

## GMC response to Department of Health (England) consultation: Supporting professionalism, reforming regulation

### The case for regulatory reform

We very much welcome this consultation as signalling the Government's recognition of the need for fundamental reform of professional regulation. The case for change was widely acknowledged and supported across all those with an interest in regulation even before the Law Commissions brought forward their proposals for reform in 2014. Since then, successive governments have repeatedly promised to reform our legislative framework and then repeatedly failed to deliver on this. Yet the need grows more acute with each year that passes.

Although the vision for reform must be focused on equipping regulation to meet the challenges of the next 20-30 years, we cannot be blind to the pressures facing the health services today and how regulation can play its part in helping to address these.

Regulation is sometimes portrayed as a barrier to development and to innovation, and an expensive one at that. In fact, regulation is well placed to be an enabler of change. At a time when the health services across the UK are under pressure and workforce supply in some areas is uncertain, regulation can help to support the UK to maintain a well-qualified and competent healthcare workforce. To do this we must ourselves be enabled. Fundamental reform of our legislative infrastructure is needed to give us the autonomy and flexibility to respond to the changing needs of the health services. Above all, we must have the flexibility to develop a new model for dealing with concerns about the fitness to practise of healthcare professionals that is efficient, cost effective, proportionate, and that allows us to direct our regulatory resources to where we can add most value. We can, and will, push the boundaries of what is possible within the limits of our existing legislation, but we have reached the extent of what is currently possible.

### A burning platform

#### *System pressures and workforce supply*

The pressures facing the UK healthcare systems are well documented and acknowledged. Regulators are not responsible for workforce issues, but we recognise the impact of regulation on the delivery, development and maintenance of health services. We have a key role in facilitating the entry to medical practice of a properly trained workforce with

the capabilities, flexibility and adaptability that professionals will need over the course of their careers.

For example, we receive around 850 applications a year from doctors who have not gone through conventional postgraduate training programmes but who wish to demonstrate that they have the knowledge, skills and experience necessary for them to get onto the Specialist or GP registers. This is necessary for them to take up NHS consultant or GP posts. The legislation governing how these applications are made and assessed is highly prescriptive, resulting in a system that is slow, bureaucratic and burdensome, requires applicants to submit over 1000 pages of authenticated evidence, and can take many months to complete. This has a direct impact on the speed with which doctors can be brought into the health system. But we cannot change the system without legislative reform.

### *UK exit from the European Union*

The UK's exit from the EU also has implications for workforce recruitment. Around 1,300 doctors a year from the European Economic Area come to the UK and are able to go straight onto the specialist and GP registers because they benefit from automatic recognition of their qualifications. If this were to cease following our exit from the EU, all of these doctors would need to apply for specialist or GP registration through the alternative assessment of their knowledge, skills and experience. This would add to the problems of NHS recruitment. However, amending legislation would help to address some of these workforce problems.

### *Changing roles, emerging professions and regulation*

The government recently consulted on proposals for bringing one or more medical associate professions (MAPs) into regulation. These proposals stemmed from the need to develop a more flexible workforce capable of meeting the changing needs of patients and health services. Regulation will provide assurance that these new groups of professionals have met the standards necessary for safe patient care and help employers to maximize the potential of the roles. But this will only be possible if legislation is brought forward which will provide for a flexible regulatory regime able to facilitate the development of these roles.

## **Securing legislative change**

Despite the publication of the consultation *promoting professionalism, reforming regulation*, the prospects for legislative reform seem more uncertain than ever. We recognise the current challenges in securing the necessary legislative time. However, as we have shown, the case for change is overwhelming. The principal changes necessary to deliver a more effective, agile and efficient regulatory regime could be achieved through secondary legislation in the form of one or more Section 60 Orders providing a single, high level framework common to all regulators. A Bill would not be required. Our work with

parliamentarians and other key interest groups shows that there continues to be widespread support for these much needed reforms.

## **Holistic not piecemeal reform**

Our current model of health and care professional regulation is based upon a historical patchwork of law that was designed for a different era. The [Medical Act 1983 \(as amended\)](#) ('the Act'), supplementary statutory instruments, and European Union law transposed into domestic legislation, provide the legal framework in which we carry out our core functions.\* The Act has been amended at various times over the last 160 years. These changes have helped regulation respond to the problems of the day but they have tended to be piecemeal in nature and prescriptive in their detail. The result is a legislative infrastructure that is extensive, cumbersome and complex. It also contains a level of prescriptive operational detail that quickly becomes out of date and hamstrings us in our efforts to innovate in response to the changing needs of society, the profession and the health services in which doctors work. Pursuing piecemeal changes to this regime is inevitably slow and inefficient, and puts continual demands on legislators that they are increasingly struggling to meet.

These problems are not unique to the GMC. Many of our fellow regulators are shackled by similar (often worse) constraints in their efforts to make regulation fit for the 21<sup>st</sup> century. Therefore, when looking at the consultation proposals it is important to understand that while they helpfully illustrate some of the current problems, what we need is a new and future-proofed regulatory architecture rather than slight remodeling of the existing detail.

## **Summary statement**

Our detailed responses to the 24 questions posed in the consultation are set out in the Annex at the end of this document. The key points we wish to highlight are:

- The legislative framework governing healthcare professional regulation is not fit for the needs of the public, professions, employers or wider health services in the 21<sup>st</sup> century.
- A new framework is required that will support regulators in their efforts to protect the public by focusing on preventing harm, helping to drive improvement and supporting professionals to deliver high quality care.

\* Our core functions set out in the Act are to set the educational standards for all UK doctors through undergraduate postgraduate education and training; decide which doctors are qualified to work here and maintain the public register of all those who are licensed to practise; set the professional standards for doctors in the UK and make sure they demonstrate on a regular basis that they are up to date and fit to practise; take action when we believe a doctor may be putting the safety of patients, or the public's confidence in doctors, at risk.

- The new framework should set out regulators' high-level duties and powers, and the outcomes they should deliver, but leave regulators to determine how those duties and powers are fulfilled (the 'what' but not the 'how' of regulation). This will give regulation the flexibility and autonomy that is needed to meet the demands of today and adapt to the changing needs of patients and health services over the next 20-30 years.
- A more flexible regulatory framework must be accompanied by enhanced accountability for regulators to the parliaments across the UK and to their key interest groups.

## Consultation Questions and Responses

### **Question 1: Do you agree that the PSA should take on the role of advising the UK governments on which groups of healthcare professionals should be regulated? Page 15**

PSA (Professional Standards Authority) is clearly one of a number of organisations that would have a role in advising governments on which groups of healthcare professionals should be regulated. However, we do not believe the role should rest exclusively with PSA. Nor should PSA be afforded a preferential position. PSA's oversight of professional regulators means it will often be well placed to provide valuable insight, but others will offer equally important, albeit different, perspectives.

The consultation is misleading in suggesting that PSA would be a wholly disinterested party with no vested interest in the outcome of its recommendations to Government. That is because PSA currently oversees the alternative system of voluntary accredited registers from which it derives significant income. PSA also levies a charge on statutory regulators linked to the size of their registrant base. In both cases, there would be a potential conflict of interest. That is not to be critical of PSA's integrity in these matters, but simply to recognise that PSA is now an integral part of the regulatory system rather than a wholly neutral and disinterested commentator.

### **Question 2: What are your views on the criteria suggested by the PSA to assess the appropriate level of regulatory oversight required of various professional groups? Page 15**

The PSA's paper '*Right-touch assurance: a methodology for assessing and assuring occupational risk of harm*' (published October 2016)\*, sets out a proposed model for assessing the risk of harm presented by different health and care professions.

The model provides a helpful framework with many of the elements that would be expected. However, while it is easy to see how it might be applied to an existing professional group seeking statutory regulation, it is less clear whether it can be successfully applied to an embryonic professional group, such as nursing associates, where the role and risk have yet to be defined.

There are also factors not included in the PSA model which are likely to be relevant. For example, it is important that there exists a body of knowledge and standards which

\* Professional Standards Authority – Right Touch Assurance : a methodology for assessing and assuring occupational risk of harm – 3 Oct 2016 - <http://www.professionalstandards.org.uk/publications/detail/right-touch-assurance-a-methodology-for-assessing-and-assuring-occupational-risk-of-harm>

contributes to the existence of a definable and clearly differentiated professional group, rather than merely the extension of an existing role. It is also necessary to take account of the relative maturity of the professional group, the extent of support within the group for the professional responsibilities that go with regulation, and the existence of an infrastructure to support the delivery of the duties and responsibilities associated with a regulated profession. These are practical considerations that go beyond the assessment of risk. We also understand that the assessment of risk in the PSA model is relative rather than absolute. A prospective profession may have a higher or lower risk profile than an existing profession, but there is no absolute measure. Inevitably, there will be a judgement involved and there is no simple calculus that will produce the right answer.

**Question 3: Do you agree that the current statutorily regulated professions should be subject to a reassessment to determine the most appropriate level of statutory oversight? Which groups should be reassessed as a priority? Why?**  
**Page 15**

In principle, we agree that the need for continued statutory regulation of different professions should be subject to periodic review. This acknowledges the fact that professional roles and the technology that helps to shape those roles will change over time. Similarly, the contexts and healthcare systems in which individuals practise, as well as societal expectations, will also change. Against that background of change, it would be unrealistic to insist that professional regulation alone should remain immutable for all time. Indeed, as regulators, we cannot argue for the importance of being given the flexibility to adapt to changing circumstances without accepting as a corollary that the nature of regulation or even the need for regulation might themselves change.

However, any reassessment should have regard for the possible unintended consequences of changes to a regulatory regime, particularly if the removal of regulation has the indirect effect of escalating risk. For example, other related structures and safety systems may become more vulnerable if regulation is removed.

We are not in a position to comment on whether there are particular professional groups that should be reassessed as a priority.

**Question 4: What are your views on the use of prohibition orders as an alternative to statutory regulation for some groups of professionals? Page 15**

We note that this was considered in the [PSA's 2016](#) paper '*Initial evaluation of the feasibility of prohibition order schemes for unregulated health and care workers in the*

UK<sup>\*</sup>. That paper found there was insufficient evidence on which to draw a conclusion about their effectiveness in a health context.

As the PSA's 2016 report also highlighted, the value of prohibition orders very much depends upon the expected outcome for the professional group concerned. They are of little value, for example, if the aim of regulation is to support improvement in professional standards and the quality of care. One of the expressed objectives of the '*Promoting professionalism*' consultation is to 'support professionals in delivering high quality care'. It is difficult to see how prohibition orders would contribute to that aim. If there are other objectives in introducing such orders there may well be potential benefits. But they are difficult to evaluate without specific proposals in relation to the groups that would be affected.

We would question whether a prohibition order scheme is a proportionate alternative to statutory regulation. If the risk to the safety of the public, potential severity of harm, numbers of professionals, or frequency of the activity are not deemed high enough to warrant statutory regulation, why would a prohibition order (with criminal sanction backing) be appropriate? A prohibition order scheme as currently described seems to require similar levels of regulatory activity, i.e. defined activities/professions, development of standards, and enforcement action where those standards aren't met. An alternative could simply be to extend the existing list of activities for which an individual requires registration with a professional regulator (i.e. extending statutory regulation) or to introduce voluntary accreditation for the profession.

The consultation suggests that... '*the relevant regulatory body would issue a prohibition order that would prevent or restrict an individual from carrying out a certain role or providing certain services. A breach of such an order could be a criminal offence and employers could be required to check the register...*' [at para 2.9]

This clearly raises the question as to who would be 'the relevant regulatory body' responsible for the creation and maintenance of the negative register, given that this is intended to apply to non-regulated professions and activities.

## **Question 5: Do you agree that there should be fewer regulatory bodies? Page 16**

The current number of regulators and the way individual professions are overseen by those regulators is more the result of history and politics than deliberate design. If we were building a model from scratch this would not be our starting point. But whilst we recognise that these arrangements contribute to the overall complexity in the healthcare

<sup>\*</sup> *Initial evaluation of the feasibility of prohibition order schemes for unregulated health and care workers in the UK,* the PSA. Accessed at <https://www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/feasibility-of-prohibition-order-schemes-initial-evaluation.pdf?sfvrsn=4>

and regulatory systems they are by no means the only factors which make the system difficult for patients and employers to navigate. Reducing the number of regulators as the consultation proposes may not, in itself, address this issue. For example, better signposting about where to bring concerns may prove a more cost effective solution than total re-organisation.

Any decision about the preferred number of regulators and how they are configured should be shaped by principles that would support the desired outcome. For example, assuming the primary driver for organising regulation is public protection, there may be advantages in bringing together professions which need to work most closely together (perhaps in a dependent relationship) based on shared standards and a shared model for (and delivery of) education and practice. The recent medical associate professions (MAPs) consultation\* would seem to illustrate the value of such an approach. But if it cannot be shown that mergers and abolitions will enhance patient safety/public protection, the case for undertaking them is weakened. Rather than starting with the number of regulatory bodies as an end in itself, we believe that the focus should be on what we want health regulation to deliver for the public and what principles should therefore govern the configuration of professional regulation, and from that would flow conclusions about how many, and how they are organised.

We have concern about possible over-reliance on the [research report cited](#) on page 7 of the consultation document, with analysis carried out by the Centre for Health Service Economics and Organisation in 2012<sup>†</sup>. It considers economies of scale and the cost-effectiveness of registrant numbers and the rationale for reduction of the number of regulators. However, there do not appear to be other principles or reasoning given beyond cost efficiency, such as quality of regulation (according to the principles of good regulation: transparency, proportionality, fairness, consistency and accountability etc). The report notes that it *'does not comment on the absolute efficiency of any particular regulator or of the system as a whole – merely whether there is evidence that some regulators appear to operate more efficiently than others'*.

Additionally, the research does not include the forecasted costs of large-scale mergers, despite the fact that this would undoubtedly reduce the predicted savings set out in the report. It is because of these gaps that further research and a much stronger evidence

\* Consultation on the regulation of Medical Associate Professions in the UK, Department of Health (England) Accessed at:

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/650554/The\\_regulation\\_of\\_MAPs\\_in\\_the\\_UK.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/650554/The_regulation_of_MAPs_in_the_UK.pdf) on 03 January 2017.

† In 2011 the PSA were asked by the Secretary of State to advise on the cost effectiveness and efficiency of the health professional regulators. Supporting analysis from the Centre for Health Service Economics and Organisation is published alongside the PSA's final report, *Cost effectiveness and efficiency review of the health professional regulators*. Accessed at:

<https://www.professionalstandards.org.uk/publications/detail/cost-effectiveness-and-efficiency-review-of-the-health-professional-regulators> 03 January 2018.

base for the proposal to reduce the number of regulators to 'three or four' should be considered before the proposals are developed any further.

It will also be relevant to consider professional issues, such as how best to foster the development of professional identity and ownership of distinct professional values. The negative effects on a professional group of stripping it of its current regulator should not be overlooked.

### **Question 6: What do you think would be the advantages and disadvantages of having fewer professional regulators? Page 16**

The consultation argues that having fewer regulators would bring a number of benefits. These include a more consistent approach to regulation, cost savings through economies of scale, simplification of the regulatory landscape for patients and employers, and a clearer system that delivers more effective public protection.

The overall landscape may appear to be a little simpler although, as indicated in our response to question 5, it is important not to overestimate the impact of this simplification given the continuing and immense complexity of the wider healthcare and regulatory environment within which professional regulation sits. Beyond that, it is difficult to know whether these benefits would be realised without knowing the government's proposed configuration or the principles that would underpin it. Nevertheless, we offer the following observations.

#### *Consistency*

There are obvious attractions in a regulatory framework that provides consistency, though consistency is not an end in itself. It is valuable insofar as it supports reliable and fair regulatory outcomes which serve to protect patients and the public. And the public would expect to see broad alignment of the regulatory ethos across all professions. But consistency of process for the sake of administrative neatness may work against these objectives.

For this reason, we have long argued for a system which provides all regulators with a shared, high level legal framework of common duties and powers against which they should be held accountable. But beneath this framework each regulator (whether there are 3, 4 or 9) should have the flexibility and autonomy to develop policies, processes and procedures which properly reflect the different contexts in which different professions train and practice.

At a high level it is, of course, desirable to see consistency across the standards expected of different healthcare professions and there is already significant alignment. Regulators have, for example, produced a shared statement in relation to the duty of candour for the professions they regulate. There is no doubt that we can and should go further. But beneath these high level principles there will often need to be a degree of specificity and differentiation which recognises the realities of professional practice within different

groups. In the case of medical practice, the level of autonomy and responsibility, the complexity, context and scope of practice, and potential risk of harm to patients, will be very different from what might be expected of, say, a dental technician. Regulation must take account of such differences if it is to operate fairly. Simply reducing the number of regulators to a 'three sizes fit all' approach will not remove that need.

There are also risks; the more professions that are assembled under the umbrella of a single regulator, the greater the risk that the ambition for regulatory consistency is reduced to the lowest common denominator.

### *Efficiency savings*

Regulation must provide value for money and regulators must be held to account for how they use the income received from their registrants. As a result of improved operational efficiency we have recently been able to reduce the ARF paid by our registrants. However, the restrictive and prescriptive nature of the legislation which currently governs our work is now inhibiting the sort of innovations that would help us achieve further efficiencies and realise additional regulatory value.

We note the finding of the report by the Centre for Health Service Economics and Organisation that: *'There is evidence to suggest that the statutory regulation of UK healthcare professionals exhibits economies of scale. On average a doubling of the registrant base is associated with a 19% reduction in unit operating costs.'*

However, there is a significant caveat to this assessment in that the report goes on to state... *'it should be noted that this estimate does not take into account any potential upfront or transition costs which may well be significant.'*

In addition, a separate 2017 report by Europe Economics (*Assessing Efficiency and Efficacy Gains in Health Professional Regulation*) noted that the case for economies of scale in a merger of some or all of the existing regulators was not fully made out. While some economies of scale were likely to be realisable at some level, diseconomies of scale were also possible. Furthermore, full merger of regulatory bodies would increase the risks associated with increased operational complexity and loss of innovation.

We therefore need to be cautious about assessing the possible efficiency savings of reducing the number of regulators based on the evidence in the cited report alone. It will be important to consider the potential estimated transitional costs and cost of closures. For example, we note the estimated set-up costs of Social Work England (an estimated £10 million), in addition to the Government contribution of up to £16m for running costs by 2020. This of course follows the recent cost incurred from the closing down of the General Social Care Council (estimated £17.6 million) and the £1.6 million to transfer the regulation of social workers to the Health and Care Professions Council in 2010. In short, major re-structuring in pursuit of cost savings will itself bring significant cost which should not be underestimated.

We are also concerned that undue focus on efficiency savings in regulation could result in a loss of quality in regulation and thus a reduction in effectiveness in protecting the public. At page 9 (3.7) of the report it is noted that, '*a higher level of effectiveness in performing regulatory functions might be expected to lead to a high unit operating cost.*' Cheaper regulation is not necessarily better regulation.

### *Simplification*

As indicated in our comments in response to question 5, we agree that the regulatory landscape is complex and that there could be benefits in simplification. However, given the even greater complexity of the healthcare landscape in which regulation operates, it is important not to overestimate the impact of reducing the number of regulators. The number of other bodies involved, the frequent abolitions, mergers and additions, and the intricacies of their connections, mean that the overall system will remain fiendishly complicated for everyone (especially patients) to navigate.

With that in mind, better signposting for the public about who does what and who to contact when, as well as better co-ordination of activities and co-operation between different bodies may be more efficacious than simply reducing the number of regulators. We consider this further in our comments on questions 13-16.

### *More effective public protection*

The purpose of regulation is public protection. Although the consultation asserts that this will be enhanced by reducing the number of regulators, no arguments are advanced or evidence adduced to support this claim. It is difficult to understand, therefore, how having fewer regulators would, in and of itself, mean that patients are safer. The more pertinent question (question 7) is how regulation should be configured to achieve this goal.

### **Question 7: Do you have views on how the regulators could be configured if they are reduced in number? Page 16**

There is no simple answer to this. Approaches which in principle seem attractive may collide with practical realities which make them seem unattractive. For example, it is often suggested that 'high-street' professions should all be grouped under a single regulator. But in practice those professions may operate in very different ways, even within a single profession. For example, not all pharmacists work in high street pharmacies, so would those who work in hospitals link to the high street regulator or some other body? Considerations relating to issues such as size, cost and efficiency will also need to inform any configuration.

One possible approach would be to group under a single regulator those professions that follow a similar model of education, training and professional practice and which are likely to work together within multi-disciplinary teams. This would support better alignment of relevant standards and delivery of training for those groups. It may also facilitate a degree

of mobility between professional groups where that is appropriate, thus helping to break down perceived (sometimes wrongly perceived) professional boundaries and support workforce flexibility. It was for these reasons that we recently proposed that the GMC should take on the regulation of Medical Associate Professions (MAPs).

This approach may not achieve the Government's declared aim of reducing the number of regulators to 3 or 4, and the practical implications would need further examination. But it perhaps offers a coherent rationale linked to better patient protection, supporting professionalism and workforce development.

**Question 8: Do you agree that all regulatory bodies should be given a full range of powers for resolving fitness to practise cases? Page 21**

Yes, we fully support proposals to provide all regulatory bodies with a consistent and flexible range of powers to resolve fitness to practise cases. However, there are a number of points we wish to emphasise.

Whilst the powers of the GMC and MPTS are currently broader than those of other regulators in the sector it is not sufficient simply to bring other regulators up to the position of the GMC. That narrow approach would simply further fossilize regulation so as to meet the needs of today without regard to the needs of the future. The last decade has seen radical changes in the way we deal with fitness to practise issues. This reflects the changing demands on, and expectations of, us, new opportunities provided by technology and changes in the wider healthcare environment. We can expect these to continue and our processes will have to continue to evolve in the decades to come if they are to remain fit for purpose. Even our current powers are deficient in a number of areas. For example, we are seeking:

- An amendment to the Medical Act so that we have discretion over whether to open a fitness to practise investigation rather than being required to do so in all cases. This will support a more proportionate regulatory approach and local resolution of concerns where that is appropriate.
- A presumption of erasure from the register where a doctor has been convicted of a serious criminal offence. This would better support public protection and public confidence and reduce the impact on patients and witnesses who may otherwise be expected to attend a public hearing.

These are illustrative of some of the changes we would like to see to our fitness to practise powers today. But they are by no means an exhaustive account of how fitness to practise will need to evolve in future. Accordingly, regulators will need a legislative framework of powers and duties which will facilitate such development if we are to provide a fair, efficient and effective system in the future.

Indeed, this need for the legislative model to be flexible and future-proofed applies equally across all our regulatory activities.

### **Question 9: What are your views on the role of mediation in the fitness to practise process? Page 21**

We do not believe that mediation is appropriate for fitness to practise procedures as they are currently designed. Indeed, to use mediation in this context is to misunderstand the purpose and nature of the fitness to practise process and of mediation. Mediation is a process by which an agreed outcome is negotiated between two or more parties assisted by a neutral third party. By contrast, the purpose of fitness to practise sanctions is to provide the minimum protection necessary to protect the public having regard to a particular threshold or standard. It would not be appropriate to negotiate a lesser sanction as part of a mediation process. Regulators must always seek the minimum outcome necessary to protect the public and retain confidence in the profession. If such an outcome was subject to negotiation with the registrant, then by implication the final agreed outcome may be less than is necessary to protect the public. Conversely, it could also in theory result in unnecessary, disproportionate and burdensome restriction on an individual's ability to practise.

The use of mediation in resolving disputes relating to healthcare may, however, be more appropriate as an early intervention method that could be used at a local level (for example, a trust or practice that has just received a complaint) to prevent unnecessary escalation of complaints.

This is not to say that other mechanisms for engaging constructively with registrants and patients do not have a place in the fitness to practise process. Consensual disposal of cases helps us to protect patients without the need for a full hearing where the registrant is willing to accept the proposed sanction. We offer to meet with some doctors at the end of an investigation to improve information sharing and help avoid unnecessary hearings. We are also exploring the introduction of facilitated meetings between doctors and patients in cases where a patient has suffered serious clinical harm and has not already met the doctor, or has not been provided with an explanation for what went wrong with their care at a local level. These meetings are intended to give patients an increased voice within the complaint framework. Meetings will run parallel to, but will be separate from, our fitness to practise processes and will not replace our role in taking action to protect patients and maintain confidence in the medical profession.

### **Question 10: Do you agree that the PSA's standards should place less emphasis on the fitness to practise performance? Page 21**

We agree that fewer standards in relation to fitness to practise would be welcome, with more focus on education and training. The PSA's annual performance reviews of the health professional regulators are a key mechanism of our accountability to the public and to the UK administrations.

In summer 2017, we responded to the PSA's consultation on standards of good regulation,<sup>\*</sup> which sought views on how/whether the standards should be reformed to be more principle-based. In our response, we highlighted that:

- There should be a greater focus on fitness to practise outcomes rather than the current focus on timeliness and volume.
- The standards need to take account of outliers and seek to normalise performance, in order to provide the PSA with an accurate picture of actual and controllable performance of a regulator.
- The standards lack recognition of our wider system responsibilities and the importance and impact of working with others across healthcare systems.
- The standards are too quantitative and need to include more qualitative measures, for example whether regulators have a culture of learning, improvement and assurance.
- In regards to standards for education and training responsibilities, the standards need to take account of the broad range of factors that affect regulators' performance in education and training and our very specific role in it.
- The PSA should be striving to encourage regulators to drive improvements and learn from best practice of others, which does not lend itself to the 'met/not met' measurement for assessing regulators against the standards.
- We also think there is a need for the PSA to move to a more risk based and proportionate approach to reviewing fitness to practise outcomes, for example, instead of the current approach to reviewing all final determinations through the PSA's section 29 appeal power.

**Question 11: Do you agree that the PSA should retain its powers to appeal regulators' fitness to practise decisions to the relevant court, where it is considered the original decision is not adequate to protect the public? Page 21**

There is clearly merit in ensuring that an appropriate body, acting to protect the public, can challenge a regulatory body's decision about a healthcare professional's fitness to practise where it reasonably considers that the outcome of the regulator's adjudication process does not sufficiently protect the public.

<sup>\*</sup> Consultation on standards of good regulation, PSA. Accessed at: <https://www.professionalstandards.org.uk/publications/detail/consultation-on-a-review-of-the-standards-of-good-regulation> on 03 January 2018.

However, where the healthcare professional in question is a doctor, the introduction of the GMC's right of appeal, following the separation of its investigation and adjudication functions with the creation of the MPTS, has made it possible for the GMC to exercise its own right of appeal in cases where it considers that MPTS Tribunals have made decisions which are not adequate to protect the public.

This reform was intended by the government to enable the organisation best placed to challenge a tribunal decision about a doctor's fitness to practise to be able to do so where it is considered that the outcome does not sufficiently protect the public. The active and successful exercise by the GMC of its right of appeal since its inception in December 2015 has, as anticipated both by the GMC and by the Department, demonstrated the significantly greater ability which the GMC has successfully to challenge individual MPT decisions about a doctor's fitness to practise where the outcome does not sufficiently protect the public.

In light of this, there would seem to us to be limited value in the retention of the PSA's powers in relation to decisions of MPTS Tribunals, particularly where its approach to reviewing all MPTS Tribunal decisions (a process it had in place before the GMC gained a right of appeal) would seem likely to result in disproportionate and inefficient use of its resources. The GMC is better placed to scrutinise and, where appropriate to appeal, such decisions. A more proportionate approach in relation to decisions of MPTS Tribunals would be for PSA to have the power to review the efficacy of the GMC's approach in pursuing appeals, looking at whether we continue to carry out this function appropriately, rather than PSA itself also having the power to appeal individual cases.

The position may be different in relation to the decisions of other regulators, where there is not an equivalent degree of separation of investigation and adjudication functions so as to enable the regulator itself to be given its own right of appeal.

**Question 12: Do you think the regulators have a role in supporting professionalism and if so how can regulators better support registrants to meet and retain professional standards? Page 24**

Yes. Our job is to protect the public. The best way we can do that is by supporting doctors' commitment to good medical practice and delivering high quality care, rather than focusing on taking fitness to practise action once something is alleged to have gone wrong. That is why supporting doctors' professionalism is the first of the four key aims in our new *corporate strategy, 2018-2020: An ambition for change* (see attached). The strategy describes how we propose to do that.

**Question 13: Do you agree that the regulators should work more closely together? Why? Page 28**

Yes. Strengthening collaboration with our regulatory partners is the second pillar of our new corporate strategy. The strategy document explains how we will do this and why.

It is, however, important to stress that the need for joint working is not simply a matter of co-operation and collaboration among professional regulators. It is, if anything, even more important that it occurs between professional regulators and the wider healthcare system, including system regulators. This is already happening, often to good effect. But we need to do more if we are to achieve genuine and collective assurance about the quality of care provided. The legislative infrastructure within which we work should do more to facilitate this.

**Question 14: Do you think the areas suggested above are the right ones to encourage joint working? How would those contribute to improve patient protection? Are there any other areas where joint working would be beneficial?**  
**Page 28**

Elsewhere in the consultation document the argument is made for regulators to have greater control over their operating procedures (see consultation question 16). This acknowledges the fact that the context of professional practice varies and that the operating environment for regulators will change over time. Regulators therefore need the autonomy and flexibility to adapt to changing circumstances.

The inherent challenge in this question is that it begins to prescribe specified areas of policy and operation where regulators must work together. These may or may not be appropriate areas for co-operation at any given time. But if they become fixed legal requirements regulators will be bound by them even if they prove ineffective or if better, more innovative solutions emerge. Regulatory practice would, once again, become fossilised and unable to adapt and take on new best practice.

Rather than attempting to mandate regulatory co-operation in certain spheres, it would be better to set a general expectation on regulators to pursue joint working, where that benefits patients and the wider system, and provide a legislative structure designed to facilitate such co-operation. Regulators would then be free to pursue those arrangements (bilateral or multilateral) which were most likely to add value. They would also be able to stop collaborations once they no longer added value. Regulators could also be held to account by PSA and the UK parliaments for the degree to which they have met the expectation.

It should also be remembered that co-operation and joint working between regulators is already extensive, albeit that it may not always be visible. Even if it is not in the public eye, it is valuable in terms of the efficiencies it brings and the opportunities created for shared standards and learning. Crucially, such arrangements have developed where there is an identified need rather than because they have been externally imposed.

In terms of the particular areas for co-operation identified in the consultation, we have the following comments.

### *Shared online register/online portal*

The regulators have previously prepared a technical analysis looking at the feasibility of this proposal. Whilst superficially attractive, the proposal was found to have significant implementation challenges arising from, among other things, differences in the datasets that would be relevant for different professions and differences in the technological capabilities of different regulators. If pursued, a single online register would need to accommodate around 1.2 million registrants. Far from simplifying matters for patients and the public, a register of this size could make it more difficult for individual professionals to be identified. Above all, for an initiative that has the potential to increase registrants' ARF, there was a lack of clarity about the need and the problem it was intended to solve.

If it was felt that more should be done to help patients and the public navigate the system and identify individual professionals, an online single portal which directed enquirers to the relevant register might be a more proportionate and practical option.

### *Single set of professional standards*

This is not a new idea. In 2001 the (then) eight professional regulators agreed a statement of the common ethical standards expected of all registered healthcare professionals. In 2011 the GMC and NMC produced a joint statement on professional values. Producing joint statements/standards of this kind creates a significant burden – for example in terms of time and resource for regulators, impacts for professionals, patients, and the organisations that would need to be consulted – so we would want to see further evidence that we understand the problem we are trying to address and that creating a new set of common standards is the right solution.

Although it is often said that different professional groups are working to different standards, specific examples of conflicts between our standards and those of other regulators are not being drawn to our attention by patients, profession or the regulators. We also question the view that a common set of high level standards will make it easier for registrants to know what is expected. Such standards would need to be at such a high level of aggregation to work across a significant number of professions that it is difficult to see how they could usefully be applied in practice. And our experience is that our registrants say they want speed of access to guidance and advice which is directly relevant to their practice/situation.

An alternative approach could be to consider ways in which the regulators could collaborate more effectively to implement existing standards in a multi-professional way. Our regional liaison service and offices across the four countries of the UK currently work with a proportion of doctors on the application of our guidance to their work. And in recent years we have piloted collaborations with trusted partners aimed at delivering improvements in professional practice over a sustained period of time. A specific example is the work we did with the Gold Standards Framework to pilot an outreach partnership programme to raise awareness, understanding and practical use of the guidance and resources GMC provide doctors to support good end of life care. This initiative was

targeted at groups of doctors in specific locations identified as struggling to consistently deliver expected standards of care for their patient population. Future work could consider providing such interventions for multi-disciplinary groups as a means of driving greater harmonisation in the interpretation and implementation of professional standards.

Whilst at a high level we should expect to see commonality across professional standards (for example, in things like the duty of candour) this would not remove the need for profession specific standards. We should therefore be cautious about how much can be achieved by generic standards.

### *A single adjudicator*

We note that previous plans to create a single adjudicator responsible for all fitness to practise decisions (the Office of the Health Professions Adjudicator -OHPA) were abandoned.

When the decision was made not to proceed with OHPA, we established the Medical Practitioners Tribunal Service (MPTS) \*. At that time, we identified that the purpose of the MPTS would be to specifically deal with adjudication in relation to doctors. However, this is a model that could potentially be broadened to include other professions and we would be open to exploratory discussions about this.

### *Sharing of back office functions*

Sharing of back office functions may bring efficiencies but these need to be evaluated at a practical and operational level rather than decided at the level of principle.

### *Are there any other areas where joint working would be beneficial?*

As indicated in our comments on question 13, we welcome the drive for greater co-operation across the sector. Our new corporate strategy sets out a number of areas where we are keen to take forward joint initiatives with our regulatory partners.

## **Question 15: Do you agree that data sharing between healthcare regulators including systems regulators could help identify potential harm earlier? Page 29**

Yes, we agree that data sharing between healthcare regulators including systems regulators (and others) could help identify potential harm earlier. Many recent Inquiries and reviews have shown that collaboration and information sharing between organisations is essential. Indeed, there has sometimes been an institutional reluctance among

\* MPTS tribunals make independent decisions based on standards set by the GMC. The MPTS is a statutory committee of the GMC, which operates separately from the GMC's role in investigating complaints.

organisations to look beyond their immediate statutory responsibilities and develop a shared view of risk and a collective approach to mitigating risk and addressing problems.

Gradually, these organisational silos are being overcome. Within England, for example, the work undertaken through the Health and Social Care Regulators Forum demonstrates that there is a collective will to improve data and intelligence sharing. Drawing on the lessons from the events at North Middlesex University NHS Trust, this has already resulted in the development of a multi-regulator escalation protocol for identifying and responding to shared areas of risk and emerging concerns which is being piloted in North London. It is hoped this will be rolled out across England in early 2018.

Another such initiative is our new web-based tool 'GMC Data Explorer' which allows a user to explore our data on the composition of the medical register in great detail. Certainly there is more to be done, and our new corporate strategy describes some of the further steps we will be taking over the next three years.

**Question 16: Do you agree that the regulatory bodies should be given greater flexibility to set their own operating procedures? Page 29**

Yes. As we hope we have made clear elsewhere in this response, regulators are labouring under constraints imposed by an outdated and overly prescriptive legislative framework. It dictates not only what we must do (our duties and powers), but how we must fulfil our responsibilities. Whilst it is entirely appropriate that legislation should set out our duties and powers, the constraint on the policies and operational procedures through which we carry out our duties hampers our agility and our ambition to innovate in the way and at the pace we would wish. For example, the lack of a discretion over whether to pursue a fitness to practise investigation means that we are often obliged to pursue investigations that would be better, and more proportionately, dealt with in other ways. At present, around 75% of our investigations do not result in the need for substantive action. That causes needless distress for both the doctors and patients involved. It is also wasteful of resources which could more usefully be deployed in measures to support good practice and professionalism so as to prevent harm from occurring.

The problem is compounded by the difficulty in updating both primary legislation and the supporting statutory rules and regulations in which policies and procedures are described. Too often we know what is wrong with our procedures but we are unable to make changes because we cannot secure the necessary parliamentary time to make or amend the relevant statutory instruments.

To achieve what is required there should be a high level legislative framework shared across all regulators. This would set out regulators' duties and powers but give them the autonomy to fulfil those duties according to changing needs. The framework would include the ability for regulators to make and amend their statutory regulations and procedure rules without the involvement of the Department of Health or Privy Council. In some circumstances, this is already possible.

However, the increased autonomy we seek in policy and operations must be accompanied by other checks and balances to ensure that regulators' powers are exercised appropriately. That should include (but not be limited to) strengthened measures of accountability.

Such a framework would have the advantage of imposing overall consistency across regulation (one of the desirable outcomes identified earlier in the consultation) while enabling innovation according to individual needs. The ability of the best to innovate will help to set the standard and expectations for all.

We stand ready to work with the Departments of Health and legislators to describe how a revised regime would operate.

**Question 17: Do you agree that the regulatory bodies should be more accountable to the Scottish Parliament, the National Assembly for Wales and the Northern Irish Assembly, in addition to the UK Parliament? Page 29**

Yes. As acknowledged in our response to question 16, improved autonomy and flexibility for regulators must be accompanied by strengthened accountability.

Part of that enhanced accountability should be accountability to the UK Parliament, the Scottish Parliament, the National Assembly for Wales and the Northern Ireland Assembly. Under the previous Government it was common practice for professional regulators who are independent of Government, but directly accountable to Parliament, to appear before the Health Select Committee for annual accountability hearings. The GMC last appeared in 2015.

We have previously recommended to Dr Sarah Wollaston MP, Chair of the Liaison Committee and the Health Select Committee in the House of Commons, that rather than convening individual accountability hearings, and considering the direction that policy is moving in, the committee may find it useful to bring all professional regulators together to consider how, in granting regulators greater flexibility, parliament can be best involved in ensuring that the level of accountability we are subject to is maintained.

As health systems in the UK diverge, it will be important for the regulators to engage directly with the four UK administrations and legislatures on issues affecting them. As a regulator with jurisdiction across all four countries we welcome and recognise the need for this. We have offices in Northern Ireland, Scotland, and Wales and work closely with the Governments in each country. We have also given written and oral evidence to committees in the devolved legislatures and are happy to continue to do so. The health committees of all legislatures are invited to participate in GMC led consultations.

The Law Commissions previously supported accountability hearings and suggested that devolved legislatures also consider similar forms of accountability. While the devolved legislatures have oversight of their respective health systems including, for example, systems regulation, responsibility for medical regulation currently lies with the UK

parliament. We note, however, that in Northern Ireland the regulation of medical practitioners is a transferred matter in respect of which the Northern Ireland Assembly may legislate. It would therefore be important that if accountability hearings were put in place for all four legislatures, there was an agreement for managing this to avoid potentially competing and conflicting demands on regulators and to minimise the duplication of regulatory effort.

Of course, we are, and should be, held to account in other ways too. One of these is through the annual performance review reports by our oversight body, the PSA. As we highlighted in our response to question 10 of this consultation, we would like to see the PSA's standards for good regulation reformed so that our annual performance reports provide greater assurance to the UK administrations, the public and the profession about the work we do to. If we were given greater autonomy to make and amend our operating rules and procedures we could also envisage a possible role for PSA in auditing the way this is done to ensure best practice has been followed.

We are also held accountable through our Trustees annual returns, as a registered charity to the Charity Commission and the Office of the Scottish Charity Regulator. The MPTS is now required to provide its own annual report to Parliament. The GMC and the MPTS are also held legally accountable by the judiciary – our decisions can be challenged through the courts via appeal and judicial review.

Finally, it must be recognised that proper regulatory accountability across the four countries should not be limited to periodic appearances before the different legislatures. To be credible, it must also include broader and ongoing engagement with all key interests in the four countries.

**Question 18: Do you agree that the councils of the regulatory bodies should be changed so that they comprise of both non-executive and executive members?**

**Page 32**

Ultimately, the constitution and composition of Councils must be a matter for parliament to decide. But whilst there may be potential merit in adopting a unitary board structure, the case for doing so is not sufficiently made out in the consultation document. We would of course be open to considering a unitary board structure in future if there was a clearer evidence-base to demonstrate that such a change would enhance our ability to protect the public.

When considering whether reform of our governance structure is warranted, it should also be noted that we are a registered charity and our council members are our trustees. We understand that unitary boards are not the norm in bodies with charitable status and introducing them could pose the problem of private benefit arising for trustees who are staff members.

As a charity (in England and Wales), the relevant standards for good governance are contained within the [Charity Governance Code](#). We believe that we successfully embody

the principles of good practice set out in the code, and are certainly compliant with our legal obligations in regards to governance.

**Question 19: Do you think that the views of employers should be better reflected on the councils of the regulatory bodies, and how might this be achieved? Page 31**

As one of our key stakeholders it is clearly important that the views of employers are taken into account in the way we make decisions affecting UK health services. However, we do not agree that it is necessary to make special provision for employers to be 'represented' on Councils. Not only would this be inconsistent with the insistence in the previous question that Council members are not appointed as 'representatives' of particular interests. It also overlooks the fact that some regulated professions are made up of mainly independent practitioners who do not have an employer/employee relationship.

Without greatly increasing the size of our Councils it is not realistic to try to incorporate within them all of key interest groups with a legitimate stake in the way regulation operates. The task for all Councils (and for the Executives that support them) therefore, is to ensure effective engagement with those groups so that their views can inform the decisions that are made. Regulators should then be accountable for demonstrating that such engagement has been undertaken conscientiously and appropriately.

**Question 20: Should each regulatory body be asked to set out proposals about how they will ensure they produce and sustain fit to practise and fit for purpose professionals? Page 31**

In broad terms, yes. However, it should be emphasised that the production of fit to practise and fit for purpose professionals is an enterprise shared across many bodies and systems, including government. It is not something that regulators alone can deliver. But they should be able to describe the regulatory contribution in their business plans and corporate strategies.

**Question 21: Should potential savings generated through the reforms be passed back as fee reductions, be invested upstream to support professionalism, or both? Are there other areas where potential savings should be reinvested? Page 32**

Regulators should be held to account for ensuring that the level of fees they charge are appropriate to the fulfilment of their statutory objectives and that they have deployed their resources efficiently and in a manner consistent with their responsibilities.

However, any attempt to prescribe in statute or elsewhere precisely how regulators must allocate their resources would seriously undermine their independence and operational effectiveness. It would risk stifling efficiency and innovation and would be at odds with the declared aim of the consultation of giving regulators greater autonomy and flexibility in the way they carry out their business for the protection of the public.

As we have noted previously in our consultation response, we have recently (and not for the first time) reduced the ARF paid by our registrants. That reflected our sound financial governance and good operational efficiency. Future regulatory reform which enables us to re-allocate resources away from fitness to practise will support our continuing efforts to ensure that regulation offers value for money.

**Question 22: How will the proposed changes affect the costs or benefits for your organisation or those you represent?**

- an increase

- a decrease

- stay the same

**Please explain your answer and provide an estimate of impact if possible. Page 33**

Since the consultation does not put forward a fleshed out model for the future of regulation it is not possible to provide a meaningful answer to this question at this stage.

**Question 23: How will the proposed changes contribute to improved public protection and patient safety (health benefits) and how could this be measured? Page 33**

Since the consultation does not put forward a fleshed out model for the future of regulation it is not possible to provide a meaningful answer to this question at this stage.

**Question 24: Do you think that any of the proposals would help achieve any of the following aims:**

**- Eliminating discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010 and Section 75(1) and (2) of the Northern Ireland Act 1998?**

**- Advancing equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it?**

**- Fostering good relations between persons who share a relevant protected characteristic and persons who do not share it?**

**If yes, could the proposals be changed so that they are more effective?**

**If not, please explain what effect you think the proposals will have and whether you think the proposals should be changed so that they would help achieve those aims? Page 37**

The proposals as articulated in the consultation are not sufficiently granular to enable a meaningful answer to this question. However, there is nothing in the issues discussed which would be obviously at odds with the equality duty.