professional standards authority
for Health and Social Care

Using accepted outcomes in fitness to practise: background, context and evidence in support of the PSA's guidance for regulators

This document sets out the evidence used to inform the PSA's guidance on **using accepted outcomes in fitness to practise**. It also sets out the context in which accepted outcomes are being introduced, including relevant background about the Government's programme of regulatory reform. Our evidence has primarily been drawn from desk research, responses to a questionnaire we issued to all the health and care professional regulators we oversee, and meetings with stakeholders. Details of the types of information we have considered are included at Annex A. The content of the questionnaire is included at Annex B.

1. About the Professional Standards Authority

1.1. The Professional Standards Authority for Health and Social Care (PSA) is the UK's oversight body for the regulation of people working in health and social care. Our statutory remit, independence and expertise underpin our commitment to the safety of patients and service-users, and to the protection of the public.

1.2. There are 10 organisations that regulate health professionals in the UK and social workers in England by law. We audit their performance and review their decisions on practitioners' fitness to practise. We also accredit and set standards for organisations holding registers of health and care practitioners not regulated by law.

1.3. We collaborate with all of these organisations to improve standards. We share good practice, knowledge and our right-touch regulation expertise. We also conduct and promote research on regulation. We monitor policy developments in the UK and internationally, providing guidance to governments and stakeholders. Through our UK and international consultancy, we share our expertise and broaden our regulatory insights.

1.4. Our core values of integrity, transparency, respect, fairness, and teamwork, guide our work. We are accountable to the UK Parliament. More information about our activities and approach is available at **www.professionalstandards.org.uk**.

2. Introduction

2.1. The Government is currently undertaking a programme of regulatory reform that will grant the healthcare professional regulators we oversee significantly more freedom to make their own rules and determine how they exercise their powers. At the same time, the reforms will transform the fitness to practise processes of the regulators, allowing many more cases to be resolved using 'accepted outcomes' without the need for a fitness to practise panel hearing.

2.2. The accepted outcomes process is a paper-based approach whereby one or more case examiner(s) make an assessment of a case based on the written information and evidence provided to them. The case examiner(s) will write a report of their findings, including their determination about whether the registrant is 'impaired'[1] and what the appropriate sanction should be.

2.3. A case examiner can conclude a case with the registrant's agreement (we refer to this as an 'accepted outcome')[2] where:

- the registrant has agreed to a final measure (sanction)
- the registrant has accepted that their fitness to practise is impaired
- the registrant has accepted the case examiner's findings.

2.4. We support these reforms, which we expect to significantly improve regulatory processes and benefit all those involved in fitness to practise cases, including complainants, the public, and registrants. We hope that they will result in a system that is more efficient, less adversarial and fairer to all concerned. However, we have also identified certain risks that may result from the use of accepted outcomes in some fitness to practise cases. These risks relate to the robustness, independence and transparency of decision making in certain contexts, as well as possible adverse impacts on public confidence and people with shared protected characteristics.

2.5. The changes to fitness to practise represent a generational shift in how the process operates, and we aim to support regulators to make the most of what the reforms can offer whilst ensuring they continue to effectively deliver the three limbs of public protection.[3] We are therefore undertaking work to help support implementation of the reforms, including producing guidance for healthcare professional regulators to use when developing their own accepted outcomes guidance and processes. This document accompanies our guidance and seeks to explain the background to the reforms and context in which they are being implemented, as well the evidence upon which our guidance is based.

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[1] Under the AAPA Order a person's fitness to practise may be impaired by reason of (i) inability to provide care to a sufficient standard, or (ii) misconduct. See **The Anaesthesia Associates and Physician Associates Order 2024: The Anaesthesia Associates and Physician Associates Order 2024 (legislation.gov.uk)**

[2] Whilst the policy intent as articulated by the Department of Health and Social Care is clear that where the registrant agrees to the measure this constitutes an 'accepted outcome', it should be noted that the AAPA Order does not use this term. The Order refers only to 'Final Measures' which are 'imposed' (rather than agreed).

[3] The three limbs of public protection are: the protection of patients, the maintenance of public confidence in the profession, an upholding proper standards of conduct and behaviour.

3. Background and regulatory context

The purpose of fitness to practise

3.1. The core purpose of health and care professional regulation is 'the protection of the public', as set out in the Health and Social Care (Safety and Quality) Act 2015.[4] This overarching duty applies to the health and care regulators we oversee[5], as well as to the PSA. Public protection is further defined by the Act as encompassing three tenets:

- to protect, promote and maintain the health, safety and well-being of the public
- to promote and maintain public confidence in the professions
- to promote and maintain proper professional standards and conduct.

3.2. These three elements are commonly known as the 'three limbs' of public protection and underpin the work of the health and care professional regulators.

3.3. Ensuring that health and care professionals are 'fit to practise' is fundamental to regulators fulfilling their duty to protect the public. Fitness to practise can be defined as having the ability to practise safely and effectively.[6] It encompasses *'having the appropriate skills, competencies, knowledge, character and health'* to perform the role.[7]

3.4. Where a professional lacks any of these, they pose a public protection risk. It is the job of regulators to ensure that these risks are managed, and that the public are protected from registrants who are not fit to practise.

The fitness to practise process

3.5. Where concerns are raised about a registrant's fitness to practise, regulators follow a formal process to determine whether a registrant is 'fit to practise' or 'impaired'. In broad terms, the fitness to practise process involves the following (as outlined in Cohen v GMC)[8]:

- Finding whether the facts are proved and if so whether they amount to misconduct, lack of competence (or other grounds of impairment)
- Considering whether the registrant's fitness to practise is currently impaired, based on the three limbs of public protection
- Deciding on what sanction is appropriate to adequately address the failings identified.

3.6. All fitness to practise cases contain the essential elements outlined above, although regulators have differing procedures for processing and disposing of cases. Each regulator's individual powers and duties are set out in their respective legislation, which is

[4] Health and Social Care (Safety and Quality) Act 2015: **Health and Social Care (Safety and Quality) Act 2015 (legislation.gov.uk)**
[5] With the exception of the Pharmaceutical Society of Northern Ireland (PSNI)
[6] General Medical Council 2023, *Fitness to practise explained*: **Fitness to practise explained - GMC (gmc-uk.org)**
[7] Finn, G et al, November 2022, *Experiences of GDC fitness to practise participants 2015 – 2021: A realist study:* **Experiences of GDC fitness to practise participants 2015 – 2021: A realist study November 2022 (gdc-uk.org)**
[8] Cohen v GMC [2008] EWCH 581: **Cohen v General Medical Council | [2008] EWHC 581 (Admin) | England and Wales High Court (Administrative Court) | Judgment | Law | CaseMine**

currently a mix of primary and secondary legislation.

Screening

3.7. The first stage of the fitness to practise process, often known as screening or triage, determines whether a referral amounts to an allegation that a registrant's fitness to practise might be impaired under one of the statutory grounds. These are: misconduct; lack of competence; a conviction or caution for a criminal offence; physical or mental health; not having the necessary knowledge of English; and a determination by another regulatory body.[9]

3.8. If a referral amounts to an allegation of impaired fitness to practise, the regulator must investigate it. At the end of the investigation, the regulator decides whether there is a real prospect of a hearing finding current impairment. A case may then either be resolved consensually (such as through undertakings or an accepted disposal) or progress to a panel hearing.

Fitness to practise panel hearings

3.9. Fitness to practise panels are normally constituted of three independent members,[10] at least one of which is a registrant and one lay person. They sit in public unless they are considering matters relating to the registrant's health or there are specific circumstances that outweigh the public interest in holding the hearing in public.

3.10. The regulator presents the case and evidence to the fitness to practise panel. The registrant may be present and represented. The panel decides whether the facts are proved, whether they amount to grounds of impairment and, if so, whether the registrant's fitness to practise is impaired either on public protection grounds (for example, because the registrant may repeat the conduct) or on public interest grounds (because a finding is necessary to uphold professional standards or maintain public confidence). If a panel decides that the registrant's fitness to practise is impaired, it then considers what sanction should be imposed. The sanctions available vary from a warning or caution, through conditions of practice, to suspension or expulsion from the register.

3.11. We can refer a decision made by a final fitness to practise panel to the High Court if we believe it to be insufficient to protect the public. This power was granted to the PSA under Section 29 ("s29") of the National Health Service Reform and Health Care Professions Act 2002,[11] and is therefore commonly referred to as our 'section 29 power'.

[9] The Government is in process of updating the legislative frameworks of the health and care professional regulators, and in doing so is likely to amend the statutory grounds of impairment. The statutory grounds listed here are correct as of January 2025, with the exception of the statutory grounds of impairment for Anaesthesia Associates and Physician Associates. For these two groups of professionals the statutory grounds of impairment are: inability to provide care to a sufficient standard, and misconduct.

[10] This is the case for all regulators except the General Optical Council which uses an independent Hearings Panel constituted of up to five panellists

[11] National Health Service Reform and Health Care Professions Act 2002: **National Health Service Reform and Health Care Professions Act 2002 (legislation.gov.uk)**

Resolving cases consensually

3.12. Whilst for most regulators, serious cases will always progress to a panel hearing, many do have the power to resolve lower-level cases by a consensual process.[12] These take the form of 'accepted disposals' in the case of Social Work England, and 'consensual disposals' or 'undertakings' for the other regulators. Cases resolved consensually involve an agreement between the regulator and the registrant that the registrant admits to the substance of any allegations that have been investigated by the regulator and agrees to the regulator's proposed sanction. This allows a case to be concluded without the need for a formal hearing.

3.13. Undertakings are a commonly used form of consensual resolution and may comprise one or more restrictions or requirements placed on a registrant. Eight of the regulators we oversee use undertakings (or similar) but there is variation across them in terms of where they are situated in the fitness to practise process.

3.14. Four regulators, General Dental Council (GDC), General Medical Council (GMC), Nursing and Midwifery Council (NMC) and (Pharmaceutical Society of Northern Ireland (PSNI), have legislation that explicitly permits them to resolve cases consensually. Three others, The Health and Care Professions Council (HCPC), General Pharmaceutical Council (GPhC), and General Osteopathic Council (GOsC), have a process by which a registrant can agree to undertakings once their case has been considered by a panel, but without any contestation of the facts that underpin the case. The General Optical Council (GOC) does not use undertakings but is able to agree a sanction with a registrant. The General Chiropractic Council (GCC) is alone in having no recourse to consensual resolution contained in either its primary legislation or its rules.

The case for change

3.15. We have long called for reform to fitness to practise to make it less adversarial, swifter and more efficient for all involved. Our 2015 publication *Rethinking regulation*[13] highlighted the expense of the current fitness to practise frameworks and the increasing numbers of complaints. In our follow-up paper *Regulation rethought*[14] we called for a radical overhaul of fitness to practise, which we described as 'protracted and expensive'. We promoted a move to a less adversarial approach with more early opportunities for remediation.

3.16. Numerous studies have outlined the negative impact on practitioner health and wellbeing of being subject to a fitness to practise investigation. A 2022 report commissioned by the GDC brought much of this evidence together and concluded that there were *'severe and far-reaching impacts on those undergoing FtP investigations. The identified impacts included those with the potential to affect the individual's personal wellbeing (e.g. feelings of vulnerability or shame, stress, loss of trust, self-doubt) and their professional wellbeing*

[12] Social Work England is currently the only health or care professional regulator able to deal with all categories of case by means of an accepted outcome.
[13] Professional Standards Authority, 2015, *Rethinking regulation*: **rethinking-regulation-2015.pdf (professionalstandards.org.uk)**
[14] Professional Standards Authority, 2016, *Regulation rethought: proposals for reform:* **regulation-rethoughtd6c718f761926971a151ff000072e7a6.pdf (professionalstandards.org.uk)**

(e.g. change of career, increased surveillance and documentation, defensive practice, blame culture).'[15]

3.17. Similarly, research by Professor Tom Bourne of Imperial College London has highlighted the emotional toll of complaints processes on doctors,[16] and GMC commissioned research has explored cases where doctors have died from suicide while undergoing a fitness to practise investigation.[17]

3.18. We have also commissioned three separate pieces of research with complainants in fitness to practise cases: *Enhancing confidence in fitness to practise adjudication*,[18] *The patient and public perspective on future fitness to practise processes*,[19] and *Public Response to Alternatives to Final Panel Hearings in Fitness to Practise Complaints*[20]. These found that complainants find panel hearings particularly stressful, with the latter report noting that all the complainants they *interviewed 'had one shared experience - that the reality of attending the hearing was more stressful than they had ever anticipated...The hearing itself was described as an intimidating and generally unpleasant experience.'*

3.19. One factor driving the high level of stress experienced by participants in the fitness to practise process is the legalistic and adversarial nature of the proceedings. As the GDC study notes*, 'the adversarial nature of the process, including legal representation and legal argumentation in many cases, firmly established the principle of 'establishing guilt or innocence' in the perceptions of those who had been through FtP. This is misaligned with the FtP process being concerned with establishing a finding of fact about a registrant's potential impairment, as set out in the legal framework governing that process.'* [21]

3.20. Not only are fitness to practise proceedings stressful for both registrants and complainants, they are also expensive and time consuming. In 2021 alone the GMC spent in excess of £46m on fitness to practise,[22] accounting for almost 40% of their total expenditure.

3.21. The time taken to resolve fitness to practise cases averages over a year for all regulators,[23]

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[15] Finn, G et al, 2022, *Experiences of GDC fitness to practise participants 2015-2021: a realist study*: **Experiences of GDC fitness to practise participants 2015 – 2021: A realist study November 2022 (gdc-uk.org)**
[16] 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: **http://bmjopen.bmj.com/content/5/1/e006687**
[17] Sarndrah Horsfall for the GMC, 2014, *Doctors who commit suicide while under GMC fitness to practise investigation: Internal review*: **Doctors who commit suicide while under GMC fitness to practise investigation (gmc-uk.org)**
[18] CHRE, 2011 '*Enhancing confidence in fitness to practise adjudication: research report'*: **Microsoft Word - 110525 Research Works FINAL REPORT.doc (professionalstandards.org.uk)**
[19] Community Research for the Professional Standards Authority, May 2020, *Patient and public perspective on future fitness to practise processes:* **patient-and-public-perspectives-on-future-fitness-to-practise-processes.pdf (professionalstandards.org.uk)**
[20] Professional Standards Authority, May 2013, *Public Response to Alternatives to Final Panel Hearings in Fitness to Practise Complaints*: **Public Response to Alternatives to Final Panel Hearings in Fitness to Practise Complaints**
[21] Finn, G et al, 2022, *Experiences of GDC fitness to practise participants 2015-2021: a realist study*: **Experiences of GDC fitness to practise participants 2015 – 2021: A realist study November 2022 (gdc-uk.org)**
[22] GMC, 2021, *Our annual report*: **annual_report_2021_full_220822.pdf (gmc-uk.org)**
[23] Professional Standards Authority, 2023, *Annual report and accounts 2022/23:* **Professional Standards Authority Annual Report and Accounts 2022/23 | PSA**

and in excess of two years for all but three (GCC, GOC, GOsC). The median time taken to conclude a case from receipt of initial complaint to final fitness to practise hearing determination varies across the regulators from 58 weeks (GOsC) to 178 weeks (SWE).[24,25] The average median time to conclude a case to final determination across all regulators is 118.6 weeks.

3.22. Whilst we do not have data to demonstrate how quickly cases could be resolved under the proposed new system using an accepted outcome, data on the time from case examiner decision to completion at final hearing provides some useful insights. This shows that for the four largest regulators[26] (GMC, NMC, HCPC, GDC) the median time from case examiner decision to completion at final hearing is 27, 54, 83 and 42 weeks respectively.[27] Whilst we cannot say that all this time would be 'saved' were a case to be closed consensually at the case examiner stage, this data does give some indication of the additional time required for a case to progress from case examiner to panel hearing.

3.23. Long waits for cases to be resolved impact the wellbeing of registrants and complainants, and pose challenges for employers as registrants may be suspended or placed on restricted duties while awaiting a final outcome.

3.24. Further, long waits for cases to be resolved may undermine the effectiveness of the process itself; witnesses may be less likely to remain engaged and willing to participate where considerable time has elapsed since the incident(s) in question. Long delays also mean that the public is not protected as quickly as they could be (albeit registrants may be subject to interim measures) and are likely to undermine public confidence in the regulatory process.

3.25. We have consistently argued that some of the negative factors outlined above could be reduced by giving regulators the power to make greater use of accepted outcomes. As we argued in Right touch reform: *'greater use of remediation and consensual disposal, for cases that are suitable, could allow regulators to fulfil [the three limbs of public protection] with less reliance on expensive and legalistic hearings.'* [28]

3.26. Consensual disposals are able to facilitate a fitness to practise process which is faster, less onerous and less stressful. Further, where a registrant does not contest the facts of the case against them, it can be a constructive means to support registrants who are willing to address identified and remediable impairment.

Regulatory reform and the impact on fitness to practise

3.27. The Government is currently engaged in a programme of reform to the health professional regulators. The first stage of these reforms is the legislation, passed in March 2024 to

[24] Note that Social Work England's data is affected by the caseload it inherited from the previous regulator of social workers (HCPC) upon its inception in 2019

[25] Professional Standards Authority, 2023, *Annual report and accounts 2022/23:* **Professional Standards Authority Annual Report and Accounts 2022/23 | PSA**

[26] By number of registrants

[27] Figures taken from the most recent set of data supplied by regulators to the PSA as part of the performance review process at the time of writing (October 2023). Unpublished.

[28] Professional Standards Authority, 2017, *Right-touch reform: a new framework for assurance of professions*: **Right-touch reform - a new framework for assurance of professions | PSA**

bring Anaesthesia Associates (AAs) and Physician Associates (PAs) into regulation under the GMC.[29] This legislation is intended to act as the 'template' for the reform of all the health professional regulators we oversee.[30]

3.28. Regulatory reform will provide the regulators with far greater freedoms to determine how they operate, including the flexibility to set and amend their own rules. The legislation will include sweeping reforms to regulators' powers and governance arrangements, and an entirely new process for handling fitness to practise.

3.29. The consultation issued by the Department of Health on bringing AAs and PAs into regulation,[31] and the subsequent Government response to that consultation,[32] sets out how the department envisages fitness to practise operating in future. Under the proposed new system there will be two final decision-making roles in the fitness to practise process: case examiners and fitness to practise panels.

3.30. Under this system more cases will be resolved by case examiners without the need for a panel hearing. This will be achieved by the introduction of new powers for case examiners enabling them to resolve cases using accepted outcomes. Under the accepted outcomes process, case examiners will carry out a detailed assessment of the case from the written information and evidence and *'where possible, make a decision on impairment and whether action is needed to protect the public.'* [33]

3.31. Where impairment is found, case examiners will be able to impose a sanction on the registrant and will have the power to conclude a case using an accepted outcome where the registrant accepts both the findings (including impairment) and the proposed measure.[34] Case examiners will also be able to impose a final measure where a registrant doesn't provide a 'reasoned response' within a reasonable time. Case examiners will have the same range of measures available to them as panels, and there will be no limitations on the types of cases they can resolve.

3.32. However, cases will still be considered by panels where the registrant does not accept the findings and/or the proposed measure, or where *'the case examiner is not able to make a decision on impairment. This could include, for example, where the evidence needs to be*

[29] The Anaesthesia Associates and Physician Associates Order 2024: **The Anaesthesia Associates and Physician Associates Order 2024 (legislation.gov.uk)**
[30] This does not include Social Work England which already operates a fitness to practise system which is substantially different from the other regulators and more in line with the proposed new system.
[31] Department of Health and Social Care, 2023, *Regulating anaesthesia associates and physician associates:* **Regulating anaesthesia associates and physician associates - GOV.UK (www.gov.uk)**
[32] Department of Health and Social Care, 2023, *Consultation response to regulating anaesthesia associates and physician associates:* **Consultation response to regulating anaesthesia associates and physician associates - GOV.UK (www.gov.uk)**
[33] Department of Health and Social Care, February 2020, *Regulating healthcare professionals, protecting the public: consultation response analysis:* **Regulating healthcare professionals, protecting the public: consultation response - analysis (publishing.service.gov.uk)**
[34] The AAPA Order requires regulators to set rules specifying the timeframe for responding, which must be no less than 28 days (see: The Anaesthesia Associates and Physician Associates Order 2024: **https://www.legislation.gov.uk/ukdsi/2024/9780348255195**)

tested at a hearing.' [35]

3.33. The Government has stated that the proposed changes will *'deliver a fitness to practise process that is swifter, fairer and less adversarial, which will benefit all parties involved in fitness to practise proceedings and, most importantly, will ensure swift public protection where needed.'* [36] This new system for handling fitness to practise cases will in due course be rolled out across the health professional regulators; DHSC has set out its intention that in future *'all regulators should have broadly consistent fitness to practise arrangements'.*[37]

3.34. The new fitness to practise arrangements contained within the AAPA Order are broadly similar to those already operated by Social Work England, which has had the power to resolve cases using case examiners and accepted disposals since its inception in 2019. However, unlike the system operated by Social Work England, the provisions under the AAPA Order enables case examiners to reach a finding on impairment.

Putting the reforms into practice: maximising benefits and mitigating risks

3.35. We support the Government's programme of regulatory reform, which heralds a new era for the regulation of health professionals. The reforms have the potential to significantly improve regulatory processes, giving regulators more freedom and flexibility to make and amend their own rules. The reforms to fitness to practise will be transformational and should allow many more cases to be resolved more quickly and easily, with benefits to all involved.

3.36. However, whilst the reforms to fitness to practise present significant opportunities for improvement, they also open up new risks which need to be considered and managed. As we noted in our *Review of Social Work England's process for accepted outcomes in fitness to practise cases: 'while the system has substantial advantages in terms of speed and avoiding the costs and other impacts of the hearing, this should not be at the expense of public protection'.*[38]

3.37. We have always maintained that public protection must remain at the heart of the reformed fitness to practise framework. In addition, the new system should be in alignment with the principles of right touch-regulation (these principles state that regulation must be: proportionate, consistent, targeted, transparent, accountable and agile).[39]

3.38. Whilst we cannot entirely anticipate how the new system will work in practice, we have a

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[35] Department of Health and Social Care, February 2020, *Regulating healthcare professionals, protecting the public: consultation response analysis:* **Regulating healthcare professionals, protecting the public: consultation response - analysis (publishing.service.gov.uk)**
[36] Department of Health and Social Care, February 2020, *Regulating healthcare professionals, protecting the public: consultation response analysis:* **Regulating healthcare professionals, protecting the public: consultation response - analysis (publishing.service.gov.uk)**
[37] Department of Health and Social Care, February 2020, *Regulating healthcare professionals, protecting the public: consultation response analysis:* **Regulating healthcare professionals, protecting the public: consultation response - analysis (publishing.service.gov.uk)**
[38] Professional Standards Authority, May 2021, *Review of Social Work England's process for 'accepted outcomes' in fitness to practise cases:* **Review of Social Work England's process for 'accepted outcomes' in fitness to practise cases | PSA**
[39] Professional Standards Authority, October 2015, *Right Touch Regulation:* **right-touch-regulation-2015.pdf**

significant evidence base built up through our oversight of Social Work England,[40] and from research findings, to suggest how the reforms may impact regulators, registrants and the public.

3.39. In broad terms, the advantages in using accepted outcomes need to be balanced against possible risks (real or perceived) to the robustness and independence of decision-making, the transparency of the process, and to public confidence.

3.40. The regulatory risks of accepted outcomes may include:

- That case examiners use accepted outcomes for the wrong cases. This might arise where the registrant has not accepted all the allegations, there are doubts over the registrant's level of insight, or the evidence would benefit from testing at a hearing
- That case examiners undercharge cases, or offer sanctions that are likely to be accepted in order to expedite case progression
- That the loss of lay and registrant input into decision-making leads to perceptions that decisions are biased or unfair to one or more interested parties
- That public confidence is undermined when high-profile, complex or serious cases are dealt with 'behind closed doors' without a public hearing. Concern may be heightened where a single case examiner makes decisions about the case
- That the accepted outcomes model reduces the voice or role of complainants in the process, and that this undermines confidence in the process or outcome
- That regulators fail to publish sufficient information about cases, meaning that the public cannot understand the circumstances of the case or the reasons for the decision. Where decisions are not sufficiently transparent, this could result in a loss of trust in the regulatory system
- That the combined effects of the above result in a system which is less effective at fulfilling the three limbs of public protection.

3.41. Not all of these risks are likely to be realised, and some may be realised but effectively mitigated. It is also likely that the benefits of using accepted outcomes will outweigh many of the disadvantages.

3.42. We want to support regulators to make the most of what the reforms can offer by maximising the benefits of the new fitness to practise framework whilst mitigating the potential risks. For the new system to be a success, it is vital that it continues to effectively deliver the three limbs of public protection.[41] In order to support the regulators with this task we have produced **guidance on using accepted outcomes in fitness to practise**. The guidance includes: factors for decision-makers to consider when determining whether a case can be disposed of using an accepted outcome; factors that may indicate a case would benefit from the involvement of more than one decision-maker; and factors for regulators to consider as part of promoting a fair and effective

[40] Social Work England's accepted outcomes process is similar to that proposed for the health professional regulators

[41] The three limbs of public protection are: the protection of patients, the maintenance of public confidence in the profession, and upholding proper standards of conduct and behaviour.

accepted outcomes process. We have also made suggestions as to what information should be published following an accepted outcome in order to maintain public confidence in the fitness to practise process and professional regulation more broadly.

3.43. This document sets out the relevant context and evidence which has informed our guidance on using accepted outcomes in fitness to practise. It should be read in conjunction with that guidance.

4. Factors to consider when deciding whether to offer an accepted outcome

4.1. Our guidance for regulators suggests a number of factors regulators should consider when determining whether a case can be fairly and safely resolved using an accepted outcome. These factors are:

- Is there a dispute of fact/conflict of evidence that can only be fairly tested at a hearing?
- Is there complexity in the case or evidence suggesting that a hearing may be beneficial?
- Would it be beneficial and proportionate to test insight at a hearing?

4.2. The rationale for the inclusion of these factors, and any supporting evidence, is set out below.

Is there a dispute of fact/conflict of evidence that can only be fairly tested at a hearing?

4.3. Whilst it is expected that a large number of cases will be capable of being disposed of using an accepted outcome, there may be cases where there is a dispute of fact that can only be fairly and effectively resolved by hearing live evidence.

4.4. Panels have the ability to ask probing questions of registrants and witnesses and allow for thorough cross-examination. They can assess information in a more dynamic way than can be achieved on paper. As we noted in our review of Social Work England's accepted outcomes process*: 'case examiners lack two tools that [panels] possess: they cannot call witnesses... and they cannot see the registrant and so gain a more concrete impression'.*[42] We cited case examiners' inability to interrogate the evidence directly as *'a major disadvantage'* of the accepted disposal system.

4.5. In responding to our fitness to practise disposal route questionnaire, a number of regulators highlighted the importance of hearing oral testimony and the ability to cross-examine witnesses in certain cases:

- *'Where there is a material dispute of fact which cannot be resolved on the papers, there is the benefit to hearing live evidence from relevant witnesses and for the*

[42] Professional Standards Authority, May 2021, *Review of Social Work England's process for 'accepted outcomes' in fitness to practise cases:* **Review of Social Work England's process for 'accepted outcomes' in fitness to practise cases | PSA**

witnesses to be questioned by other parties to the proceedings and the panel' [healthcare professional regulator]

- *'A full and frank review of all the evidence takes place during a hearing and this might not be the case if it is considered on the papers. This review allows the testing and challenging of evidence to ensure that it is accurate and relevant.' [healthcare professional regulator]*

4.6. The benefit of hearing live evidence was also highlighted by fitness to practise panel members in the GDC/NMC funded report *The concept of seriousness in fitness to practise cases.*[43] Panellists suggested that being able to question registrants presented an opportunity to test written evidence:

- *"You're... thinking well how deep is that, or is it something someone helped them write a week before, so the opportunity to ask the registrant questions and to try and explore than a bit more is hugely beneficial.' (Lay panel chair and panel member)*[44]

4.7. There is no doubt that important facts often do come to light only as a result of a hearing. For example, in a case considered by the Medical Practitioners Tribunal Service (MPTS) the panel considered the evidence against a doctor caught using his phone to cheat in an exam.[45] The determination notes that in evidence submitted in writing the doctor had *'expressly stated that he had not planned to use his phone in advance of the Examination.'* However, *'it was only in answering the Tribunal's questions that [the Dr] admitted that he had used his phone throughout the Examination and that he had been thinking about cheating, if he could, in the week before the Examination.'* This particular case involved serious professional dishonesty and therefore the panel gave *'serious consideration'* to a sanction of erasure. In such cases which lie on the borderline between sanctions, the ability to test the evidence may take on even greater significance.

4.8. The importance of hearing live testimony was also a recurrent theme in our research with patients and the public on the future of fitness to practise.[46] Participants expressed concerns that if a case did not go to a hearing this may equate to a less thorough assessment of the evidence, and that without cross-examination regulators may fail to ascertain 'the truth':

- *'[research participants] pointed out that sometimes only the 'true' character becomes apparent during a face to face meeting and that issues or true feelings (for example, a lack of remorse on the part of the registrant) could be masked on paper.' [extracted from 'The patient and public perspective on future fitness to practise processes', Professional Standards Authority, May 2020]*

4.9. The same study noted the existence of *'a cultural discourse that honesty (or dishonesty)*

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[43] Bryce, M et al, February 2022, *The concept of seriousness in fitness to practise cases*: **The concept of seriousness in fitness to practise cases (gdc-uk.org)**

[44] Bryce, M et al, February 2022, *The concept of seriousness in fitness to practise cases*: **The concept of seriousness in fitness to practise cases (gdc-uk.org)**

[45] Medical Practitioners Tribunal Service, April 2023, *Record of determination: Dr Chak Ip:* **dr-chak-ip-6-apr-23.pdf (mpts-uk.org)**

[46] Community Research for the Professional Standards Authority, May 2020, *Patient and public perspective on future fitness to practise processes:* **patient-and-public-perspectives-on-future-fitness-to-practise-processes.pdf (professionalstandards.org.uk)**

or remorse can be seen on a person's face.' This was important to the patients and members of the public who participated.[47] However, it should be acknowledged that although the public may believe that the character or honesty of a witness can be better judged in person, case law sets out that a witness's credibility should not be assessed on their demeanour, nor the confidence with which they give evidence.[48]

4.10. Some regulators outlined in their responses to our questionnaire that conflicts of evidence should be able to be resolved by case examiners, and should only be referred to a panel in exceptional circumstances:

- *'Where case examiners are faced with competing versions of events, then it is only where they consider that neither one is more probable than the other, based on their assessment of all the written evidence, that they will be justified in referring the matter to a panel' [healthcare professional regulator]*
- *'Exceptionally where decision on impairment can't be reached on the papers, a hearing provides an alternative mechanism which may allow an evidential dispute to be resolved' [healthcare professional regulator]*

4.11. In our review of Social Work England's accepted outcomes process we concluded that there were cases which were *'likely to be less suitable for summary assessments based on the papers only.'* These included cases where there were disputes about the material facts or uncertainty around the background to, and seriousness of, the conduct (for example, if the registrant interprets the facts in a way which contradicts the impression of other witnesses or where there may be concerns about the evidence of those witnesses).[49]

4.12. Social Work England's guidance on fitness to practise notes that while their case examiners cannot resolve conflicts of fact *'they can assess the weight of the evidence. In some instances where there is a factual dispute, there may be clear and cogent evidence supporting one side of the dispute. This may also be confirmed and supported by other evidence. The evidence to the contrary may also be inconsistent or wholly implausible.'* [50] We agree that in many cases the weight of evidence will mean that case examiners are able to make a robust decision about competing evidence. However, as the Social Work England guidance goes on to note*, 'if there is a significant evidential dispute, the case may need to be referred to a hearing'.*[51]

4.13. We are of the view that where there is competing evidence which is material to the case, and where two or more differing accounts are plausible and the dispute cannot be

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[47] Community Research for the Professional Standards Authority, May 2020, Patient and public perspective on future fitness to practise processes: **patient-and-public-perspectives-on-future-fitness-to-practise-processes.pdf (professionalstandards.org.uk)**

[48] R (on the application of) Dutta v General Medical Council [2020] EWHC 1974 (Admin): **High Court Judgment Template**

[49] Professional Standards Authority, May 2021, *Review of Social Work England's process for 'accepted outcomes' in fitness to practise cases:* **Review of Social Work England's process for 'accepted outcomes' in fitness to practise cases | PSA**

[50] Social Work England, December 2022, *Case examiner guidance:* **Case examiner guidance - Social Work England**

[51] Social Work England, December 2022, *Case examiner guidance:* **Case examiner guidance - Social Work England**

resolved with reference to the other evidence that is available, the substantive panel is the correct arena for testing the evidence of both the registrant and the witness. Further, there may be cases where the account given in writing by one or more parties appears lacking, or where case examiners consider that the evidence of the registrant or a witness would benefit from further exploration/examination.

4.14. Case examiners may wish to consider whether further written evidence could be obtained which would enable them to reach a decision before they consider referral to a panel. We would not recommend that case examiners refer a case to a hearing solely because they had insufficient evidence, where further documentary evidence could effectively fill the gap. However, written evidence is not a direct substitute for oral testimony and is not capable of being tested in the same way. There may still be instances where the case examiner determines that, even with the benefit of the additional information, a hearing is needed to fairly test a dispute of fact or conflict of evidence.

4.15. We do not seek to spell out circumstances or types of cases where a hearing may be required to test the evidence, but would expect case examiners to be able to identify these. In our review of Social Work England's accepted outcomes process we noted that *'all the cases where we considered that the decision might be insufficient to protect the public, were ones which in our view ought to have been heard by panels. Since Case Examiners are the gate-keepers deciding whether a matter should reach a panel, it is essential that their training and guidance should stress these considerations.'* [52]

Is there complexity in the case or evidence suggesting that a hearing may be beneficial?

4.16. In responses to our fitness to practise disposal route questionnaire, two regulators suggested that a panel hearing may be beneficial where the case under consideration is particularly complex:

- *'There may be some types of cases that might be more appropriately dealt with by a panel hearing. This could include cases involving more complex or challenging clinical issues, where there is a difference of opinion that needs to be explored.' [healthcare professional regulator]*

4.17. This is supported by the report *Advice on biases in fitness to practise decision-making in accepted outcome versus panel models* for the Professional Standards Authority,[53] which suggests that 'paper heavy cases' (which can to some extent serve as a proxy for complexity) may be less suitable for an accepted outcome. However, the author makes this recommendation on the basis that decision-makers may be more prone to certain biases (e.g. the absent-mindedness bias) in such cases, rather than due to an explicit need to hear oral evidence.

4.18. We would expect case examiners to be generally capable of dealing with complex cases

[52] Professional Standards Authority, May 2021, *Review of Social Work England's process for 'accepted outcomes' in fitness to practise cases:* **Review of Social Work England's process for 'accepted outcomes' in fitness to practise cases | PSA**

[53] Cuthbert, L, 2021 for the Professional Standards Authority, *Advice on biases in fitness to practise decision-making in accepted outcome versus panel models for the Professional Standards Authority*: **advice-on-biases-in-fitness-to-practise-decision-making.pdf (professionalstandards.org.uk)**

without the need to refer to a panel. However, they may wish to consider whether the complexities arising in a case are such that the evidence or issues under consideration would benefit from further exploration, examination or discussion at a hearing to support understanding and decision-making.

4.19. This could arise, for example, with a case turning on complex clinical details involving a number of expert witnesses. In such cases, pre-hearing case meetings can be useful in that they can enable experts to produce a joint report, leaving adjudicators to deal only with the outstanding disputed points. The subsequent hearing provides an opportunity for the panel to test the evidence of the expert witnesses, and others. There may be cases involving a tricky ethical dilemma, where it would be beneficial for decision-makers to be able to discuss the implications for public protection across all three limbs, in order to reach a sound decision.

4.20. It is for case examiners to decide whether the complex aspects of a case or the evidence suggest that a hearing would be beneficial.

Would it be beneficial and proportionate to test insight at a hearing?

4.21. Insight can be described as *'a registrant's genuine understanding and acceptance of the concerns which have been raised in relation to their conduct or competence.'*[54] In fitness to practise proceedings, registrants can demonstrate insight in a range of ways, usually involving accepting that they should have behaved differently and expressing remorse, showing empathy and understanding, and taking steps to remediate. This is set out in case law in Kimmance v GMC, where the judgement notes that *'a doctor or other professional who has done wrong has to look at his or her conduct with a self-critical eye, acknowledge fault, say sorry and convince a panel that there is real reason to believe he or she has learned a lesson from the experience.'*[55]

4.22. Insight plays an integral role in fitness to practise as it is key to understanding the ongoing risk posed by a registrant and is relevant to an assessment of any attitudinal failings. The relevance of remediation and risk of repetition to the assessment of current impairment is underpinned by case law (for example Cohen v GMC)[56] and is detailed in the sanctions (and other) guidance published by regulators. A registrant who shows genuine insight and attempts to remediate is more likely to comply with any conditions placed on them, and less likely to repeat the behaviour, than one who does not. Such is the importance of insight that failure to express it is likely to lead to a more serious sanction, whereas demonstrating full insight may mitigate the need for any regulatory action at all:

- *'A key factor in determining what, if any, sanction is appropriate is likely to be the extent to which a registrant recognises their failings and is willing to address them. Where a registrant does recognise their failings and is willing to address them, the risk of repetition is reduced.' [HCPC 'Sanctions Policy']*[57]

[54] Health and Care Professions Council, March 2019, *Sanctions Policy*: **sanctions-policy.pdf (hcpc-uk.org)**
[55] Dr Kimmance v GMC [2016] EWHC 1808 (Admin): **Kimmance v General Medical Council | [2016] EWHC 1808 (Admin) | England and Wales High Court (Administrative Court) | Judgment | Law | CaseMine**
[56] Cohen v GMC [2008] EWCH 581: **Cohen v General Medical Council | [2008] EWHC 581 (Admin) | England and Wales High Court (Administrative Court) | Judgment | Law | CaseMine**
[57] Health and Care Professions Council, March 2019, *Sanctions Policy*: **sanctions-policy.pdf (hcpc-uk.org)**

- *'Evidence of the nurse, midwife or nursing associate's insight and any steps they have taken to strengthen their practice will usually be central to deciding whether their fitness to practise is currently impaired' [NMC 'Insight and Strengthened Practice']*[58]
- *'[risk is increased where] the doctor has demonstrated a lack of insight in relation to their dishonest behaviour. This may increase the likelihood of future repetition and the overall risk posed by the doctor.' [GMC 'Making decisions on cases at the end of the investigation stage: Guidance for the Investigation Committee and case examiners']*[59]

4.23. The central role of insight in determining appropriate regulatory action makes its assessment crucial to the impairment and sanctions stages of the fitness to practise process. When cases are disposed of using accepted outcomes, insight will have to have been demonstrated on paper, most commonly in the form of reflective statements/pieces of writing. This is often accompanied by evidence of more concrete action to remediate failings such as evidence of attendance at relevant training courses.

4.24. There remain doubts over the extent to which insight can be determined on the papers alone in more difficult and complex cases and those which may indicate serious/fundamental attitudinal issues. This was considered in the Court of Appeal judgment of The Professional Standards Authority vs. The Health and Care Professions Council and Benedict Doree,[60] where the judgement outlined that oral evidence may sometimes be the *'best'* and *'only convincing'* evidence of insight (although the Court accepted that it was possible for insight to be demonstrated on paper):

- *'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... 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.'*

4.25. Insight was also considered in Kimmance, where Mr Justice Kerr noted that: *'Nine times out of ten, you cannot [demonstrate insight] if you do not turn up to the hearing. The panel will want to ask questions'.*[61]

4.26. The panel's role in probing insight is further explored in the report *The concept of*

[58] NMC, 2021, *Insight and strengthened practice:* **Insight and strengthened practice - The Nursing and Midwifery Council (nmc.org.uk)**
[59] GMC, 2021, *Making decisions on cases at the end of the investigation stage: Guidance for the Investigation Committee and case examiners:* **Making decisions on cases at the end of the investigation stage: Guidance for the Investigation Committee and case examiners (gmc-uk.org)**
[60] Professional Standards Authority and (1) The Health and Care Professions Council (2) Benedict Doree [2015] EWHC 822 (Admin): **The Professional Standards Authority v The Health And Care Professions Council & Anor [2017] EWCA Civ 319 (28 April 2017)**
[61] Dr Kimmance v GMC [2016] EWHC 1808 (Admin): **Kimmance v General Medical Council | [2016] EWHC 1808 (Admin) | England and Wales High Court (Administrative Court) | Judgment | Law | CaseMine**

seriousness in fitness to practise cases[62] which notes that:

- *'Panel members explained the importance of being able to question registrants and examine their evidence in person in informing their views of that registrant's insight into their conduct, and the extent of any remorse shown or remediation activities undertaken. These factors are key to panels' decisions about whether the registrant has effectively mitigated any risk posed by their past conduct, and strongly inform decisions about impairment and sanction.'*

4.27. This view is supported by the Doctor's Defence Service, which notes that*: 'MPTS panels and GMC prosecutors have a knack of asking questions that draw out the hollowness of a doctor's assurances, that they have full insight.'*[63]

4.28. In responding to our questionnaire on fitness to practise disposal routes, a number of regulators expressed the view that insight is easier to assess at a hearing, and some detailed the types of cases where they believed this to be particularly relevant:

- *'A key part of the fitness to practise process is testing whether a registrant has insight into the issues under investigation. Therefore, a factor in deciding whether a case should be dealt with by accepted outcome or panel hearing is whether the registrant is able to show insight and whether the format allows for that insight to be explored or examined. For example, in cases involving dishonest behaviour, criminal activity or a poorly managed health concern, it may be best for the case to go to a panel hearing. This would more easily allow the registrant to demonstrate their insight and the panel to assess that insight, than could happen through the accepted outcome process.' [healthcare professional regulator]*
- *Cases [more appropriately dealt with by a panel are ones] where insight and remediation would be difficult for a registrant to demonstrate or a case examiner to determine...These include cases which are so egregious that declarations of insight and remediation may be contested by others. Such cases may include allegations of:*
    - *Sexual misconduct*
    - *Bullying and discrimination*
    - *Dishonesty e.g. fraud*
    - *Pre-meditation*
    - *Allegations that fall within the 'Listed Offences' but were not charged by CPS (e.g. rape). [health/care professional regulator]*
- *'We have found that panels may be better placed to undertake an assessment of the level of insight and remediation as they are able to ask a [registrant] to address these areas in person and test them accordingly.' [healthcare professional regulator]*

4.29. However, this view was not universally shared among regulators, with some stating that case examiners are experienced at taking insight into account and capable of making a

[62] Bryce, M et al, February 2022, *The concept of seriousness in fitness to practise cases*: **The concept of seriousness in fitness to practise cases (gdc-uk.org)**
[63] Doctors Defence Service, *Reflective Writing in GMC Cases – Showing Insight*: **Reflective Writing in GMC Cases – Showing Insight | Doctors Defence Service – UK.**

robust assessment:

- *'Case examiners are already experienced at taking insight into account when making decisions under the current legislation. In the future, as part of the reforms, we will have the power to require information from the professional at an early stage and throughout the process. This includes comprehensive written evidence of insight and strengthened practice. We expect that an earlier engagement with the professional on insight and strengthened practice will help case examiners to carry out a robust assessment of insight.' [healthcare professional regulator]*

4.30. Whilst we accept that case examiners are experienced at assessing and weighing all the evidence before them, we maintain the view that panels often have an advantage in assessing insight in terms of seeing the registrant in person, hearing oral evidence and being able to ask probing questions.

4.31. Hearing oral testimony may also help to overcome some of the other challenges of assessing insight on paper. These are primarily that:

- registrants may receive significant support in producing their reflective statements
- technology such as AI is increasingly capable of writing such statements.

4.32. Whilst some regulators told us that they would train their case examiners to identify statements that may have been produced using AI, it is not clear whether such training would be effective. Whilst some sectors use technology to identify AI generated text, there is evidence that, at present, such software is flawed. Research has indicated that in the university sector, attempts to combat the use of AI are *'ineffective'* with software aimed at detecting it being found to have been *'neither accurate nor reliable.'*[64]

4.33. In our own reviews of the regulators' current practices, we have found deficiencies in the way that case examiners assess insight on the papers on some occasions. We have also previously said that we *'question the reliability of written statements as evidence of insight'* and stated that we didn't support consensual disposals where *'insight is a major factor in determining impairment or where it may be difficult to establish whether insight is genuine'.*[65] We have also noted that *'while insight can be demonstrated on paper through reflective pieces, the clarity with which it comes across may vary... We have seen, in a number of cases from other regulators, panels finding themselves better able to get a picture of a registrant's insight by seeing the registrant in person and being satisfied that, for example, a non-restrictive sanction may be appropriate.'*[66]

4.34. Overall, we are of the view that whilst panels generally might be better placed to assess insight, it clearly would not be proportionate to refer all cases where there is a question about insight to a panel. We would therefore only expect cases to be referred on this basis where the doubts are significant and/or the evidence available is incomplete or lacking

[64] The Times, 4 September 2023, *Students 'double cheat' to hide AI in their answers*: **Students 'double cheat' to hide AI in their answers (thetimes.co.uk)**
[65] Professional Standards Authority, 2017, *Right-touch reform: A new framework for assurance of professions*: **Right-touch reform - a new framework for assurance of professions | PSA**
[66] Professional Standards Authority, May 2021, *Review of Social Work England's process for 'accepted outcomes' in fitness to practise cases:* **Review of Social Work England's process for 'accepted outcomes' in fitness to practise cases | PSA**

credibility. In such cases panels are better placed than case examiners to make a full and robust assessment. This may be particularly important in cases where there are deemed to be serious attitudinal issues.[67]

4.35. However, it should be noted that a registrant's denial of the allegations at the investigation stage does not necessarily prohibit a finding that they have insight. While case law sets out that a registrant's denial of the allegations is relevant to insight and risk of repetition, this is not to say that admissions are necessary for a finding of insight to be made.[68] Insight may be demonstrated through, for example, a registrant proactively undertaking training in relation to the allegation at an early stage and reflecting on how their practice could be improved and what they would do differently. Further, even where insight has not been demonstrated, we do not suggest that this should automatically result in referral to hearing where it would not be beneficial or proportionate to do so.

5. Factors to consider when determining the composition of decision-makers

5.1. At present, all health professional regulators that use case examiners as part of a consensual resolution process assign two case examiners per case: one registrant and one lay.[69] This is also the case for Social Work England, which has the power to resolve all categories of case by means of case examiners offering an accepted disposal.[70] Fitness to practise panels (which are usually comprised of three people) always include a registrant and a lay person.

5.2. Using one lay and one registrant case examiner per case has two distinct advantages:

- using one registrant and one lay decision-maker is widely seen as fair to both the public and the profession subject to regulation
- the use of more than one decision-maker may result in more robust decisions and help to reduce bias.

5.3. The AAPA Order does not mandate the use of more than one case examiner, although the Government has made clear that they intend regulators to be able to use more than one where appropriate, stating that *'the regulator is best placed to assess where multiple case examiners may or may not be required.'*[71] The Order also provides discretion to regulators in terms of whether case examiners are registrants and/or lay people (although

[67] Research into seriousness in fitness to practise suggests that all regulators consider sexual misconduct, dishonesty and criminal convictions to be serious. See: Bryce, M et al, February 2022, *The concept of seriousness in fitness to practise cases*: **The concept of seriousness in fitness to practise cases (gdc-uk.org)**

[68] Sayer v General Osteopathic Council [2021] EWHC 370 (Admin) upheld that that: 'It is wrong to equate maintenance of innocence with lack of insight. Denial of misconduct is not an absolute bar to a finding of insight. Admitting misconduct is not a condition precedent to establishing that the registrant understands the gravity of the offending and is unlikely to repeat it.' Available at: **Sayer v General Osteopathic Council [2021] EWHC 370 (Admin) (24 February 2021) (bailii.org)**

[69] A registrant case examiner must be a practicing member of the profession. A lay case examiner is someone who is not, and never has been, a member of the profession.

[70] Rule 34 of Social Work England's Fitness to practise rules 2019 sets out the requirement for cases at the case examiner stage to be considered by at least one lay person and at least one registrant.

[71] Department of Health and Social Care, 2023, *Consultation response to regulating anaesthesia associates and physician associates:* **Consultation response to regulating anaesthesia associates and physician associates - GOV.UK (www.gov.uk)**

requirements for registrant and lay members will continue to apply to panels and there continues to be an expectation of lay representation at Board level). This means that in future, regulators will have greater flexibility in terms of the composition and number of case examiners they use. This will likely reduce costs, especially where a regulator decides that a single case examiner is sufficient.

5.4. While there are advantages in terms of cost and efficiency in the single case examiner model, there are also potential risks to fairness, or perceptions thereof.

Lay representation in decision-making

5.5. The principle that fitness to practise decision-making should involve lay people and registrants is a long-established one. The issue was examined in detail in the Fifth Shipman Report which criticised proposals to curtail the involvement of lay people in fitness to practise decision-making and concluded that it was a *'fundamental requirement for lay involvement in all cases that might be closed without referral to a FTP panel.'*[72] The report goes on to note that *'lay involvement in all decisions is likely to result in improved quality decision-making.'* [73]

5.6. In terms of registrant representation, this is something that is widely valued by regulated professionals, as highlighted by regulators in response to our fitness to practise disposal route questionnaire:

- *'Many registrants take assurance from being judged by people who share their professional background.' [healthcare professional regulator]*
- *'Registrants may take comfort from being judged by someone who has 'walked in their shoes' and understands their profession.' [healthcare professional regulator]*

5.7. The majority of regulators that responded to our questionnaire reported that they intended to continue to use both registrant and lay case examiners in most cases in any future fitness to practise arrangements:

- *'Our view is that it is important for both lay and professional case examiners to be involved in decision-making in order to maintain the confidence of members of the public and the professionals on our register in our FtP processes.' [healthcare professional regulator]*
- *'It has been standard practice for many years within regulation for a professional to be 'judged' by a peer and a member of the public. This has seemed to work well. [healthcare professional regulator]*

5.8. In contrast, some questioned the need for such an arrangement, particularly as the registrant case examiner may not work in the same field or speciality as the person subject to fitness to practise proceedings, and the lay case examiner is not a patient representative.

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[72] The Shipman Inquiry, 2004, *Fifth report: Safeguarding Patients: Lessons from the Past - Proposals for the Future*: **[ARCHIVED CONTENT] The Shipman Inquiry - Fifth Report (nationalarchives.gov.uk)**
[73] The Shipman Inquiry, 2004, *Fifth report: Safeguarding Patients: Lessons from the Past - Proposals for the Future*: **[ARCHIVED CONTENT] The Shipman Inquiry - Fifth Report (nationalarchives.gov.uk)**

5.9. In our view, registrant representation in decision-making may bring benefits in terms of maintaining the confidence of the profession and for the quality of decision making. It would be reasonable for regulators to take this into account when developing fitness to practise processes, although we acknowledge that there are a range of ways of ensuring registrant input, for example through expert reports.

5.10. We know from various research reports that we have commissioned that whilst the public largely support the use of accepted outcomes in fitness to practise, they do have concerns over the robustness and independence of decision making.[74] [75] Much of this concern is driven by a fear that regulators may be biased in favour of registrants. For example, our report *The patient and public perspective on future fitness to practise processes* highlighted that *'whilst participants were unsure if the individual regulators would actually favour registrants, there was certainly a fairly widespread assumption that this was a possibility.'*[76]

5.11. From a public protection - and particularly public confidence - perspective, we are of the view that lay representation in decision-making must remain a feature of the fitness to practise process. We would expect regulators to be mindful of the need to incorporate lay decision-makers at some point in the process.

The use of single decision-makers

5.12. Research into decision-making has emphasized that all decision-making processes, and indeed all individual decision-makers, are affected by bias.[77] Whilst it is not possible to eliminate bias from decision-making, it is important to reduce it where possible.

5.13. Research we commissioned into biases in fitness to practise decision-making defined cognitive biases, and their impact, as follows:

- *Cognitive biases are mental shortcuts which reduce the cognitive load on an individual but bias the way attention is then allocated in processing data the individual receives. This has a number of effects including: making us be too quick to make a decision (ignoring evidence that is contrary to our opinion), being overly zealous in justifying our personal opinions, and selectively searching for evidence that supports our past judgments, rather than objectively evaluating all the information available to us.*[78]

[74] Community Research for the Professional Standards Authority, May 2020, *Patient and public perspective on future fitness to practise processes:* **patient-and-public-perspectives-on-future-fitness-to-practise-processes.pdf (professionalstandards.org.uk)**
[75] Professional Standards Authority, May 2013, *Public Response to Alternatives to Final Panel Hearings in Fitness to Practise Complaints*: **Alternatives to final panel hearings for fitness to practise cases – the public perspective | PSA**
[76] Community Research for the Professional Standards Authority, May 2020, *Patient and public perspective on future fitness to practise processes:* **patient-and-public-perspectives-on-future-fitness-to-practise-processes.pdf (professionalstandards.org.uk)**
[77] Cuthbert, L, 2021 for the Professional Standards Authority, *Advice on biases in fitness to practise decision-making in accepted outcome versus panel models for the Professional Standards Authority*: **advice-on-biases-in-fitness-to-practise-decision-making.pdf (professionalstandards.org.uk)**
[78] Cuthbert, L, 2021 for the Professional Standards Authority, *Advice on biases in fitness to practise decision-making in accepted outcome versus panel models for the Professional Standards Authority*: **advice-on-biases-in-fitness-to-practise-decision-making.pdf (professionalstandards.org.uk)**

5.14. The study notes that biases are likely to occur in fitness to practise decision-making as *'cognitive biases are particularly likely to influence reasoning when people are making decisions under uncertainty.'* [79] The research outlines a comprehensive list of biases that may affect both individual and group decision-making, including absent-mindedness bias, ambiguity bias, blind spot bias, and the backfire effect.[80] It concludes that there are different biases likely to impact case examiners and fitness to practise panels, and suggests that on the basis of these, some cases may potentially be more appropriate for disposal by one route over the other. The author suggests that cases more suited to an accepted outcome include those with *'very little missing information and very little ambiguity'* whereas those which may be more appropriate for a panel are:

- 'Paper-heavy cases as there would be less likelihood of a number of the biases which would impact on an individual decision maker considering matters on the papers having a significant effect e.g. the absent-mindedness bias.
- Cases which may involve different cultural considerations (providing the panel itself is diverse) as individual decision makers may be more prone to blind spot bias and to stereotyping, whether intentionally or not.
- Cases with significant 'gaps' in the information and/or with substantial ambiguity as to what occurred.'[81]

5.15. The above recommendations notwithstanding, we do not think the evidence is sufficiently robust to recommend cases progress to a panel hearing purely on the basis of mitigating risk of bias. As we noted in our review of Social Work England's accepted outcome process, *'there appears to be nothing inherent in the role of Case Examiners which makes their decisions of higher or lower quality than those of panels. The good decisions that we saw were reasoned to a similar level to good panel decisions and the poor ones we saw were not markedly worse than poor panel decisions.'*[82]

5.16. However, we do see merit in regulators considering which cases may benefit from the involvement of more than one decision-maker. As the research into biases notes, whilst all individuals are susceptible to bias, it is likely that *'each decision maker would be affected differently by different biases, especially if the backgrounds of the Case Examiners were diverse.'*[83] It is therefore likely that two decision-makers may counteract

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[79] Cuthbert, L, 2021 for the Professional Standards Authority, *Advice on biases in fitness to practise decision-making in accepted outcome versus panel models for the Professional Standards Authority*: **advice-on-biases-in-fitness-to-practise-decision-making.pdf (professionalstandards.org.uk)**

[80] See pages 10-17 of the following for a description of these, and other, biases that may impact decision making: Cuthbert, L, 2021 for the Professional Standards Authority, *Advice on biases in fitness to practise decision-making in accepted outcome versus panel models for the Professional Standards Authority*: **advice-on-biases-in-fitness-to-practise-decision-making.pdf (professionalstandards.org.uk)**

[81] Cuthbert, L, 2021 for the Professional Standards Authority, *Advice on biases in fitness to practise decision-making in accepted outcome versus panel models for the Professional Standards Authority*: **advice-on-biases-in-fitness-to-practise-decision-making.pdf (professionalstandards.org.uk)**

[82] Professional Standards Authority, May 2021, *Review of Social Work England's process for 'accepted outcomes' in fitness to practise cases:* **Review of Social Work England's process for 'accepted outcomes' in fitness to practise cases | PSA**

[83] Cuthbert, L, 2021 for the Professional Standards Authority, *Advice on biases in fitness to practise decision-making in accepted outcome versus panel models for the Professional Standards Authority*: **advice-on-biases-in-fitness-to-practise-decision-making.pdf (professionalstandards.org.uk)**

each other's biases to some extent.

5.17. This is supported by the interviews with decision-makers conducted as part of the research into seriousness in fitness to practise:

- *'Other forms of informal calibration during decision-making came from the process of discussion between decision-makers. At both Case Examiner and FtP panel stages, interview participants described how working with colleagues to make decisions served to moderate those decisions. The composition of panels changes with each case, and participants described that working with different people brought different perspectives and experiences to the decision-making process'.*[84]

5.18. The importance of decision-makers working together is also emphasised in job specifications for the case examiner role, with the NMC's job description noting that: *'you will reach consensus on the most appropriate outcome for a case...You may initially have divergent views, but will negotiate to reach agreement.'*[85]

5.19. Not only does using a single decision-maker potentially increase the risk of bias, there is also increased risk in terms of perceptions of bias and unfairness. Our research with patients and the public noted that *'particular concerns were expressed about a small number of people (sitting on Investigating Committees or as Case Examiners) making decisions on cases in private with no further oversight.'*[86] This was also discussed in the report of the Fifth Shipman Inquiry, which noted that *'concern was also expressed by some individuals and organisations that the proposed model would place too much responsibility in the hands of one individual.'*[87] This point was further echoed in responses to the Government consultation on regulating healthcare professionals, with the consultation analysis quoting one respondent as follows: *'there is a risk of lack of impartiality and unconscious bias when decisions are made by one person'.*[88]

5.20. In responding to our fitness to practise disposal route questionnaire, some regulators suggested that the number of decision makers required could vary depending on the case:

- *'The level of input needed may vary depending on the characteristics of a case and a case dealing with a conviction for child abuse might not require the same input as a case dealing with a complex clinical issue' [healthcare professional regulator]*

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[84] Bryce, M et al, February 2022, *The concept of seriousness in fitness to practise cases*: **The concept of seriousness in fitness to practise cases (gdc-uk.org)**

[85] NMC, 2019, *Job description:* case examiner – lay: **google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwiGjvTXtM2BAxUyQkEAHY_pBJcQFnoECDkQAQ&url=https%3A%2F%2Fwebmicrosites.hays.co.uk%2Fdocuments%2F6167491%2F0%2FCase%2BExaminer%2B%2B-%2BLay%2BRole%2BProfile.doc%2F6d249b9f-e1d5-7598-1c04-ad7b8c1d7fd5%3Ft%3D1594114538454&usg=AOvVaw0Z9F_Eskn9Jz1OJpNJ7r3O&opi=89978449**

[86] Community Research for the Professional Standards Authority, May 2020, *Patient and public perspective on future fitness to practise processes:* **patient-and-public-perspectives-on-future-fitness-to-practise-processes.pdf (professionalstandards.org.uk)**

[87] The Shipman Inquiry, 2004, *Fifth report: Safeguarding Patients: Lessons from the Past - Proposals for the Future*: **[ARCHIVED CONTENT] The Shipman Inquiry - Fifth Report (nationalarchives.gov.uk)**

[88] Department of Health and Social Care, February 2020, *Regulating healthcare professionals, protecting the public: consultation response analysis:* **Regulating healthcare professionals, protecting the public: consultation response - analysis (publishing.service.gov.uk)**

5.21. Although the evidence on bias in decision-making is not conclusive, there are legitimate concerns that the use of a single decision-maker may increase the risk and/or perception of bias. Conversely, there is evidence that decision-makers working together may bring a wider perspective which can help to counteract bias and may lead to more balanced decisions.

5.22. We agree with the view expressed by some regulators that some cases could be safely and fairly resolved using a single decision-maker. These are likely to include cases where there is little ambiguity about the facts and current impairment, such as those involving a conviction.

5.23. Cases that may benefit from more than one decision-maker are likely to be those which are complex or 'paper heavy', involve significant ambiguity as to what has occurred and/or as to current impairment, or where there are particular cultural considerations.

5.24. In addition to the number of decision-makers assigned to a case, it is important that regulators have due regard to the training and expertise of those making decisions. As we outlined in our advice to the Secretary of State on how public confidence is maintained in fitness to practise:

- *'the views of Panellists and the Courts are inevitably shaped by their background and experience. Although Panel members have assured us that they exercise the utmost professionalism in carrying out their role and seek to avoid channelling their own views directly, regulators must play a role by ensuring that Panels have access to a wide range of public views to broaden their thinking and by seeking to ensure that Panels are drawn from a sufficiently diverse pool.'*[89]

5.25. Whilst the above is focused on fitness to practise panellists, it applies equally to case examiners. From an equality, diversity and inclusion (EDI) perspective, having decision makers with cultural competence is an important part of reducing bias and promoting fair decisions in fitness to practise - and this becomes all the more important if a regulator is using single decision-makers. This aligns with Standard 3 of our Standards of Good Regulation, which includes the requirement for regulators to *'ensure that its processes do not impose inappropriate barriers or otherwise disadvantage people with protected characteristics'.*[90] Our guidance document on the standard further outlines that regulators should *'provide appropriate training on EDI issues to help staff, panellists and others to make fair and unbiased decisions.'* [91]

6. Factors to consider when publishing case examiner decisions

6.1. The shift away from a panel-based hearings model to the paper-based accepted outcomes model has the potential to reduce the transparency of the decision-making process, which may in turn have adverse consequences for public confidence and the maintenance of standards. Whilst panel hearings are by and large conducted in public,

[89] Professional Standards Authority, 2019, *How is public confidence maintained when fitness to practise decisions are made? Advice to the Secretary of State*: **How is public confidence maintained when fitness to practise decisions are made? | PSA**
[90] Professional Standards Authority. *The Standards of Good regulation*: **Standards of Good Regulation | PSA**
[91] Professional Standards Authority, 2023, *Guidance for regulators: assessing performance against Standard 3:* ***Assessing performance against Standard 3 - guidance for regulators***

accepted outcomes will be considered and agreed in private. This has led to concern from some stakeholders about decisions being made 'behind closed doors', and corresponding concerns that this may affect the quality and robustness of decision-making.

Promoting transparency and public confidence

6.2. As we have previously explored, 'public confidence' and the 'public interest' (terms which are closely related) are somewhat nebulous concepts.[92] However, there is an understanding common to regulators and the public that there is a 'public interest' in decisions being made in an open and transparent way. This corresponds with Article 6 of the European Convention on Human Rights which enshrines the right to a fair and public hearing.[93]

6.3. Whilst the legislation underpinning Social Work England determines that a case must be referred to a panel if it is in the public interest to do so, no such provision is contained within the AAPA Order.

6.4. Two separate pieces of research we commissioned have identified that decisions being made in private is an area of concern. Research with patients and the public found that participants *'were concerned about decisions being made 'behind closed doors' and felt that, in the emerging fitness to practise model, action needs to be taken to ensure that information is accessible.'*[94] A further study with members of the public found *'an assumption that because the visible, public face of the process would be removed that the whole FtP complaints process would become more closed, and that complaints would be more easily 'brushed under the carpet' than they are at the moment.'*[95]

6.5. A similar point was raised in the Shipman Inquiry, which cautioned against the introduction of processes that may result in a loss of transparency.[96] AvMA (Action Against Medical Accidents) have also warned that *'there are already significant concerns around the transparency of decision making with existing procedures operated by some regulators.'*[97]

6.6. Ensuring that decisions are transparent and accessible is a key means by which confidence in regulators, and regulatory processes, is maintained. Although we have previously stated that we *'are not aware of evidence that public hearings are the most effective means of maintaining public confidence',* we have also noted that the accepted

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[92] Professional Standards Authority, 2019, *How is public confidence maintained when fitness to practise decisions are made? Advice to the Secretary of State*: **How is public confidence maintained when fitness to practise decisions are made? | PSA**

[93] Equality & Human Rights Commission, *The Human Rights Act – Article 6: Right to a fair trial*: **Article 6: Right to a fair trial | Equality and Human Rights Commission (equalityhumanrights.com)**

[94] Community Research for the Professional Standards Authority, May 2020, *Patient and public perspective on future fitness to practise processes:* **patient-and-public-perspectives-on-future-fitness-to-practise-processes.pdf (professionalstandards.org.uk)**

[95] Professional Standards Authority, May 2013, *Public Response to Alternatives to Final Panel Hearings in Fitness to Practise Complaints*: **Alternatives to final panel hearings for fitness to practise cases – the public perspective | PSA**

[96] The Shipman Inquiry, 2004, *Fifth report: Safeguarding Patients: Lessons from the Past - Proposals for the Future*: **[ARCHIVED CONTENT] The Shipman Inquiry - Fifth Report (nationalarchives.gov.uk)**

[97] Action against Medical Accidents, 2021*, AvMA response to Regulating Healthcare Professionals, Protecting the Public*: **AvMA-Response-to-Regulating-Healthcare-Professionals-June-2021.pdf**

outcomes model *'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'.*[98]

6.7. In responding to our questionnaire on fitness to practise disposal routes, most regulators were of the view that public confidence in decision making could be maintained by publishing fitness to practise decisions, be that in respect of a panel hearing or an accepted outcome:

- *'Public confidence in the Accepted Outcome process is achieved through good quality decisions and transparency about those decisions. We propose that full decision-reasoning for action taken in the Accepted Outcome process will be published in the same way as for tribunal decisions.' [healthcare professional regulator]*
- *'Transparency and openness are essential when handling cases disposed of using an accepted outcome. We believe that it is essential to publish the allegations, the acceptance of those allegations by the registrant and the outcome from the panel. This marks the seriousness of the concern and allows the public to understand how the regulator has dealt with the concern.' [healthcare professional regulator]*

6.8. However, some felt simply publishing the outcome of a paper-based process would not always be enough, and that there would still be cases where a hearing was required to satisfy the public interest:

- *'We believe that cases involving the public interest are precisely the sorts of cases that may benefit more from a panel hearing, to support open justice' [healthcare professional regulator]*

6.9. We acknowledge that there are differing views on how public confidence in decisions, and decision-making, can be achieved, particularly in cases that are likely to be of greater interest to the public. We are not persuaded that there are categories of cases that should be referred to a panel purely on public interest grounds, particularly as this is not provided for in the AAPA Order. However, this is an area we may review over time. This does not apply to Social Work England, for whom it is a legislative requirement to consider whether cases should be referred to a hearing in the public interest.

6.10. In our view, the public interest in transparent decision-making determines that the decision itself, the information underpinning it, and the way it is communicated are capable of maintaining public confidence and declaring and upholding professional standards. The public must be able to have confidence in both the process and the outcome. Key to achieving this is ensuring that sufficient detail about cases and how they are resolved is published.

6.11. In order for a decision to maintain public confidence and uphold professional standards it must be publicly available and include enough detail so that a third party with no prior knowledge of the case would be able to fully understand both the basis of the concern and the rationale for the decision. To satisfy these requirements, it is likely to be

[98] Professional Standards Authority, 2017, *Right-touch reform: a new framework for assurance of professions*: **Report (for web)**

necessary to include:

- sufficient details of the regulatory concern or allegations
- the relevant facts and background of the case
- details of the admissions and submissions made by the registrant
- the regulator's decision in respect of the statutory grounds
- the regulator's assessment of impairment
- the final outcome including sanction.

6.12. There are, however, cases where some of the information outlined above should remain confidential, for example those involving a registrant's health concerns, or where there is other sensitive or confidential evidence. There are also some limited and exceptional circumstances where it may be appropriate for the registrant to be granted anonymity, as set out in case law.[99]

Case law

6.13. The requirement to give clear reasons for regulatory decisions is also underpinned by case law. For example, in the case of PSA and General Optical Council v Honey Rose, Justice Collins Rice outlines a panel's obligation to uphold public confidence by giving proper reasons for its decision:

- *"... the duties that expert tribunals have to the public - to ensure that the public can understand why certain decisions have been reached in its name; can be reassured that healthcare professionals on whom they must depend are well and fairly regulated; and can know that the overarching obligation professionals have to deserve the trust the public places in them, and to discharge their professional duties with the interests and safety of patients uppermost, has a secure foundation."*[100]

6.14. Similarly, in the case of Professional Standards Authority for Health and Social Care v General Medical Council [2023] EWHC 967 (Admin) the court quashed a finding of the Medical Practitioners Tribunal Service on the basis of 'serious procedural irregularity' due to a failure by the panel to give cogent reasons for its decision. The judgement noted that a panel must *'expose the relevant analysis so the reader understands what the principal issues were, and what the Panel made of them. This is part and parcel of their function in protecting the public interest.'*[101]

6.15. We consider that the level of detail included by Social Work England in its published case examiner decisions[102] serves as a good template for other regulators to follow. In providing

[99] See for example GMC v X [2019] EWHC 493 (Admin), available at: **2019_ewhc_493_GMC_v_Dr_X.pdf (oldsquare.co.uk)** and MXM v GMC [2022] EWHC 817 (Admin), available at: **Dr MXM v General Medical Council [2022] EWHC 817 (Admin) (06 April 2022) (bailii.org)**

[100] PSA and General Optical Council v Honey Rose [2021] EWHC 2888 (Admin) at [82]: **Professional Standards Authority for Health And Social Care v General Optical Council & Anor [2021] EWHC 2888 (Admin) (01 November 2021)**

[101] *Professional Standards Authority for Health and Social Care v General Medical Council [2023] EWHC 967 (Admin): **https://www.judiciary.uk/wp-content/uploads/2023/04/PSA-v-GMC-judgment-270423.pdf***

[102] Social Work England, *Case examiner decisions*: **https://www.socialworkengland.org.uk/concerns/hearings-and-decisions/case-examiner-decisions/**

full details of regulatory concerns, grounds for actions, the reasoning behind any decision-making, and the final sanction, regulators can ensure that their duties to uphold public confidence and maintain standards are discharged in relation to the publication of fitness to practise decisions that are resolved by way of an accepted outcome.

7. Promoting a fair and effective accepted outcomes process

7.1. In addition to ensuring that cases are determined by way of the most appropriate route, involve the right composition of decision-makers, and that published determinations are sufficiently detailed, we will expect regulators to have robust processes in place to ensure the fairness and effectiveness of investigation and decision-making procedures. Regulators should have particular regard to:

- ensuring that complainants (particularly where the complainant is a patient or service user) are treated with dignity and respect, feel heard, and are kept informed throughout each stage of the accepted outcomes process
- ensuring that case examiners' use of accepted outcomes is fair and proportionate, and that case examiners do not face pressure to offer sanctions that are insufficient to protect the public on the basis that they are more likely to be accepted
- ensuring that equality, diversity and inclusion is fully considered within the accepted outcomes process, and to minimise risks that the process results in adverse outcomes for complainants or registrants with certain protected characteristics compared with those who do not share those characteristics.

7.2. Regulators should also consider how they communicate with patients, the public and registrants, and seek to ensure that all communications are compassionate.

Complainant voice in accepted outcomes

7.3. Fitness to practise proceedings are concerned with whether the registrant in question has the skills, abilities, competence and character to practise safely. Action taken against a registrant is focused on the need to protect the public (in the widest sense), not to deliver 'justice' to those who may have been harmed by a registrant's actions, nor to punish the registrant for wrongdoing. The role of complainants is therefore to provide evidence relevant to the regulatory concern.

7.4. It is imperative that complainants (particularly where they are patients or service users) feel that their concerns have been heard within the fitness to practise process, that they are treated with respect, and that they are kept informed about the progress of the case. This is not just because doing so is right and fair, but because the fitness to practise process itself is reliant on the goodwill and co-operation of witnesses and those who report wrongdoing in order to function. Regulators would be incapable of discharging their duty to protect the public without the support and confidence of complainants.

7.5. Through our commissioned research and our engagement with patient groups we have heard concerns that the accepted outcomes process may marginalise complainants. Our research with patients and the public on the future of fitness to practise found that participants' *'immediate question'* was whether *'patients or service users will still have a*

voice in the process.'[103] The research concludes that while on the whole accepted outcomes are supported, the requirement for patients to have a voice was felt to be *'essential.'*

7.6. Similarly, AvMA has welcomed the ability for cases to be dealt with more swiftly through the accepted outcomes process but cautioned that *'this should not be at the expense of excluding patients and families from the process.'*[104] AvMA has raised a particular concern about whether patients will have the right and opportunity to respond to evidence, particularly where the evidence of the registrant counteracts the evidence of the patient.

7.7. We believe that ensuring patients and service users who are witnesses in proceedings are treated with dignity and respect, feel heard, and are kept informed, is vital to ensuring confidence in the regulatory process. This should include ensuring that complainants (particularly where the complainant is a patient or service user) are afforded the opportunity to provide further evidence where appropriate. This may involve providing the complainant with a copy of the registrant's response and seeking further submissions from them.

The role of case examiners in proposing fair and proportionate accepted outcomes

7.8. The change in the status of decision-makers from independent members (panels) to employees (case examiners) is one of the most significant differences between the two models of disposal.

7.9. Our oversight of Social Work England has shown us that case examiners are generally skilled and proficient at making good decisions and proposing accepted outcomes to registrants that are fair and proportionate.

7.10. However, the fact that case examiners are less independent of the regulator than panel members could result in certain regulatory risks. In particular, the workloads of case examiners may be subject to targets which could affect the objectivity of their decisions. This risk may be heightened in a context in which regulators are experiencing major backlogs in fitness to practise cases.

7.11. Concern about the (lack of) independence of case examiners has been extensively highlighted by consumer research, patient groups and other stakeholders. Two pieces of research we have commissioned have found concerns amongst the public that regulators may offer lighter sanctions to registrants who are willing to forego a hearing.[105] [106] In one of

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[103] Community Research for the Professional Standards Authority, May 2020, *Patient and public perspective on future fitness to practise processes:* **patient-and-public-perspectives-on-future-fitness-to-practise-processes.pdf (professionalstandards.org.uk)**

[104] Action against Medical Accidents, 2021, *AvMA response to Regulating Healthcare Professionals, Protecting the Public*: **AvMA-Response-to-Regulating-Healthcare-Professionals-June-2021.pdf**

[105] Professional Standards Authority, May 2013, *Public Response to Alternatives to Final Panel Hearings in Fitness to Practise Complaints*: **Alternatives to final panel hearings for fitness to practise cases – the public perspective | PSA**

[106] Community Research for the Professional Standards Authority, May 2020, *Patient and public perspective on future fitness to practise processes:* **patient-and-public-perspectives-on-future-fitness-to-practise-processes.pdf (professionalstandards.org.uk)**

these, the public explicitly raised the possibility that regulators' decision-making would be influenced by the imperative to save costs: *'some [participants] wondered if regulators would be tempted to be more lenient with registrants in order to ensure that more cases are agreed and, therefore, avoid an expensive and lengthy hearing.'*[107]

7.12. This view is supported by some with extensive knowledge of the fitness to practise process, including Dame Janet Smith, Chair of the Shipman Inquiry who has expressed concerns that caseworkers may be subject to targets, and by AvMA:

- *'There have been continued assurances that 'plea bargaining' will not take place but in reality, there will be pressures on case examiners to identify outcomes that are more likely to be accepted and which will bring a case to a conclusion, creating in effect an 'internalised' form of plea bargaining' [AvMA]*[108]

7.13. From our oversight of Social Work England's accepted outcomes process we have seen no evidence that case examiners are routinely offering inappropriately lenient sanctions. There is in fact some evidence to suggest that at times registrants may benefit from their case proceeding to a panel.[109]

7.14. However, we do expect regulators to be alive to the risk of case examiners' judgement and objectivity being impacted by targets or other internal pressures. Regulators should ensure that quality assurance processes are in place to mitigate such risks.

Equality, diversity and inclusion considerations

7.15. The move to a paper-based approach in fitness to practise may have differential impacts, both positive and negative, on people with shared protected characteristics. This applies to complainants (and other witnesses) and to registrants.

7.16. Some participants in the fitness to practise process may feel better able to express themselves verbally than in writing, or vice versa. This may apply particularly to people with certain disabilities, those who are neurodiverse, and those for whom English is not their first language.[110]

7.17. We expect regulators to conduct an equality impact assessment as part of the development of their accepted outcomes process and to take steps to mitigate any negative impacts identified on people with shared protected characteristics or other needs and/or vulnerabilities. This should include making reasonable adjustments to normal processes to meet the needs of individuals.

7.18. We are also aware of some evidence that accepted outcomes are offered to registrants who may not be found to be impaired were the case to progress to a hearing, and that this

[107] Community Research for the Professional Standards Authority, May 2020, *Patient and public perspective on future fitness to practise processes:* **patient-and-public-perspectives-on-future-fitness-to-practise-processes.pdf (professionalstandards.org.uk)**
[108] Action against Medical Accidents, 2021*, AvMA response to Regulating Healthcare Professionals, Protecting the Public*: **AvMA-Response-to-Regulating-Healthcare-Professionals-June-2021.pdf**
[109] Finn, G et al, November 2022, *Experiences of GDC fitness to practise participants 2015 – 2021: A realist study:* **Experiences of GDC fitness to practise participants 2015 – 2021: A realist study November 2022 (gdc-uk.org)**
[110] These factors were identified by regulators in response to our fitness to practise disposal route questionnaire.

may affect fairness.[111] [112] Registrants may accept the sanction offered in order to avoid the stress of a hearing and see the case concluded more quickly. This risk was highlighted both in our review of Social Work England's accepted disposal process, and by participants in the GDC's report on experiences of fitness to practise: *'A contentious point is that it is often 'better' for registrants to go to a full panel "to have their voice heard and be deemed innocent", rather than accept undertakings. Registrants need to balance the wait, the hearing, and stress against getting an earlier, but perhaps less fair decision.'*[113]

7.19. The decision whether to agree to an accepted outcome or progress to a panel hearing may be impacted by the registrant's access to legal advice. This in turn is likely to be affected by a number of factors including the profession of the registrant and their place of qualification. For example, the GDC and NMC report on seriousness in fitness to practise identified that legal representation *'was reported by interviewees to vary between professional groups, with doctors, dentists and pharmacists typically said to have legal representation while nurses, dental care professionals and pharmacy technicians were reported as having higher levels of self-representation.'*[114]

7.20. There are also distinct variations within the same profession, with, for example, a higher percentage of GPs with overseas qualifications lacking legal representation when compared with those who qualified in the UK.[115] The differential rate of legal representation matters because research demonstrates that legal representation is positively correlated with more lenient sanctions in fitness to practise.[116]

7.21. We therefore believe that the accepted outcomes process has the potential to impact differently on different groups. Those with legal representation (which may be more likely to include members of 'wealthier' professions as well as those who hold a UK qualification) may end up, when averaged across the group, with more lenient sanctions than those lacking representation. It is likely that the two groups will vary in terms of their protected characteristics. We would expect regulators to be mindful of this risk and monitor outcomes for different groups.

7.22. We also recommend that regulators routinely seek feedback from people (including complainants, registrants and other witnesses) who have participated in a fitness to practise process to identify learning and/or areas for improvement. This feedback should also be used to enhance understanding of differential impacts on groups with shared

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[111] Professional Standards Authority, May 2021, *Review of Social Work England's process for 'accepted outcomes' in fitness to practise cases:* **Review of Social Work England's process for 'accepted outcomes' in fitness to practise cases | PSA**

[112] Finn, G et al, November 2022, *Experiences of GDC fitness to practise participants 2015 – 2021: A realist study:* **Experiences of GDC fitness to practise participants 2015 – 2021: A realist study November 2022 (gdc-uk.org)**

[113] Finn, G et al, November 2022, *Experiences of GDC fitness to practise participants 2015 – 2021: A realist study:* **Experiences of GDC fitness to practise participants 2015 – 2021: A realist study November 2022 (gdc-uk.org)**

[114] Bryce, M et al, February 2022, *The concept of seriousness in fitness to practise cases*: **The concept of seriousness in fitness to practise cases (gdc-uk.org)**

[115] Pulse, 16 May 2022, *Overseas GPs lack representation at fitness-to-practise hearings and face 'harsher sanctions':* **Overseas GPs lack representation at fitness-to-practise hearings and face 'harsher sanctions' - Pulse Today**

[116] Pulse, 16 May 2022, *Overseas GPs lack representation at fitness-to-practise hearings and face 'harsher sanctions':* **Overseas GPs lack representation at fitness-to-practise hearings and face 'harsher sanctions' - Pulse Today**

protected characteristics.

8. Annex A – Method

8.1. Our evidence has primarily been drawn from desk research, questionnaire responses from the health and care professional regulators we oversee, and meetings with stakeholders.

8.2. We have reviewed:

- consultations and policy papers issued by Government with respect to regulatory reform, including the Physician Associates and Anaesthesia Associates Order
- guidance produced by the regulators for decision-makers including for case examiners and fitness to practise panels
- relevant research and policy papers. This has included research we have commissioned into public and patient perspectives on fitness to practise and biases in decision-making. We have also reviewed papers published by regulators and others including on experiences of fitness to practise
- relevant public inquiry reports
- reviews we have conducted into the accepted outcomes and undertakings procedures operated by the regulators we oversee
- responses to the questionnaire we issued to regulators on fitness to practise disposal routes (available at Annex B)
- a selection of published case examiner decisions and fitness to practise tribunal determinations
- relevant case law

8.3. We have also met with patient groups, employer representative bodies, a selection of the regulators that we oversee, regulators from sectors outside of health and social care, and a regulator from within health and social care that does not fall under our remit.

8.4. In producing this document, we have sought to assimilate all relevant evidence and draw out key points for consideration.

9. Annex B – Survey questions

9.1. The questions below were included in a questionnaire sent to all regulators we oversee seeking their views on fitness to practise disposal routes post regulatory reform. The questionnaire was sent on 26 July 2023.

1. Under the reformed FtP system, do you envisage there being cases that would be more appropriately dealt with by a panel hearing rather than an accepted outcome, irrespective of whether the registrant accepts/may accept the findings and any proposed measure? If yes, please give details.
2. What factors (if any), might mean that a case would be more appropriately dealt with by means of a panel hearing than an accepted outcome?
3. Under the reformed FtP system, it is not expected that cases will be referred for a panel hearing on public interest grounds. Do you have any observations or concerns about the ability of the accepted outcomes model to maintain public confidence in terms of the process by which cases are dealt with? If so, how could such concerns be mitigated?
4. What are the benefits of the accepted outcomes model, and what can the model deliver that a panel hearing cannot?
5. What benefits does a hearing have over a decision made on the papers?
6. Under the new system, what do you envisage a panel being able to do that case examiners cannot?
7. How can regulators ensure a robust assessment of insight as part of an accepted disposal? What steps can be taken to ensure that registrants are not relying on AI to help produce reflective statements?
8. How important do you think it is, if at all, for decision-making to include input from both a registrant and a lay person? Might this vary in importance depending on the characteristics of the case?
9. What information do you think it is necessary to publish about cases disposed of using an accepted outcome in order to maintain public confidence?
10. Are you aware of any particular impacts the new powers to use accepted outcomes will have on people with protected characteristics (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation)?
11. Are you aware of any research, guidance or data that might be relevant to determining how FtP cases should be disposed of?
12. How can consistency of approach to fitness to practice between regulators be promoted post regulatory reform?
13. Do you have any other comments or observations you would like to make?