only involves updating details annually on the register and adhering to the values in the GTCS’ standards.³⁸¹
- 5.51 A final rationale for registering a non-practising individual is to cover claims made after a practitioner’s full membership and insurance has lapsed. This is how an

³⁷⁶ House of Lords, 2008, Hansard. Available at <https://www.publications.parliament.uk/pa/ld200708/ldhansrd/text/80325-0013.htm> [Accessed 2 November 2017].

³⁷⁷ General Chiropractic Council. *The non-practising registration fee*. Available at <https://www.gcc-uk.org/registration/information-for-chiropractors-who-are-on-the-register/non-practising.aspx> [Accessed 2 November 2017].

³⁷⁸ Health and Care Professions Council. CPD FAQs. Available at <http://www.hpc-uk.org/registrants/cpd/faqs/> [Accessed 8 May 2017].

³⁷⁹ General Pharmaceutical Council. *I am shortly going on maternity leave, what will happen with my registration?* Available at <https://www.pharmacyregulation.org/content/i-am-shortly-going-maternity-leave-what-will-happen-my-registration> [Accessed 2 November 2017].

³⁸⁰ Royal College of Veterinary Surgeons. *Registration Categories*. Available at <http://www.rcvs.org.uk/registration/check-the-register/register-categories/> [Accessed 8 May 2017].

³⁸¹ General Teaching Council for Scotland. *Professional Update For Retired Teachers And Retired Teachers Engaging In Supply Work*. Available at <http://www.gtcs.org.uk/professional-update/professional-context/retired-teachers-and-supply-work.aspx> [Accessed 2 November 2017].

accredited register, the British Association of Sport Rehabilitators and Trainers, views the purpose of its 'Non-practising Graduate' membership.³⁸²

- 5.52 Except for the three regulators in the table above, no other statutory health and care professional regulators have non-practising registers. The GPhC explains its rationale as follows: its role is only to 'register those who are appropriately qualified, fit to practise and have met continuing professional development requirements'. It goes on to suggest that 'pharmacists and former pharmacists who do not wish to register with the GPhC could nevertheless join the professional leadership body'.³⁸³ We responded to the Law Commissions' review of regulation in 2013 that registering non-practising individuals was "a relic of professional self-regulation" and "only benefiting registrants who wish to retain their 'status' as professionals beyond their practising careers".³⁸⁴ Our view has not changed since then, and we echo the GPhC's statement above as well as the Law Commissions' view that 'the registration of non-practitioners can serve to undermine the main purpose of the registers, which is to indicate which professionals are fit to practise and continue to meet the regulators' standards'. Although the Law Commissions argued that there were limited circumstances where non-practising registers could be of use and proposed 'restricted' use of the tool, we believe that there is no place for this register function.³⁸⁵
- 5.53 One of those limited circumstances for the use of non-practising registers is by the GMC. Doctors require both registration and a license in order to practise. It is possible for a doctor to be a non-practising registrant by being registered but without a license. Licensing is a key part of the GMC's revalidation process to check doctors are fit to practise.³⁸⁶ It is also used when the GMC deals with indemnity or insurance issues (the license can be withdrawn from doctors without the appropriate insurance or indemnity in place). Therefore, there will be some individuals who may logically become non-practising registrants as an outcome of that process.
- 5.54 We do not support regulators registering non-practising individuals: this serves a purpose beyond the regulator's primary role of protecting the public. This would require a change of legislation to implement. We note though that the GCC and

³⁸² British Association of Sport Rehabilitators and Trainers. *Types of Membership*. Available at <https://www.basrat.org/home/typesofmembership> [Accessed 2 November 2017].

³⁸³ General Pharmaceutical Council. *Why are there no provisions for a non-practising register?*. Available at <https://www.pharmacyregulation.org/content/why-are-there-no-provisions-non-practising-register> [Accessed 2 November 2017].

³⁸⁴ Law Commissions, 2013. *Regulation of health care professionals Regulation of social care professionals in England Consultation Analysis*, pg. 69. Available at http://www.lawcom.gov.uk/wp-content/uploads/2015/03/cp202_regulation_of_healthcare_professionals_analysis-of-responses_complete.pdf [Accessed 2 November 2017].

³⁸⁵ Law Commissions, 2014, *Regulation of Health Care Professionals Regulation of Social Care Professionals in England*, pg. 64. Available at http://www.lawcom.gov.uk/wp-content/uploads/2015/03/lc345_regulation_of_healthcare_professionals.pdf [Accessed 2 November 2017].

³⁸⁶ UK Government, 2009. *Explanatory Memorandum to the General Medical Council (Licence To Practise) Regulations Order Of Council 2009*, Pg. 2. Available at http://www.legislation.gov.uk/ukxi/2009/2739/pdfs/ukxiem_20092739_en.pdf [Accessed 2 November 2017].

GOCs use non-practising status for issues like maternity, when there are often more appropriate tools at regulators' disposal (as mentioned in 5.47). However, we recognise that the GMC's licensing structure makes its use of non-practising status necessary.

Provisional registration

- 5.55 Provisional registration involves an individual being conditionally registered prior to full registration such as when a graduate practitioner must complete a year of supervised practical work before being registered. It could be argued that student registration by the GOC is a type of provisional registration (see below for more information on student registration). Currently, only the GMC uses provisional registration. On the GMC's register, doctors who are provisionally registered have the following statement next to their name: 'Provisionally registered with a licence to practise'. Outside the health and care world, a Scottish teacher will be classified by the GTCS as 'provisional' on the GTCS register if they are provisionally registered.³⁸⁷ There may be merit to provisional registration as it transparently shows that a practitioner has not achieved registration and is acting under supervision. However, this must be clearly explained in order to differentiate from full registration.
- 5.56 It is of note that the GPhC and PSNI have systems of 'pre-registration'. Following graduation, students must complete a year of pre-registration training in a pharmacy and pass a registration examination before they can register as a pharmacist with both regulators. The students are not actually registered. Both the GPhC and PSNI hold a separate list of graduates.³⁸⁸

Student registers

- 5.57 The GOC is required by legislation to hold a compulsory student register (for as long as a student is in education) and is the only regulator we oversee to undertake this role.³⁸⁹ In social care, the Northern Ireland Social Care Council, Social Care Wales and the Scottish Social Services Council register students. In 2015/16, students comprised 18% of the GOC's registrant base. Some respondents to the Law Commissions report considered students 'much more conscious of their professional role through being registered with the regulatory body from the point of entering professional training'. As being on a register is a core function of a professional regulator, it could be argued that a register has the ability to make a student more 'conscious' of their professional role. A register offers the chance for the public to search practitioners they will have contact with and the Medical Protection Society see this as a potential use for student

³⁸⁷ General Teaching Council for Scotland. *Provisional (Conditional) Registration*. Available at <http://www.gtcs.org.uk/registration/registration-fee/cancelling-registration.aspx> [Accessed 2 November 2017].

³⁸⁸ Sometimes termed as student registration.

³⁸⁹ It is of note that social work students are regulated in Northern Ireland, Scotland and Wales.

registers 'where students have contact with the public as part of their training, registration would be appropriate'.³⁹⁰

- 5.58 The GOC noted that a detracting factor of maintaining an up-to date student register is the creation of 'some significant administrative costs for training providers, as well as for the GOC, since it is necessary to cross-check the information received from students with the enrolment records held by training providers'.³⁹¹ The Medical Defence Union also mentioned the potential for student registers to be a burden if a regulator decided to introduce a student register as a regulator would need to setup a process for removal from register for example.³⁹²
- 5.59 In accordance with the principles of right-touch regulation, we argue that any regulatory activity should balance the regulatory force and target risk. Maintaining a student register may mean unnecessary excess regulatory force by a regulator given how little risk a student may take on. Therefore, student registration is probably unnecessary and any risk can be competently managed by pre-registration. The regulator has a role supporting education providers, through advice and guidance on standards to ensure that providers were successfully managing the risks associated students in training. In our view education providers have a clear responsibility, working with employers who provide the placements, to ensure that practice placements are sufficiently safe for students and for service users. Full student registration with a regulator is no substitute for this. For more comprehensive details of our views on student registration, we have completed research into student registration in 2008 and 2010.³⁹³

Fitness to practise details

- 5.60 A critical piece of information found on registers are any current or past fitness to practise details relating to a registrant. As the HCPC points out, a regulator needs to strike a balance between the rights of the registrants and the 'risk of harm by non-disclosure of information'.³⁹⁴ In *Health professional regulators' registers* we considered that regulation should be proportionate in how it deals with (not a means of punishment) registrants, but in the interests of public protection and regulatory transparency we give more weight to the rights of patients than professionals. In the same report, we also recommended that all

³⁹⁰ Law Commissions, 2013. *Regulation of health care professionals Regulation of social care professionals in England Consultation Analysis*, pg. 62. Available at http://www.lawcom.gov.uk/wp-content/uploads/2015/03/cp202_regulation_of_healthcare_professionals_analysis-of-responses_complete.pdf [Accessed 2 November 2017].

³⁹¹ General Optical Council, 2012, *General Optical Council response to the Law Commissions' joint consultation document 'Regulation of health care professionals' and 'Regulation of social care professionals in England'*, pg. 18.

³⁹² Law Commissions, 2013. *Regulation of health care professionals Regulation of social care professionals in England Consultation Analysis*, pg. 62. Available at http://www.lawcom.gov.uk/wp-content/uploads/2015/03/cp202_regulation_of_healthcare_professionals_analysis-of-responses_complete.pdf [Accessed 2 November 2017].

³⁹³ Available at <http://www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/student-fitness-to-practise-2010.pdf> and <http://www.professionalstandards.org.uk/docs/default-source/publications/advice-to-ministers/student-registration.pdf> [Accessed 2 November 2017].

³⁹⁴ Health and Care Professions Council, 2013, *Fitness to Practise Publication Policy*, pg. 1.

regulators should publish information about erased professionals for five years on the register (the table below shows this recommendation has not been enacted by all regulators).³⁹⁵

- 5.61 The Law Commissions stressed the importance of listing individuals who have been erased from the register:

‘...regulators should establish a list of persons whose entry has been removed following a finding of impairment. Simply omitting a name from the register does not give the clarity required for public protection. Furthermore, being removed can be compared to a current sanction in the sense that it is ongoing and remains in force unless registration is subsequently restored. It follows that removal should be treated in the same way as any current sanction.’³⁹⁶

- 5.62 The Authority agrees with the Law Commissions’ arguments above, and would add the further benefits of giving the user confirmation of identity, enabling them to avoid an unregulated service, and report if that professional is still practising. We would simply stress that it must be clear to users, that the individual is no longer on the register, and that he or she has been removed as a result of a fitness to practise issue. Only four (GCC, GDC, GMC and NMC) of the nine regulators list erased registrants when searching a register. We recommend that the remaining regulators work towards implementing this initiative.
- 5.63 On the topic of displaying information on the register about individuals, the EU’s General Data Protection Regulation (GDPR) will come into force in May 2018. A significant part of this regulation is ‘right to be forgotten’, which will enable an individual to request the deletion or removal of personal data where there is no compelling reason for its continued processing’. We consider that the ‘right to be forgotten’ would not ordinarily apply to data which regulators publish on registers or when a registrant has been struck off. This is because the Information Commissioner’s Office suggests that an organisation may not have to comply to a request to erase personal data if the data is being used due to a legal obligation or public interest.³⁹⁷
- 5.64 We also would like to see greater consistency in the length of time for which conditions, undertakings, warnings and suspensions are on shown on the register. For example, the GOsC displays a registrant’s suspension on the register for the duration of the suspension plus two years, whilst the GOC only displays the suspension on the register for the duration of the registrant’s suspension. Further information showing the range of different sanction publication durations can be found at Appendix VI.

³⁹⁵ Professional Standards Authority, 2010. *Health professional regulators’ registers Maximising their contribution to public protection and patient safety*, pg. 24. Available at <http://www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/health-professional-regulators-registers-2010.pdf?sfvrsn=8> [Accessed 2 November 2017].

³⁹⁶ Law Commissions, 2014. *Regulation of Health Care Professionals Regulation of Social Care Professionals in England*, pg. 85. Available at http://www.lawcom.gov.uk/wp-content/uploads/2015/03/lc345_regulation_of_healthcare_professionals.pdf [Accessed 2 November 2017].

³⁹⁷ Information Commissioner’s Office. Available at <https://ico.org.uk/for-organisations/data-protection-reform/overview-of-the-gdpr/individuals-rights/the-right-to-erasure/> [Accessed 2 November 2017].

Table 11: Searches displaying erased professionals

Regulator	Erased professional found when searching register
GCC	Yes
GDC	Yes
GMC	Yes
GOC	No
GOsC	No
GPhC	No
HCPC	No
NMC	Yes
PSNI	No

- 5.65 Notably, the GOsC has a list of all osteopaths who are recently under interim suspension orders, undertakings, and Professional Conduct Committee and Health Committee decisions.³⁹⁸ Similarly, the GOC publishes monthly amendments to the register on its website.³⁹⁹
- 5.66 We recommend regulators work towards more consistent durations for FtP information to remain on registrants' entries. We also recommend all regulators have functionality to search for erased registrants, so that when a visitor searches any regulator's register, the visitor should be able to find details of individuals who have been erased from the register.
- 5.67 We also believe that all regulators should display information about individuals who have been erased should be available to check for a minimum of five years. This recommendation is the same as in 2010 and follows on from our position that minimum of five years should elapse before any registrant who had been struck off could reapply to join the register.⁴⁰⁰

³⁹⁸ General Osteopathic Council. *Decisions*. Available at <http://www.osteopathy.org.uk/standards/complaints/hearings/decisions/> [Accessed 2 November 2017].

³⁹⁹ General Optical Council. *Monthly Amendments to the Register*. Available at <https://www.optical.org/en/Registration/the-register/monthly-amendments-to-the-register/index.cfm> [Accessed 2 November 2017].

⁴⁰⁰ Professional Standards Authority, 2010. *Health professional regulators' registers Maximising their contribution to public protection and patient safety*, pg. 24. Available at <http://www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/health-professional-regulators-registers-2010.pdf?sfvrsn=8> [Accessed 2 November 2017].

Future of the register

5.68 This section focuses on proposed register functions and ideas that are not currently used by any of the UK health and care professional regulators we oversee. It looks at whether these register functions and ideas could enhance UK public protection. We discuss the possibility of a single register amongst UK regulators on the next chapter.

A tiered register

5.69 As the register's main purpose is to provide information to a diverse audience, regulators may want to add more details to the register. An example of this is the GMC's recent proposal for registrants to provide information voluntarily which would sit on their register entry alongside mandatory information usually found on the register (registration number etc). They named this approach the 'tiered register'. They proposed that voluntary information could include:

- recognised credentials
- completion of a national medical licensing examination
- higher qualifications
- scope of practice
- declaration of competing professional interests
- languages spoken
- practice location
- registrant photo
- a link to the website of the place where they work
- a link to recognised feedback websites.⁴⁰¹

5.70 The GMC argued that the tiered approach would 'enable the register to provide a much richer description of a doctor's professional life than is currently possible'.⁴⁰² A Lead Regional Liaison Advisor for the GMC added that providing more information would help reassure patients about a doctor's 'expertise in more specific areas of medicine', help patients make more informed decisions about their care, and enable the register to act as a single source of information for those searching for more information about doctors (rather than scouring multiple sources across the internet). A more specific potential benefit of the tiered register is that if it included photos, it could 'allow patients to virtually "meet

⁴⁰¹ General Medical Council, 2016 *Developing the UK medical register: a public consultation*, pgs. 10-11. Available at https://gmc.e-consultation.net/econsult/uploaddocs/Consult730/LRMP%20Consultation%20final_W%20form%2012.7.16_distributed.pdf [Accessed 8 May 2017].

⁴⁰² General Medical Council, 2016. *Developing the UK medical register: a public consultation*, pg. 11. Available at https://gmc.e-consultation.net/econsult/uploaddocs/Consult730/LRMP%20Consultation%20final_W%20form%2012.7.16_distributed.pdf [Accessed 8 May 2017].

their doctor” before their first visit and potentially lessen some of the anxiety that some patients may experience’.⁴⁰³

- 5.71 One of the potential disadvantages of such a tiered register would be inconsistency of information across different entries, if not all doctors initially provided the data.⁴⁰⁴ The General Practitioners Committee of the BMA deputy chair criticised the proposal for turning the register into a ‘beauty parade or a site to compete against others to have the longest set of qualifications’. He went on to say that ‘keeping some of this information up to date could also place an added workload and stressful burden on doctors at a time many are already under significant pressure’.⁴⁰⁵ There were also concerns over safety and privacy of registrants as a result of the tiered register.⁴⁰⁶
- 5.72 More information could help inform register viewers to make a more informed decision about a registrant. The register though is part of regulators’ statutory purpose of enhancing public safety by giving information as to whether a professional is safe to practice and meets a regulator’s standards. It is not intended to be a tool for comparing registrants’ quality of practice, or for showing career advancement. We do not recommend the use of tiered registers in the UK health and care regulatory environment. The Medical Directory and other repositories of information are better placed to serve this purpose for statutory regulated professionals. Where the statutory obligations do not apply, some accredited register holders run directories, for example the British Association for Counselling & Psychotherapy. However, the directory is clearly demarcated from the register.⁴⁰⁷

Prohibition orders

- 5.73 Prohibition orders (sometimes known as negative registers or barring schemes) are lists of individuals barred from practising a profession or activity. In the health and care sector there are very few prohibition order schemes, though some do exist in Australia. There are instances of this model of register in the UK however; examples include the Disclosure and Barring Service, the Financial Conduct Authority and the Pensions Regulator.
- 5.74 Unlike the current UK statutory health regulation models, prohibition orders focus more on what practitioners should not do than on what they should do. In a

⁴⁰³ Wren, J, 2016. *Answering your questions about our consultation on the medical register*, General Medical Council. Available at <https://gmcuk.wordpress.com/2016/09/05/answering-your-questions-about-our-consultation-on-the-medical-register/> [Accessed 2 November 2017].

⁴⁰⁴ General Medical Council, 2016. *Developing the UK medical register: a public consultation*, pg. 11. Available at https://gmc.e-consultation.net/econsult/uploaddocs/Consult730/LRMP%20Consultation%20final_W%20form%2012.7.16_distributed.pdf [Accessed 8 May 2017].

⁴⁰⁵ GP Online, 2016. *GMC overhaul risks turning medical register into 'beauty parade', GPs warn*. Available at <http://www.gponline.com/gmc-overhaul-risks-turning-medical-register-beauty-parade-gps-warn/article/1401101> [Accessed 2 November 2017].

⁴⁰⁶ GP Online, 2016. *Doctors reject proposals to include photos on GMC register*. Available at <http://www.gponline.com/doctors-reject-proposals-include-photos-gmc-register/article/1419379> [Accessed 2 November 2017].

⁴⁰⁷ The BACP register is available at http://www.bacpregister.org.uk/check_register/. The BACP Directory is available at <http://www.itsgoodtotalk.org.uk/> [Accessed 2 November 2017].

feasibility study of prohibition order schemes for the UK Department of Health, we found that this orientation meant prohibition orders were ‘unlikely to raise standards of competence or foster professionalism in any meaningful way’.⁴⁰⁸ We found in the same report some advantages to prohibition orders such as the potential for the scheme to apply to multiple unregistered practitioners. We concluded that there ‘may be a place’ for such schemes in the UK health and care sector where there is a ‘clearly identified problem and where risks have been thoroughly assessed’.⁴⁰⁹ If the Government was to introduce negative registers in health and care, it would be necessary to ensure the purpose and format were explained to the UK public, employers who would be likely also to be using other forms of register.

⁴⁰⁸ Professional Standards Authority, 2016. *Initial evaluation of the feasibility of prohibition order schemes for unregulated health and care workers in the UK: Advice to the Secretary of State for Health*, pg. 46. Available at <http://www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/feasibility-of-prohibition-order-schemes---initial-evaluation.pdf> [Accessed 2 November 2017].

⁴⁰⁹ Professional Standards Authority, 2016. *Initial evaluation of the feasibility of prohibition order schemes for unregulated health and care workers in the UK: Advice to the Secretary of State for Health*, Available at <http://www.professionalstandards.org.uk/latest-news/latest-news/detail/2016/12/05/are-prohibition-order-schemes-feasible-for-unregulated-health-and-care-workers> [Accessed 2 November 2017].

Conclusion

- 5.75 Regulators' public registers are mostly consistent and clear in their presentation of data, which will help protect the public. There are variations though, as there are register functions which few or only one regulator uses. There are also discrepancies in how some information is displayed between regulators. We have drawn the recommendations below from this chapter but caution that this is not an exhaustive list of what might be done to improve registers. There may be issues which have not been covered in the chapter or have been, but have not been explicitly laid out below.
- 5.76 We have composed the recommendations from a policy standpoint. However, further exploration of financial and resource impacts will be required. We also note that for some recommendations to occur, alterations to legislation may be necessary.
- 5.77 Our recommendations are as follows:
- That the GCC and GOsC should not continue to register non-practising registrants. This would require alterations to the relevant regulators' legislation.
 - That when a register-user searches for an individual who has been erased by a regulator, the individual should be immediately viewable. It is important that if a user searches for a practitioner they can clearly see if the practitioner is registered, erased or not registered. Currently, only four of the nine regulators offer this functionality.
 - That regulators should continue on the trajectory of keeping a pared down approach to registers. We believe only details necessary for the purposes of public protection should be on the register. If a register user wishes to find surplus information which is unrelated to public protection, they should use other resources (such as a professional's practice's website or a directory).
 - That specialist lists and registers should only be used by regulators if a potential harm to the public in the specialist practice is identified and can be mitigated by using such instruments. This applies to annotations too.
 - That there needs to be more consistency in the length of time sanctions are published on registers. At the moment, there is disparity between regulators in how long sanctions such as suspensions are displayed on the register.
 - That employers may benefit from wider implementation by regulators and registers of the HCPC's multiple registrant search function for employers, which allows a user to search up to 100 registrants per search (the GMC allows similar functionality, but searching up to 10 professionals).
 - That more registers should include functionality such as 'sounds like' in order to help searchers when spelling mistakes are made. Only five of the regulators have soft searching functionality when searching for a professional on a register

- We have seen that holding a student register has the potential to create unnecessary burdens for training providers and regulators. Before considering whether holding a student register is unnecessary there should be review of the risk of all aspects of student registration (for example fitness to practise).

6. A single assurance body

- 6.1 In the previous chapters of this report, we have discussed in detail four areas of regulatory policy development. We have sought to describe current arrangements, and to set out both change that might be changed incrementally, and that which might be achieved in the longer term. In doing so we have drawn on our previous work, a wide range of sources of evidence, and the ongoing dialogue within the sector.
- 6.2 On 31 October 2017, the UK-wide Government consultation *Promoting professionalism, reforming regulation*⁴¹⁰ was published. The consultation seeks views, amongst other matters, on whether there should be fewer regulatory bodies; what would be the advantages, and if reduced in number, what should the new configuration be?
- 6.3 Developing the ideas that have been put forward in this report has strengthened the view that we first put forward in *Regulation rethought*, that a single UK-wide assurance body should be created for all health and care occupations. In our section on harm prevention, we pointed to the value of collecting, analysing and using fitness to practise data to prevent future harm – a task that would be made considerably simpler and more effective under a single assurance body. Our review of the fitness to practise function calls for greater consistency of process and thresholds: our proposed model, which includes the development of a common statement of professional practice for all registrants, would enable this. A common statement would also help to improve public understanding of what to expect from health and care workers and when to report a concern to the regulator, and could lead to greater alignment of learning outcomes for students to ensure that these joint values were translated into the approach to education and training for all professionals. It would also support the development of more flexible models of training, bring greater consistency of approach, improve inter-professional collaboration and learning, and make it easier for training to meet national workforce and health priorities. Finally, our chapter on registers highlighted a number of problematic inconsistencies between the registers and possible improvement, which could easily be addressed under our proposed structure, the public face of which would be a single register.
- 6.4 In *Regulation rethought*, we set out a series of problems that arise from the current regulatory system:
- ‘The public often find the regulatory system hard to navigate, particularly when they have a concern or complaint and want to report it in the right way; the role of the regulator is easily misunderstood. Employers have to engage with multiple regulators in order to check their workers’ registration, report concerns and support revalidation and continuing professional development. People in multi-disciplinary teams work to different standards and may be subject to different decisions by different regulators for the same or similar events for which they

⁴¹⁰ Department of Health, October 2017. *Promoting professionalism, reforming regulation*. Available at <https://www.gov.uk/government/consultations/promoting-professionalism-reforming-regulation> [Accessed 2 November 2017].

have individual and shared responsibility. They may be subject to different sanctions which patients, employers, and registrants find hard to reconcile. Educators too are affected by multiple regulators with different standards and quality assurance mechanisms. This may inhibit their ability to train practitioners who are centred on patients' needs, with shared values, and who can work across professional boundaries within health and care. Team roles and functions may change as population needs, technological innovations or service requirements alter.

6.5 We continued:

'Those striving to redesign service delivery, integrate care, or introduce new working practices may be frustrated and delayed by the difficulties inherent in flexing scopes of practice or creating new roles, because of protected titles and boundary protection by particular professions. Those seeking to bring about change are also seeking independent assurance about the standards and competencies of those who are not subject to statutory professional regulation. Regulation is often cited as a barrier to innovation, although that is not always so, whereas its position should be one of enabling both change to practice and flexible roles in the workforce'.

6.6 We remain of the view that these problems should be addressed through the creation of a single assurance body. This is illustrated at Figure 8 which shows our most recent thinking on this proposal. Such a body would be responsible for a range of functions for all registered groups, to include maintaining and publishing a single register, recording those individuals currently statutorily regulated, or on accredited registers, and including other groups within the workforce. We believe that this arrangement would offer benefits to the public and employers in terms of the accessibility and transparency of regulation, providing a single destination to check registered practitioners and to raise concerns. We have acknowledged previously that there would be significant transition costs; however, our work on cost-effectiveness and efficiency in the UK and in Australia suggests the longer-term potential to realise substantial economies of scale once established and operational.

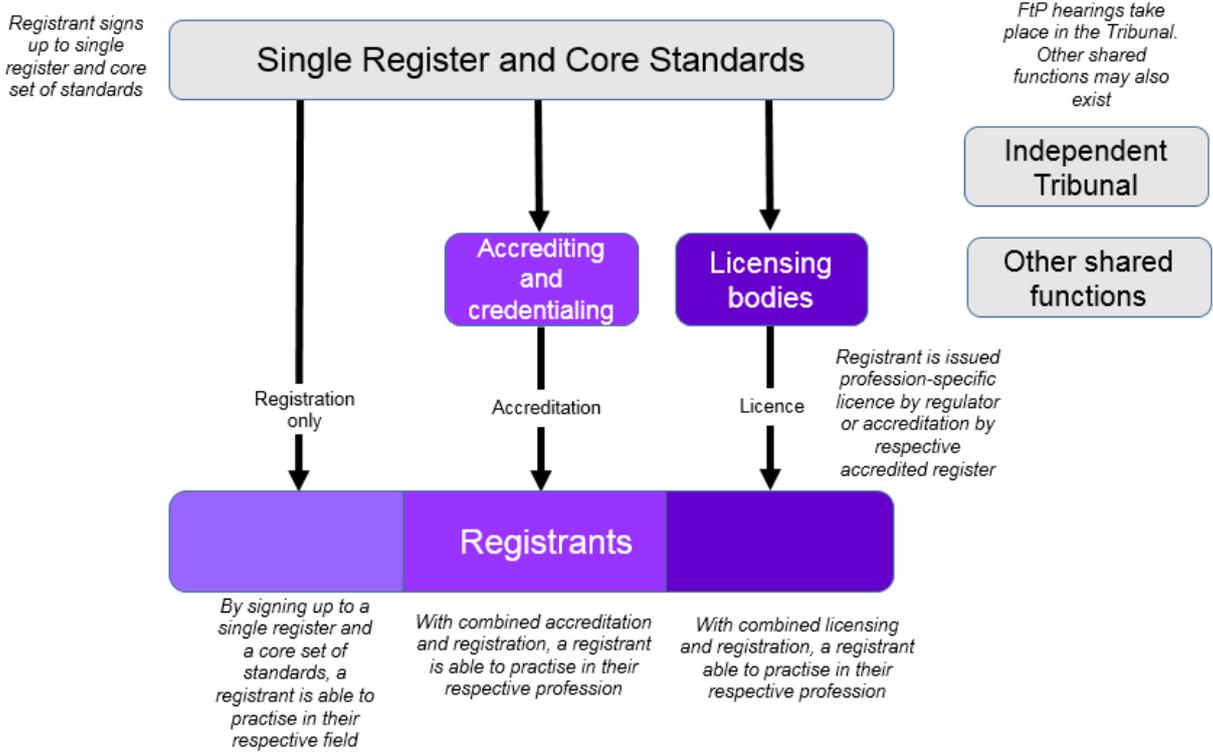
6.7 Under our proposal the model would be underpinned by a consistent approach to assessing risk of harm, such as we have previously set out in *Right-touch assurance: a methodology for assessing and assuring occupational risk of harm* ©.⁴¹¹ Those presenting the highest risks would require a licence to practise in addition to registration in order to practise their profession. A second group, those currently under the remit of accredited registers, would be both registered and accredited. In future this would also cover credentialed groups.⁴¹² A third, those presenting the lowest risk of harm, would be required to be registered.

⁴¹¹ Professional Standards Authority, 2016. *Right-touch assurance: a methodology for assessing and assuring occupational risk of harm* © Available at [https://www.professionalstandards.org.uk/docs/default-source/publications/right-touch-assurance---a-methodology-for-assessing-and-assuring-occupational-risk-of-harm-\(october-2016\).pdf?sfvrsn=0&sfvrsn=0](https://www.professionalstandards.org.uk/docs/default-source/publications/right-touch-assurance---a-methodology-for-assessing-and-assuring-occupational-risk-of-harm-(october-2016).pdf?sfvrsn=0&sfvrsn=0) [Accessed 2 November 2017].

⁴¹² We use the term credentialling here to refer to the NHS project to develop a method of ensuring safety of patients of unregulated occupations, rather than for example the GMC's use of the term for specific areas of medical practice.

- 6.8 The assurance body would be responsible for setting out a statement of professional practice, or common set of standards, which would apply to registrants in all three categories. The statement of professional practice would define the standards of conduct, behaviour and ethics required of all registrants, irrespective of their profession or occupation. Profession and occupation-specific standards would also be required, tailored to the clinical practice of each.
- 6.9 We propose that the single body would be responsible for the receipt, investigation and prosecution of concerns about breaches of standards on a shared basis. An independent tribunal service should perform the adjudication function across all professional groups for whom this type of approach is deemed appropriate.
- 6.10 Within this structure, regulatory bodies would continue to exist to provide the function of licensing and setting the profession-specific standards. A range of requirements could apply for award and renewal of the licence, depending on the levels of assurance required, including restricting scopes of practice where necessary.
- 6.11 As we have previously argued, the creation of a shared public-facing register and a licensing system would provide a simple means for the public, employers, commissioners and others to find registered practitioners and to check that they are licensed. It would also help better public understanding of the purpose of regulation, since the concept of licensing is well understood by the public, in particular in relation to driving licences and the Driver and Vehicle Licensing Agency. As we have said before, we are not claiming that driver licensing is as complex an activity as regulating health professionals, but we do believe that the language of registration and licensing would provide a frame through which the purpose and functions of regulation can be made clearer and more accessible to everyone.

Figure 8: a single assurance body



6.12 We believe that a single assurance body and the other reforms we have set out would meet the three principles which we previously set ourselves to test proposals for change, in that they would be proportionate to the harm they seek to prevent, simple to understand and operate, and effective and efficient. In the context of the recent publication of *Promoting professionalism, reforming regulation*, we recommend that serious consideration is given by stakeholders to this proposal.

7. Appendices

Appendix I: Professional Standards Authority Section 29 database categorisation of charges

- Adverse health
- Alcohol
- Breach of confidentiality
- Child pornography
- Conviction
- Data protection violations
- Dishonesty re qualifications/professional memberships/convictions/registration
- Dishonesty/fraud/theft
- Drugs
- Failure to comply with conditions
- Failure to follow Health & Safety regs/infection control
- Failure to follow regulatory body's advice/procedures
- Failure to have appropriate indemnity insurance
- Failure to maintain appropriate professional boundaries
- Failure to refer
- Failure to undertake conclusive post mortem/scrutinise cremation forms
- Failure to visit/examine/assess/diagnose/follow up
- Inappropriate allegations
- Inappropriate anaesthesia
- Inappropriate delegation of care
- Inappropriate use of employer's computer/IT systems
- Inappropriate/failure in prescribing/administration of medication
- Inappropriate/inaccurate dispensing of medication - pharmacy
- Manslaughter
- Miscellaneous
- Misleading advertising of services

- Police caution
- Poor performance/lack of competence
- Poor storage of drugs
- Poor working relationships
- Poor/inaccurate record-keeping and/or history-taking
- Poor/lack of communication
- Practising whilst not registered
- Rough handling of patients
- Sexual misconduct
- Substandard care/treatment
- Treating without consent
- Verbal abuse
- Violent/aggressive behaviour
- Insufficient knowledge of English language

Appendix II: Summary of regulators' continuing fitness to practise activity (as at October 2017; source: inter-regulatory continuing fitness to practise group)

Regulator	Description of scheme	Centralised/decentralised	Frequency	Status/further developments in progress?
GMC	<p>Revalidation based on participation in a local system of appraisal. Doctors are required to demonstrate how they continue to meet the core values laid out in <i>Good Medical Practice</i>.</p> <p>Registrants must collect and reflect on a range of information relating to compliance with the standards for their appraisal including: CPD</p> <ul style="list-style-type: none"> ● Quality improvement activity ● Significant events ● Feedback from colleagues ● Feedback from patients ● Review of complaints and compliments. 	<p>Responsible Officers provide a recommendation to the GMC who will make a formal decision on revalidation and whether the doctor is able to remain on the medical register.</p> <p>The medical royal colleges and faculties can also give advice on how doctors meet requirements in specialties or general practice.</p>	<p>Doctors are required to have a regular appraisal but the Responsible Officer will make a formal recommendation on revalidation every five years.</p>	<p>The GMC published an interim report on revalidation in April 2016, with the final report due in 2018.</p> <p>In 2017 the GMC also published Sir Keith Pearson's review of revalidation which included a number of recommendations and the GMC response to this report.</p>
GCC	<p>Shortly due to consult on a new system of enhanced CPD based</p>	<p>Submissions will be made centrally to the GCC who</p>	<p>The system will</p>	<p>The GCC has been piloting the scheme and is due to consult</p>

	<p>on the new GCC Code which came into effect in June 2016.</p> <p>Key requirements include:</p> <ul style="list-style-type: none"> ● Annual requirements for registrants to complete learning activities demonstrating ongoing compliance with the Code ● New requirements across a three year cycle, including: <ul style="list-style-type: none"> ● An objective activity e.g. A case based discussion, peer observation and feedback, patient feedback ● A CPD activity in an area identified by the GCC as important to the profession as a whole ● Peer discussion to demonstrate engagement with learning development and reflective practice 	<p>will make decisions about ongoing registration. The GCC will also retain a system of annual sampling and auditing.</p>	<p>operate on a three year cycle with some annual requirements and annual sampling and audit of submissions.</p>	<p>on it shortly, with a view to rolling it out fully in 2018.</p>
<p>GPhC</p>	<p>The GPhC has published a consultation on a three-stage model based on their revised standards for pharmacy professionals which were introduced in 2017.</p> <p>Key elements include:</p>	<p>The framework will be defined centrally and audited centrally, day to day compliance will be decentralised.</p>	<p>Annual</p>	<p>The GPhC have carried out piloting of the scheme and have a consultation ongoing with a view to introducing the new system in 2018.</p>

	<ul style="list-style-type: none"> • A required element of CPD covering issues of particular relevance to pharmacy professionals <ul style="list-style-type: none"> • A peer discussion element • a reflective case study based on an event from practice which has benefited patients or service users. 			
PSNI	<p>PSNI are shortly to introduce a new system of ensuring continuing fitness to practise, taking a risk-based approach in line with the principles of good regulation and the PSA's 2012 paper.</p> <p>The model will include three components:</p> <ul style="list-style-type: none"> • Self-certification - compliance with CPD requirements, health and character and professional indemnity <ul style="list-style-type: none"> • Enhanced CPD based on registrants completing CPD relevant to their scope of practice as well as additional elements including peer discussion, compliance with the code • Independent 	Centralised - PSNI will receive a recommendation from an independent assessor and will decide on continued registration of the registrant.	Likely to be every five years.	Piloting and stakeholder events to take place ahead of formal roll-out.

	assessment/verification to triangulate the evidence			
GOsC	<p>The GOsC has agreed CPD standards focussing on engagement with the scheme and which must be met for the registrant to complete one three year cycle. These include ensuring that CPD covers:</p> <ul style="list-style-type: none"> ● Range of practice ● Quality of care ● Benefit to patients ● Portfolio – an ongoing record of CPD completed. <p>The key elements of the model are:</p> <ul style="list-style-type: none"> ● 90 hours of CPD over three years to include at least 45 hours of learning with others over the cycle ● CPD covering the four domains of the Osteopathic Practice Standards ● CPD in mandatory area relevant to osteopathy – communication and consent ● Objective CPD activity – 	<p>Mainly decentralised as osteopaths will receive sign-off on the requirements from another colleague to achieve ongoing registration although the GOsC will carry out targeted audit and</p> <p>The GOsC has developed draft ‘peer discussion review’ guidelines with groups of osteopaths across the UK. These guidelines provide a ‘walk through’ document to support osteopaths to discuss their practice and CPD with another colleague and to demonstrate the CPD standards.</p>	<p>CPD self-declarations will take place annually with sign-off happening every three years</p>	<p>Currently piloting with a first wave of adopters with full roll out expected in Autumn 2018.</p>

	<p>patient feedback, peer observation, clinical audit, case based discussion)</p> <ul style="list-style-type: none"> • A peer discussion review with a colleague to demonstrate compliance with the scheme. 			
HPCP	<p>HPCP registrants are required to comply with CPD standards at all times:</p> <ol style="list-style-type: none"> 1. You must maintain a continuous, up-to-date and accurate record of CPD activities; 2. You must demonstrate that your CPD activities are a mixture of learning activities relevant to current or future practice; 3. You must seek to ensure that your CPD has contributed to the quality of your practice and service delivery; 4. You must seek to ensure that your CPD benefits the service user; 5. You must, upon request, present a written profile (which must be your own work and supported by evidence) explaining how 	<p>Registrants are responsible for participating in and maintaining their individual record of CPD although HPCP will conduct a random audit for each renewal period.</p> <p>Those audited must submit a CPD profile during the renewal period. The profile contains a list of all CPD undertaken during the previous two years, plus a statement in more detail about a small number of activities as examples. This should state how the individual has met the five standards for CPD, and more specifically how the activities described have benefited their practice and service users. Each profile is assessed by two assessors and registrants</p>	<p>Registrants are required to maintain an up to date record of CPD at all times and auditing is on a two-year cycle in line with registration renewal for the relevant professional group.</p>	<p>The requirements have been in place since 2006 – revised guidance due to be published in summer 2017 encouraging registrants to seek third party feedback and undertake activities involving interaction.</p>

	<p>they have met the standards for CPD.</p> <p>The system is outcomes focused so HCPC does not prescribe number of hours/days or assign points to different types of activities but asks registrants to reflect on the impact of CPD activity.</p>	<p>will be permitted time to make up the shortfall if necessary.</p> <p>CPD also may or may not be linked to employer-led performance management/CPD systems, managed centrally by HCPC.</p>		
NMC	<p>All nurses and midwives need to meet a range of revalidation requirements designed to show that they are keeping up to date and demonstrating their continued ability to practise safely and effectively. These requirements include:</p> <ul style="list-style-type: none"> • Practising a minimum number of hours • Undertaking 35 hours of continuing professional development (CPD) • Obtaining five pieces of feedback about their practice • Writing five reflective accounts linking CPD/ feedback/their practice to the Code • A reflective discussion with another NMC 	<p>Mixed - registrants provide declarations to the NMC about their compliance with revalidation and that they have received confirmation from an appropriate person at a local level.</p> <p>The NMC is responsible for making decisions about each registrant's renewal.</p>	Three-year cycle.	Revalidation currently in its first year of operation. The NMC are carrying out surveys of stakeholders and registrants and commissioning independent research to assess effectiveness.

	<ul style="list-style-type: none"> registrant; Providing a health and character declaration; and Having appropriate cover under an indemnity arrangement. <p>Registrants are expected to keep these records in a portfolio.</p>			
GDC	<p>The GDC is currently in the process of moving to a new system of CPD requirements.</p> <p>Currently it considers both 'verifiable' and 'general' CPD. While there are no specific requirements, there are certain topics which are recommended.</p> <p>The new scheme will not include general CPD and will see new requirements introduced for the various groups for the number of hours of verifiable CPD which they must complete.</p>	<p>Mixed. The framework and the auditing will be centralised, but development plans and training needs will be established locally.</p>	<p>Five-year cycle with annual returns.</p>	<p>The GDC has been carrying out piloting and evaluation of the new scheme and aim to roll out fully in 2017.</p>
GOC	<p>Under the Continuing Education and Training scheme all registrants must undertake CPD activities in all areas of their current scope of practice as defined in the Standards of Competence for their profession. These are the standards of</p>	<p>Mixed approach. Registrant records, approval system for CET activities, provider registration and auditing processes are all centralised via an online platform. Delivery of CET</p>	<p>Three-year cycle</p>	<p>The GOC has recently undertaken an evaluation exercise with stakeholders to evaluate the success of the first CET cycle and has been exploring its approach in this area through the recent Education strategic review</p>

competence that underpin pre-registration education or for those that undertake specialisms will have an expanded scope of practice and therefore an expanded requirement for CET.

CET is a points and competencies based system. Every three years registrants must complete CET activities in all areas of their current scope of practice. A minimum of 36 points must be completed in total, with half of all CET points gained from 'interactive' activities involving peers. One point equates roughly to one hour, but can vary depending on the type or intensity of the activity.

Optometrists, Contact Lens Opticians and Therapeutic Prescribers must also undertake one peer review activity per cycle, involving the discussion of real clinical cases with their peers with the intention of reflection on practice and shared learning.

All CET is approved in advance by a group of GOC approvers before it can count towards the

decentralised through network of approved CET providers and registrant-led activities. Optical professional bodies have a large role in the provision of CET.

which is considering the optical education pathway.

registrants CET requirement. CET activities are mainly delivered by GOC registered CET providers. Registrants can lead peer review activities, but again, must seek advance approval of these activities. All registrant CET records, the CET approval process and the registration of CET providers is managed through an online portal, which can be accessed by all stakeholders.

Reflection on practice and planning of CET by registrants are encouraged through an online Personal Development Plan (PDP), with some elements of this being compulsory. CPD activity outside of CET can be recorded within the PDP, although only the CET activities are compulsory.

If a registrant fails to meet the minimum requirements of CET, then they will be removed from the register. Details of process for removal can be found on our website:

<https://www.optical.org/en/Education/CET/process-for-removals.cfm>

Appendix III – Key information – Regulators’ quality assurance processes

Regulator	Number of education and training providers regulator oversees (2017)	Approval of institutions and/or programmes	Provisional Registration /student registration?	QA of annotation on the register/ specialties/ CPD	Last time reviewed	Ongoing monitoring (paper-based, in person) simplify
General Chiropractic Council	3	Programmes only.	No	No annotations or specialties.	Review of the education and training standards and QA process due to be implemented from 2017/18 academic year.	From 2017/18 approval for existing programmes will no longer have an end date. Annual paper based monitoring information will be required and providers will be required to notify the GCC of substantive programme changes to existing programmes throughout the year.
General Dental Council	49	Dental Authority status is conferred on institutions by the Privy Council. The GDC approves programmes run by Dental Authorities.	No	QA of specialty education.	Process and standards last reviewed in 2015. The GDC's 2017 discussion paper <i>Shifting the Balance</i> outlines plans for a review of quality assurance with the aim of moving towards a risk based approach for 2018/19.	Annual paper-based monitoring and inspection on a five-year cycle. Inspections can be brought forward if a programme undergoes major change or annual monitoring identifies risks. For new schools there are annual visits carried out to follow the progress of the first cohort of students until graduation.

General Medical Council	35 Medical Schools and 17 Deaneries/ LETBs	The GMC approve educational institutions or groups of institutions which are permitted to run a primary medical qualification.	Yes - after medical degree, foundation year 1 doctors are provisionally registered until full post-graduate training completed.	The GMC also approve the programmes for both specialty and sub-specialty training in the UK and for foundation only programmes delivered overseas linked to UK universities.	The QA process for medical education and training were last reviewed during 2012/13 following the 2010 merger of the Postgraduate Medical Education and Training Board with the GMC. New standards published in July 2015 and introduced from January 2016 and a range of changes have been made to the QA process since. The QA process will be reviewed again in 2018.	All medical schools and deaneries are required to provide a paper report annually. Visits/inspections are carried out by region, by theme, risk-based visits or enhanced (regular) monitoring for medical schools which they are concerned about. New courses receive annual monitoring visits until the first cohort graduates.
General Optical Council	17	Programmes and approval of the institution.	Student registration until they are fully practising.	QA of annotations on the register.	The GOC are currently in the process of a strategic review of their approach to education and training.	Ongoing monitoring is carried out with a risk-based approach through annual self-reporting. GOC follow up on conditions from QA reviews.
General Osteopathic Council	11	Programmes only.	No	No	Guidance for Osteopathic Education Institutions revised in 2015. GOsC	Major review and re-approval of recognised courses every three to five years. Interim reviews may be carried out in between to follow up on conditions

					currently reviewing quality assurance process with a view to introducing more flexibility to approve and re-approve programmes and reviewing the Osteopathic Practice Standards.	imposed or to respond to concerns or queries raised by students or members of the public.
General Pharmaceutical Council	87	Able to approve both institutions and programmes but only accredits or recognises programmes.	No.	Approval pharmacists independent prescribing programmes for annotation to the register of pharmacists .	GPhC has recently consulted on the new education and training standards for pharmacy technicians which will be published at the end of 2017. Standards for education and training for pharmacists were last revised in 2011 and the accreditation last revised in 2013. The foundation degree accreditation methodology was last revised in 2011 and pharmacy technician	Annual paper-based monitoring. MPharm degrees are reaccredited every six years and interim visits are carried out every three years. Other pharmacy courses are normally reaccredited every three years.

					accreditation methodology revised in 2010.	
Health and Care Professions Council	145	Able to approve both institutions and programmes but only approves programmes.	No.	No.	Standards of education and training were recently revised in 2017 and due for publication in July 2017. The HCPC is currently reviewing its approach to quality assurance.	HCPC grant open-ended approval of programmes and respond proportionately to issues on a case-by-case basis. They require annual monitoring reports to be submitted and notification of major changes, and they will investigate concerns raised, or review approval at any time to follow up on areas of concern.
Nursing and Midwifery Council	79	Approval of institutions and programmes.	No.	The NMC also sets standards for certain post-registration training.	The quality assurance framework is evaluated and refined annually but was last updated in 2013. The process outlined in the QA handbook is updated annually. The NMC has commissioned an independent review of their approach to quality assurance of education and training which is due to report in 2017.	Re-approval of approved courses every six years. Annual paper based monitoring of self-assessments, and risk-based monitoring visits to providers which have issues of concern alongside a cycle of review visits based on region or by theme.

Pharmaceutical Society of Northern Ireland	2	Approval of programmes.	No	Quality assurance of pre-registration training (must be carried out by trainees after completion of an MPharm degree).	PSNI standards for pre-registration training last reviewed in 2012.	Joint accreditation of educational institutions with the GPhC every six years and interim visits every three years.
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Appendix IV: Search criteria and data fields provided by regulators for health professionals

Regulator	Search options
GCC	<p>Any combination of:</p> <ul style="list-style-type: none"> • Registration number • Name • Surname • Town/City • County • Postcode
GDC	<p>Six registers to choose from – dentists, dental care professionals, specialist lists, temporary registrant dentist, visiting practitioners: dental care professional, visiting practitioners. Any combination of</p> <ul style="list-style-type: none"> • Forename (including sounds like option) • Surname (including sounds like option) • Town • Postcode <p>Users can choose to include erased registrants. When searching the dental care professional register, there is the option to select a job title. When searching the specialist lists, there is an option to select a specialty.</p> <p>Or, by registration number</p>
GMC	<p>Any combination of</p> <ul style="list-style-type: none"> • GMC Reference number • Given name • Surname (with sounds like option) • GP register option • Gender

GOC	<p>Three registers to choose from – dispensing opticians, optometrists and students; optician’s practice in local area; registered businesses.</p> <p>To search for an individual:</p> <ul style="list-style-type: none"> • First name • Last name (with sounds like options) • GOC number • Gender
GOsC	<p>Search by postcode, town, registration number or surname</p> <p>Or, by County or Country</p> <p>Advanced options of: disabled access, home visits, and Welsh spoken.</p>
GPhC	<p>For pharmacist register</p> <p>Registration number</p> <p>Or</p> <p>Forename</p> <p>Surname (with option of ‘sounds like’)</p> <p>Advanced option to search within results to determine if a registrant is an independent and/or supplementary prescriber.</p>
HPC	<p>Select a profession then:</p> <p>Registration number or surname</p>
NMC	<p>Combination of</p> <ul style="list-style-type: none"> • Personal Identification Number (PIN) • First name • Last name
PSNI	<p>In ‘Search for Pharmacist’ area, enter:</p> <p>Registration number or surname</p>

Appendix V: Register entry details: details of attributes currently publicly visible on each regulator's register entry.⁴¹³

	GMC	GOC	PSNI	GPhC	HCPC	GOsC	GDC	GCC	NMC
Registration Number	X	X	X	X	X	X	X	X	
Title			X						
Name	X	X	X	X	X	X	X	X	X
Gender	X	X				X		X	
Status	X	X		X	X	X	X		X
FTP Information	X	X	X	X	X	X	X	X	X
Qualification	X	X				X	X	X	X
Registration Date	X		X	X	X	X	X	X	X
Provisional Registration Date	X								
Specialist Register Date	X								
GP Register Date	X								
Designated Body	X								
Responsible Officer	X								
ARF Due Date	X								
Registered As		X							
Registered Specialties	X	X					X		
Date of Most Recent Registration		X				X			
Location		X		X	X	X			X
Registered Practice(s)		X				X	X	X	
Registration Valid until					X		X		X
Place of Training						X			
Email						X		X	
Superintendent				X					
Profession					X				
Annotations (additional qualifications)				X	X				
Registration Type	X						X		
Doctor in Training	X								
Training Deanery/LETB	X								
Training Programme Speciality	X								
GMC Approved Trainer	X								
Trainer Deanery/LETB	X								
Trainer Programme Speciality	X								

⁴¹³ General Medical Council, 2017. *Technical Analysis Combined Register Portal*.

Appendix VI: Publication times for fitness to practise data on a registrant's entry

(Asterisk (**)) indicates the fitness to practise finding relates to the registrant's health.)

Regulator	Finding	Length of time finding will remain on register entry
GCC	Registrant receives conditions	For duration of conditions and for one year after the period ends
	Registrant receives suspension	For duration of suspension and one year after the period ends
	Registrant is removed	Immediately removed but remain searchable on register
	Registrant receives interim order	From the date of the interim order is served to when proceedings close
	Registrant admonished	For duration and one year after period ends
	Health FtP problems found in registrant	For duration of condition
GDC ⁴¹⁴	Fitness to practise not impaired	One month
	Fitness to practise impaired but no sanction imposed	One month
	Fitness to practise impaired – reprimand	One year
	Fitness to practise impaired – conditions	For the period of the conditions and for a period of one month when fitness to practise no longer impaired
	Fitness to practise impaired – suspension	For the period of suspension and for a period of one month when declared no longer impaired
	Fitness to practise impaired – erasure	Five years following date of erasure
	No interim order imposed	One month on the Hearings page but not against the registrant's entry on the online register
	Interim order imposed	For the period of the imposition of the order and for one further month after the order has ceased

⁴¹⁴ General Dental Council, 2016. *GDC Disclosure and Publication Policy*, pp. 6-8. Available at <https://www.gdc-uk.org/api/files/Disclosure%20and%20Publication%20Policy.pdf> [Accessed 2 November 2017].

	Fitness to practise impaired but no sanction imposed*	One month
	Fitness to practise impaired – conditions*	For the period of the conditions and for a further period of one month when fitness to practise is no longer impaired
	Fitness to practise impaired – suspension*	For the period of suspension and for a further period of one month when fitness to practise is no longer impaired
GMC ⁴¹⁵	Doctor erased by medical practitioners tribunal and subsequently restored to register	As long as the doctor is registered with the GMC plus 5 years if they leave
	Doctor received a suspension of more than 3 months	15 years from the date the suspension expires
	Doctor received a suspension of 3 months or less, or conditions or undertakings	10 years from the date the sanction expires or is revoked
	Doctor received a finding of impaired fitness to practise but no sanction	Five years from the date of the end of the MPTS hearing
	Doctor received suspension, conditions or undertakings because of impaired fitness to practise solely on the grounds of health*	Remove from publication as soon as sanction expires/is revoked
	Doctor received impairment finding but no sanction solely on grounds of health*	No publication on the online register
	Doctor was erased by medical practitioners tribunal	10 years from the date of erasure
	Doctor received a sanction other than erasure	Five years from the date the doctor left the register (subject to relevant 10 and 15 year maximum periods)
	Doctor received a finding of impaired fitness to practise but no sanction	One year from the date the doctor left the register (subject to five year maximum period)
	Doctor received suspension, conditions or undertakings solely on the grounds of health	One year from the date the doctor left the register (subject to the sanction still being active)
GOC ⁴¹⁶	Warning (from FTPC)	Duration of warning

⁴¹⁵ General Medical Council. *Proposed time limits for the publication of fitness to practise information*. Available at http://www.gmc-uk.org/DC9005_List_of_publication_time_limits.pdf 65749892.pdf [Accessed 2 November 2017].

⁴¹⁶ General Optical Council. *Fitness to Practise and Hearings Publication and Disclosure policy*.

	Conditions (including interim conditional orders)	Duration of the conditions
	Erasure	Not put on register
	Suspension (including interim suspension orders)	Duration of the suspension
	Where conditions are imposed, those relating to health or other personal matters will not be published	
GOsC⁴¹⁷	Investigating Committee decision to impose an Interim order	Duration of the interim order
	Notice of a Professional Conduct Committee Interim Order hearing (s24(1)(a) of the Act)	Not put on register (but is placed on website)
	Professional Conduct decision to impose an Interim Order	Duration of the interim order
	Health Committee decision to impose an Interim Order	Duration of the interim order
	Admonished	Six months
	Conditions of practice	Duration of the Order plus one year
	Suspension	Duration of the Order plus two years
	Removal	Name does not appear on register (but does stay on website for five years)
GPhC⁴¹⁸	Warning (from IC or FtPC)	Two years
	Undertaking	Duration of the undertaking plus two years
	Conditions	Duration of the condition plus two years
	Suspension	Duration of the suspension plus five years
	Removed	Indefinitely
	Interim Order	Duration of the order
	No impairment found but a warning necessary	Two years
HPC⁴¹⁹	Conditions of practice orders and suspension orders	Information will remain on the register as long as the order is in place.

⁴¹⁷ General Osteopathic Council, 2013. *Fitness to Practise Publication Policy*, pg. 6.

⁴¹⁸ General Pharmaceutical Council, 2015. *GPhC Publication and Disclosure Policy*. Available at https://www.pharmacyregulation.org/sites/default/files/gphc_publication_and_disclosure_policy_vseptember_2014.pdf [Accessed 2 November 2017].

⁴¹⁹ Health and Care Professions Council, 2013. *Fitness to Practise Publication Policy*

	Striking off	Name does not appear on online register (the published decision will remain on the HCPC register for five years)
	Caution	Information on the caution order will only be published for as long as the caution order has effect
	Interim Orders	Information on the interim order will only be published for as long as it has an effect
	*The HCPC has discretion to not publish information about registrants, for example if publication would 'disclose confidential information about a person's health'.	
NMC ⁴²⁰	Undertaking	Displayed on the public register against the registrant's entry for the length of time they have been imposed
	Warning	Displayed on the public register against the registrant's entry for the length of time they have been imposed
	Interim order	Displayed on the public register against the registrant's entry for the length of time they have been imposed
	Removed	Name appears on the online register when searching until they make a successful application for restoration, until they are deceased and we receive notification of their death or otherwise for 60 years
	Suspension	Displayed on the public register against the registrant's entry for the length of time they have been imposed
	Conditions	Displayed on the public register against the registrant's entry for the length of time they have been imposed
PSNI ⁴²¹	Warning	Two years
	Suspension	Duration of the suspension plus five years

⁴²⁰ Nursing and Midwifery Council. *FtP Publication Guidance*. Available at https://www.nmc.org.uk/globalassets/sitedocuments/ftp_information/ftp-publication-guidance.pdf [Accessed 2 November 2017].

⁴²¹ Pharmaceutical Society Northern Ireland, 2014. *Policy on the disclosure and publication of fitness to practise information*, pg. 9. Available at <http://www.psni.org.uk/wp-content/uploads/2012/11/Policy-on-the-disclosure-and-publication-of-FtP-information-June-2014.pdf> [Accessed 2 November 2017].

	Conditions	Duration of the condition plus five years
	Undertaking	Duration of the undertaking plus five years
	Interim Order	Duration of the Order
	*All sanctions in relation to a pharmacist will be displayed on the Pharmaceutical Society NI online register. The only exception to this is matters relating solely to the registrant's health which is treated as confidential.	

8. Annex: Summary of regulators' responses on the future of fitness to practise

8.1 As part of this project, we asked the regulators four questions:

- What do you see as the main problems with your current fitness to practise framework? Please list up to three.
- Aside from additional resources, what solutions would you offer to these problems?
- What in your view are the most compelling arguments for major reform to the way regulators deal with concerns about health and care professions?
- What radical solutions do you see to the issues you identified under the previous question? Feel free to include those which might extend beyond the limits of your organisation and require major legislative change.

8.2 We received responses from eight of the nine regulators. Some were corporate responses, while others reflected the personal views of colleagues with fitness to practise expertise. The key themes and points raised are summarised below.

Problems

8.3 There was a near-unanimous view that the current fitness to practise models are outdated – with the exception of a couple of the regulators who have more up-to-date founding legislation.

8.4 Almost all felt that that FtP processes were too slow and expensive, overly legalistic, and unnecessarily adversarial. One regulator went so far as to question what evidence there was that the benefits of the current system outweigh the costs, and more than one referred to the strain it puts on both registrants and complainants/witnesses. The difficulty of amending legislation combined with the lack of autonomy given to the regulators by the current legislative framework mean that fitness to practise is unable to adapt to change.

8.5 The main challenge the regulators appear to be grappling with is the increasing caseload, and an evolution in the nature of the complaints received (for example 'paid for' treatments are leading to more complaints about the quality of service that do not call into question fitness to practise). Several put this down to societal changes, such as the loss of deference towards professionals, and changes in the healthcare system.

8.6 Also mentioned were the move to more inter-professional working and blurring of lines of responsibility; and the development of more robust local assurance mechanisms, such as responsible officers for doctors, for dealing with less serious concerns.

8.7 Several regulators raised the lack of consistency in the way concerns are dealt with across the different professional regulators, and across the sector more broadly. Some commented on the lack of a common threshold for referral to regulators, and a lack of a common understanding of the role of the professional regulator among the panoply of organisations with regulatory-type functions, such as the Disclosure and Barring Service and the NHS Performers' List. One regulator commented specifically on the lack of a shared understanding of the

'public interest', while several suggested the purpose of fitness to practise was generally unclear. One respondent argued that the regulators' role should not be to uphold the highest moral standards among the professions. This was seen as a vestige of a bygone era, out of step with public views (as was indicated by the Authority's research on public attitudes to dishonesty), and regulators were considered ill-equipped to make such moral judgments.

- 8.8 A further response suggested that the concept of fitness to practise was too binary, and did not reflect the range of concerns that might emerge about a professional's conduct or competence. The options for dealing with failings were seen to be correspondingly inflexible.
- 8.9 Linked to the above, some respondents felt there were insufficient powers enabling regulators to work together on the incidents in which more than one profession was involved.
- 8.10 There was a comment about the role of the Professional Standards Authority – suggesting that our focus on the length of time taken to complete a case was unhelpful. It was also put to us that regulation generally acts as a barrier to innovation.

Solutions

- 8.11 An overwhelming majority of the responses called for a more flexible legislative framework, that gave them powers to make changes through rule-making. One regulator also felt that officers of the Council should be given more decision-making powers rather than relying on committees or panels.
- 8.12 Nearly all the responses called for a less adversarial and/or more inquisitorial approach (though reservations were expressed about the term 'inquisitorial'), with the investigation seeking to establish the facts rather than build a case for the prosecution – although it was pointed out that there would need to be a clear evidence-base for moving to an inquisitorial framework. One response called for a rethinking of the role of patients in the FtP process, whose voice can get lost in adversarial proceedings that set the regulator against the registrant. Such an approach could also provide learning in relation to incidents that could support the wider patient safety agenda.
- 8.13 One respondent indicated that the move away from an adversarial approach would require a shift in public and government expectations about the purpose of professional regulation, but that the Government's safe spaces agenda might indicate a move in this direction. The need to clarify the purpose of FtP and of regulation more generally was also brought up elsewhere – in particular to move away from protecting the reputation of the profession, and more explicitly to one that protects individual patients.
- 8.14 As part of a less adversarial approach, nearly all wanted more options for remediation at the early stages and early engagement with the registrant. This was sometimes linked to the introduction of case examiners. It was suggested in one response that hearings should only be used where there is a factual dispute, and in another that hearings may not even be the most effective way of testing evidence. One response supported the introduction of consensual disposal but only for cases where the registrant shows insight, the failings are remediable, and there are no serious attitudinal issues. They also stressed that consensual disposal decisions required greater transparency than at present, and either oversight by the Authority, or reports published periodically by the regulator.

- 8.15 One response described a model based on a licensing scheme, similar to what was described in *Regulation rethought*. In terms of fitness to practise, action would be taken against breaches of individual licensing conditions, including revoking the licence, attaching conditions to it, and a range of other options to give the regulator flexibility.
- 8.16 There was general support for more use of ‘upstream’ regulatory measures, but disagreement about whether these would have a tangible impact on the FtP caseload. It was put forward in one response that performance cases might need to be dealt with differently from conduct cases.
- 8.17 While many expressed concerns about the lack of consistency, these were not necessarily followed up with practical suggestions for how this problem could be addressed. One regulator suggested that common threshold criteria could be set across the regulators for acceptance of a case, to be developed in consultation with the wider system – an idea that could be linked with the recommendation made by another regulator that there should be a better understanding of the risks presented by professionals and what professional regulation can do to prevent harm. Another response called for greater use of joint investigations, perhaps with evidential findings and conclusions from one regulator’s investigation being adopted by the panel of another regulator. There were further suggestions that a common adjudication body could support greater consistency, though one regulator argued that sharing adjudication functions would not necessarily lead to cost savings.
- 8.18 Several responses called for a more coherent framework across all the bodies involved in supporting the patient safety agenda, and dealing with complaints – with a shared understanding of who is responsible for what. Local solutions were frequently mentioned, and the role of the employer were seen as particularly important – for professionals working within an employment framework. Performance issues were seen as most likely to fall under the responsibility of other bodies, such as employers or the National Clinical Assessment Service (NCAS). It was suggested that regulators should only get involved if a concern cannot be addressed locally.
- 8.19 A number of regulators set out suggestions that were specific to their particular situation:
- Moving from separate committees (health and conduct) to a single fitness to practise committee
 - Suspension orders not having to be reviewed systematically
 - Moving from a conduct-based regime to one based on impairment of fitness to practise
 - Powers for FtP committees to issue cost orders
 - More effective interim order powers.

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