GMC response to Department for Education /& Department of Health and Social Care consultation: Social Work England – consultation on secondary legislative framework.

Summary comments

We very much welcome this consultation as further signalling the Government's recognition of the need for fundamental reform of professional regulation. We have provided detailed responses to each of the questions posed by the consultation document below.

However we are conscious that this framework may serve as a model for the regulation of other professions. Given this, we would like to offer our view on the applicability of the proposed framework in this broader context.

As we commented in our recent response to the Department of Health (England) consultation: *Supporting professionalism, reforming regulation*, an effective model of professional regulation would:

- Serve as an enabling framework, affording autonomy and flexibility to respond to the changing needs of health and social care service, rather than 'hard-wiring' into practice a regulatory approach built around the challenges of today

- Provide discretion to determine how a regulator should discharge agreed high level duties, responsibilities and requirements through processes, policies and procedures

- Enable this discretion to be applied promptly and swiftly within a framework of enhanced accountability (to provide assurance that this discretion – through the process of rule-making – has been applied appropriately in accordance with good practice principles)

- Take account of and adopt the Professional Standards Authority's (PSA) principles of effective regulation.

Regulation should be able to adapt and flex to the changing demands and needs of the workforce – in order to maintain and ensure safe, ethical practice (irrespective of the profession concerned). Where this does not happen, regulation can serve as a significant barrier to both progress, and critically, the ability of the service to meet the needs of its patients and / or service users.

This is best illustrated through an example we referred to in our recent consultation. We receive 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 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.

With a focus on high level duties and the autonomy – through specific rule making powers - to determine how these should be applied in practice, we broadly support the approach adopted by the Social Work England (SWE) regulations. We consider this to be a broadly positive step forward and we hope that the principles advocated here will set an appropriate precedent for professional regulation.

However, we recognise that there are important differences between SWE and the other regulators of health and care professionals. As a charitable organisation independent of Government, we would have concerns over the introduction of a formal approval process for individual rules (aside from the requirement for public consultation – where appropriate). And furthermore, if such an approach were to be extended to the other regulators, in our view, we would also question whether a formal approval process would restrict the ability of regulators to respond promptly and swiftly to changing circumstances (if each regulator is competing for limited Departmental attention).

We would suggest that oversight in this regard restrict itself to ensuring that rule making has followed due process and in accordance with best practice principles – a function which we believe could be undertaken by the Professional Standards Authority.

Finally, we are happy for our responses to this consultation to be published.

Question 1) Do you agree that SWE should have the power to register social workers in England with conditions?

The General Medical Council currently has no power to grant conditional registration at the point of application to the register (aside from conditions imposed following a fitness to practise investigation). In our view, doctors are either fit to practise or they are not (as far as registration is concerned) – and explaining the distinction between individuals with conditions and those without would be challenging.

If a decision is made to proceed with conditional registration, further thought may be required on how the register would be annotated for conditions that apply to ill-health. For reasons of patient confidentiality, we do not disclose any conditions or undertakings that relate to this.

Question 2) Do you agree with the proposal to introduce proportionate English language controls as a registration requirement?

Yes – we support the proposal in principle – for the reasons set out in the consultation document.

Question 3) Do you agree that SWE should have the power to annotate additional qualifications, specialisms and accreditations?

We broadly support this proposal in principle (mindful of any privacy concerns shared by registrants) and in addition, the assumption that this will require the collection of more

detailed information on a social worker's scope of practice. Improved up to date data on scope of practice will support a more risk-based, proportionate and targeted model of regulation. Furthermore, it would also provide more meaningful information for the public, a key audience for the register. However, it will be important that any annotations to the register are consistent with and relevant to SWE's overarching statutory objectives.

Question 4) Do you agree that current ftp sanctions should be annotated on the register?

Yes. We are committed to transparency about both our processes and decisions and believe that being open about the action we take in response to serious concerns about doctors is in the interests of the public and the medical profession. We support transparency about decisions related to a social worker's fitness to practise and believe this would be an important aspect of delivering public protection and maintaining confidence in the social work profession.

We particularly welcome the extension of the use of warnings to cases, either resolved by way of accepted disposal or referred to a hearing, where the case examiners or the tribunal find the social worker's fitness to practise impaired. This would enable Social Work England to issue a warning to social workers where impairment is found, but suspension or erasure would be a disproportionate response. We believe that this would constitute a more proportionate response to such cases, enabling social workers to continue working where this is deemed suitable whilst maintaining public confidence by providing a response to a finding of impairment.

Question 5) Do you agree that SWE should have a rule-making power to determine the length of time that expired sanctions are annotated on the register?

We agree that SWE should have this rule making power but would suggest that this power make provision for the development of guidance to inform decision making on appropriate time limits (rather than prescribe set time limits for particular sanctions).

We have a statutory duty under section 35B(4) of the Medical Act 1983 to publish, in such a manner as we see fit, a range of decisions by medical practitioners tribunals, interim orders tribunals and investigation committees, and undertakings agreed with doctors. Our Publication and Disclosure policy outlines our approach to the routine publication and disclosure of fitness to practise information, which is based on the principle of a proportionate approach when displaying this information online or sharing it with those who request it.

To ensure a proportionate approach to publishing information, we have recently consulted on and revised our own approach to time limits to balance the importance of transparency about the fitness to practise action we have taken with the impact on doctors from having information about expired sanctions publicly available. Our new policy moves away from indefinite publication and sets out a range of time limits according to the type of action

taken, whether or not the doctor remains registered, and whether or not the action was taken solely on the grounds of the doctor's health.

We consider that this discretion is essential to our role to protect the public and maintain public confidence in the profession and its regulation.

Question 6) Do you agree that SWE should be able to determine the criteria for the approval of education and training courses and qualifications in regulatory rules?

Yes – no further comment to add.

Question 7) Do you agree that SWE should have the power to suspend education and training course approval?

Yes – no further comment to add.

Question 8) Do you agree that SWE should have the power to attach conditions to education and training course approval?

Yes – we are supportive of the proposal. Currently, the GMC has powers to attach conditions and withdraw approval of training for postgraduate education only. We do not have similar powers for undergraduate education – for which our only sanction is to remove an institute from the list of medical degree awarding bodies. We would argue for a more proportionate and nuanced suite of regulatory sanctions for education and training (including the ability to approve and / or withdraw approval for undergraduate training programmes) and therefore support the precedent that these regulations set.

Question 9) Do you agree with the approach to allow SWE to approve other post-qualification specialisms relating to social work using the approval scheme for initial education and training set out in regulations and regulatory rules?

Yes – although as part of this process, we would suggest that any scheme for postgraduate education and training consider and promote flexible training pathways as part of the approval process. This would facilitate the process of switching between specialities for social care workers (enabling individuals to undertake truncated courses which account for their knowledge, skills and experience acquired through previous related specialist training courses). As far as the GMC is concerned, barriers in EU and UK legislation prevent us from introducing full flexibility for doctors who would like to change specialities while in training – an issue we would like to see changed through legislative reform.

Question 10) Do you agree that the proposed fitness to practise inquiry approach provides for:

- **A robust investigation process**
- **A clear and transparent mechanism for hearings**
- **A clear separation between investigation and adjudication; and**
- **A clear right of appeal?**

Robust investigation process

We welcome the proposed approach highlighted in paragraph 49 of the consultation to create a flexible, efficient and proportionate fitness to practise process by setting out core requirements in regulations, while addressing operational details in rules to be determined by the regulator which will be subject to consultation. We also strongly support a framework where thresholds for undertaking an investigation are not included in the regulations and are set by the regulator in its rules, which would be subject to consultation.

Although we are in agreement with the general principles set out in the consultation and draft regulations, we are not in a position to comment on the robustness of the process without further details.

Clear and transparent mechanism for hearings

We support the mechanisms set out in the draft regulations as part of a clear and transparent adjudication process.

However, we note that the proposals include a panel composition of two adjudicators whereas the Law Commission recommendations in its report in 2014 recommended a minimum of three adjudicators on a panel. Before commenting further, it would be helpful to understand the rationale behind this proposal.

Clear separation between investigation and adjudication

The draft regulations state that the realistic prospect test will be applied by the case examiners at the end of the investigation process. They set out that sanctions can only be imposed by case examiners or by adjudicators in the fitness to practise framework. They also specify that a person may not be appointed under more than one of the following roles in relation to the same fitness to practise inquiry: investigator, case examiner and adjudicator. We agree that this provides separation between investigation and adjudication.

To deliver a higher degree of separation and assurance of independent decision making by panels, we established the Medical Practitioners Tribunal Service in June 2012 which became a statutory committee of the GMC in 2016 and is directly accountable to Parliament through a requirement to submit an annual report. Our operational separation is also ensured by the GMC appointing a senior judicial figure to lead the MPTS with responsibility for the day to day running of the MPTS and the delivery of an efficient adjudication service. It may be that Social Work England may want to explore further separation mechanisms between the investigation and adjudication functions.

Clear right of appeal

There is clearly merit in ensuring that an appropriate body, acting to protect the public, can challenge a decision about a health and/or social care professional's fitness to practise

where it reasonably considers that the outcome of the impartial adjudication tribunal process does not sufficiently protect the public.

The introduction of the GMC's right of appeal, following the separation of its investigation and adjudication functions with the creation of the MPTS, 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. In any case where the Medical Practitioners Tribunal makes a decision which imposes a lesser sanction than we sought at the hearing, we therefore review the decision and consider whether the sanction (if any) imposed by the Tribunal is sufficient to protect the public (including public confidence in the medical profession).

The criteria which we apply when deciding whether or not to issue an appeal are published on our website at Appeals by the GMC pursuant to s.40A of the Medical Act 1983 ("s.40A appeals") – Guidance for Decision-makers. We therefore never take the decision to appeal a Medical Practitioners Tribunal (MPT) finding lightly. An appeal will only be issued where, after careful consideration of all of the relevant circumstances, we conclude that the decision of the Tribunal was insufficient to protect the public, which includes a failure to take appropriate action to maintain public confidence in the medical profession. In each case we will also seek advice from external lawyers before proceeding.

Our right of appeal was introduced, by statutory amendment, with effect from 31 December 2015 following a full public consultation in 2014. As the government made clear in its Consultation Response Report published in January 2015, providing a right of appeal for the GMC to challenge MPTS decisions had been a long term objective that was part of the proposals surrounding the establishment of OHPA and was originally legislated for in 2008 alongside that (although repealed alongside the abolition of OHPA). It had also been an explicit recommendation of the Parliamentary Health Committee.

The government explained that the policy intention was 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.

Question 11) Do you agree with the inclusion of provisions for:

- **Accepted disposal;**
- **Automatic removal; and**
- **Criminal convictions resulting in custodial sentences?**

Accepted disposal

Accepted disposal of cases helps regulators to protect patients without the need for a full hearing where the registrant is willing to accept the proposed sanction. We agree with the suggested provisions for accepted disposal and most particularly support the extension of such powers to allow accepted disposal outcomes in suspension and erasure cases.

Although we can currently agree accepted disposals in some cases we are unable to do so where there is a realistic prospect that, if the allegations were referred to a tribunal, the doctor would be erased from the register. We believe that this power, which we are also seeking to acquire, would enable a less adversarial approach. Such an approach would reduce the stress associated with the hearing process for both social workers and service users, particularly those who are vulnerable, while also taking suitable action to protect service users and far more swiftly than is possible when a tribunal is required to impose a sanction. We also welcome the intention set out in paragraph 54 of the consultation document to ensure appropriate safeguards are in place to ensure that the process is fair and transparent.

Automatic removal

As the proposal includes a process for social worker's to make representations we note that this proposal is also often called a 'presumption of erasure' as it is not automatic to the extent that the social worker has an ability to make representations. The consideration of the role of presumption of erasure powers for health professional regulators has been discussed for several years. It formed part of the Law Commission and PSA recommendations for the regulation of healthcare professionals in 2014. We supported the recommendation at the time and continue to support it on the basis that it would provide public confidence in processes by enabling regulators to move swiftly to take action in a small number of cases involving convictions for the most serious criminal offences.

We believe this power would avoid the need for putting witnesses, victims and the doctor through an additional hearing process and the delay that such a hearing involves where the criminal offence is so serious that continued registration as a doctor is untenable. We were always clear that the list of such offence would be very short and would only include the most serious convictions. In addition, we have only, and would only ever support the presumption of erasure where it included a process for representations by the registrant and a right of appeal for the registrant and was restricted to a short list of the most serious convictions such as murder and sexual abuse of children.

Criminal convictions resulting in custodial sentences

We agree with the inclusion of provisions for criminal convictions resulting in a custodial sentence, a power which is also held by us under Rule 5(1) of the General Medical Council (Fitness to Practise) Rules 2004 (as amended). This enables the Registrar to refer all convictions resulting in a custodial sentence, whether immediate or suspended, directly to a Medical Practitioners Tribunal.

Cases involving criminal convictions will have already had a full police investigation and a criminal trial involving detailed presentation and rebuttal of the evidence, and deliberations by a jury. An investigation by Social Work England into matters involving criminal convictions without full access to that information and deliberations raises clear concerns. In addition, a custodial sentence indicates a level of seriousness that would meet the realistic prospect test that an adjudicator would find the social worker's fitness to practise

impaired, and therefore it is reasonable that those cases are referred directly to the adjudicator.

Question 12) Do you agree with the proposed list of offences that would result in automatic removal?

We would support the inclusion of offences resulting in a presumption of erasure for only the highest level of criminal offences where there could be no question that a conviction under that category makes continued registration of a professional registrant untenable. This should be strictly limited to only a very small number of categories and in all cases the sentencing must have included a custodial sentence.

Therefore, we would agree with the offences listed 1 to 7 in the draft regulations. However, for offences listed 8 to 13 (blackmail; extortion; and sexual assault offences under section 3 of the Sexual Offences Act 2003, Section 3 of the Sexual Offences (Scotland) Act 2009 and Article 7 of the Sexual Offences (Northern Ireland) Order 2008), we would only support the inclusion of these offences if the sentencing included a custodial sentence (including suspended sentences).

At this point we do not envisage extending this process to any other categories of offence.

Question 13) Do you agree that SWE should be required in regulations to provide specific information about its core regulatory functions for:

- **the public**
- **registrants; and**
- **education providers?**

We fully agree that a regulator should provide specific information about its core regulatory functions for those groups impacted by it, be they public groups, registrants or education providers. However, we would question whether it is necessary for this good practice principle to be set out as a prescriptive duty within the regulations. Alternatively, if there is a compelling argument for this duty to be set out within the regulations, we would suggest that the regulations place a general requirement to provide information (relating to its core regulatory functions or otherwise) to any group impacted by its regulatory duties (including employers), where in the public interest to do so, rather than limiting itself to the three groups set out above.

Question 14) Do you agree that SWE should be required in regulations to prepare and publish a strategic plan?

We agree with the proposal and the drive towards greater transparency that this signals.

Question 15) Do you agree that SWE should be allowed through regulations to determine the relevant period to which its strategic plan will apply?

Again, we agree that SWE should have the flexibility to set the period to which the Strategic plan will apply.

Question 16) Do you agree that advisers should be able to provide the following to the regulator on matters relating to any of its functions:

- **information;**
- **specialist or expert advice; or**
- **recommendations?**

Yes, we believe that SWE should be able to use advisers to provide information, specialist advice or recommendations on any of its functions as appropriate. However, this should be conditional on the basis that the regulator has the discretion to determine whether, and if so how, it should act on the information received.

We would also suggest that recommendations only be sought in situations where the regulator feels this would be appropriate, would be in the public interest, or would further the pursuit of its statutory and strategic objectives. If advisers do not have a detailed understanding of the regulator and the regulator's environment, a situation might arise in which recommendations are either inappropriate (taking into account the regulator's remit) or not feasible to deliver. It would be helpful to avoid a situation in which the regulator is perceived to be publically disregarding recommendations that are actually not feasible to implement.

Question 17) Do you agree there are other advisory roles that advisers could usefully undertake in supporting the regulator to deliver its functions?

We agree that there a number of suitable roles that advisers can perform. At the GMC, our Associates (an appointed group made up of qualified and trainee doctors and non-medical (lay) experts) partake in a number of activities across the organisation. In addition to those potential roles set out in paragraph 65 of the consultation document, Associates can also serve as:

- performance assessors – assessing a doctor's performance and providing a report to the GMC when there are concerns about a doctor's ability to practise safely
- health examiners and medical supervisors
- examiners and panel members for our Professional and Linguistic Assessments Board (PLAB) test for International Medical Graduates seeking to practise medicine in the UK.

There may be equivalent roles that advisers could perform for the SWE. In addition, they may play a critical role in providing expert input into policy development across SWE's regulatory functions. However, we would caution against setting and therefore 'fossilising' a prescriptive list of potential roles within the regulations, for the reason that this may limit their potential involvement in future unforeseen ways.

Question 18) Do you think there should be any limitations on the role that advisers can play in supporting the regulator to deliver its functions?

We do not think that their role be limited through the regulations, rather, the regulator should have the discretion to employ and deploy advisers as it sees fit, in order to effectively

deliver its statutory and strategic objectives. However, it is essential that advisers be drawn from both registrant and lay service user populations, to ensure that any expert advice reflects the viewpoints of both of these groups.

Question 19) Do you agree that SWE should have a rule-making power to set out the detail about the appointment of advisers?

It should be for the regulator to determine how advisers are appointed in order to ensure that a proportionate and flexible approach can be taken depending on the circumstances, and particularly, the role that the adviser is expected to perform. For this reason, we agree that SWE should have a rule-making power to set out how it intends to appoint advisers (ensuring that any potential conflict of interest is identified and addressed through this process).

Question 20) Do you agree that the regulations should provide for SWE to set out the detail about how it will charge fees in relation to registration in regulatory rules?

We agree that SWE should have discretion to set out how it will charge fees – any attempt to prescribe in statute or elsewhere precisely how SWE must allocate its resources would seriously undermine its independence and operational effectiveness. However, we acknowledge that SWE should be held accountable for ensuring that the level of fees it charges is appropriate to the fulfilment of its statutory objectives and that it has deployed its resources efficiently and in a manner consistent with its responsibilities.

Question 21) Do you agree that the regulations should provide for SWE to set out the detail about how it will charge fees in relation to approval for education and training courses in regulatory rules?

We agree that SWE should have the ability to consider appropriate charges – particularly for those education and training courses offered overseas. We acknowledge that any fee structure would need to be nuanced and proportionate. For example, the GMC is obliged to assure UK undergraduate qualification offered overseas. Although UK universities will typically cover any direct costs associated with this, we currently have no power to recover our opportunity costs. This leads to a situation in which registrants are footing the bill for training which brings little immediate benefit to the UK. Charging for overseas provision will also help to reduce the cost of regulation for registrants.

Question 22) Do you agree that there should be an oversight process only for certain rules?

As we believe should be the case for all health and social care professionals, it is vital that any regulatory framework provides sufficient flexibility and agility to amend processes promptly and respond to the changing needs of the health and social care workforce (rather than prescribe rules for addressing the challenges of today). To enable this, we would argue that regulators should have the autonomy and discretion to determine how they will meet the high level duties, responsibilities and requirements set out within the regulatory framework.

Therefore, provided any change of process (or new rule) is capable of meeting the required outcome, this should not be subject to formal approval from the Department of Education, the Department of Health and Social Care, or the Secretary of State for Health and Social Care. Depending on the extent to which new rules are likely to impact upon external stakeholders, public consultation can provide the necessary transparency, challenge and oversight.

Furthermore, every rule-making power has been granted in recognition of importance – in terms of the need for clarity, transparency and flexibility. We do not believe that different levels of importance should be attached to rule making by requiring some to have formal oversight when compared to others. Every high level duty and responsibility should carry equal weight in the regulations and this should similarly apply to rule making powers.

We would also suggest that any (more formal) oversight focus instead on the process for developing rules, effective audit and performance review, and ensuring that good practice has been followed as opposed to approving certain rules in a piecemeal manner.

Question 23) If so, which regulatory rules do you think should be subject to an oversight process?

N/A – we do not believe that any regulatory rules should be subject to formal oversight, beyond the need for public consultation where appropriate.

Question 24) Which of the three possible oversight processes outlined do you think is most appropriate?

As stated above, we do not believe that any formal oversight (beyond public consultation) should be employed for particular rules. We acknowledge that SWE is a non-departmental public body rather than a charitable body, and therefore this may require a different form of oversight. However, we are mindful that the SWE regulations may serve as a model for the regulators of other health and care professionals and therefore we would argue that the requirement for explicit approval for rule making (from either the Department of Health and Social Care, or the Secretary of State) will present a significant barrier, and potential bottleneck, to agile and swift reform (particularly if rolled out to other regulators beyond SWE).

However, putting that to one side and in considering what might be the best fit for SWE, option two would appear to provide the greatest level of transparency and expediency. We would suggest that, for those rules where appropriate to do so, public consultation should serve as the starting point (and ideally, some level of external engagement would already have informed the development of the rule making process at an early formative stage). Furthermore, establishing a process whereby any rule comes into force unless an objection is raised on an exception basis (by the Secretary of State) would appear to offer a more proportionate approach rather than require every rule to be submitted and scrutinised for formal approval – which may serve as a barrier to a regulator's ability to respond rapidly to changing circumstances.

Question 25) Do you have any suggestions for alternative oversight processes for SWE's regulatory rules?

As above, we suggest that oversight focus on the process of rule making, effective audit and performance review – ensuring that this has followed due process and good practice, and as part of this, falls within the confines of the duties set out within the regulations. We believe that the Professional Standards Authority (the PSA) has a critical role to play here. We agree that SWE, and regulators of health and care professionals more widely, should be held to account through the PSA's annual performance review process. As part of this we could envisage a role for the PSA in auditing the process of rule-making to ensure that this has been followed appropriately.

Question 26) Do you agree that SWE should be required to co-operate with the range of organisations set out in the draft regulations?

We support the proposal to improve openness, information sharing and better co-operation through this requirement. We agree that there should be a duty to cooperate with relevant organisations and other persons, where this is either in the interests of the public or the regulator (in so far as it supports their statutory and strategic objectives) to do so. We therefore believe that SWE should be free to pursue arrangements (whether this be information sharing, coordinated regulatory activity or something else) which are most likely to add value and be able to stop collaboration when this no longer does so - this should be reflected within the regulations. Furthermore, we would also suggest that any accountability framework (potentially as part of the annual PSA review) consider the degree to which SWE has met this requirement.

Question 27) In addition, do you think that SWE should be required to co-operate with:

- **relevant inspectorates (e.g. Ofsted and the CQC)**
- **the police**
- **NHS bodies (e.g. the NHS Commissioning Board; clinical commissioning groups; and NHS trusts or NHS foundation trusts); and**
- **The disclosure and Barring Service (DBS)?**

We would suggest that relevant inspectorates would be covered under Paragraph 6 (1) (d) of the draft regulations and that NHS bodies would be covered by Paragraph 6 (1) (e). We would suggest that a less prescriptive approach be taken as far as bodies to cooperate with are concerned. The risk is that certain bodies will be omitted (for example, by referring solely to NHS bodies, you omit providers of independent healthcare) and that other organisations will cease to exist, merge, or change their name over time – which would require further amendment to the regulations. We would suggest that the regulations simply set out an expectation that the regulator will co-operate with any relevant organisation and / or persons where this is either in the public interest or supports the delivery of the regulator's statutory and strategic objectives.

It is also important to remember that SWE's ability to co-operate will only be as effective as the readiness of others to co-operate with it. There should, therefore, be an equivalent requirement on its regulatory partners to co-operate with SWE.

Question 28) Are there any other bodies that you think SWE should be required to co-operate with?

As set out above, we do not believe that the regulators should prescribe an exhaustive list of bodies.

Question 29) Do you think that the level of detail about the scope of the Secretary of State's powers with regard to default powers and remedial directions, including the power to appoint advisers, is sufficient?

The nature and scope of the Secretary of State's powers in this area appear to be appropriate for an NDPB, but would not be appropriate in the case of an independent statutory regulator.

Question 30) If not, what further detail would you expect to see in regulations?

N/A

Question 31) Do you agree that the Secretary of State should have powers to publish the remedial direction and the action required?

We agree that in the case where the Secretary of State has made a remedial direction it would be appropriate for this to be published.

Question 32) Do you agree that the Secretary of State should be required, through regulations, to appoint an independent person/s to take registration and fitness to practise decisions where they are delivering the functions of the regulator?

Yes, we agree.

Question 33) Do you think that the level of detail in regulations about the scope of the PSA's oversight role is sufficient?

Yes.

Question 34) If not, what further detail would you expect to see in regulations in relation to this area?

We do not suggest that any additional detail be included.

Question 35) Do you agree that SWE should fund the PSA on the same basis as other health and care regulators?

The same approach should be applied to SWE as applies to the other health and care regulators.

Question 36) How do you think that the proposed changes will affect the costs for your organisation or those you represent?

As the professional regulator for doctors, we not believe that the proposed changes will affect the costs for our organisation. We also assume that there will be no impact on the costs of our registrant population.

Question 37) Do you think that the proposed changes will bring particular benefits for your organisation or those you represent? Please explain your answer and provide an estimate of impact if possible.

None that we are aware of. However, we believe that the flexible framework set out by the regulations, with greater levels of autonomy to determine how particular duties and requirements are met, is a positive step forward for regulation more generally. As noted above, we believe that this will enable regulation to play its role in responding to the new and emerging challenges rather than being perceived as a barrier to progress.

Question 38) 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?**
- **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?**

As the regulator for doctors, and on the basis of the consultation document and draft regulations alone, we do not feel able to offer an informed and meaningful view. However, we do not believe that the proposals will give rise to a situation that is obviously at odds with the equality duty.

Question 39) If answered yes to any of the above questions, could the proposals be changed so that they are more effective?

N/A

Question 40) If you have answered 'no' to any of the above questions, 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?

N/A