Annex A: Call for Views on Right-touch regulation – questionnaire

We will use the responses to this questionnaire to inform our review.

It would be helpful to us if you could be specific when referring to particular sections of the Right-touch regulation paper, and provide examples where relevant.

Please note that we do not expect all respondents to answer every question.

PART I: Questions about you

1. Your name and/or the name of your organisation

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5. How would you describe your organisation (or your own role if more relevant)?

The General Medical Council (GMC) is an independent organisation that helps to protect patients and improve medical education and practice across the UK.

- We decide which doctors are qualified to work here and we oversee UK medical education and training.
- We set the standards that doctors need to follow, and make sure that they continue to meet these standards throughout their careers.
- We take action when we believe a doctor may be putting the safety of patients, or the public's confidence in doctors, at risk.

Every patient should receive a high standard of care. Our role is to help achieve that by working closely with doctors, their employers and patients, to make sure that the trust patients have in their doctors is fully justified.
Part II: Questions about Right-touch regulation

6. Where did you first hear about Right-touch regulation?

We became aware of PSA’s ideas about right-touch regulation when PSA first consulted on its proposals prior to their publication in 2010.

7. What use have you or has your organisation made of Right-touch regulation, if any?
   (Please illustrate with specific examples if relevant)

The six principles of right-touch regulation are an extension of the five principles of good regulation established by the Better Regulation Executive in 2000. As such, they are well-recognised and help to inform our approach to regulation across a range of activities. Indeed, PSA’s 2010 document specifically references our four layer model of regulation as an example of appropriately balancing regulatory responsibilities between individuals, employers and regulators as part of right-touch regulation.

Since many of the principles are so integral to a modern regulatory approach, colleagues may not always explicitly and consciously reference right-touch regulation in their day to day work, even though ideas such as proportionality, transparency and accountability are routinely reflected what they do.

Nevertheless, two examples of where it has been explicitly referenced in our work are in the Review of the GMC’s Role in Doctors CPD: Final Report from 2011 (paragraph 34) and the 2014 Report of the Review of Quality Assurance of Medical Education and Training. In the CPD report, in particular right-touch regulation was used to support the case for a limiting the scope and nature of our regulatory interventions grounds of proportionality.

The following paragraphs, while not an exhaustive account of how we have sought to apply right touch regulation, provide some further examples across different areas of our business.

Identify the problem before the solution

Our annual State of medical education and practice (SoMEP) report provides an evidence-based view of the trends and risks emerging in the sector.

Our aim in publishing this is to:

- use GMC and other data to provide a picture of the medical profession in the UK and to identify some of the challenges it faces
- promote discussion and debate about some of the practical steps we and others could take in better supporting doctors and improving patient care.

Increasingly, the evidence and analysis provided through this report are helping to inform and guide our regulatory interventions. For example, concern identified in the
2011 report about the support provided for new registrants provided the catalyst for the development of our current Welcome to UK Practice programme.

**Quantify the risks**

Our Patient Safety Intelligence Forum (PSIF) (established in 2014) helps us to coordinate and consider information from across the GMC and the implications of this information for patient safety and medical practice. Our Senior Management Team then draws on this information to assess our regulatory interventions and consider what further action we, and/or others, may need to take. In particular, PSIF will:

- review internal and external information from across the organisation to identify trends, issues and areas relevant to patient safety and medical practice that may require further investigation, information-gathering, tactical, operational or policy intervention
- as appropriate, contribute to the improvement of cross-organisational information and data analysis, which could lead to intelligence on specific issues, individuals or geographies
- consider and make recommendations on strategic or operational policy relevant to intelligence received, and task the appropriate team to develop proposals for action.

Although PSIF is still in its early stages of development, it is already starting to help us to better quantify and manage regulatory risks.

**Get as close to the problem as possible**

We are increasingly working to close the gap between what can be perceived as remote, national regulation and the need for the regulator to be down ‘on the pitch’ with those directly involved in the management and delivery of healthcare. This helps us better understand the problems we are trying to address and how we might work with others to solve them. Examples of this are the establishment of our Regional Liaison Service and the Employer Liaison Service.

Another example is how, in 2014, we changed the way we deal with some complaints that do not meet the threshold for investigation. Rather than opening a new investigation to look at each of these concerns and writing to all the doctor’s employers, we now share this information with the doctor and his or her Responsible Officer (RO). We ask the doctor to make the local complaints manager aware of the complaint and advise them that they must reflect on the complaint as part of their revalidation. If the RO or complaints manager identifies further issues, they can escalate the matter to us for further consideration. Our Employer Liaison Advisors are also available to follow up these letters and discuss them with the RO as required. Not only does this approach allow less serious matters to be dealt with closer to the actual problem, but it is also a proportionate regulatory intervention.
8. More generally, what impact do you think Right-touch regulation has had, if any, on your area of work? (Please illustrate with specific examples if relevant)

See the answer to question 7 above.

9. Which aspects of Right-touch regulation do you think are most important and why? (Please refer to specific sections from the document if possible, and illustrate with examples)

It would be fruitless to single out one element of the right touch approach above all others. They operate as a package, but their relative importance will vary depending upon the problem to be addressed.

For example, in developing our approach to the regulation of CPD it was important to be able to understand and balance a range of different considerations and possible interventions. First, we needed to recognise that in medicine the issue was not whether doctors were undertaking CPD but whether they were doing the right sort of CPD (identifying the problem). Decisions about what would be right for each individual were best taken locally in the context of doctors’ annual appraisal rather than imposed nationally by the GMC (get as close to the problem as possible). We also needed to acknowledge that in medicine there already exist well developed structures to support doctors CPD through the work of the medical royal colleges and others (proportionality). We therefore concentrated on developing principles and guidance which would support a more outcome focused approach to CPD which linked with revalidation (focus on the outcome).

10. Which parts of Right-touch regulation do you find most useful and why? (Please refer to specific sections from the document if possible, and illustrate with examples)

Please see paragraph 1 of our response to question 9.

11. Which parts of Right-touch regulation do you find least useful and why? (Please refer to specific sections from the document if possible, and illustrate with examples)

As indicated in response to question 9, the relative importance of the different elements of Right-touch regulation will shift depending on the issue being addressed. It would be wrong to suggest that any one element is unimportant or not useful.

12. Which elements or concepts do you think would be most suitable for further development?

Joint working is mentioned briefly in Right-touch regulation, but is an increasingly important aspect of our work.
The joint work by regulators to develop a statement on health professionals’ duty of candour, and our work with the NMC to develop explanatory guidance on applying the principles of candour in practice, both demonstrate an appetite and need for more joint working. This is likely to become increasingly important if the Law Commission Bill is implemented because it will impose a single legislative framework on all regulators and will introduce a duty to cooperate across a wide range of activities.

13. **Which elements do you think require updating and how?**

Any review of right-touch regulation might wish to take account of recent academic literature on the craft of regulation. As PSA will be aware, the 2014 IAMRA conference highlighted some of the issues.

14. **Are there any other ways in which we could build on Right-touch regulation?**

Linked to our comments regarding joint working, right-touch regulation may also have a role in helping to highlight the importance of professional regulators sharing information in order to ensure the best outcome for patients. We have initiated information sharing agreements and memoranda of understanding with different partners around the UK.

But it may be necessary to go beyond the mere sharing of information and explore what genuinely joined up regulation would look like. Successive public inquiries and reviews have highlighted the limits of different agencies acting wholly independently within their established remits, but without sufficient reference to, or necessarily understanding, the wider picture. In an increasingly complex healthcare environment, problems are likely to be multifactorial. A piecemeal approach to solving those problems is more likely to fail to meet the challenges of right-touch regulation such as proportionality, understanding of risk, and avoidance of unintended consequences. We therefore need to consider how we work towards collective assurance around common problems and whole systems solutions, without compromising our individual responsibilities or independence.

Our response reflects the increased focus of the need for our regulatory roles to be exercised collaboratively with partners across the health sector. Right-touch regulation should ensure the regulatory response is executed by those best able to effectively deliver the outcome. Proportionality would suggest that the organisation that can most effectively deliver the desired outcome for the least intervention should do so. The challenge is to ensure the principles are applied to a risk as it exists within the whole health sector and to determine the right approach by the right body, rather than each body determining its own individual ‘right-touch’ response. We feel the current principles could more accurately capture this context.
15. We would like to start to position Right-touch regulation within the relevant literature. In your view, how does it link to other published work?

No comment.

16. Have you referenced it in any academic or other work?

As indicated in response to question 7, we have made explicit reference to right-touch regulation in Review of the GMC’s Role in Doctors CPD: Final Report (2011) and the 2014 Report of the Review of Quality Assurance of Medical Education and Training.

17. Are there any other comments you would like to make about Right-touch regulation?

We believe it is important that regulators are able to modernise with changing times and continuously look to rationalise and improve our work without adding to the burden of regulation. In order to achieve this aim, regulators need a legislative framework which achieves the right balance between operational autonomy to innovate and respond quickly and efficiently to society’s expectations whilst ensuring effective accountability and oversight of the regulators. Should the Law Commission Bill replace the existing regulatory statutes (for the GMC, the Medical Act 1983), the legislative framework should enable regulators to work even more effectively towards the Right-touch principles.

We would like to be able to quote and attribute material from your response in our published summary and final reports.

☐ Please tick this box if you do not want us to quote your response.

☐ Please tick this box if you are happy for us to quote your response but do not want us to attribute the quote to you.

If you have ticked either of these boxes, please explain why you regard the information you have provided in this questionnaire as confidential.

We will manage the information you provide in response to this consultation paper in accordance with our information security policies which can be found on our website (www.professionalstandards.org.uk).

Any information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA) the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).
If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential.

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