General Medical Council

Regulating physician associates and anaesthesia associates

Proposed rules, standards and guidance: report on the public consultation

December 2024

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Proposed rules, standards and guidance: report on the public consultation

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Foreword

On 13 December 2024, we will welcome physician associates (PAs) and anaesthesia associates (AAs) into regulation. This will be the first time since 1957 that we have been responsible for regulating a profession other than doctors. It reflects the changing nature of healthcare provision and the growing importance of the multidisciplinary team in the way healthcare is delivered.

The legislation that will bring PAs and AAs into regulation is now settled. It provides a template for a more modern and flexible model of regulation that we anticipate will eventually be rolled out for, and benefit, doctors and all other healthcare professionals. We are urging the UK government to press on and complete this task of reforming the regulatory landscape for all.

Most audiences agree that regulation of PAs and AAs is needed. We are very aware that the choice of the General Medical Council (GMC) as regulator has caused concern for some doctors and their representatives, and that views on the role of these professions are mixed. The forthcoming review commissioned by the UK government will examine some of the questions about their role in the health services. But we are confident that the decision to regulate will support the further development of high standards for these professions and enable consistency and coherence in the way they and doctors are regulated. This will benefit patients and the public, healthcare providers, and, of course, the three professions themselves.

Our task has been to translate the powers and duties given to us in the legislation for PAs and AAs into operational reality. Key to this are the rules which set out how our various processes and procedures will work and the supporting standards and guidance for these professionals. Taken together the rules, standards, and guidance should give PAs and AAs certainty about what we will expect of them as regulated professionals and assurance about what they can expect of us.

Before finalising our rules and standards, we needed to consult doctors, PAs, AAs, the public, other healthcare professionals, and stakeholders on what we've proposed. That was the focus of *Regulating anaesthesia associates and physician associates: consultation on our proposed rules, standards, and guidance*, launched in March 2024. It described the nuts and bolts of how regulation will work for PAs and AAs. These are complex, technical matters that some stakeholders said were difficult to engage with, but they are nonetheless important. Some also felt that our consultation did not address wider issues of concern to them about the role and deployment of PAs and AAs in the health services.

We are extremely grateful to the many individuals and organisations who responded to our consultation and provided constructive feedback on how the rules, standards, and guidance could be improved. They have, unquestionably, been improved by that feedback.

This report sets out in detail the results of our consultation, showing where respondents agreed with our proposals and, just as importantly, where they disagreed and why. It also describes how we have adjusted our proposals in view of the feedback, as well as our reasoning where we have not done so. It contains a wealth of both quantitative and qualitative data and analysis. Like the consultation itself, the report is lengthy, detailed, and, in places, technical. We feel this level of detail is important if we are to do justice to the 3,011 individuals and organisations who shared their views with us.

Carrie MacEwen

Chair, General Medical Council

Executive summary

Introduction

In July 2019, the UK government asked us to regulate two additional professional groups, physician associates (PAs) and anaesthesia associates (AAs).

The Anaesthesia Associates and Physician Associates Order (AAPAO), drafted by the UK government and laid in the UK and Scottish Parliaments on 13 December 2023, established a legislative framework for the regulation of these two professions.

To implement the requirements of the AAPAO, we needed to create rules, standards, and guidance. These would prepare us for the regulation of PAs and AAs, which comes into force on 13 December 2024. This was the focus of our consultation.

In this report, we set out our response to the consultation feedback and the changes we've made to our rules, standards, and guidance. This executive summary gives an overview of the contents of the report.

Who we heard from

We're grateful to everyone who took part in our consultation. We received a total of 3,011 consultation responses, made up of 2,930 individual and 81 organisation responses. There is a more detailed breakdown of the profile of respondents in **Part 2** and **Annex B** of this report.

Our consultation was supported by engagement with stakeholders and other audiences in the months leading up to, and during, our consultation.

Additionally, we commissioned research (referred to in this report as 'public research'). The public research explored the views of patients and the public on the upcoming changes to the way we'll regulate all our registrants (doctors, PAs, and AAs), but focused particularly on the introduction of PA and AA regulation. We used both the findings of our consultation and the findings of the public research to develop the decisions set out in this report.

Our decisions

We have carefully considered the views, and supporting reasons, put forward by respondents.

In **Part 4** of this report, we summarise the comments made by respondents in relation to the rules, standards, and guidance that we consulted on and the changes we made as a result. We've set out the key themes and changes from each consultation topic below.

A lot of the feedback we received, particularly from those who disagreed with our proposals, covered issues that were outside the scope of our consultation or already settled in law by the provisions of the AAPAO. It related to concerns about the regulation and practice of PAs and AAs more broadly, as opposed to our rules, standards, and guidance. We nevertheless recognise the importance of many of the issues raised. Although not set out in this executive summary, **Part 3** of the report summarises the key concerns of respondents and how they'll be addressed by the GMC and other bodies outside of this consultation.

Our proposals – key changes we've made

- For fitness to practise accepted outcome decisions, and all substantive decisions made under Article 10 of the AAPAO, we will use two case examiners instead of a single case examiner as originally proposed.
- In our decision-making principles (impairment), we've expanded the list of behaviours that indicate a high level of seriousness to include cases where a PA or AA deliberately misled patients or others about their registration status.
- We've amended our registration, re-entry to the register, and removal rules so that reflective practice material cannot be required as part of registration, re-entry, or removal applications.
- To improve the clarity of our standards, rules, and guidance, we've made drafting changes throughout. We've also confirmed where some processes will be supported by further guidance, and where more detail will be available than is contained in the rules.
- We've amended the timescales within which we must give notification of particular decisions to make sure those affected are informed promptly. And, in relation to our fees rules, we've increased the period of notice we must give that the payment of fees is due.

The feedback to our consultation was extensive and wide-ranging. Although it has not been possible or appropriate to incorporate every suggestion into our rules, standards, and guidance for PAs and AAs, in this executive summary we have covered many of the key changes made.

We've provided full details in other parts of this report.

Education and training

We consulted on two sets of education and training standards. These are our curricula standards, which cover the requirements that curricula developers need to meet, and course standards, which cover the requirements that providers must meet to deliver courses and award PA and AA qualifications. We also consulted on education rules, which set out our approach to approving and quality assuring each PA and AA curriculum and course.

Respondents' feedback on our standards focused on the need for greater specificity or greater alignment with our other standards (for example, our standards for postgraduate medical curricula, *Excellence by design*). There were many drafting suggestions to clarify expectations or introduce more specific requirements for providers. We have redrafted selected standards to

better align with their equivalent standard in *Excellence by design* or *Promoting excellence*, and clarified some requirements. We've also introduced a requirement that training providers make sure learner PAs and AAs are identifiable while on placements.

Respondents' feedback on the rules focused on their clarity and accessibility. We've made various drafting changes to improve this. Respondents made several suggestions about our approach to the approval of training. For example, in response to feedback about the workability of provisions related to attaching conditions to an approved curriculum or course, we've amended the rules to allow for more flexibility.

Registration

Establishing a PA and AA register

We consulted on the form and keeping of the register rules. These set out the proposed content of the registers and how information will be maintained. However, much of the feedback we received focused instead on how information about PAs and AAs should be displayed on our website. We've published information separately about how our online registers will distinguish between doctors, PAs, and AAs.

Gaining entry to the PA and AA register

We consulted on registration, removal, and re-entry rules. These cover our processes for registration applications, removal from the register, and re-entry to the register following removal. Feedback indicated that our rules needed to be more specific about the required standards or include more guidance about the types of evidence we will accept in support of applications. Some of the information requested is already contained in the AAPAO and therefore doesn't need to be replicated in the rules. However, one of the key changes we've introduced is to make clear that PAs and AAs cannot be required to provide evidence of reflective practice as part of an application. This also applies to re-entry and removal applications.

Our guidance will explain the evidence that applicants who are existing PAs and AAs will have to provide, for example, that all PAs must pass, or already have passed, the Physician Associates National Examination or Physician Associate Registration Assessment.

Re-entry to the PA and AA register

Our rules set out the process for applying to re-enter the register, including where this follows removal as a result of action under our fitness to practise procedures.

Respondents questioned the evidence requirements for re-entry. These will be set out in published guidance. The guidance will show how evidence requirements will vary depending on how long someone has been off the register and the reason for their removal. In this way we can build appropriate flexibility into our processes and make sure our requirements in each case are proportionate.

We received questions about the restrictions on the number of times a person can apply for re-entry to the register. We've clarified that the restriction of three attempts applies to any re-entry

application that was refused since the PA or AA's last removal from the register either for an offence listed in the AAPAO or because of a final measure.

Removal from the PA and AA register

Our draft rules covered our process for removal from the register. This included circumstances in which removal is non-voluntary (for example, where we would automatically remove someone from the register), as well as voluntary removal, where a PA or AA chooses to leave the register. We also consulted on when removal measures will take effect.

Respondents had various questions about the removal process. These included the circumstances in which a removal could occur, who would be notified, and the timescales for different parts of the process. In response to the feedback, we've amended our rules to clarify some of the timescales within which we must notify a PA or AA of our decision. We've deliberately not specified in the rules the timescales within which PAs and AAs must provide us with information. This is to make sure that we can deal with removals flexibly on a case-by-case basis.

In relation to voluntary removal, issues raised by our respondents included: who will make the decision about removal; the independence of the decision-making process; the timescales within which we and the applicant must take particular action; and the handling of applications where there's also a fitness to practise concern. The changes we've made include an amendment to the rules to enable withdrawal of a voluntary removal application from a tribunal in some circumstances.

Some respondents wanted us to undertake more exhaustive checks before granting voluntary removal – even where there are no known fitness to practise concerns about the applicant. However, we are keen not to create unnecessary administrative burdens which would impede PAs and AAs from legitimately choosing to leave the register.

Fitness to practise

We consulted on fitness to practise rules, which covered all stages of the fitness to practise process. In the following paragraphs, we focus on the areas where we've made key changes to our processes. Details of further changes we've made can be found in the full report.

Initial assessment

Initial assessment refers to our assessment of a complaint or information received which we consider raises a question about a PA or AA's fitness to practise. Respondents wanted more clarity about this process, including how decisions are made about whether to refer a matter to case examiners and about the notification of decisions to those affected. Further details about the process will be set out in guidance that will support the rules. But we've amended the rules to provide a five-day timeframe for us to communicate decisions about the outcome of health and performance assessments.

Some respondents wanted changes to the grounds on which we could take action under our fitness to practise procedures. They argued for health to be introduced as an additional ground. However, the permitted grounds are already specified and fixed in the AAPAO and we do not

have the legal power to amend these through the rules. Instead, we have included in guidance how we'll deal with health concerns.

Accepted outcomes and single case examiners

Accepted outcomes refers to the process whereby case examiners can propose appropriate regulatory action (referred to as a 'final measure') for that PA or AA. The PA or AA has the option of either accepting or rejecting the proposed measure. Where they do not accept it, their case will be referred for determination by a tribunal. We had proposed that accepted outcome decisions would be made by a single case examiner.

Although there was some support for a single case examiner model, this was significantly outweighed by respondents' support for two or more case examiners, with mixed views on whether this should apply to every case or some types of case only. Respondents felt that our proposals for a single case examiner risked biased decision making and could reduce the quality and fairness of outcomes.

We've now changed our approach and will use two case examiners for these decisions (and all substantive decisions made under Article 10 of the AAPAO). Where the two case examiners cannot agree on the decision— in terms of whether the PA or AA's fitness to practise is impaired, whether to issue a warning (if no impairment is found), the proposed final measure, and whether to grant voluntary removal – the case will be referred to a panel of three case examiners for a decision.

Composition of panels

Across several consultation questions, we received comments about the composition of tribunals. Respondents questioned whether PAs and AAs should be eligible to sit on tribunals relating to the regulation of PAs and AAs or whether doctors should carry out this role. In the short term, it is likely that doctors will be needed to serve on tribunals for PAs and AAs because there won't be enough registered and appropriately experienced PAs and AAs to serve in this role. However, in the longer term, doctors, PAs, and AAs should all be eligible to serve as registrant panel members for fitness to practise tribunals dealing with PA and AA cases.

Decision-making guidance

We consulted on three sets of principles that will form the content of decision-making guidance for case examiners and tribunals. The principles will apply to PAs and AAs from 13 December 2024 and doctors from 1 April 2025. They are principles for impairment guidance, principles to inform guidance on what restrictive action is required, and principles to inform guidance on warnings.

We've made various drafting changes across these principles in view of the feedback we have received. We've summarised in the paragraphs below some of the key issues raised and changes we've made.

Feedback on the principles for impairment guidance included suggested additions for types of behaviour that should be treated as indicating a high level of seriousness. We've added cases where a PA or AA has deliberately misled others about their registration status. Additionally, we

have made other drafting amendments to clarify our approach to impairment and how decision makers should assess risk to public protection.

We've updated our principles to inform restrictive action guidance. These include:

- clarifying how time spent under an interim order/measure may be relevant when establishing the length of restrictive action
- explaining how suggestions about alternative conditions should be handled
- expanding on particular aspects of our decision-making principles.

We've amended our principles to inform guidance on warnings to clarify the cases where a warning is likely to be appropriate.

Revisions and appeals

We consulted on rules for revising and appealing decisions that we make. Revisions allow us to correct a decision when we agree it was wrong or where circumstances have materially changed since it was made. Appeals enable an individual to appeal a decision we've made on the basis that it's wrong or unjust. In most cases, appeals will be made to an internal appeal panel, run by us.

We've clarified some of the terminology used within the rules, including our definition of 'eligible person', which sets out who can request a revision of a decision.

Further, we've clarified the scope of the decisions covered by the revisions rules. We've made clear that decisions about the approval of education and the grant of registration are not revisable as these can be rectified through other means.

We can also confirm that the purpose of internal appeals is not to re-hear the original decision in a case simply because it was unfavourable to the PA or AA, but to review a decision on the basis that it was wrong or unjust. We can confirm that our process for running internal appeals will not prevent new evidence from being heard where this is relevant to the decision being appealed.

Fees

We consulted on draft fees rules for PAs and AAs. As required by the AAPAO, these covered the principles and processes surrounding the charging of fees, but not the amount to be charged. We published indicative fee levels separately on 21 November 2024 and a full schedule of fees will be confirmed on 13 December 2024.

We received a lot of feedback about the fee value and factors that should be considered when establishing this. Many respondents wanted assurances that doctors would not subsidise PA and AA regulation. Respondents also wanted to see more transparency about how fees are calculated and spent. In relation to the detail of the rules, we received feedback that we should give PAs and AAs greater notice of when the fee is due and not charge fees for revisions and appeals.

In response, we've extended the notice period for informing PAs and AAs that their fee is due and made further drafting changes after internal consideration to improve clarity of the rules.

We can also confirm that PA and AA regulation will not lead to any increase in fees paid by doctors.

Equality, diversity, and inclusion

We consulted on our Equality Impact Assessment (EQIA) and the effects of our proposals on opportunities to use the Welsh language.

In relation to the EQIA, we received a wide range of feedback relating to additional impacts for us to consider, such as the risk of bias from the use of single case examiners. Respondents identified actions for us to take to help mitigate adverse impacts on individuals with protected characteristics.

We've addressed some feedback by amending our proposals – for example, our decision to use two case examiners instead of one. We will also continue to monitor the impacts of our proposals in the coming years and will develop a plan to take this forward.

In relation to the Welsh language, respondents' feedback focused on the need for documents, services, and processes to be provided in Welsh. Some respondents raised points that have implications for our approach to regulation more broadly, rather than solely to the introduction of regulation for PAs and AAs. We will need to reflect further, over the coming months, on the feedback provided and consider the implications of this for our policy approach to the Welsh language more generally. In the meantime, we will continue to comply with our obligations under the *Welsh Language Standards* (standards set by the Welsh Language Commissioner that we are required to comply with as a regulator with functions in Wales).

Part 1: Introduction

In July 2019, the UK government asked us to regulate two additional professional groups, physician associates (PAs) and anaesthesia associates (AAs).

The Anaesthesia Associates and Physician Associates Order (referred to as the AAPAO throughout this document), drafted by the UK government and laid in the UK and Scottish Parliaments on 13 December 2023, establishes a legislative framework for the regulation of these two professions.

Between 26 March and 20 May 2024, we consulted on our proposed approach to regulating these professions.

As this was a necessarily detailed and complex consultation, we also wanted to make sure that we heard views on our proposals from voices that were less likely to be heard, as part of our consultation process. We therefore commissioned research with members of the public to explore their views on the upcoming changes to the way that all our registrants (doctors, PAs, and AAs) will be regulated.

In this report we respond to the feedback we received and set out the changes we've made as a result.

The General Medical Council

The General Medical Council (GMC) is the independent regulator of doctors in the UK. We currently work with doctors, their employers, their educators, and others to:

- set the standards of patient care and professional behaviours doctors need to meet
- make sure doctors get the education and training they need to deliver good, safe patient care
- check who is eligible to work as a doctor in the UK and check they continue to meet the professional standards we set throughout their careers
- give guidance and advice to help doctors understand what's expected of them
- investigate where there are concerns that there is a current and ongoing risk to public protection, and take action if needed.

From 13 December 2024, our role will expand to include the statutory regulation of PAs and AAs, for whom we'll also undertake these functions.

The background to this consultation

In October 2017, the UK government consulted on whether PAs and AAs should be brought into statutory regulation and, if so, who the regulator should be. The clear outcome of the public consultation was that they should be regulated.

Following this consultation, the UK government asked us to regulate both professions. Since 2019, we've been developing our regulatory model for PA and AAs.

The UK government ran two further public consultations to develop the legislation that would govern the regulation of PAs and AAs. The first consultation, in March 2021, focused on its policy approach to reforming the regulation of healthcare professionals and to introducing statutory regulation for PAs and AAs. The second consultation, in February 2023, focused on draft legislation for bringing PAs and AAs into regulation.

The legislation that requires us to regulate PAs and AAs, the AAPAO, was laid in the UK and Scottish Parliaments on 13 December 2023 and is now law.

To implement the requirements of the AAPAO, we needed to create a series of rules, guidance, and standards – the focus of this consultation – to prepare us for the regulation of PAs and AAs, which will come into force on 13 December 2024.

Our consultation also sits against a backdrop of wider regulatory reform. We've long called for reform of professional regulation for doctors, reforms that will now be based on the legislative framework that the UK government has created for PAs and AAs. The AAPAO will be the template for regulation of doctors and other healthcare professions. Therefore, introducing this new, modern regulatory framework for PAs and AAs marks a first step towards wider reform for all healthcare professions – enabled by greater legislative consistency across the different regulators. It'll also:

- mean that other professions, including doctors, will benefit from a more modern and flexible regulatory framework
- help us to address many of the long-standing problems caused by the existing legislative framework.

What we consulted on

The *Regulating anaesthesia associates and physician associates: consultation on our proposed rules, standards, and guidance* focused on our proposed approach to regulating PAs and AAs – specifically, the draft rules, standards, and guidance needed to implement the AAPAO. These set out our proposed approach to regulating these professions.

Our proposals focused on the rules made under our powers in the AAPAO. These describe the operational processes and procedures through which we'll implement the legal duties and powers that are set out in the AAPAO. Within our consultation, we sought views on seven sets of rules, covering each of our functional areas.

Additionally, our consultation focused on two sets of education and training standards, and three sets of decision-making policy principles that will inform fitness to practise guidance. Our

standards set out the professional values, knowledge, skills, and behaviours that we expect those we regulate to have, deliver, or demonstrate under our framework. And our guidance supports appropriate decision makers to make fair, objective, proportionate, and transparent decisions.

Our consultation included 27 questions, focusing on each of our proposed sets of rules, standards, and guidance. They were grouped by regulatory function, in the order that PAs and AAs are likely to encounter them across their career. These functions are listed below.

Education and training for PAs and AAs – covering:

- the standards that must be met by providers of education and training to award PA and AA qualifications
- our processes for approving and quality assuring the education and training provided.

The form and keeping of the register of PAs and AAs – covering:

- the information that must be recorded on the register for all PAs and AAs
- our responsibility for recording, amending, and maintaining register records.

Entering and re-entering the register of PAs and AAs – covering:

- the requirements that PAs and AAs must meet to register with us and the process for doing so
- the requirements that PAs and AAs must meet to re-enter the register if they have been removed from it, and the process for doing so.

Removal from the register of PAs and AAs – covering:

- our processes through which a PA or AA's entry on the register can or must be removed.

Dealing with concerns about PAs and AAs (fitness to practise proceedings) – covering:

- our processes for assessing, investigating, and adjudicating when a concern is raised about a PA or AA's practice
- our process for taking action because of a fitness to practise concern by issuing a warning or imposing a measure (restriction) on a PA or AA's registration; and our process for keeping fitness to practise measures under review
- policy principles to inform guidance on how we'll take decisions when fitness to practise concerns have been raised (which will apply to doctors as well as PAs and AAs).

Changing and challenging our decisions – covering:

- our process for revising some GMC decisions
- our process for handling internal appeals against our decisions.

Fees – covering:

- our approach to charging fees for our functions.

We also consulted on the extent to which our proposals meet the requirements of the Public Sector Equality Duty and the standards issued by the Welsh Language Commissioner.

We did not consult on:

- the question of whether PAs and AAs should be brought into statutory regulation
- whether they should be regulated by us
- what their professional title should be.

These questions have already been the subject of UK government consultations and legislative scrutiny by the UK and Scottish Parliaments. They are now enshrined in law. Instead, the purpose of this consultation was to seek stakeholder views on how we should regulate PAs and AAs and whether our proposals were clear, fair, and proportionate.

Our consultation – who we wanted to hear from

We invited responses from:

- doctors
- PAs and AAs
- the public
- other healthcare professionals
- any other individuals or organisations who are likely to be affected by, or use, our processes governing the regulation of PAs and AAs, including stakeholder organisations.

We collected demographic data about our respondents – and **Annex B: Respondent breakdown** provides a full breakdown of this.

Although the focus of our consultation was on PA and AA regulation, we noted in our consultation document that our proposals also had implications for the regulation of doctors. This was for two key reasons.

- First, this is because we propose that the fitness to practise decision-making guidance that will apply to PAs and AAs should also be introduced for doctors. Therefore, through this consultation, we sought views from doctors, PAs, and AAs on the proposed policy principles that would inform the content of this guidance.

- And second, this is because the AAPAO is expected to serve as the basis for the statutory functions, legal powers, and duties that will apply to doctors once new legislation is laid to reform the *Medical Act 1983*. Given this, we anticipate that the rules and guidance for PAs and AAs described in our consultation document will provide the basis for those which will be introduced for doctors. We therefore wanted to seek an initial view from doctors to inform their future development – while noting that a further consultation will follow at a later date.

Listening to partners across the UK's healthcare systems

This consultation wasn't the start of our engagement with our audiences on how we regulate PAs and AAs.

We've been working collaboratively with stakeholders and other audiences for some time about the new legislation and proposed reforms. In the months leading up to, and during, our consultation, our teams met with 47 organisations across the healthcare systems. This included PA and AA representatives, doctor representatives, patient groups, royal colleges, and employers. We also ran a series of events in spring with doctors in training; patient organisations; equality, diversity, and inclusion (EDI) groups; and responsible officers. Throughout these meetings and events, we provided stakeholders with an overview of what we were consulting on to help them feel informed and able to respond to our consultation.

Responding to consultation feedback

As a framework for the regulation of PAs and AAs, we recognise that our consultation proposals were, by necessity, detailed and complex. We are therefore grateful to everyone who took the time to respond to our consultation.

The purpose of any consultation is to understand the views of a wide range of stakeholders who might be affected by, or have an interest in, our proposals – and to use this evidence to deliver a more effective proposal. It is therefore not a referendum on the introduction of any proposals.

We've reviewed all the responses and have carefully considered the views, and supporting reasons, put forward by respondents, to inform the development of our final approach.

The structure of this report

We've divided our report into several sections.

- **Part 2** focuses on who responded to our consultation, and our approach to engaging patients and the public through separate commissioned research.
- **Part 3** addresses feedback from those who did not respond to the purpose and content of our consultation (through providing feedback on the proposed rules, standards, and guidance) but instead provides responses that concerned other aspects of the regulation and practice of PAs and AAs. This particularly came from respondents who disagreed with our proposals and covered issues that were outside the scope of our consultation or already settled in law by the provisions of the AAPAO. We nevertheless recognise the importance of many of the issues raised, and so Part 3 summarises the key concerns and how they will be addressed by the GMC and other bodies outside of this consultation.
- **Part 4** summarises the feedback that we received for each question, drawing on our consultation, and where appropriate our research with members of the public. We've set out the overall number of respondents who answered 'agree', 'disagree', and 'neither agree nor disagree/don't know' for each question, and provided an indication of how this varied between selected audience groups. We've then summarised the qualitative reasons that respondents shared for their views, indicating how these differ by audience group, and used quotes to illustrate particular themes where we had consent to use these. Finally, we've set out our response to that feedback and summarised the changes we are making as a result.
- **Annex A** provides an overview of the approach we took, and a summary of the methodology that we used to analyse the results from our consultation.
- **Annex B** gives the demographic breakdown of respondents.
- **Annex C** is our public research report (see **Part 2** for more information).

Part 2: Who we heard from

We opened our consultation to anyone who wished to share views on the draft rules, standards, and guidance. We were keen to get a diverse range of views, including from both organisations and individuals. We promoted our consultation widely to make sure we heard from doctors, PAs, AAs, the public, other healthcare professionals, and stakeholders.

Overview of responses

We received a total of 3,011 consultation responses. This was made up of 2,930 individual and 81 organisation responses. These were submitted to us via our online survey and through emails to our consultation inbox.

In particular, we heard from 1,909 doctors; 422 patients, members of the public, and carer/patient relatives or advocates; and 385 PAs and AAs (including PA and AA students). A full breakdown of the responses from individuals is set out below. A full demographic breakdown of these respondents is set out in Annex B.

Type of individual	Number of respondents
Doctor	1,909
Physician associate	307
Patient	217
Member of the public	180
Other healthcare profession	56
Physician associate student	44
Carer/patient relative or advocate	25
Anaesthesia associate	24
Anaesthesia associate student	10
Lay GMC/Medical Practitioners Tribunal Service associate	2
Other individuals	117
Blank responses	39

We also received responses from 23 doctor organisations, 11 higher education institutions (including medical schools), 11 National Health Service (NHS) or health and social care organisations, nine public/regulatory bodies, seven PA/AA organisations, and five postgraduate bodies. A full breakdown of the responses from organisations is set out below.

Type of organisation	Number of respondents
Doctor organisation	23
Higher education institution (including medical school)	11
NHS or health and social care organisation	11
Regulatory body	7
Physician associate organisation	6
Postgraduate body	5
Patient organisation	3
Public body	2
Anaesthesia associate organisation	1
Independent healthcare provider	1
Other organisations	9
Blank responses	2

Feedback from patients and the public

During our consultation, we wanted to make sure that we heard views on our proposals from a wide range of audiences.

We knew that our consultation was, by necessity, detailed and complex. We also knew that this would mean some voices were less likely to be heard as part of our consultation process – specifically, patients and the public.

Therefore, to complement the consultation feedback from patients and the public, we commissioned research to explore the public's views on the upcoming changes to the way in which all our registrants (doctors, PAs, and AAs) will be regulated. This focused particularly on the introduction of regulation for PAs and AAs.

The research involved in-depth focus groups and one-to-one interviews with 58 people from a broadly representative sample of people across the four countries of the UK. Because our consultation was technical and detailed, we designed the research to present our proposals to members of the public in an accessible and engaging way.

- Rather than share the draft rules and decision-making principles, we created a pre-read that mirrored the structure of our consultation, but at a higher level. This included real-life scenarios that took participants through a registrant's journey with us, from their education to joining the register to what happens if a fitness to practise concern arises.

- The researchers then used slides to present this information visually during the focus groups.
- We provided extra information about our current and future role that facilitators used to answer questions or provide clarity throughout the discussions.
- We also asked the researchers to adapt their approach to the needs of the groups, to make sure we heard from people with a range of health conditions as well as those less likely to engage with us. The researchers offered one-to-one telephone interviews for those who preferred to engage with the researchers through this format.

Although we've drawn extensively on the detailed feedback provided through our consultation to identify changes to our rules, standards, and guidance, we've also assessed how far our consultation themes align with the more general commentary provided by the research. Both the findings of our consultation and the findings of the public research were used to develop the decisions set out in this report. In **Part 4** of this document, we provide a brief account of relevant research findings for each of our consultation questions under the headings 'Public research findings'.

The full research report is included in **Annex C**.

Part 3: Wider issues raised by respondents

We received comments on various issues about the regulation and practice of PAs and AAs more broadly – as opposed to the specific rules, standards, and guidance that we consulted on. This particularly came from respondents who disagreed with our proposals and covered issues that were outside the scope of our consultation or already settled in law by the provisions of the AAPAO.

We nevertheless recognise the importance of many of the issues raised. We've therefore provided a summary of these below. Where appropriate, we've also set out how these have been, or are being, addressed by the GMC or other bodies, outside of this consultation.

The regulation and titles of PAs and AAs

We received a significant number of comments calling for the GMC to not be the regulator of PAs and AAs, or to say that PAs and AAs should not be professions or regulated at all.

As we set out in our consultation document, in 2017 the Department of Health and Social Care (DHSC) held a public consultation on whether PAs and AAs should be brought into statutory regulation and which healthcare regulator would be most suitable to regulate one, some, or all of the medical associate professions. Following their consultation, DHSC asked the GMC to regulate PAs and AAs.

The legislation to enable this to happen was laid in the UK and Scottish Parliaments in December 2023 and is now law. As such, we are now legally required to start regulating PAs and AAs from 13 December 2024.

Linked to this, we also received a smaller number of comments relating to the professional titles of physician associate and anaesthesia associate. However, these titles are now enshrined in the AAPAO and not something we have any discretion over.

PA and AA scope of practice

Some respondents stated that they couldn't respond to our consultation questions adequately without first understanding the scope of practice of PAs and AAs.

As for all healthcare professionals, the tasks that PAs and AAs undertake will vary depending on their individual skills and competence and the requirements of their employer. The scope of practice of PAs and AAs will also depend on what is permitted by law. For example, the law restricts who can undertake particular forms of healthcare work and so a PA or AA is currently prevented from performing some tasks, such as prescribing and signing death certificates.

Although we do not set the scope of practice for PAs and AAs, as their regulator, we'll set:

- the learning outcomes that need to be achieved through education
- the standards that applicants must meet to enter our register
- the registration assessments which must be passed by new graduates, international applicants, and those who have taken a prolonged break in practice.

Through these functions, we will ensure that only PAs and AAs with the knowledge, skills, and behaviours to work safely are entered onto our register. Once registered, it is for employers to determine how best to deploy and utilise individuals safely to address local need.

Our educational standards set out the capabilities that PAs and AAs require for registration, but they do not impose ceilings on what individual PAs and AAs can do once registered.

This is because competence varies by individual – and will be shaped by a PA or AA's supervised training and experience. Professional bodies are working to advise on the competencies needed for an individual to safely undertake an activity or procedure.

As we set out within *Good medical practice* and more detailed guidance, doctors, PAs, and AAs 'must recognise and work within the limits of [their] competence'. They must have access to a clinical supervisor, and must work with them to agree appropriate limitations to their practice. We've also issued *Effective clinical governance to support revalidation* guidance for employers on the clinical governance of PAs and AAs. This reiterates that PAs and AAs must work under the supervision of doctors and that appropriate governance structures (for their practice) must be in place.

PA and AA salary and pay

Some respondents highlighted issues relating to PA and AA salaries compared with that of doctors at an equivalent stage in their career.

Although this was raised by some as a factor that should be taken into account when setting fees (see **Part 4**), on a more general level, we don't play any role in establishing the salaries of the professions we regulate. Pay is a matter defined by employers, and therefore it wouldn't be appropriate for us to comment on this.

GMC use of the term 'medical'

Some respondents expressed concern about our use of the term 'medical' to describe aspects of our regulation which apply to doctors, PAs, and AAs. This included challenging our decision to apply *Good medical practice* to all professionals regulated by the GMC.

Our position remains that it is appropriate to use the term 'medical' in some instances to describe our regulatory approach to all registered professionals. We consider PAs and AAs to be part of the medical team because they work closely with, and are supervised by, doctors.

We have also already consulted extensively on this issue. In 2022, we consulted on updates to Good medical practice, where the updated draft expressly applied to all three professions. In this,

we use the collective term 'medical professionals' to describe doctors, PAs, and AAs. Once regulation begins, PAs and AAs – as well as doctors – will have to follow Good medical practice, which sets out the standards of care and behaviour expected of all our registrants.

We also remain the General Medical Council, as PAs and AAs are medical associate professions – and the name of the organisation (GMC) is set by the *Medical Act 1983* rather than the AAPAO.

We'll continue to make clear the differences between doctors, PAs, and AAs. We also plan to use the term 'medical professionals' only when appropriate to the circumstances. Outside of our professional standards guidance, most of our communications will be tailored to refer to each profession individually.

Some respondents also expressed concern over the application of *Good medical practice* for all three professions, querying how a shared set of standards could apply in each case. To address this point, we propose to make the following changes once regulation commences. We will:

- confirm within the introduction to *Good medical practice* that it applies to doctors, PAs, and AAs registered with us
- emphasise that *Good medical practice* does not contain clinical standards, and so doesn't address the specific knowledge, skills, and capabilities for each profession; rather, it sets out the standards of care and professional behaviour expected of all three
- amend paragraph 82 of *Good medical practice* to add the following statement: 'You should introduce yourself to patients and explain your role in their care'
- add a reference to the additional resources that we are developing on the supervision of PAs and AAs (see the section on PA and AA supervision below).

Clarifying the respective roles of doctors, PAs, and AAs

Several respondents expressed concern that GMC regulation of PAs and AAs could lead to confusion about the difference between their roles and the role of doctors.

We agree it is vital that patients must always be clear about who is treating them and their role within the team.

Regulation will be helpful in this context. Our professional standards will say that PAs and AAs should introduce themselves to patients and explain their role in their care.

Regulation will also mean that we are able to consider whether action is needed if an individual registered with us falls below the standards we set – including instances where they are not open and transparent about their role or qualifications.

In March 2024, we also announced that we would implement an alphabetical prefix for PA and AA GMC reference numbers and make sure there is prominent labelling of profession type on our public-facing registers. This means that in future when patients search the registers it will be very clear whether an individual is a doctor, a PA, or an AA.

The Faculty of Physician Associates has guidance on 'titles and introduction', which provides a standardised way of using the PA title. The guidance also highlights the importance of explaining this to patients and colleagues.

Concerns about the effect of PAs and AAs on the role of, and resources for, doctors

We received comments expressing concern that PAs and AAs are taking resources away from doctors, such as supervisors and training placements. A smaller number of respondents were concerned that the regulation of PAs and AAs signals an intent to eventually replace doctors with PAs and AAs.

We have always been clear that, as a multiprofessional regulator, we will recognise and regulate doctors, PAs, and AAs as three distinct professions. PAs and AAs don't have the same knowledge, skills, and expertise as doctors. They are not doctors, and they can't replace them.

We work with others across the health system to make sure that doctors get the education and training they need to deliver good, safe patient care. Our approval of postgraduate training for doctors is on the basis that training organisations can deliver the opportunities for trainees to achieve their curricular requirements and meet our standards.

We've also publicly called on system leaders across the four countries of the UK to collectively address pressures on doctor training capacity, supervisors, and trainees as part of their work to implement long-term workforce plans. We've urged them to:

- grow training opportunities and capacity across the system
- increase the trainer workforce
- protect time for training
- ensure employers are providing training opportunities.

Why we did not consult on particular topics

We consulted on a wide range of proposals governing the regulation of PAs and AAs, but there were some issues that we didn't consult on – specifically, revalidation and post-qualification training.

It remains our intention to introduce revalidation for PAs and AAs. The AAPAO includes requirements for periodic assessment of PAs and AAs. PAs and AAs should also be participating in appraisal and collecting supporting information from the time they join the register, in line with our updated *Guidance on supporting information for revalidation*. We're still finalising our approach to this but have provided some initial details on our website. We'll be consulting on our rules for revalidation before the end of the transition period. This is the two-year period set by the AAPAO in which the titles of PA and AA are not protected. PAs and AAs must have registered with us by the end of the transition period to be able to continue practising in the UK.

Good medical practice also requires doctors, PAs, and AAs to:

- 'keep [their] professional knowledge and skills up to date' and to 'take steps to monitor, maintain, develop, and improve [their] performance and the quality of [their] work'
- 'regularly [take] part in training and/or continuing professional development'
- 'regularly [reflect] on the standards of care [they] provide'.

Unlike for doctors, there is no formal post-qualification training framework for PAs and AAs. As such, this area was not covered in our consultation. Once PAs and AAs are regulated, we'll consider what role we should play in the future development of post-qualification frameworks for PAs and AAs.

PA and AA supervision

Some respondents wanted further information about our planned approach to PA and AA supervision – specifically, further details on the accountability and responsibility of the supervising doctor.

PAs and AAs have been part of multidisciplinary teams in health services across the UK for many years. Many doctors already supervise colleagues or lead teams that include PAs and AAs. Our guidance for doctors is clear that (as with other professionals they supervise and work alongside) doctors are not accountable for the decisions and actions of PAs and AAs. This is provided that doctors have delegated to PAs and AAs in line with our *Delegation and referral* guidance. This advice will not change with the entry of PAs and AAs into statutory regulation.

When it comes to good supervision, there isn't a one-size-fits-all approach because individuals who are being supervised develop their skills, competence, and experience over time. This means that named supervisors should agree a level of supervision appropriate to each individual's skill level, competence, experience, role, and the nature of the task.

In preparation for PAs and AAs joining our registers, we are bringing together our existing advice about the supervision of PAs and AAs. This will be published as a new page on our ethical hub after regulation commences on 13 December 2024.

Our ongoing role

Regulation is a vital step towards strengthening both patient safety and public trust in these professions. It will help provide assurance to patients, employers, and colleagues that PAs and AAs have the right level of education and training, meet the standards that we expect of the professions we regulate, and can be held to account if serious concerns are raised.

We recognise that the discussion about the PA and AA role and deployment continues. It's important that we all engage to proactively address these issues and to provide clarity and assurance for patients, doctors, PAs, and AAs alike.

As always, we're committed to working closely with our partners across the health system to ensure that regulation is implemented effectively and supports our shared goal of improving patient safety and care.

Regulation for PAs and AAs will come into effect on 13 December 2024 and so finalising the core elements of regulation remains our current focus. In **Part 4**, we set out how consultation feedback has shaped our approach to regulation across our key functions.

Part 4: Responding to the feedback and our decisions

General commentary

This part of the report details the feedback we received for each question, and our response to that feedback.

For each question we have:

- summarised what we proposed in *Regulating anaesthesia associates and physician associates: consultation on our proposed rules, standards, and guidance*
- provided quantitative data for each question (please be aware, we have rounded up percentages so in some instances these do not add up to 100%)
- summarised the themes from comments submitted in response to each question
- summarised the relevant findings from our public research
- set out our response to the feedback
- provided an at-a-glance summary of the changes we have made to our draft rules, standards, and guidance.

There were also some recurrent themes. Rather than repeat these in each question, we have summarised them below.

Alignment in processes between doctors, PAs, and AAs

Several respondents stated that our proposals for PAs and AAs should align with our current processes for doctors.

The AAPAO introduces a new and more modern approach to regulation than we currently have for doctors under the *Medical Act 1983*. This new approach brings with it opportunities to develop rules and guidance which are more flexible, and in turn better meet the needs of regulation today and in the future.

The AAPAO is also different from the *Medical Act 1983* in many ways. This means that we would not be able to replicate our current processes for doctors – even if we wanted to.

Our approach to rule drafting

Some respondents argued for greater specificity in the rules. In drafting the rules and standards, we've attempted to provide clarity and assurance about how our processes will work, so that those affected know what will be expected of them and what they can expect of us. At the same time, it is important that our rules are not too prescriptive, so that they don't prevent flexibility or impede our ability to respond to new or emerging situations. Where we've chosen not to include prescriptive detail in the rules themselves, and where appropriate to do so, we will publish policies and guidance to support our decision makers to make fair, objective, proportionate, and transparent decisions.

Education and training

What we proposed

Once regulation comes into force, we will introduce a framework for approving and monitoring the delivery of pre-qualification education for PAs and AAs.

We consulted on two sets of draft education and training standards, covering:

- the requirements that curricula developers will need to meet (our 'curricula standards')
- the standards that providers must meet to deliver courses and award PA and AA qualifications (our 'course standards').

We also consulted on draft rules, which set out our approach to approving and quality assuring each PA and AA curriculum, course, and qualification.

Question 1: To what extent do you agree or disagree that the standards set out within the *Standards for PA and AA curricula* describe the essential criteria that must be met for each AA and PA curriculum to be approved?

What we heard

Overall responses		**Responses from individuals**					**Responses from organisations**	
			Total	**Public**	**Doctors**	**PAs/AAs**		
Total responses	2,800	Total responses	2,731	404	1,760	379	Total responses	69
Total comments	1,474	Total comments	1,427	200	1,038	62	Total comments	47
Agree	28% (796)	Agree	28% (759)	32% (129)	12% (209)	98% (370)	Agree	54% (37)
Disagree	63% (1,755)	Disagree	64% (1,738)	60% (244)	78% (1,369)	1% (5)	Disagree	25% (17)
Neither agree nor disagree or don't know	9% (249)	Neither agree nor disagree or don't know	9% (234)	8% (31)	10% (182)	1% (4)	Neither agree nor disagree or don't know	22% (15)

Of the 3,011 individuals and organisations that responded to the consultation, 2,800 responded to this question. Of these:

- 796 (28%) agreed
- 1,755 (63%) disagreed
- 249 (9%) neither agreed nor disagreed or did not know.

Analysis of comments – curricula standards

We received a large volume of feedback on the clarity of our curricula standards. Some respondents (largely doctors and members of the public) stated that the standards felt vague, and were too high level or too hard to understand. As one respondent noted:

> *'The standards appear to be more of an overview, rather than very detailed. I believe this detail on each point is critical, as inevitably there will otherwise be "interpretation" of standards, which results in legal "flexibility/watering down" in how such standards are met. The ultimate consequence is of creating lower quality successful PA/AA professionals than we ideally should be aiming for.' (Doctor)*

Those respondents (doctors, PAs and AAs, and some organisations) who supported our proposals felt that the standards were proportionate and reasonable, and welcomed the standardisation that these brought. However, they also made suggestions for improving the standards, including the need to take into account the impact of PA and AA training on doctors – a view also held by those who disagreed with our proposals:

> *'CR [curriculum requirement] 1.5[*] specifies the requirement to demonstrate identification and addressing of key interdependencies between PA/AA curriculum and the training and practice of other healthcare professionals. [The organisation] highlights strengthening this by adding consideration of training and trainer capacity within the system in this respect.' (Organisation, NHS or Health and social care organisation)*

Other respondents suggested that the standards more clearly set out the desired behaviours and attitudes that we expect for individual learners. Some respondents went further to suggest that the standards should additionally set out the competencies and practical skills that will be needed to meet the high-level learning outcomes – although others queried the feasibility of this without a defined scope of practice.

[*] CR1.5 of the draft curricula standards set out a requirement for curricula developers to: Demonstrate how the key interdependencies between the curriculum and the training and practice of other healthcare professionals have been identified and addressed.
This is now CR1.5 in the final curricula standards.

> *'Overall, the standards seem reasonable – however, although they state a link to* Good medical practice*, I wonder if references to knowledge, skills and capabilities should also include an explicit reference to professionalism. Professionalism and ethical conduct are a key component of medical school training for doctors, so I think this needs to be a very clear requirement of PA and AA curricula as well.' (Doctor)*

Some respondents argued that our standards were not sufficiently robust or rigorous, and called for these to be subject to a regular programme of external review. Others noted that the standards allowed for too much variation in how courses could be delivered or did not articulate the knowledge and experience required to enter a course.

A postgraduate body noted that the curricula for PAs and AAs should be reconsidered given that the 'landscape' has changed since these were consulted upon in 2021. They went on to note that including elements of prescribing and medicines safety in a 'capabilities in practice' framework may imply that learners should have more than a basic understanding only and be able to carry this out in practice. They also asked for stakeholders to have an opportunity to contribute their views before the curricula are approved.

Other respondents suggested that, because PAs will be working across a range of specialty areas, we should consider the development of specialist curricula for each of these, to mirror our approach for doctors. A doctor organisation drew comparisons with our guidance for postgraduate curricula, *Excellence by design*, and made drafting suggestions to ensure greater alignment with this.

Drafting suggestions

Additional drafting suggestions provided by respondents included the following.

- A suggestion from a patient organisation that our standards be revised to
    a) promote the development of resilience within students
    b) ensure that clinical placements do not affect the supervision and training of doctors in training.
- A suggestion from a doctor organisation that our standards should describe how PA and AA roles are differentiated from doctors – to emphasise that their capabilities are different from the skills and competences of doctors.
- A suggestion from a higher education institution that we establish a minimum review period for the curricula and maintain a record of redundant elements that are removed following each review.
- A suggestion from some respondents that the standards need to confirm that PAs and AAs must work under supervision.

- A suggestion from a doctor organisation that the curricula standards clarify expectations around assessment:

  'One of the most notable omissions is that there are no standards for a programme of assessment. Instead, standards and requirements for assessments are included in Standards for the delivery of PA and AA pre-qualification education *and so while the Faculty of Physician Associates and the Royal College of Anaesthetists have responsibility for the respective PA and AA curricula, it would appear that it is up to each course provider to decide how best to assess individuals on these courses, based on the relevant curriculum.' (Organisation, doctor organisation)*

Our response to the above suggestions/comments is set out in the 'Our response: questions 1 and 2' section below.

Question 2: To what extent do you agree or disagree that the standards set out within the *Standards for the delivery of PA and AA pre-qualification education* describe the essential criteria that must be met for an AA and PA course to be approved?

What we heard

Overall responses		Responses from individuals					Responses from organisations	
			Total	Public	Doctors	PAs/AAs		
Total responses	2,753	Total responses	2,686	398	1,723	378	Total responses	67
Total comments	1,322	Total comments	1,279	185	863	124	Total comments	43
Agree	19% (535)	Agree	19% (504)	10% (39)	11% (196)	58% (219)	Agree	46% (31)
Disagree	62% (1,699)	Disagree	63% (1,682)	60% (238)	77% (1,324)	2% (6)	Disagree	25% (17)
Neither agree nor disagree or don't know	19% (519)	Neither agree nor disagree or don't know	19% (500)	30% (121)	12% (203)	40% (153)	Neither agree nor disagree or don't know	28% (19)

Of the 3,011 individuals and organisations that responded to the consultation, 2,753 (91%) responded to this question. Of these:

- 535 (19%) agreed
- 1,699 (62%) disagreed
- 519 (19%) neither agreed nor disagreed or did not know.

Analysis of comments – course standards

As with question 1, several respondents asked for greater specificity within the standards, to increase their clarity, robustness, and rigour.

> *'there needs to be more clarity with regards to the individual PA/AA with specific outcomes to achieve clinical competencies to practice'. (Organisation, postgraduate body)*

Some respondents focused their feedback on clinical placements, querying how these would be run, and who would be responsible for students attending these:

> *'The majority of AA training seems to take place mainly within the workplace on clinical attachments, and that workplace employs these individuals. It is unclear who the responsibility lies with for these students and how the placements are assessed. These standards do not seem to address this.' (Organisation, professional association)*

A patient organisation noted the importance of good quality placements, and other respondents (largely PAs and AAs, members of the public, and some organisations) suggested that these could be enhanced through ensuring that they give opportunities for direct patient care and be of sufficient duration to enable students to develop the required capabilities (and that the standards should require this).

As with question 1, many respondents (largely doctors, some doctor membership bodies, and an educator body) felt that the standards should account for the impact of PA and AA training on medical students, and doctors in training, and also the capacity of individual doctors to supervise learners. Some respondents commented on the need for standards to have:

> *'safeguards to ensure educators are fully supported, have the necessary time, and are properly compensated for any additional duties undertaken in supervising and assessing PA/AA students'. (Doctor)*

A postgraduate body suggested that the standards should require the supervisor to be named, noting that:

> *'PAs must be supervised by a named senior doctor (a GMC registered consultant, GP, specialist or associate specialist (SAS)) who may delegate that responsibility to another doctor according to the clinical tasks and the environment in which these are being performed. It is the role of that supervisor to also delegate appropriate tasks. It is not clear the distinction that supervision must be provided by a senior doctor. We welcome this point already forming R [requirement] 1.11[*].' (Organisation, postgraduate body)*

Other respondents (mainly PAs and AAs) focused on the mechanisms that would exist for learners and others to raise concerns, both locally and nationally – if their learning needs were not being met, or if they faced discrimination or bullying. A regulatory body stated that 'raising concerns is important but is more successful in positive learning environments'. It queried 'if there was room in the standards to describe in more detail what a just culture looks and feels like in practice before dealing with raising concerns'.

Respondents also highlighted concerns around resource constraints. One employer noted:

> *'concerns regarding the lack of appropriate funding for LEPs [local education providers] to provide the infrastructure to maintain the quality of clinical teaching and educational governance'. (Organisation, NHS or Health and social care organisation)*

[*] R1.11 of the draft course standards said: Organisations must make sure learners have an induction in preparation for each placement that clearly sets out: a) their duties and supervision arrangements; b) their role in the team; c) how to gain support from senior colleagues; d) the clinical or medical guidelines and workplace policies they must follow; e) how to access clinical and learning resources. As part of the process, learners must meet their team and other health and social care professionals they will be working with. Learners on observational visits at early stages of their programme should have clear guidance about the placement and their role.
R1.11 is now R1.12 in the final course standards.

And another organisation said:

> *'there is a lot of emphasis on appropriate support and learning opportunities within the learning environment, which is extremely positive, however, there are risks with significant issues with placement capacity across the UK, with several types of learners often competing for learning opportunities in a specific learning environment'. (Organisation, postgraduate body)*

Drafting suggestions

Additional drafting suggestions provided by respondents included the following.

- Require local education providers to ensure that arrangements for clinical supervision are in place.
- Ensure that mechanisms are in place for information to be shared between the higher education institution and the organisation providing clinical placements (to ensure continuity of learning).
- Clarify the amount of time required for training under R2.10* and R4.2†.
- Ensure that all PA courses include a qualified PA and a qualified doctor as part of the teaching team.
- Ensure that courses include opportunities for learners to prepare for the Physician Associate Registration Assessment (PARA).
- Ensure that the standards take account of the differences in how PAs and AAs are trained. One higher education institution noted that:

> *'student anaesthesia associates are appointed by NHS Trusts and then engage with a HEI [higher education institution] course post-appointment. This is a different position (as far as we are aware) than PA students (and medical students) who are enrolled in a university course and then sent on placement to a hospital/community practice. This means that HEIs who provide AA courses have fewer options if a hospital is not providing an appropriate learning environment (we cannot deploy students elsewhere, for example), and this emphasises the need for partnership between HEIs and hospitals (LEPs [local education providers] in this document) in achieving high standards.' (Organisation, higher education institution)*

* R2.10 noted: Organisations responsible for managing and providing education must monitor how educational resources are allocated and used, including ensuring time in trainers' job plans.
This is now R2.10 in the final course standards.
† R4.2 noted: Educators must have enough time in job plans to meet their educational responsibilities so that they can carry out their role in a way that promotes safe and effective care and a positive learning experience.
This is now R4.2 in the final course standards.

Our response

The consultation feedback for questions 1 and 2 focused on the need for greater clarity and increased specificity across both sets of standards. In response to this feedback, we've made drafting and structural improvements where necessary to improve this. The standards will be reviewed again as part of our future education and career development programme.

Curricula and course standards – alignment with other standards

We've redrafted selected standards so that they more closely align with their equivalent standard in our standards, *Excellence by design*, which provide standards for the development and design of postgraduate medical curricula, and *Promoting excellence*, which provides standards for the delivery of postgraduate programmes. For example, we have now redrafted our curriculum standard CS3.1 to the following:

> *'The curriculum must describe the generic and shared outcomes, expected knowledge, skills, capabilities, levels of performance and experience that learners must demonstrate to progress or complete their course.'*

Curricula standards – ownership, approval, and review of curricula

In response to concerns that some respondents raised about the ownership of each curriculum, including concern that some parts of the curricula may be withdrawn without consultation, we will set out in guidance more detail about how approved curricula may be varied – which will require an application to be made requesting approval for this. Our guidance also sets out a change log that curricula developers will need to complete to record any amendments or removals from the existing curricula.

We will publish our guidance and process map showing in more detail how the curriculum approval process works. This will give more clarity about the steps we take to gather input from various stakeholders, including doctors, as part of this.

We do not propose to introduce a regular cycle of review for individual curricula because we already have several mechanisms in place to verify how well the curricula are working – including quality assurance processes and our post-implementation reviews.

Curricula standards – learning outcomes content

In response to feedback noting a perceived lack of learning outcomes within the curricula standards, we consulted on learning outcomes in 2021 and these are set out within the *Generic and shared learning outcomes for PAs and AAs*. Our curricula standards require providers to demonstrate that their course can deliver these outcomes.

Curricula standards – registration assessments

We have worked with stakeholders to make sure that the curricula set out the knowledge, skills, and experience necessary to pass our registration assessments. However, there was no previous requirement within the standards to make sure that the curricula and registration assessment maps contained the same information. Therefore, we have now included a new standard (CR3.4)

requiring a curricula developer to consider the content maps that inform our registration assessment to make the link between the two clearer:

> *'Organisations developing curricula must demonstrate how they have considered the requirements of the relevant registration assessment content map.'*

Curricula standards – safety

In response to feedback suggesting that our standards require associate learners to be supervised, we've created a new standard (CR3.4). The new standard will require curricula developers to provide guidance on how the course will deliver the curriculum safely – which we would expect to also cover arrangements for supervision:

> *'Provide guidance on the appropriate educational methods and approaches and learning opportunities necessary to ensure safe learning environments and to meet the learning outcomes.'*

Curricula standards – capacity of educators

Feedback about the capacity of trainers and educators to teach PAs and AAs will be addressed by CR2.3 (and we'll set out in guidance how the capacity of educators can be evidenced to demonstrate compliance with this requirement):

> *'Explain how the curriculum is feasible, practical, and sustainable.'*

We also note that, as part of our post-implementation review of approved curricula, we will take into account feedback from trainers to understand any capacity concerns.

Course standards – raising concerns

In response to the feedback around raising concerns and the suggested additional requirements to strengthen this, we agree that learners should be able to raise concerns both locally and nationally where they feel that their learning needs are not being met. However, our existing standards already make provision for this, and therefore we do not consider further amends to be necessary. For example:

- S2.2 requires organisations to have systems in place to address concerns about patient safety, the standard of care, and the standard of education
- R2.7 requires organisations to have systems in place for raising and acting on concerns.

Course standards – seeking patient consent

We agree with the feedback given by some respondents that, as part of the process of seeking consent, patients should be made aware that associates will be involved in their care. We've amended R1.10 to require all training providers to make sure learner PAs and AAs are identifiable while on placements. This now says:

> *'Organisations must have a reliable way of identifying learners in respect of the stage of education they are at and which profession they are training for. They must make sure all*

staff members take account of this, so that learners are not expected to work beyond their competence.'

We've also updated R1.8 and R1.11 to require tasks needing patient consent to be undertaken under appropriate medical supervision, and to ensure that patients are made aware of the stage of education and profession of those providing their care. These requirements now say:

> *'Organisations must make sure that learners on placement are supervised, with an appropriate level of clinical supervision at all times by an experienced and competent supervisor, who can advise or attend as needed. The level of supervision must fit the individual learner's competence, confidence and experience, as well as the learners' course requirements for supervision. The support and clinical supervision must be clearly outlined to the learner and the supervisor. Tasks that require patient consent should only be carried out under the direct supervision of the doctor responsible for taking consent.'*
>
> *'Patients must be made aware that a learner is involved in their care, along with their stage of education and the profession they are training for.'*

Box 1: Course and curricula standards – the changes we've made

- Various drafting amendments to improve the clarity of the curricula and course standards, including:
  - amending CR1.2 and replacing 'graduate' with 'those completing the curriculum'
  - redrafting CS3.1 to make it clearer: 'The curriculum must describe the generic and shared outcomes, expected knowledge, skills, capabilities, levels of performance and experience that learners must demonstrate to progress or complete their course.'
- Various drafting amendments to correct inaccuracies within the curricula and course standards including:
  - amending R1.10 to require training providers to make learner PAs and AAs identifiable
  - amending drafting to clarify that a learner must only carry out consent tasks under the direct supervision of the doctor who is responsible for the consent being taken, and to make patients aware that care may be provided by an associate learner (R1.8 and R1.11).
- New standards which require curricula developers to:
  - consider the requirements of the relevant registration assessment content map (CR3.5)
  - provide guidance on how the course can implement the curriculum safely through supervision (CR3.4).

Question 3: To what extent do you agree or disagree with our proposed approach to approving education and training, as described within our rules?

What we heard

Overall responses		Responses from individuals					Responses from organisations	
			Total	Public	Doctors	PAs/AAs		
Total responses	2,755	Total responses	2,687	397	1,725	378	Total responses	68
Total comments	1,351	Total comments	1,307	186	904	113	Total comments	44
Agree	28% (781)	Agree	28% (741)	32% (128)	11% (190)	98% (370)	Agree	59% (40)
Disagree	63% (1,738)	Disagree	64% (1,722)	61% (243)	79% (1,361)	1% (5)	Disagree	24% (16)
Neither agree nor disagree or don't know	9% (236)	Neither agree nor disagree or don't know	8% (224)	7% (26)	10% (174)	1% (3)	Neither agree nor disagree or don't know	18% (12)

Of the 3,011 individuals and organisations that responded to the consultation, 2,755 (91%) responded to this question. Of these:

- 781 (28%) agreed
- 1,738 (63%) disagreed
- 236 (9%) neither agreed nor disagreed or did not know.

Analysis of comments – approval rules

Several responses to this question related more broadly to the proposed education and training framework, rather than the specifics aspects of our rules.

For example, across all responses to the question, respondents raised concerns in relation to the impact of PA and AA education on medical training or the practice of other healthcare professionals. A doctor organisation noted that the approval process should take into account whether the provider has the capacity, resources, and facilities to deliver safe and relevant learning opportunities, clinical supervision, and practical experiences for learners, as required by their curriculum or training programme.

Respondents who disagreed or said neither/don't know also commented more generally on the safe delivery of care for patients. There was a range of comments in relation to this, primarily focusing on the importance of the education framework setting out clear competencies for PAs and AAs – to make sure that they practise in a safe and appropriate manner:

'I disagree with the proposed approach to approving education and training as described in your rules. The approach focuses on procedural compliance and administrative benchmarks rather than ensuring rigorous, comprehensive medical education and clinical training.' (Member of the public)

Respondents also gave some specific feedback on the rules. Some of those who disagreed or answered 'neither/don't know' to this question raised concerns that the proposals were too broad and non-specific for respondents to comment properly, or found them to diverge from the approach to medical approvals without explanation.

Several respondents also found it difficult to comment on the proposals without a defined scope of practice for PAs and AAs. In contrast, those who agreed with the question felt that the level of information was appropriate and the approach sufficiently rigorous and comprehensive.

Approval process

A regulatory body noted that the rules state that we must approve a curriculum or course if it meets the standards, rather than have the power to do so. They queried whether it would be more appropriate in terms of patient safety to maintain a degree of flexibility over the final decision on approval in case significant risks arise outside the scope of the standards.

They also queried the drafting of rule 4, arguing that this gave too much discretion. Currently, rule 4 states that we 'may' take into account the failure of the applicant seeking approval of a course to clearly indicate in any published material that the course is not yet approved. They argued that we should always consider this factor.

Other respondents queried or commented on:

- how we would make sure that the approvals process is consistent across different training arrangements – for example, where teaching is class-based
- the information that should be included in applications for approval
- the importance of maintaining the quality of clinical placements across local education providers
- the fact that our proposals lack clinical detail and detail on post-qualification education.

The approval of pre-existing courses

Many respondents expressed concerns about transitional arrangements for the approval of existing PA and AA schools, which they felt may not meet our standards and may present patient safety concerns. Several noted the high pass rates of many existing courses and felt this showed insufficient academic rigour.

Parity of the proposed approach with existing medical training processes

There was a mix of views in relation to this, with some suggesting that our proposed approach should mirror our approach to approving medical education and training. Others noted that we should take a different approach (without necessarily stating how). One postgraduate body was

positive about the alignment of the proposed approach with medical education approval, and noted that our approach was reasonable and proportionate.

Stakeholder representations during the approval process

Several respondents (including a doctor representative organisation) noted the importance of doctors, or doctor representative organisations, being involved because of their supervisory role. A PA organisation, alongside other respondents, noted it would be helpful for the rules to include information on how we'll decide which independent experts may be called on to advise:

> *'Expert advice sources should be named, or at least an indication of the type of body that would provide this.' (Organisation, PA organisation)*

Drafting suggestions

Additional drafting suggestions included:

- adding a provision to expressly prioritise the training of medical students
- considering the workability of the requirement for applications to include an agreement in principle* with placement providers
- revisiting how we serve notice of our decisions.

Our response to the above suggestions is set out in the 'Our response: questions 3–5' below.

* Course providers must demonstrate that they have an agreement in place with a local provider to host clinical placements for associates. Rule 5 of our education and training rules requires course providers to submit the agreement as part of their application for course approval.

Question 4: To what extent do you agree or disagree with our proposed approach to monitoring and quality assuring pre-qualification education and training, as described within our rules?

What we heard

Overall responses		Responses from individuals					Responses from organisations	
			Total	Public	Doctors	PAs/AAs		
Total responses	2,748	Total responses	2,680	399	1,713	378	Total responses	68
Total comments	1,219	Total comments	1,180	176	855	50	Total comments	39
Agree	29% (800)	Agree	28% (757)	33% (130)	12% (208)	97% (365)	Agree	63% (43)
Disagree	62% (1,705)	Disagree	63% (1,691)	61% (242)	77% (1,327)	1% (5)	Disagree	21% (14)
Neither agree nor disagree or don't know	9% (243)	Neither agree nor disagree or don't know	9% (232)	7% (27)	10% (178)	2% (8)	Neither agree nor disagree or don't know	16% (11)

Of the 3,011 individuals and organisations that responded to the consultation, 2,748 (91%) responded to this question. Of these:

- 800 (29%) agreed
- 1,705 (62%) disagreed
- 243 (9%) neither agreed nor disagreed or did not know.

Analysis of comments – monitoring and quality assurance rules

As with other questions, several respondents suggested that our rules lacked clarity, and were too vague, too high level, or too generalised. Respondents who disagreed or neither agreed nor disagreed with the question highlighted a potential lack of objectivity within our monitoring and quality assurance proposals, where they involve self-assessment activities. A small number of respondents expressed a preference for greater emphasis on external, third-party inspections rather than GMC-run monitoring:

> *'The proposed approach to monitoring and quality assurance is inadequate, relying too heavily on self-assessment by educational institutions. This can lead to conflicts of interest and biased reporting. More frequent and thorough inspections by independent bodies are necessary to ensure consistent high standards.' (Doctor)*

Some felt that quality assurance and monitoring processes should be stricter for PA and AA courses than medical courses given that they are novel. Others noted that the use of 'may' not

'must' in the framing of our activities made the requirements too light-touch. Respondents also emphasised the importance of system partners working together to make sure that issues identified with education and training are appropriately addressed.

One regulatory body highlighted that the rules make no specific mention of how concerns about curricula or courses would be dealt with, and they queried whether we would have the power to investigate concerns outside of the monitoring and quality assurance processes. A patient organisation was concerned about safeguards for whistleblowers to safely raise concerns about the quality of education and supervision at an organisation. They recommended we use all available information (including fitness to practise information) when considering these.

Other respondents stated concerns over a perceived emphasis on procedural compliance over 'substantive, qualitative outcomes' (Doctor). They questioned how data and insights drawn from our UK medical education database and national training surveys could better inform our quality assurance and monitoring processes. Some respondents queried the frequency of self-assessment questionnaires that providers will need to complete, and the level of resource we will need to evaluate each PA/AA programme regularly.

Respondents who supported our proposals did so on the basis that they aligned with our approach to medical education quality assurance and monitoring, which was felt to strike the correct balance between flexibility and clarity.

> *'The rules relating to monitoring and quality assurance are succinctly and clearly set out. We think the rules include the right amount of detail, giving a clear overview of the range of quality assurance activity the regulator may undertake, while retaining a degree of flexibility about how those activities are undertaken.' (Organisation, regulatory body)*

Across nearly all groupings, respondents noted the importance of seeking representations from various stakeholder groups within the quality assurance and monitoring process. They advocated greater involvement from educators, doctors working alongside PAs and AAs (including supervisors), and other stakeholders such as PAs or AAs, to give them an opportunity to provide their views on whether a course provider was meeting our standards. Some respondents also stressed the importance of taking account of diverse views during the quality assurance and monitoring process to ensure that it is robust and evidence based.

Our response to the above suggestions/comments is set out in the 'Our response: questions 3–5' section below.

Question 5: To what extent do you agree or disagree with our proposed approach to attaching conditions to or withdrawing our approval of education and training, as described within our rules?

What we heard

Overall responses		Responses from individuals					Responses from organisations	
			Total	Public	Doctors	PAs/AAs		
Total responses	2,706	Total responses	2,637	393	1,680	379	Total responses	69
Total comments	894	Total comments	857	137	593	46	Total comments	37
Agree	35% (942)	Agree	34% (897)	38% (149)	19% (323)	96% (363)	Agree	65% (45)
Disagree	47% (1,284)	Disagree	48% (1,272)	47% (185)	59% (993)	1% (5)	Disagree	17% (12)
Neither agree nor disagree or don't know	18% (480)	Neither agree nor disagree or don't know	18% (468)	15% (59)	22% (364)	3% (11)	Neither agree nor disagree or don't know	17% (12)

Of the 3,011 individuals and organisations that responded to the consultation, 2,706 (89%) responded to this question. Of these:

- 942 (35%) agreed
- 1,284 (47%) disagreed
- 480 (18%) neither agreed nor disagreed or did not know.

Analysis of comments – conditions and withdrawal of approval rules

As with other questions in this section, a large number of respondents made general comments about the impact that supervising PAs and AAs could have on doctors' training – and the availability of educators to assess them. Respondents made a suggestion that in future, training or supervision time should be identified as 'protected time' – with any breaches of this resulting in the withdrawal of a course's approval.

Respondents raised concerns about the imposition of conditions on course approvals and the withdrawal of approvals from courses, and how this would affect students – as well as doctors and the availability of resources. Some respondents felt that the rules were too light-touch, and needed clearer criteria for when we'll impose a condition or withdraw approval. Others questioned whether we'll enforce conditions, and whether these conditions would drive improvement in the delivery of education and training.

'One issue is the potential for ambiguity and subjectivity in determining when to attach conditions or withdraw approval. Without clear and objective criteria, there's a risk of inconsistency and unfairness in these decisions, which could negatively impact both educational institutions and students.' (Doctor)

Other suggestions included ensuring that appropriate mitigations are in place when a decision to withdraw approval is made. For example, a PA organisation suggested that we inform providers in advance of any proposal to attach a condition, or withdraw approval, so that they can support the higher education institution and its students.

Across nearly all categories of respondents, those who supported our proposals welcomed the ability to take action against a particular course rather than the whole institution, whereas others welcomed the similarities in approach with our regulation of medical education and training.

'We agree with the proposed approach attaching conditions to or withdrawing approval of pre-qualified education and training particularly where they relate to patient safety or learner wellbeing. We presume that this is the approval of the course rather than the training institution so will allow more targeted conditions if concerns are identified. This will also mean that other courses run [in] the institution can continue if concern in the PA course is identified.' (Organisation, regulatory body)

Some respondents supported the idea of publishing conditions or highlighting these on GMC Connect* to promote transparency. One encouraged us to consider how digital solutions and tools can support our processes. This respondent felt that such tools could also offer robust evidence of decision making and allow qualification/course representatives to securely give additional evidence and information as required, and maintain a monitoring history for each course/qualification.

Respondents also identified several areas within the rules that required greater clarity. These included providing:

- clearer timeframes for how long providers will have to address concerns that we've identified (and the steps they'll need to take to address these)
- more information about potential conditions and in what circumstances they could be attached
- clearer criteria for when we'll consider withdrawing our approval of a course

* GMC Connect is our secure portal for sharing documents with royal colleges, faculties, responsible officers, employers, and others.

- clearer information on how the withdrawal of approval (and conditions) affects those who are already on the course, those who have not yet started the course, and those who have recently completed the course and obtained a qualification. As one patient organisation noted:

> *'There will be a question as to what happens to those individuals who have already graduated from an organisation that is now found to be lacking in the quality of education and training provided. The extent to which this is an issue will depend in part on the nature of the registration assessment process and its effectiveness as a safeguard and quality control.' (Organisation, patient organisation)*

Public research findings

The full research report is included in **Annex C**.

Research participants were given an example of how we'll oversee a PA studying a Physician Associate Practice MSc to demonstrate our quality assurance processes. They were not asked to comment on the curricula and course standards, so did not provide any feedback on these.

Participants were generally positive towards our proposed approach. They agreed with both content and teaching methods and thought that the proposals could appropriately identify areas of poor performance.

Participants supported regular checks, which they felt would better reflect the pace of change in the subject. However, some queried the depth and breadth of the checks themselves and were sceptical about whether we have the necessary resources to undertake these. Participants were also unclear whether we would check the clinical placements, which they felt should also be checked.

There was some concern about the examination burden for students, additional administrative work for universities, and perceived duplication with the work of higher education regulators.

Overall, the approach was felt to be sufficiently rigorous to protect the public interest, with a positive impact on participants' trust in the quality of education received by PAs and AAs.

Our response

General comments – education and training rules

In response to the feedback we received about the clarity or accuracy of particular rules, including our use of language, we have made several drafting amendments. We have clarified:

- the circumstances in which a curriculum approval application might be refused (rule 4)
- how we'll deal with a prospective course provider's failure to make it clear publicly that they do not yet have approval (rule 5)
- that the list of quality assurance activities we may undertake is non-exhaustive (rule 7).

We've also noted the feedback requesting that we provide, within the rules, our criteria for imposing conditions or revoking approval of a course or curriculum. However, this level of detail would make the rules unnecessarily prescriptive and so we will set this out in guidance instead.

Approval

We note the feedback suggesting that we retain the discretion to withhold approval from a course that meets the standards, but where wider concerns not linked to the standards nevertheless exist. However, the standards are intended to give a comprehensive account for providers of our course approval requirements. If there are additional requirements, these should be made explicit within the standards. It would be both unfair and lacking in transparency were we to apply additional criteria that providers had not been made aware of.

We also note the feedback, including from some higher education institutions, that they may struggle to provide evidence of agreements in principle with placement providers when applying for course approval (rule 5). In raising this issue, they cited the difference between employment arrangements for PAs, who are enrolled on a university course but sent on placements in healthcare settings, and for AAs, who are employed directly by an NHS trust engaging with the higher education institution. We acknowledge that organisations seeking approval of an AA course may need a different approach to meet this requirement and we will provide tailored advice on how they can do so.

Feedback also suggested we should reconsider our decision not to allow for conditional approval of curricula in the way we do for courses. Although we appreciate this would align the approaches to curricula approvals and course approvals, in practice we anticipate curricula approvals to be an iterative process. Curricula are designed by a group of experts in consultation with stakeholders before they are submitted for approval. There are various stages across the curricula approval process where prospective curricula owners will be able to respond to feedback we give when making a decision to approve their curriculum, and then resubmit an amended version that accounts for our feedback. We would then approve a curriculum once we are satisfied that it entirely meets our standards. Introducing the option to approve curricula with conditions would unnecessarily complicate this process and add no practical value.

Power to attach conditions/revoke approval

Other feedback related to the workability of some provisions. Occasionally, we will need to act swiftly to protect the public and learners, and so we will need to attach conditions immediately, before undertaking a full investigation. However, on further reflection, we consider that our rules (specifically rule 10) are drafted too narrowly to allow this, so we've revised them for greater flexibility.

We disagree, however, that this approach should be replicated in respect of the power to revoke approvals set out in rule 11. It would be overly punitive to be able to revoke approval of a curriculum or course on the basis of any information we receive without investigating first to understand the level of risk posed to patients or learners. Having now widened rule 10, our rules will enable us to act swiftly to impose conditions in the first instance where we consider it necessary and where we receive information from any source of a potential risk. We can then investigate further to determine whether withdrawal of approval is a necessary further step.

In respect of feedback supporting the idea of publishing conditions, it should be noted that the AAPAO already requires us to publish these.

Additional comments

We received feedback relating to wider concerns about education and training. For example, we note suggestions made by doctor representative organisations that educators' views should always be taken into account when undertaking quality assurance. However, we've already engaged with medical educators to prepare PA and AA courses for regulation.

Other feedback suggested that the rules should allow for course approval to be time limited. We do not agree that we need to limit our approval in this way because any approval is subject to ongoing monitoring and quality assurance, which will pick up any concerns about a course. Where such concerns do arise, the rules will allow us to impose conditions. These may require the course provider to take appropriate action, within a stated period, to address the concern.

Some of the feedback received suggested that we should regulate post-qualification training for PAs and AAs. Although our rules currently do not allow for this, they retain the flexibility for us to change our approach if our policy position changes in the future.

Many of the issues raised by our respondents can be, and have been, addressed, but we'll need to consider the feedback we received on wider issues, which do not need to be resolved for the beginning of PA and AA regulation. Examples of these include the following:

- Ensuring that educators have the time, resources, and support to train doctors, PA students, and AA students. Part of achieving this will involve promoting innovation, including using technology and learning from the pandemic to explore alternative approaches that can use educators' skills more effectively. However, it will also need a significant increase in the supply of multidisciplinary educators to meet the expected demand. We will work with educators' representatives, UK governments, regulators, and statutory education bodies in supporting these ambitions.
- Understanding how we can use data – for example, insights generated through the UK medical education database or national training surveys, to support our regulatory activities and contribute to the work of partners across the UK health system.
- Developing a publication policy for our quality assurance processes. We will publish course provider self-assessment questionnaires, our comments on these, and an annual quality assurance summary. The summary will give an overview of the annual engagement we've undertaken with the provider, the main findings from our quality assurance activities, and any next steps that need to be taken by that provider during the following annual cycle.
- Exploring the balance between training opportunities for different cohorts of students. We will be able to gather insights through the quality assurance process once regulation starts, which will enable us to consider further some of the feedback we've received. This will also enable us to assess if there are any particular differential impacts we need to understand and address.

Box 2: Education and training rules – the changes we've made

- Amended our rules to make clearer the circumstances in which we 'must' refuse a curriculum approval application, compared with those where we 'may' do so (rule 4).
- Amended our rules to confirm that when considering an application for approval we will always take into account if a prospective course provider did not make it clear publicly that it isn't yet approved (rule 5).
- Amended our rule to confirm that the list of monitoring and quality assurance activities we may undertake under rule 7 is non-exhaustive. We've added wording to note this includes 'information or evidence that relevant standards may not be met' (rule 7).
- Amended our rules to allow us to attach conditions to an approved curriculum or course where we receive information or evidence suggesting this is necessary. This may be information or evidence that's been gathered in the process of an investigation we've undertaken, or outside of this process (rule 10).
- Made technical drafting changes to improve the clarity of rules.

Establishing a register of PAs and AAs

What we proposed

Once regulation begins, and we start granting registration to PAs and AAs, we'll establish a single register for PAs and AAs, with one part for PAs and one part for AAs. The AAPAO requires us to record some specific information in each register about each registrant and we must ensure that it stays accurate and up to date.

We're required to publish selected information from the register and information which we are satisfied is necessary to protect the public. We publish this information on our website, and we refer to it as our 'online register'.

We consulted on our draft form and keeping of the register rules for PAs and AAs. These set out:

- the format of the register
- the information that'll be contained within the register about each registered PA and AA
- our process for amending entries in the register.

Our rules do not cover the publication of information on our 'online register'. This will instead be set out in our registration information publication and disclosure policy, which will be published when regulation commences.

We proposed that we would not require the recording of each registrant's gender information or the method of paying the annual fee for registration. This is because this information isn't specified in the AAPAO and there's no clear public protection basis for inclusion in the register. However, we proposed to continue collecting gender information on a voluntary basis as part of our routine diversity monitoring.

Question 6: To what extent do you agree or disagree with our proposed approach to the form and keeping of the register, as described within our rules?

What we heard

Overall responses		Responses from individuals					Responses from organisations	
			Total	Public	Doctors	PAs/AAs		
Total responses	2,817	Total responses	2,751	400	1,785	374	Total responses	66
Total comments	1,725	Total comments	1,679	226	1,201	125	Total comments	46
Agree	21% (582)	Agree	20% (542)	11% (44)	13% (233)	60% (223)	Agree	61% (40)
Disagree	66% (1,862)	Disagree	67% (1,847)	60% (240)	83% (1,473)	1% (5)	Disagree	23% (15)
Neither agree nor disagree or don't know	13% (373)	Neither agree nor disagree or don't know	13% (362)	29% (116)	4% (79)	39% (146)	Neither agree nor disagree or don't know	17% (11)

Of the 3,011 individuals and organisations that responded to the consultation, 2,817 (94%) responded to this question. Of these:

- 582 (21%) agreed
- 1,862 (66%) disagreed
- 373 (13%) neither agreed nor disagreed or did not know.

Analysis of comments – establishing a PA and AA register

Many respondents did not focus on the detail in our rules about the content of the PA and AA register. Instead, respondents expressed views about the information they feel we should publish about PAs and AAs on our online register.

Where we received responses relating to the rules there was strong support for the register of PAs and AAs to be separate from the register for doctors – which the AAPAO requires us to do. One postgraduate body noted:

> '*The register should be separate from the Medical Practitioners' register because they are different professions and also the demographic data needs to be collated separately.' (Organisation, postgraduate body)*

On our proposal to not mandate the collection of gender information, one organisation encouraged us to continue collecting such information on a voluntary basis to better understand the composition of our registrant base and the workforce more broadly. They also suggested that

we offer registrants the ability to self-identify their gender using a term of their choosing. Beyond this organisation, only a small number of respondents commented on this proposal.

A few respondents requested further clarity on how we'll maintain the register. A trade union body requested clarity on how long registrants would have to update their contact details where these have changed, and a further respondent suggested that we consider a regular audit programme to ensure the accuracy and completeness of the register.

Other respondents queried the distinction between information we'll add to the register (the focus of these rules) and the information that we'll choose to publish for each individual registrant on our online registers. For example, some queried whether we'd publish information which would identify the registrant (eg photographs and contact details), noting that such information should not be shared widely owing to privacy and safety concerns. We can confirm that we won't publish personally sensitive information.

Additional comments

Most responses to question 6 focused on creating a clear distinction between doctors, PAs, and AAs and the information that we should make publicly available about registrants. This was linked to concerns about potential confusion over whether an individual is registered as a doctor, PA, or AA and the patient safety impacts stemming from this. There was also support for clearly stating a registrant's profession on the online register.

Respondents advocated that a PA or AA's reference number needed to be different from the version used for doctors. Some felt that providing PAs and AAs with a GMC reference number in the same numerical format as doctors would lead to confusion and false equivalence with doctors. They therefore felt the format for PAs and AAs should be different.

Many respondents argued that our proposal for a single letter prefix for PAs and AAs was insufficient to clearly distinguish between these groups (although there remained some support for this from doctors, PAs and AAs, and some organisations). One respondent noted that a single letter prefix would:

> *'further facilitate confusion amongst HCPs [healthcare professionals] reading medical notes and patients who are reading their own medical notes from an access request … many HCPs would see a "GMC number" and automatically assume that that person is a doctor, as the GMC has only regulated doctors previously'. (Nurse)*

Respondents made alternative suggestions for the format of the reference number, with the options proposed by one doctor organisation, 'MAP01AA123' for AAs and 'MAP01PA123' for PAs, being two of the more popular examples.

Some respondents also suggested that we should publish information about PAs and AAs on a different website or webpage, or create a separate search function. The aim of this would be to further reduce the potential for confusing PA and AA roles with those of doctors.

We also received comments (mainly from individual doctors) that PAs and AAs should not be added to the GP or specialist registers. Some respondents linked this to reducing the risk of PAs and AA misrepresenting their qualifications and roles. The register of PAs and AAs will be distinct and separate from the medical register, GP Register, and Specialist Register. Only doctors who've

completed approved UK training or who've demonstrated the knowledge, skill, and experience required to practise as a GP or specialist in the UK can gain entry to the GP and specialist registers. Individuals may hold dual registration (ie as a PA and a doctor) but they'll have to demonstrate the individual registration standards and requirements for each of those distinct professions.

Respondents also commented on the need for PAs and AAs to be allocated a named supervisor, who would need to be a registered doctor on our list of recognised trainers and who had consented in writing to supervise them. Some respondents also want us to publish the supervisor's name on the registrant's entry on the online register. One respondent noted:

> '*Supervision of PA/AAs is a key component of registration. As dependent practitioners, they cannot work fully autonomously. We believe this needs to be reflected in their registration status since they cannot work in active practice without a supervisor. A solution would be to have a field which references whether their registration is "active" with the named supervisor on the record, or "inactive".' (Organisation, doctor organisation)*

A small number of respondents wanted the register to include information about previous qualifications of PAs and AAs, ordered by date of qualification. This included details of a PA or AA's original degree used to gain entry to a PA or AA course, as well as any other qualifications obtained relating to the membership of another regulated health profession or registration with another regulator.

Some respondents also wanted us to publish more detailed information about the scope of roles and duties of registered PAs and AAs, their specialties (if applicable), and the areas they are working in. Suggestions for additional information to publish included the location of a PA or AA's place of work/employing organisation and their indemnity arrangements. However, a doctor organisation cautioned that any additional information should:

> *'be driven not by a concern to satisfy public demand for more information but by a concern to protect the public through the provision of useful and reliable information about a registrant's professional practice'. (Organisation, doctor organisation)*

Our response

Much of the consultation feedback focused on how we should display information about PAs and AAs on our website, and what information we should publish. It didn't therefore address the detail of our rules for the form and keeping of the register. However, we've responded below to the key points raised and how our approach to publication will address these.

Some respondents suggested that we should publish details of registrants':

- individual supervisors
- individual scopes of practice
- employment location
- indemnity arrangements.

To do this, firstly we'd have to specify in our rules that we want to record this information on the register of PAs and AAs. Then we'd need to collect it from each PA and AA when they apply for registration. Most applicants wouldn't have this information when applying for registration and it would change frequently throughout their careers. We have therefore chosen not to include these requirements in our form and keeping rules as they'd have a generally negative impact on the overall integrity of the register and would be disproportionately burdensome for us and individual registrants to keep up to date.

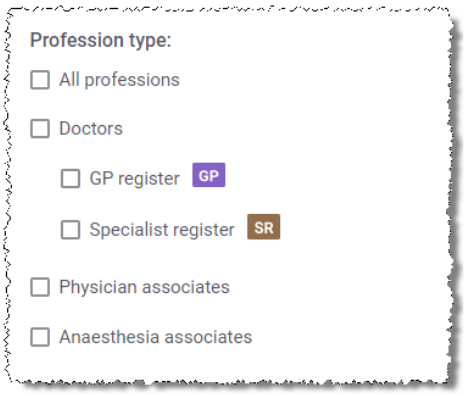
Some of the feedback questioned our requirements that each registrant must provide and maintain their contact details. The AAPAO requires us to record this information in the register of PAs and AAs, and our rules place responsibility on registrants to keep this up to date as only they'll know when it has changed. It's important for registrants to do this, as we need to be able to contact them about their registration. The AAPAO recognises the importance of a regulator being able to contact its registrants, as it permits us to remove a registrant's entry from the register if they have not maintained an effective means of contact.

With regard to recording details of individual qualifications, we'll publish details of each registrant's PA or AA qualification which we've verified and accepted as demonstrating the standard of education and training necessary for registration with us. We do not agree that there are public protection grounds to record details of additional qualifications that PAs and AAs have at, or gain following, registration on either the register of PAs and AAs or the online register. These qualifications have no bearing on an individual's registration status and don't provide additional assurance to the public that they have met the standards of education and training required to hold registration in the UK.

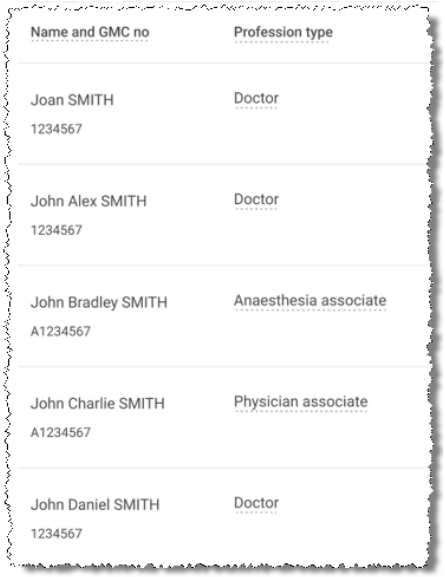
We've selected the prefix that we propose to introduce to the GMC reference numbers for PAs and AAs – the letter 'A' (for associate) at the beginning of their GMC reference number to distinguish between doctors, PAs, and AAs. We explored alternative options, but these proved prohibitively expensive for both the GMC and some employers who would have had to update their IT systems. In selecting the prefix, we also took into consideration that 'PA' is already used as a prefix by the Health and Care Professions Council and 'MAP' (medical associate profession) is not a widely used term.

Some respondents expressed concerns about the need to be clear, through our online registers, whether an individual is a doctor, PA, or AA, or holds dual registration. Earlier this year we set out the steps we were taking to help ensure this, which include:

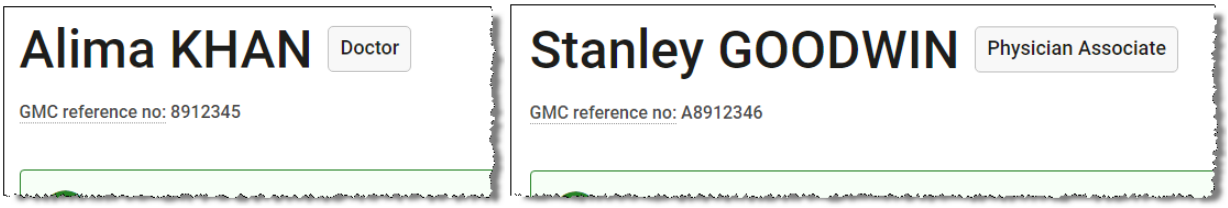
- allowing users to search for an individual by filtering by profession type:



- setting out clearly on the search results page which profession an individual belongs to:



- clarifying, on each individual's public record, which profession they belong to:



Box 3: Form and keeping of the register rules – the changes we've made

- We haven't made any changes to the rules governing the form and keeping of the register on the basis of the feedback we received. We have, however, used it to inform our approach to how we display information about PAs and AAs on the online registers, to clearly distinguish between the three professions we will regulate.

Gaining entry to the PA and AA register

What we proposed

We'll assess whether applicants for registration meet our standards and requirements. Those who do will be included in the register of PAs and AAs.

We consulted on draft registration rules for PAs and AAs. These set out:

- our procedure for registration applications
- the information that's required in support of an application
- our process for assessing that information, including determining whether a qualification obtained from an overseas provider is acceptable
- our process for notifying applicants of our decisions.

Our rules set out the process of applying for registration at a high level and are supported by explanatory guidance. These documents explain the evidence that applicants, including those who are already qualified or working as PAs or AAs in the UK, can provide to satisfy us that they meet the standards. For example, to demonstrate knowledge and skills, PAs must have a pass in either the Physician Associates National Examination or PARA. All AAs who started their courses from September 2023 onwards will have to pass the new Anaesthesia Associate Registration Assessment.

The AAPAO requires all PAs and AAs to meet the required standards and requirements for registration, irrespective of where they qualified.

Question 7: To what extent do you agree or disagree with our proposed approach to registration, as described within our rules?

What we heard

Overall responses		Responses from individuals					Responses from organisations	
			Total	Public	Doctors	PAs/AAs		
Total responses	2,708	Total responses	2,642	393	1,696	375	Total responses	66
Total comments	1,283	Total comments	1,245	187	858	115	Total comments	38
Agree	21% (578)	Agree	20% (535)	11% (43)	13% (222)	59% (220)	Agree	65% (43)
Disagree	61% (1,647)	Disagree	62% (1,631)	58% (228)	76% (1,294)	1% (4)	Disagree	24% (16)
Neither agree nor disagree or don't know	18% (483)	Neither agree nor disagree or don't know	18% (476)	31% (122)	11% (180)	40% (151)	Neither agree nor disagree or don't know	11% (7)

Of the 3,011 individuals and organisations that responded to the consultation, 2,708 (90%) responded to this question. Of these:

- 578 (21%) agreed
- 1,647 (61%) disagreed
- 483 (18%) neither agreed nor disagreed or did not know.

Analysis of comments – gaining entry to the PA and AA register

Registration requirements

Our registration requirements were described by some respondents (doctors, members of the public, and other individuals) as being too light-touch – with our thresholds for registration described as too low.

Respondents asked how we could assess qualifications, competence, knowledge, and skills without a defined scope of practice. They suggested that we more clearly define and standardise our requirements.

More broadly, there were comments suggesting that the qualifications that PAs and AAs must obtain to register with the GMC do not appropriately prepare them for the roles that they will undertake following registration. Some respondents also suggested that these courses are not of a sufficient standard. Others suggested applicants need to have passed a national assessment, a programme in PA studies, or an accredited level 7 qualification for entry onto the register.

Comments also focused on how PAs and AAs can evidence their knowledge and skills, as well as demonstrate they meet the standards of performance and conduct. This led to the following suggestions for the registration process.

- Any PA or AA who is not already on, or who has already been removed from, the existing voluntary registers run by the Faculty of Physician Associates and the Royal College of Anaesthetists, must be 'investigated' – as part of the registration process.
- Applicants should be specifically asked to declare (as part of their declaration that they are fit to practise) if they have ever worked beyond their scope of competence.

There were mixed views relating to the registration of those PAs and AAs already working and the planned arrangements during the transition period (the two-year period is set by the AAPAO and is the period where the titles of PA and AA are not protected and a PA or AA is not required to register with us to work in the UK).

There was support for the flexibility proposed but other respondents were more cautious. For example, some respondents felt that PAs and AAs who are practising at the point they seek GMC registration should have any historic concerns about their practice investigated as part of the registration process. Another respondent (a PA) suggested that PAs wishing to join the register during the transition period and who are not on the Faculty of Physician Associates' voluntary register should have to evidence their continuous professional development (CPD), and that if they are unable to do this, the GMC should consider placing conditions on their registration.

Other respondents opposed any arrangement for automatic registration of those already practising and/or on existing voluntary registers. The reasons given included the need for fresh competency assessments and potential patient safety concerns.

Evidence required for registration

Many of the comments relating to the level of information and evidence that needs to be provided for registration mirror the comments in the previous section – these related to:

- the appropriateness of the qualifications being provided as evidence
- a lack of clarity over which qualifications would be acceptable
- a lack of clarity over whether PAs currently working would be exempt from sitting the PARA. Others queried how we'll ensure these applicants continue to meet the required standards.

One drafting query, raised by a regulatory body, noted our intention to set out in guidance how an applicant 'must fulfil' various registration requirements. They suggested that if we require particular types of evidence that we consider to be acceptable, then this should be included in the rules, rather than provided as guidance.

> *'If certain types of evidence are considered mandatory, to ensure transparency and accountability we believe that strict requirement should be stated in the rules.' (Organisation, regulatory body)*

There was some support for our proposal to be flexible in how applicants can evidence that they meet our standards for registration. However, some respondents went on to query what

evidence would need to be provided by PAs and AAs that are already working, as well as by PAs and AAs who are already qualified but not currently working.

Several PA organisations, and some individual PAs and AAs, suggested that evidence of CPD should be a requirement for registration where applicable.

Proposed registration processes

Respondents provided a mix of views on our process for assessing qualifications. There were suggestions that it should be the same process that is currently used for doctors, whereas others indicated the process should be unique to recognise the differences between the roles undertaken by the different professions – as well as their training and qualifications.

Some respondents, including a professional association and a postgraduate body, queried how we'll assess evidence provided by PAs and AAs from outside the UK and how we'll make sure their qualifications are comparable with UK qualifications. Other respondents requested clarity as to whether applicants with overseas qualifications would need to sit the registration assessments for PAs and AAs.

A regulatory body suggested that we amend our rules to make sure that where we receive information about an applicant's fitness to practise as part of our verification processes, we always disclose that information to the applicant.

This organisation further queried the fairness of rule 6, which enables us to refuse to make a decision on an application for registration and close it if an applicant fails to provide further information that we've asked for. This means there is no decision that can be revised or appealed. It was observed that in these instances we should make a decision on the information that we already have.

Public research findings

The full research report is included in **Annex C**.

During the research with members of the public, Shift Insight gave participants background information about the medical register for doctors, and the requirement to keep a separate register of PAs and AAs. Researchers introduced a case study of a newly qualified PA who completed a PA postgraduate course and met the learning outcomes to be able to apply to join the register of PAs and AAs.

Participants were generally positive towards our proposed approach to joining the medical and PA and AA registers and thought that adopting a consistent approach to regulation across doctors, PAs, and AAs was fair.

There was particular support for establishing a single registration standard for PAs and AAs that all applicants would need to meet – irrespective of whether they qualified in the UK or overseas. However, some participants felt that some countries and providers might not need to be subject to the same level of checks on account of perceived differences in the quality of education and training.

There were some concerns about the burden of evidencing the registration standard for UK students, and the use of registration exams to test the knowledge of registrants.

Our response

Our standards for registration and evidence requirements

The feedback indicated that some respondents wanted to see greater specificity in our rules about the standards required for registration.

Our approach is to create high-level rules which set out the process of registration and explain in guidance how applicants can demonstrate they meet the standards. This provides a more flexible and responsive framework. We have a duty under rule 5 to provide this guidance for applicants, which will be maintained and updated as we develop experience and understanding about the types of evidence applicants can provide.

We agree with the feedback that the proposed drafting of rule 5 indicated that our guidance would set out the evidence that applicants must provide. Instead, it is the rules that set out what applicants must provide, whereas the guidance sets out how applicants may provide it. We have therefore changed the rule to say 'may fulfil' rather than 'must fulfil'. This clarifies that the guidance we will produce will include advice on the types of evidence that can be submitted.

For this reason, we've also decided not to include evidence of CPD as a formal requirement for registration. But as we'll set out within our guidance, the types of evidence applicants can provide may differ depending on their individual circumstances – and therefore evidence of CPD may be appropriate and helpful in some cases.

How we'll assess applicants during the transition period

The registration standards and information requirements set out in the AAPAO are the same for all applicants.

Under Article 1(2) of the AAPAO, following the introduction of regulation on 13 December 2024, there is a two-year transition period for existing PAs and AAs to register with us. After this period, anyone practising in the UK using the title of 'physician associate' or 'anaesthesia associate' will have to be registered with the GMC.

We'll explain in our guidance the types of evidence that we will consider to be acceptable, for the purpose of registration during this period, from PAs and AAs who are practising or have recently practised in the UK. In these circumstances we will also take into account when the applicant passed a registration assessment and their employment history.

In response to other points raised by respondents, we can confirm that there is no automatic registration of individuals – PAs and AAs applying for GMC registration will have to demonstrate how they meet the registration standards and information requirements.

Applicants will also be required to demonstrate how they meet the standards of conduct and ethics. We undertake an assessment of fitness to practise at the point of registration which involves applicants answering a series of questions about their fitness to practise, and an assessment of other relevant information provided by the applicant and/or obtained by us.

The grant of registration is a binary decision and we have no powers to grant conditional registration. This is an important aspect of public protection. Applicants either meet the registration standards and information requirements or they do not, in which case they will be refused registration.

How we'll assess applicants with an overseas qualification

Rule 4 sets out the process for assessing international qualifications, which will take place before an application for registration is made. Our guidance will explain that all international PA or AA qualifications will be assessed against our acceptable overseas qualification (AOQ) criteria. This will consist of separate criteria for PA qualifications and for AA qualifications and will be published once regulation commences.

If the qualification meets the PA or AA AOQ criteria, it is acceptable for the purpose of that individual applying for registration and will fulfil the education and training standards. If the qualification doesn't meet the AOQ criteria, there is no right of appeal and the individual cannot apply for registration.

Our registration procedure

We agree with the regulatory body's comment on rule 6 that it would be unfair for us to refuse to make a decision on a registration or re-entry application where an applicant hasn't provided further information that we've requested. This provision has now been removed from the rules.

We have amended our rules to clarify that where verification processes reveal information which raises a question about the fitness to practise of an applicant, we will disclose this additional information to the applicant.

We've also amended our registration and re-entry rules to make clear that we can't require an applicant to provide evidence of reflective practice in their registration or re-entry application. This is in line with similar restrictions that exist in our fitness to practise process – following the recommendations of the Williams Review.

Box 4: Registration rules – the changes we've made

- Included a new provision which means we can't require an applicant to provide reflective practice material as part of registration and re-entry applications (rule 6).
- Removed the power to close an application where an applicant has not provided additional information we've requested (rule 6).
- Clarified that our guidance will include examples of evidence that can be provided to meet our registration and re-entry requirements, rather than specifying evidence that must be provided.
- Clarified that information gathered during evidence verification must be disclosed to the applicant where it relates to their fitness to practise (rule 6).
- Amended rules to confirm that we may make a decision to grant or refuse registration and re-entry applications, where an applicant has not provided additional information (rules 6 and 23).
- Made technical drafting changes to improve the clarity and consistency of the rules.

Re-entry to the PA and AA register

What we proposed

Where PAs and AAs have been removed from the register and are seeking re-entry, we'll assess whether they meet the registration standards and requirements. In specified circumstances we will carry out an assessment to determine that their fitness to practise is not impaired.

Our rules for re-entry set out:

- our procedure for applying to re-enter the register, including restrictions on applications for re-entry in some cases
- the circumstances in which the applicant must demonstrate that their fitness to practise is not impaired
- our procedure for assessing re-entry applications following removal because of a fitness to practise final measure or where fitness to practise concerns need to be assessed
- how we'll notify individuals of our decision on re-entry.

When a PA or AA applies to re-enter the register, we'll ask for evidence of the steps taken by applicants to maintain their knowledge and skills during their time off the register.

Question 8: To what extent do you agree or disagree with our proposed approach to re-entry, as described within our rules?

What we heard

Overall responses		**Responses from individuals**					**Responses from organisations**	
			Total	**Public**	**Doctors**	**PAs/AAs**		
Total responses	2,641	Total responses	2,578	384	1,645	374	Total responses	63
Total comments	849	Total comments	820	132	579	45	Total comments	29
Agree	31% (812)	Agree	30% (770)	35% (134)	14% (231)	94% (353)	Agree	67% (42)
Disagree	53% (1,394)	Disagree	54% (1,381)	51% (196)	66% (1,093)	2% (9)	Disagree	21% (13)
Neither agree nor disagree or don't know	16% (435)	Neither agree nor disagree or don't know	14% (427)	14% (54)	20% (321)	3% (12)	Neither agree nor disagree or don't know	13% (8)

Of the 3,011 individuals and organisations that responded to the consultation, 2,641 (87.7%) responded to this question. Of these:

- 812 (31%) agreed
- 1,394 (53%) disagreed
- 435 (16%) neither agreed nor disagreed or did not know.

Analysis of comments – re-entry to the PA and AA register

Several respondents (largely doctors and members of the public) who disagreed with this question stated that re-entry should not be permitted in some circumstances. One common theme was the need for strict consequences for the impersonation of doctors. As one respondent stated:

> *'I would support that if a PA or AA falsely claims to be a medical doctor, physician, or medical professional, they should be removed from the register permanently.' (Doctor)*

Other factors cited as reasons for prohibiting re-entry included engagement in fraudulent activities, operating outside of scope of practice, and prolonged absence from the register.

Some respondents suggested that our proposed approach should more closely align with the re-entry process for doctors. Respondents (largely doctors, some members of the public, and other individuals) felt that the proposed process for PAs and AAs was either too complex or ambiguous (without specifying how) or was less stringent than our current process for doctors. In contrast, other respondents (largely doctors and PAs and AAs) felt that the rules set out a clear and proportionate framework for re-entry. As one respondent put it:

> *'The rules offer thorough description of procedure and process included within the approach to registration/removal and re-entry. The approach appears to provide proportionate and fair conditions for re-entry to the register, with clear description of timeframes indicated.' (Organisation, NHS or Health and social care organisation)*

Those who drew comparisons with our framework for doctors criticised the absence of any proposal to indefinitely suspend an individual – it should be noted that the AAPAO does not provide us with this power.

Supervision

Some respondents identified supervision as a necessary component of the re-entry process. Several respondents suggested that PAs and AAs who re-enter the register should work under close supervision. It should be noted that all practising PAs and AAs are expected to work under the supervision of doctors and consultant anaesthetists (or other autonomously practising anaesthetists), respectively. A few respondents felt that PAs and AAs should be subject to provisional registration if they had been off the register for an extended period, or conditional registration if their fitness to practise remained impaired.

Evidence requirements

Respondents (largely doctors, members of the public, and some organisations) discussed the evidence required for re-entry. They suggested that further training and assessment may be required in some instances, and queried how some types of evidence should be obtained (for example, references from employers).

A doctor organisation queried our approach to requesting additional evidence of English language capability if an individual had been removed from the register for longer than two years. They compared this with our current approach for doctors, where there is not an equivalent test for those still on the register, noting:

> *'this seems to make an inappropriate presumption that the English language ability will be lost in an arbitrary fashion simply by not being on the register'. (Organisation, doctor organisation)*

A regulatory body queried how we would assess the fitness to practise of PAs and AAs seeking re-entry to the register. They questioned some elements of our processes – matters which are set out in the AAPAO and therefore not subject to change. They said:

> *'We agree that regulators must be satisfied that applicants are safe to practise, but when considering unproven allegations about fitness to practise, it is not necessarily for the applicant to "disprove" those allegations. The regulator should be expected to make appropriate enquiries and the applicant must cooperate fully with those enquiries to enable the regulator to make a sound, evidence-based decision.' (Organisation, regulatory body)*

Another organisation queried why an individual must provide evidence of their fitness to practise to re-enter the register if their conviction for the listed offence that led to their original removal is quashed.

There were also requests (from some doctors, a member of the public, and other individuals) for clear and objective criteria on how we'll assess whether an individual (ie a PA or AA) took active steps to maintain their knowledge and skills following their removal from the register.

Although there was support for varying our evidence requirements according to the length of time off the register, a few respondents highlighted the need for us to provide guidance on:

- how individuals can maintain their skills and knowledge during this time
- how much time must pass before they are required to re-sit an examination (if at all).

Additional comments

Other procedural points that individuals focused on included the composition of re-entry panels for those cases where the PA or AA was removed by final measure – with some respondents (largely doctors) emphasising the need for doctors to sit on these – and our restrictions for making further re-entry attempts. For example, a trade union body felt that the requirement for PAs and AAs to wait a further 12 months before submitting a second application was unfair if they only narrowly did not meet our requirements beforehand. And a small number of respondents focused on the number of attempts permitted, with some noting that we should

reduce the number of permitted attempts, and others stating that we should allow additional attempts in some circumstances.

Public research findings

The full research report is included in **Annex C**.

During the research with members of the public, Shift Insight gave participants information on registrants being removed from the registers for a range of different reasons (which included voluntary and non-voluntary removal). They also outlined how the GMC will manage this process, including what happens if a professional wants to re-join the register, and how this differs from what is currently in place.

Participants recognised the fast-paced nature of healthcare and agreed that those applying to re-enter the register would need to prove they are still up to date and fit to practise. They recognised there would be a difference in the level of evidence needed for those who left to practise elsewhere, compared with those who stopped practising for some time.

Our response

Re-entry following removal due to fraud or error, automatic removal, and removal for not holding adequate insurance or indemnity

Some of the feedback we received either queried how aspects of our re-entry process would work or sought assurances over the safeguards that would prevent applicants from using this as a means of getting past our fitness to practise proceedings. We've given further clarification below.

- We accept that our previous approach to re-entry for those removed for fraudulently obtained registration or registration made in error was not right. We've changed the rules to require PAs and AAs to demonstrate, in this scenario, all the registration standards and requirements irrespective of how long they have been off the register. Those who were removed for fraudulently obtained registration must also demonstrate that their fitness to practise is not impaired.
- Where a PA or AA has been removed for failing to maintain adequate and appropriate insurance and indemnity, and are now seeking re-entry, they will be required to demonstrate that they have or will have in place adequate and appropriate insurance and/or indemnity to be re-entered on to the register. This will be required irrespective of how long they have been off the register.
- Where an individual has been removed from the register because of a listed offence, but the conviction was subsequently quashed, the individual will still be required to demonstrate that they are fit to practise when seeking re-entry. This is because, for example, even though their listed conviction is quashed, it may have been replaced with a non-listed offence conviction or there may have been other concerns about their fitness to practise at the point they were removed (that were not related to their listed offence conviction).

Re-entry restrictions

We have noted the request for further clarity on the restrictions that apply to re-entry applications. We have clarified that an 'attempt' is any re-entry application that was refused since the PA or AA's last removal from the register for an offence listed in the AAPAO or a final measure. There are no restrictions on re-entry applications where an application was refused on the basis that the applicant did not meet the standards and requirements for registration.

Where a re-entry application was refused on fitness to practise grounds, the rules include a 12-month period that must elapse before a second re-entry application can be submitted. There is no restriction if an application was refused because the applicant did not meet the registration standards and requirements.

Some respondents wanted us to create a new category of 'provisional' or 'conditional' registration for PAs and AAs seeking re-entry in some circumstances. For example, in cases where their fitness to practise was impaired. However, we consider that permitting re-entry for PAs or AAs who don't meet all the registration standards and requirements would introduce a risk to public protection. This position is consistent with our approach for first time registration.

Evidence requirements for re-entry

Our rules set out the process for re-entry. Our guidance will give examples of evidence that we will accept in support of a re-entry application, tailored according to the time or reason that someone has been off the register following their removal. In response to the questions raised about resitting the GMC registration assessment, we can confirm that a PA or AA will need to re-sit this if they have been off the register for longer than two years.

We note the comment from a doctor organisation querying why we were seeking evidence of English language capability for individuals seeking re-entry in some circumstances. We have a duty to ensure that anyone re-entering the register meets all our standards, including language proficiency. For those off the register for short periods, we don't consider it proportionate to require this evidence. However, for those off the register for more than two years, we think it is both proportionate and necessary for public protection to ask for recent evidence. When a PA or AA is on the register, we can be assured that they're practising in English and therefore maintaining their English language skills. However, if they've been off the register, they may not be living or practising in an English-speaking environment.

We have also now included a rule that prevents us from requiring evidence of reflective practice when seeking further information for a re-entry application. We have also amended our rules to clarify that the deadlines that we set for applicants to provide us with representations may be extended in exceptional circumstances.

Box 5: Re-entry rules – the changes we've made

- Specified the re-entry standards and requirements that must be met for individuals who were removed because of fraudulently obtained registration or registration granted in error (rules 22 and 25).
- Provided discretion to extend time periods to allow PAs and AAs to make written representations in support of applications for re-entry (rule 23).
- Clarified that information gathered during evidence verification must be disclosed to the applicant where it relates to their fitness to practise (rule 23).
- Clarified that it is a limit of three attempts since the last registration where the re-entry application was refused. This applies to cases where the associate was automatically removed because they committed one of the serious criminal offences listed in the AAPAO or because they were subject to a final measure of removal.
- Clarified that our guidance will set out examples of evidence that can be provided to meet our registration and re-entry requirements, rather than evidence that must be provided.
- Amended rules to confirm that we may make a decision to grant or refuse registration and re-entry applications, where an applicant has not provided additional information (rules 6 and 23).
- Included a new provision which means we can't require an applicant to provide reflective practice material as part of registration and re-entry applications (rule 23).
- Made technical drafting changes to improve the clarity of rules.

Removal from the PA and AA register

What we proposed

Once regulation comes into force, we will remove an associate's entry from the register in circumstances required by the AAPAO, and decide whether to remove an associate's entry from the register when they request this.

We consulted on draft registration rules for PAs and AAs. These set out our procedure for removing entries from the register. This includes the following:

- the steps we'll take when removing an associate's entry from the register
- our ability to request information from an associate or make other enquiries necessary – to decide whether to remove an associate from the register
- our process for notifying associates of our decisions to remove their entries from the register.

The AAPAO also provides us with a new duty to automatically remove associates convicted of a 'listed' offence. These are serious criminal offences which are incompatible with registration as a healthcare professional. They include offences such as murder, rape, human trafficking, and slavery.

Question 9: To what extent do you agree or disagree with our proposed approach to removal, as described within our rules?

What we heard

Overall responses		**Responses from individuals**					**Responses from organisations**	
			Total	**Public**	**Doctors**	**PAs/AAs**		
Total responses	2,663	Total responses	2,599	388	1,662	374	Total responses	64
Total comments	1,032	Total comments	996	150	662	110	Total comments	36
Agree	24% (637)	Agree	23% (598)	14% (56)	17% (283)	55% (206)	Agree	61% (39)
Disagree	50% (1,325)	Disagree	50% (1,312)	47% (182)	63% (1,042)	3% (11)	Disagree	20% (13)
Neither agree nor disagree or don't know	26% (701)	Neither agree nor disagree or don't know	27% (689)	39% (150)	20% (337)	42% (157)	Neither agree nor disagree or don't know	19% (12)

Of the 3,011 individuals and organisations that responded to the consultation, 2,663 (88%) responded to this question. Of these:

- 637 (24%) agreed.
- 1,325 (50%) disagreed.
- 701 (26%) neither agreed nor disagreed or did not know.

Analysis of comments – removal from the PA and AA register

Our proposed procedures for removing PAs and AAs from the register received mixed feedback. Some respondents (largely doctors and members of the public) felt these were not robust enough and were a risk to patient safety as they did not ensure immediate action. By contrast, respondents in favour of our proposals (made up of a mix of respondents, including doctors, PAs and AAs, members of the public, and organisations) described these as fair, transparent, and rigorous.

A common theme across the feedback received was the need for greater clarity, with respondents wanting further detail to understand how our proposed approach would work. For example, respondents wanted to see additional guidance on the thresholds that would trigger removal. One doctor said:

> *'without clear guidelines and criteria for removal, there's a risk of arbitrary decision-making and potential injustices'. (Doctor)*

Respondents also wanted to understand what we would consider to be adequate insurance and indemnity for PAs and AAs – given that failure to hold this would result in removal from the register.

Automatic removal

In relation to automatic removal, several respondents suggested we permit this in a wider range of circumstances, and beyond the listed offences set out in the AAPAO – for example, automatically removing any PA or AA who claims to be a doctor. However, our duty to automatically remove someone from the register is set out in the AAPAO and only applies where an associate has been convicted of a listed offence. We therefore have no ability to vary this. Anyone falsely claiming to be a doctor would be committing a criminal offence under the *Medical Act 1983*. Where a PA or AA was registered and was found to be falsely claiming to be a doctor, they would also be referred to our fitness to practise proceedings.

A doctor organisation felt it was unfair that if an associate is automatically removed from the register and their criminal conviction is subsequently quashed, that associate must re-apply to join the register:

> '*We consider this unfair and believe the status quo should simply be restored automatically … however, we do agree that once restored it should be open to GMC to consider whether an initial assessment of fitness to practice is appropriate.' (Organisation, doctor organisation)*

A conviction for a listed offence could be quashed many years after the original conviction. It is also possible that although the listed conviction is quashed, it could have been replaced with another conviction or that there were other fitness to practise concerns at the time the PA or AA was automatically removed. To ensure public protection, we remain of the view that it is appropriate for these individuals to apply for re-entry, at which point we can ensure that they meet the standards and requirements for registration and that their fitness to practise is not impaired.

Drafting suggestions

Some respondents wanted to see our proposals replicate the processes that we currently use for doctors. However, other respondents welcomed the increased flexibility that our new proposals brought:

> *'[They] will ensure swift action can be taken for the protection of patients, the public and colleagues … this will be a welcome addition in the regulations for doctors as part of wider regulatory reform in the future.' (Organisation, membership body)*

Some respondents, including a doctor organisation, trade union body, and regulatory body, suggested specific drafting amendments for our rules to provide greater clarity about our powers and proposed processes. For example, the regulatory body queried if the rules, as drafted, prevent us from making any decision if we receive comments (representations) from the associate:

> *'We agree that the associate should be warned that if they do not make representations within the specified time period the Registrar[*] will make a decision regardless. However, some of the drafting could wrongly infer that the Registrar can only make a decision in the absence of representations.' (Organisation, regulatory body)*

We are content that the rules do not prevent this and allow us to make a decision irrespective of whether we receive representations from the PA or AA (or not).

The doctor organisation proposed revisions to confirm that automatic removal only applies for individuals convicted of listed offences once the rules are in effect (and not for convictions that precede this date). We can confirm that associates convicted of a listed offence before 13 December 2024 will not be removed automatically. The AAPAO only permits us to remove associates convicted of listed offences after the legislation takes effect. As the AAPAO is clear on this point, we do not propose to additionally set this out within our rules.

This doctor organisation also proposed amendments to clarify that it is the conviction that would be quashed, and not the listed offence, as currently set out in rule 9.

The trade union body wanted to see cases of removal for fraudulent registration considered by a panel, rather than addressed through written submissions, as this:

[*] The AAPAO requires us to appoint a Registrar to undertake some statutory functions. The Registrar is our Chief Executive.

'*would afford associates the opportunity to present their case to a panel, who have the benefit of independent legal advice, and gives the panel the opportunity to test the available evidence'. (Organisation, trade union body)*

Decision making, representations, and notifications

A small number of respondents (all doctors) suggested that decisions about the removal of a PA or AA should not be made by us and instead should be made by doctors. Others mentioned the need for any decision to take into account the views of doctors supervising PAs and AAs – to reflect the 'dependent status' of PAs and AAs.

Several respondents emphasised the importance of our processes being fair and equitable. A medical defence organisation wanted to see removals stemming from a failure to comply with a performance or health assessment during the fitness to practise process (rule 15) exercised with 'significant caution and safeguards'. They proposed some additions to the rules to ensure this.

The medical defence organisation and a doctor organisation both made a general point about ensuring that adequate and reasonable time are provided for associates to supply requested information. The doctor organisation pointed out that safeguards to limit our ability to require information relating to reflective practice should apply to removal and re-entry decisions, as well as decisions relating to fitness to practise (which the AAPAO already requires). As previously noted in this report, we've now amended the registration rules to take this into account.

Some respondents asked who would be notified of removals. A regulatory body and a postgraduate body wanted to know whether we would inform employers about removal decisions. Specifically, the regulatory body wanted employers to be notified and decisions published if an associate was removed for fraudulent entry. They also thought employers should be notified if an associate is removed for failure to pay a required fee or maintain adequate insurance and indemnity. Additionally, they wanted to clarify whether (and if so how) such removals would engage our fitness to practise proceedings. The postgraduate body wanted to understand if other countries would be notified when an associate is removed from the register because of fitness to practise concerns.

Some respondents suggested that we should notify PAs and AAs of our removal decision immediately, rather than within the five days currently allowed by our rules. Another respondent queried how quickly we would notify PAs and AAs if, following our initial communication that we intended to remove them, we decided not to remove them from the register. For example, if they had taken the action required, such as providing evidence of their indemnity or insurance, or paying their outstanding fee.

We received several comments relating to the grounds for removal, with respondents noting that we should have the ability to permanently remove PA and AA entries from the register. The AAPAO allows for applications to be made to re-enter the register and, although the rules include restrictions on the number of re-entry applications in some circumstances, we do not consider it proportionate to introduce further restrictions to applications.

Our response

In response to the consultation feedback, we've made several amendments to the rules. These include confirming that we cannot require reflective practice material from a PA or AA when seeking additional information to inform our removal decision.

We can also clarify that an associate may seek re-entry when their conviction for a listed offence is quashed (including if it is substituted with a non-listed offence).

Notifications

We accept that we should have included a timescale for notifying a PA or AA that we've changed our decision to remove them from the register. We've amended our rules to confirm that we'll now notify the PA or AA within five business days.

We've retained the maximum five business day limit for notifying associates of decisions to remove them from the register – rather than requiring this to be immediate. We will always aim to notify associates of our decisions as soon as possible, but there may be exceptional circumstances where we want to ensure that appropriate support mechanisms are in place first. We wouldn't be able to do this if we amended the rules to make notification of removal decisions an immediate requirement.

The online register of PAs and AAs will reflect that the associate's entry has been removed and we'll publish removal decisions in line with our publication and disclosure policies. Changes to entries on our online register will also link to NHS systems, including the associate's electronic staff record. However, unless we've undertaken a fitness to practise investigation into that associate, we'll not hold information about their employer on record, and therefore will be unable to notify them of an associate's removal.

We'll review how we communicate decisions about removing entries from the register when we develop and consult on rules for the revalidation of PAs and AAs.

Thresholds for removal

Several respondents queried some aspects of our removal process, including the threshold for removal. We'll set out in policy the thresholds for removing an entry from the register where we have the discretionary power to do so.

Where a PA or AA is removed because of conviction for a listed offence and that conviction is quashed, the AAPAO requires that individual to seek re-entry. There's no provision for an individual to be automatically restored.

Timescales

We agree with respondents who said that, where we request a PA or AA to provide information to inform our decision making, we must provide a reasonable amount of time for them to do so. We've not added specific time limits to the rules as we think it would be better to have the flexibility to set the timeframe based on what is reasonable on a case-by-case basis. In establishing this, we'll consider:

- the level of public protection risk

- what is realistic given the nature of the information that we've requested
- whether the information is already held by the PA or AA or whether they would need additional time to gather it or request it from a third party.

We also have the discretion to extend time limits if needed.

Decision maker

The AAPAO sets the Registrar, and not a panel or tribunal, as the decision maker for removing entries where it is determined that registration was fraudulently obtained. Therefore, we've not changed the decision maker for these cases in the rules.

Box 6: Removal rules – the changes we've made

- Updated the rules to prevent us from requiring reflective practice material when making registration removal decisions (rule 10).
- Amended rules to clarify that where we've notified an associate that we intend to remove their entry from the register, but subsequently decide not to remove them, we must notify the associate within five business days (rules 15–20).
- Made technical drafting changes to improve the clarity of rules.

Question 10: To what extent do you agree or disagree with our proposed approach to handling requests for removal (including where there may be outstanding fitness to practise concerns), as described within our rules?

What we heard

Overall responses		Responses from individuals					Responses from organisations	
			Total	Public	Doctors	PAs/AAs		
Total responses	2,635	Total responses	2,572	385	1,637	375	Total responses	63
Total comments	795	Total comments	769	126	542	39	Total comments	26
Agree	34% (888)	Agree	33% (845)	35% (136)	18% (301)	93% (350)	Agree	68% (43)
Disagree	46% (1,205)	Disagree	47% (1,198)	45% (173)	57% (938)	2% (9)	Disagree	11% (7)
Neither agree nor disagree or don't know	21% (542)	Neither agree nor disagree or don't know	21% (529)	20% (76)	24% (398)	4% (16)	Neither agree nor disagree or don't know	21% (13)

Of the 3,011 individuals and organisations that responded to the consultation, 2,635 (87%) responded to this question. Of these:

- 888 (34%) agreed
- 1,205 (46%) disagreed
- 542 (21%) neither agreed nor disagreed or did not know.

Analysis of comments – requests for removal

We received mixed views about our proposals. Where respondents generally disagreed, they saw our proposals as too lenient and not prioritising patient safety – with one organisation noting that removal decisions should be made independently of us. Respondents who generally agreed felt our proposals were clear, proportionate, comprehensive, and in the interests of patient protection.

Some respondents (largely doctors) felt that voluntary removal should not be permitted where there are outstanding fitness to practise concerns in case this be viewed as a means of avoiding scrutiny, and that fitness to practise proceedings should be allowed to continue:

> *'they should be thoroughly investigated irrespective or voluntary request for removal to allow for informed decision making on re-entry applications'. (Doctor)*

However, some organisations welcomed the ability for associates to request to remove themselves from the register in such circumstances.

Many respondents wanted further information about some aspects of our proposals. For example, a regulatory body wanted to further understand the link between voluntary removal and re-entry. And a medical defence organisation called for:

> '*clarity around how such an application [for removal] should be made (content and method), how the referral should be made and how such applications should be determined in order to minimise any delays to the Tribunal hearing'. (Organisation, medical defence organisation)*

A regulatory body asked for additional information on how the Registrar would make a voluntary removal decision where there are fitness to practise concerns that have not yet been referred to case examiners. A doctor organisation sought clarity on how we would deal with voluntary removal requests when fitness to practise concerns have been referred to a tribunal, as well as our timescales for considering the request and reaching a decision on whether to grant it.

One organisation welcomed the more streamlined approach to voluntary removal but felt it would be important for us to publish the reasons that associates gave for requesting this – together with their intended next steps and their protected characteristics, where available, to help inform understanding of workforce trends.

Some respondents expressed concern over the fairness of decision making. For example, an AA student noted that our proposals:

> '*would give one person (the case handler) a lot of power, which can lead to biased decisions'. (AA student)*

A regulatory body argued that in the interests of transparency, voluntary removal decisions should be published, but noted that there is nothing in the rules that requires publication.

Another respondent suggested that where we request information, we should specify within the rules when that information should be provided by – rather than simply state 'by the date specified by the Regulator'. It was felt that this carried a risk of unfair treatment and may lead to unnecessary stress for associates. This same respondent also queried what resources or mechanisms will be put in place to support and protect associates from the negative consequences of removal decisions.

Public research findings

The full research report is included in **Annex C**.

Research participants were informed that registrants may be removed for a variety of reasons – because they are retiring; are moving to work in another country; want to stop working as a doctor, PA, or AA; or do not meet our standards. They were then given an example of a GP taking early retirement from the NHS and moving overseas, and further details on the removal process that would then follow. Although discussion focused on doctors, Shift Insight also probed for reflections on PAs and AAs.

Participants were generally supportive of our proposals to make it quicker, fairer, and easier for registrants to leave the register where they request this. However, a small minority had concerns about our proposals, perceiving these to be less stringent – through enabling individuals to leave the register without grievances or issues having been fully aired. Some participants focused on a perceived risk of 'bad apples' being able to leave the register unnoticed or without punishment.

Although most were supportive, a minority felt the current system used for doctors offered a greater ability to flag lower-level concerns that might still be important but not aired. Participants queried whether the process could include a check with employers to make sure that there are no outstanding concerns that might inform our decision on whether to grant removal.

Our response

In response to the consultation feedback, we've made several amendments to the rules. These include confirming that we:

- cannot require reflective practice material from associates when seeking additional information to inform our removal decision
- can withdraw the referral of a voluntary removal application to a tribunal where appropriate to do so. This would be done in instances where an investigation into a PA or AA's fitness to practise has been withdrawn from a tribunal and is being considered by case examiners, making it more appropriate for them to also determine the request for voluntary removal instead of holding a tribunal just for that purpose.

Decision making

Several respondents queried how some aspects of our voluntary removal process would operate, with some of these querying who would make a decision, and how we would ensure 'independence' in our decision making.

The AAPAO provides a power for the Registrar to determine voluntary removal applications. Where a PA or AA wants to challenge the Registrar's decision, they can appeal to an internal appeal panel first and then to the courts.

Where there are fitness to practise concerns that have not yet reached the case examiner stage, the Registrar will decide whether to grant or refuse an application for voluntary removal. We'll publish guidance next year on how decision makers will determine whether it's in the public interest to grant removal before the conclusion of any fitness to practise proceedings. This is the same test that would be applied by case examiners and tribunals, should the voluntary removal request be referred to them.

Where the associate is subject to fitness to practise proceedings and requests voluntary removal, the Registrar must send the case to either case examiners or tribunal. We will publish separate guidance next year which sets out the factors that case examiners and/or tribunals will use to determine whether to grant the request in these circumstances.

Requests for information and publication

We agree that where we ask a PA or AA to provide further information to inform our decisions, they must have a reasonable amount of time to do so. We've not added specific time limits to the rules as we think it would be better to have the flexibility to set the timeframe based on what is reasonable on a case-by-case basis. We'll consider the risk to public protection and what is realistic given the nature of the information that we've requested. We also have the discretion to extend this timeframe if required.

Our publication and disclosure policies will set out our approach to publishing voluntary removal decisions. Where there are no fitness to practise concerns, we'll publish our decision and the voluntary removal outcome on the online register of PAs and AAs. Where there are fitness to practise concerns at the point voluntary removal is granted, we'll also publish the outcome and decision on the online register, where this is made by case examiners or tribunal. As for all decisions, we'll not publish details of decisions that relate to health concerns.

Most applicants seeking voluntary removal tend to do so because they are taking parental leave or a career break, are moving abroad, or are retiring. Where there are no fitness to practise concerns, we think that PAs and AAs should be able to easily leave the register. We do not plan to include checks or requirements for PAs and AAs to provide us with further information at this point.

We do not believe that it would be appropriate, or proportionate, to include additional steps to ask employers if they have any outstanding fitness to practise concerns before making a decision about a voluntary removal application. Where there are local concerns about fitness to practise, we expect that these will have been raised with us and already taken into account as part of our decision. Where fitness to practise concerns weren't known about, or arise when a PA or AA has been removed from the register, we'll address these as part of any future re-entry application.

We also do not consider there to be a public protection reason to require PAs or AAs to provide us with their reasons for leaving the register. We can, and do, support workforce planning through separate research into reasons for leaving the register. Where applicants have previously provided demographic information, we can also use this information to identify trends in voluntary removal requests.

Box 7: Voluntary removal rules – the changes we've made

- Amended our rules to clarify that two case examiners will assess a voluntary removal application (where there is a fitness to practise concern that has reached the case examiner stage or where the associate has been referred to a tribunal and a decision has been made for the case examiners to determine their application) (rule 12).
- Amended rules to enable withdrawal of a voluntary removal application from a tribunal where a referral of an allegation to a tribunal has been withdrawn (rule 13).
- Updated the rules to prevent us requiring reflective practice material as part of removal applications (rule 10).
- Made technical drafting changes to improve the clarity of rules.

When removal measures will take effect

What we proposed

Within our consultation document, we proposed that PAs and AAs will be notified of our decision to remove their entry from the register within five business days. We also proposed that our decision would take effect from the point that notice has been served on the PA or AA.

Question 11: To what extent do you agree or disagree with our proposals for when decisions to remove an entry from the register will take effect?

What we heard

Overall responses		**Responses from individuals**					**Responses from organisations**	
			Total	**Public**	**Doctors**	**PAs/AAs**		
Total responses	2,604	Total responses	2,541	378	1,621	373	Total responses	63
Total comments	681	Total comments	658	108	465	32	Total comments	23
Agree	34% (874)	Agree	33% (831)	37% (140)	17% (283)	93% (347)	Agree	68% (43)
Disagree	44% (1,147)	Disagree	45% (1,138)	43% (162)	55% (899)	2% (7)	Disagree	14% (9)
Neither agree nor disagree or don't know	22% (583)	Neither agree nor disagree or don't know	23% (572)	20% (76)	27% (439)	5% (19)	Neither agree nor disagree or don't know	17% (11)

Of the 3,011 individuals and organisations that responded to the consultation, 2,604 (86%) responded to this question. Of these:

- 874 (34%) agreed
- 1,147 (44%) disagreed
- 583 (22%) neither agreed nor disagreed.

Analysis of comments – when removal measures will take effect

In circumstances where an associate is removed from the register because of a failure to meet particular requirements, such as payment of the required fee or maintenance of adequate insurance and indemnity, we proposed to notify and remove the associate within five business

days of our decision (unless the associate takes action during this period to meet our requirements).

Some respondents (including doctors, PAs and AAs, members of the public, and some organisations) were critical of this approach and felt that the proposed timeframe for removal should be either shorter than five days or immediate:

> *'removal from the register and direct communication with the Associate should be immediate. It seems unlikely these decisions will be made outside of office hours, therefore, should be no reason why communication should wait up to 5 working days.' (Doctor)*

A regulatory body further supported this view, noting:

> *'for those rare occasions where there is automatic removal for such a serious offence as to be incompatible with being a healthcare professional, might there be a way of expediting the notification to all relevant parties more quickly than within five business days to further strengthen public protection'. (Organisation, regulatory body)*

Continuing this theme, other respondents (largely doctors) suggested that we should include provisions for emergency suspensions, other restrictions on practice, or automatic removals where there are serious concerns. This would allow for swifter action to be taken, while the removal process is underway. However, it should be noted that the AAPAO does not permit this.

Supportive comments noted that our proposals for measures to take effect immediately were clear, logical, robust and appropriately stringent:

> *'the rules provide a clear and logical framework for the timing of such removals, which is essential for maintaining order and transparency in the regulatory process while safeguarding public safety'. (Doctor)*

In cases of automatic removal, some respondents commented on our process of notifications. A membership body suggested the inclusion of an additional step in our process, whereby employers are required to confirm that they have received notification that a person is no longer registered (to ensure they are aware that registration has been revoked).

With regard to the appeals process, some respondents (largely organisations) who disagreed with our proposals felt that removal should be delayed from taking effect until the appeal period has elapsed. Others (largely individuals) felt that removal should be immediate.

> *'A period of appeal should be built into the decision to remove someone from the Register where their entry has been found to be incorrectly or fraudulently procured.' (Organisation, trade union body)*

Other respondents who agreed with our proposals did so with the caveat that decisions could still be appealed following removal, or on the basis that we have the discretion to delay the removal decision from taking effect until after the conclusion of an appeal in some circumstances. A regulatory body suggested that this might be appropriate in cases:

> *'where [we are] satisfied public protection does not require immediate removal'. (Organisation, regulatory body)*

We also received some calls to clarify how some parts of the removal process would operate. For example, some organisations suggested that we need to clarify the timescales for each part of the removal process, including the length of time case examiners or a tribunal will take to consider removal applications, as well as when that removal will take place.

Our response

We note the feedback suggesting that removal should take place as soon as our decision has been made. However, the AAPAO requires us to first notify a PA or AA of our decision before removing them.

We considered the range of views and have decided to retain a maximum period of up to five days to notify the PA or AA that their entry on the register has been removed. We will normally notify PAs and AAs of these decisions straight away; however we want to retain some flexibility where it is necessary to first ensure that additional support is in place for the PA or AA.

Removal will then take effect from the point that notice of our decision is served. We've further clarified within the rules that this also applies to requests for voluntary removal, in response to the feedback that we've received.

It's not possible, or desirable, to set out a fixed timeframe for making a decision on a voluntary removal application given the variety of circumstances. Where there are no concerns raised at the point a voluntary removal application is made, it will be straightforward and quicker to make a decision, compared with the more complex situations faced by decision makers when there are ongoing fitness to practise cases. We'll aim to make decisions swiftly, taking into account the circumstances of the request, and any related public protection concerns.

Box 8: When removal measures should take effect – the changes we've made

- Confirmed that removal decisions will come into effect at the point that notice of our decision is served.

Responding to concerns

What we proposed

We will have a process for dealing with concerns when they are raised about a PA or AA's fitness to practise.

We consulted on our rules for operating this process. These set out our approach for each stage of the fitness to practise process as follows.

- **Initial assessment** – where we consider that a question has arisen as to whether a PA or AA's fitness to practise is impaired, we'll carry out an initial assessment of the allegations. We will then consider whether regulatory action is likely to be needed to protect the public (referred to in our rules as the 'test for onward referral'). Where we consider this test to be met, we'll refer the concern to two case examiners for further consideration.
- **Interim measures and interim measure reviews** – interim measures are temporary restrictions that may be applied to a PA or AA's registration while we are investigating a concern, where that's necessary to protect the public or is in the interests of the associate. An interim measure can be either a 'suspension' – which prevents an individual from practising – or 'conditions' – which either restrict practice or require the PA or AA to do something (for example, comply with monitoring of a health condition). Our rules set out a process for determining whether an interim measure may be needed. The AAPAO also requires us to periodically review interim measures, and so our rules also set out our approach for doing this. We proposed a flexible framework for reviewing measures, whereby reviews can be completed either by a case examiner or through a tribunal hearing.
- **Accepted outcomes** – our rules describe how case examiners will handle concerns that are referred to them. Case examiners must consider all information relevant to the case, including any written representations from the associate. They may then reach a view on whether an associate's fitness to practise is impaired. Where case examiners determine that an associate's fitness to practise is not impaired, they may close the case with no action or issue a warning. Where case examiners determine that an associate's fitness to practise is impaired, they will propose appropriate regulatory action (referred to as a 'final measure') to that associate. If the associate agrees to the final measure, this will come into effect without the need for a tribunal hearing. Where the associate does not agree with the proposed action, the case examiners will refer the concern to a fitness to practise tribunal to be decided (which the associate is able to attend with their legal representative). Where the associate does not respond to the case examiners' proposal by agreeing or disagreeing, the case examiners have the discretion to impose a final measure or refer the case to a tribunal.
- **Adjudication** – the adjudication process is used to reach outcomes in cases that are not resolved by case examiners through the accepted outcome process. In these circumstances, tribunals will consider the concern and determine whether regulatory action is needed. Tribunals can impose a warning where they do not find that an associate's fitness to practise

is impaired, or put in place appropriate restrictive action – conditions, suspension, or removal from the register where they find fitness to practise impairment. Within our consultation document, we also proposed an enhanced role for case managers,[*] enabling them to resolve a wider range of issues in advance of the hearing and to issue practice directions. Case managers do not decide the outcome of cases but they can give directions to the parties and determine preliminary issues to ensure a fair and efficient adjudication process.

- **Final measure reviews** – where case examiners or a tribunal have imposed a final measure on an associate's registration, that measure can be reviewed at any time to decide if their fitness to practise remains impaired. When practice remains impaired, we can take appropriate action to address the current and ongoing risk to public protection. Our rules describe the process for undertaking reviews, which includes a proposal for case examiners to review final measures 'on the papers'[†] without the need for a hearing – unless the associate requests this, or we consider it to be necessary.

We also consulted on the following principles that will form the content of fitness to practise decision-making guidance – which will apply to PAs and AAs from December 2024, and to doctors in 2025 following a transition period. We've pushed back the introduction of our guidance for doctors to allow sufficient time to train our staff on how to apply this (taking into account the volume of doctor cases going through our fitness to practise procedures).

- **Principles to inform impairment guidance** – a finding of impairment can only be made where a doctor, PA, or AA is assessed to pose a current and ongoing risk to public protection. These principles outline the key factors that are relevant to assessing this risk.
- **Principles to inform guidance on what restrictive action is required** – restrictive action can be taken to address the current and ongoing risk posed by a doctor, PA, or AA. These principles outline the key factors that are relevant to determining which type of restrictive action to apply, for example, conditions on registration, suspension, or removal/erasure from the medical register.
- **Principles to inform guidance on warnings** – warnings may be issued when the behaviour or performance of a doctor, PA, or AA represents a significant departure from our professional standards and should not be repeated. This applies where the doctor, PA, or AA's behaviour or performance falls just short of posing a current and ongoing risk to public protection. These principles outline the key factors relevant to deciding when a warning might be an appropriate regulatory response.

[*] Case managers are individuals appointed by the Medical Practitioners Tribunal Service for the purpose of managing cases referred to an Associate Tribunal for a hearing. The management of cases includes giving directions on case preparation and deciding matters relevant to the just and expeditious management of a case, such as establishing some preliminary legal arguments made by a party to the proceedings and postponement applications.
[†] 'On the papers' refers to a review of written evidence.

Initial assessment

Question 12: To what extent do you agree or disagree with our proposed approach to initial assessment, as described within our rules?

What we heard

Overall responses		Responses from individuals					Responses from organisations	
			Total	Public	Doctors	PAs/AAs		
Total responses	2,627	Total responses	2,564	376	1,653	369	Total responses	63
Total comments	1,108	Total comments	1,067	144	736	108	Total comments	41
Agree	21% (549)	Agree	20% (517)	11% (43)	13% (219)	56% (205)	Agree	51% (32)
Disagree	59% (1,544)	Disagree	60% (1,528)	56% (210)	74% (1,220)	2% (8)	Disagree	25% (16)
Neither agree nor disagree or don't know	20% (534)	Neither agree nor disagree or don't know	20% (519)	33% (123)	13% (214)	42% (156)	Neither agree nor disagree or don't know	24% (15)

Of the 3,011 individuals and organisations that responded to the consultation, 2,627 (87%) responded to this question. Of these:

- 549 (21%) agreed
- 1,544 (59%) disagreed
- 534 (20%) neither agreed nor disagreed or did not know.

Analysis of comments – initial assessment

Many respondents (largely doctors and members of the public) felt that the initial assessment process was not sufficiently robust or rigorous enough to adequately assess the competence of PAs and AAs. As one respondent commented.

> *'While the guidelines emphasize a structured process for evaluating fitness to practice and public protection, they do not sufficiently ensure that PA's possess the rigorous and comprehensive training needed for high-quality patient care. The approach relies heavily on procedural and contextual factors, which may not adequately address the fundamental differences in training and experience between PAs and fully licensed physicians.' (Member of the public)*

Some respondents cited concerns about the decision-making process as their reason for disagreeing with our proposed approach to initial assessment. Specifically, they argued that

doctors must be involved in any decision to refer a concern to a case examiner, because PAs and AAs work under their supervision and 'should not be permitted to self regulate' (Doctor).

Clarity of the process/test for onward referral

There were mixed views over the clarity of the process. Although some respondents (doctors, PAs and AAs, and some organisations) commented that the process was both clear and transparent, others called for greater clarity. A regulatory body questioned our ability to withdraw a referral to a case examiner once the test for onward referral has been met, querying why this was needed. They also commented that our rules provided little information on the process that leads up to the test for onward referral and noted that this should be set out in published guidance. Another organisation, made a similar point, noting that:

> *'the rules do not state how concerns should be accepted for consideration and it may not be appropriate that that element is included within these rules, but the ease and accessibility considerations afforded in the referral process are important and should be outlined for the public in some format'. (Organisation, software company)*

A doctor organisation and medical defence organisation both queried the terms we used to describe the test for onward referral. And specifically, what we meant by a 'reasonable likelihood' that we'll need to take regulatory action to protect the public. They queried how we would define this. Other respondents queried how our initial assessment would interact with local processes for managing concerns at the provider level, and whether this should be explicitly set out within the rules.

Some respondents commented on the timeliness of the process. An employer welcomed the 'improved flexibility of the process, and likelihood of swifter resolution' (Organisation, NHS or Health and social care organisation).

Grounds for action

Several respondents – both those agreeing and those disagreeing with our proposals – commented on the two grounds for action set out in the AAPAO (misconduct, and inability to provide care to a sufficient standard). Several doctors and organisations disagreed with the lack of an explicit ground for health concerns. A trade union body requested further information on how health cases will be assessed under our proposed framework and a doctor organisation suggested that this be explicitly set out within the rules.

Some respondents argued that some types of case – for example, convictions for involvement in non-violent protests – should be excluded from fitness to practise proceedings. Further commentary on this point is set out in question 18 below.

Additional comments

Of those who supported our proposals, several respondents (both individuals and organisations) noted that the process seems to be fair and proportionate.

A small number of additional themes were highlighted. Some respondents queried how we would prevent vexatious complaints about PAs and AAs.

Others had specific drafting suggestions for, and queries about, the process of notifications. These included:

- amending the rules to require us to notify associates that a complaint had been made against them (even if the test for onward referral is not met)
- adding timescales for notifying individuals of specific decisions
- clarifying if associates would be informed of evidence disclosures to complainants and other third parties.

Several respondents raised concerns over the potential for bias in our decision making and queried what training decision makers would receive, and how their decision making would be quality assured to mitigate this.

Our response

Applying the test for onward referral

Having undertaken an initial assessment, the AAPAO requires us to refer the complaint to case examiners where we consider it's appropriate to do so. In our rules, we set out how we'll determine whether it is appropriate to refer a matter to case examiners. This is defined in the rules as 'the test for onward referral' and will be met where we consider there is a reasonable likelihood that regulatory action is needed to protect the public.

Some respondents highlighted the lack of detail on the process, and decisions, that lead up to the test for onward referral. As is the case now, the detail of how we assess and investigate concerns and how we make decisions will be set out in guidance. Guidance will cover matters relating to when health, performance, or English language assessments may be needed. It will also set out relevant considerations where there are ongoing local investigations being undertaken by the PA or AA's employer or other third-party investigations, such as by the police.

A regulatory body expressed concern that there is no mechanism for the public to challenge a decision to close a complaint at this early stage. However, we've included decisions on whether or not to refer a matter to our case examiners in the list of revisable decisions in our revision rules (see 'Changing and challenging our decisions' below). Where a member of the public or other party disagrees with our decision to close a concern during initial assessment, they may challenge this by requesting a revision.

We've taken on board the feedback which questioned the appropriateness of our power to withdraw a referral to case examiners and have now amended the rules to remove this provision. We've instead added into our rules the ability for us to refer further relevant information to our case examiners, where we receive this after the onward referral. The PA or AA will also be permitted to comment ('make representations') on this information. This information can then be considered by the case examiners when determining whether a case can be closed with no action or whether regulatory action is required.

Grounds for action

The AAPAO sets out that an associate's fitness to practise can only be impaired on the grounds of misconduct or inability to provide care to a sufficient standard. Therefore, we can't introduce additional grounds for taking action in our rules. Since there is no explicit ground for addressing health concerns of an associate, we've outlined our approach to such cases in guidance. Our decision-making principles (see questions 18–20) describe the key factors to consider when determining if an associate is likely to be impaired under these two permitted grounds.

Notifications

In response to the feedback we received about notifications, we've introduced a timeframe of five business days for communicating the outcome of a health or performance assessment to the associate (which we may commission to inform our decision on whether regulatory action is likely to be needed).

Other issues

In response to the feedback we received about vexatious complaints, and our process for dealing with these, we do not consider it to be necessary to include a provision on this within the rules. This is because we can already close a case at any point during the initial assessment stage if we consider there's no substance to the concern – including if the PA or AA was the target of a vexatious complaint.

Box 9: Initial assessment rules – the changes we've made

- Amended rules to clarify that we must notify an associate of the outcome of a health or performance assessment within five days (rule 6).
- Removed our power to withdraw a referral to case examiners but we've added in a provision which allows us to refer further relevant information to the case examiners (after the onward referral) (rule 6).
- Technical drafting changes to improve the clarity of rules.

Interim measures

Question 13: To what extent do you agree or disagree with our proposed approach to initial measures and interim reviews, as described within our rules?

What we heard

Overall responses		Responses from individuals					Responses from organisations	
			Total	Public	Doctors	PAs/AAs		
Total responses	2,565	Total responses	2,502	368	1,601	369	Total responses	63
Total comments	771	Total comments	741	109	541	30	Total comments	30
Agree	31% (793)	Agree	30% (753)	36% (131)	13% (215)	96% (354)	Agree	63% (40)
Disagree	55% (1,403)	Disagree	56% (1,390)	54% (200)	69% (1,101)	1% (5)	Disagree	21% (13)
Neither agree nor disagree or don't know	14% (369)	Neither agree nor disagree or don't know	14% (359)	10% (37)	18% (285)	3% (10)	Neither agree nor disagree or don't know	16% (10)

Of the 3,011 individuals and organisations that responded to the consultation, 2,565 (85%) responded to this question. Of these:

- 793 (31%) agreed
- 1,403 (55%) disagreed
- 369 (14%) neither agreed nor disagreed or did not know.

Analysis of comments – interim measures

Of those who disagreed with this question, several respondents (typically doctors, members of the public, and other individuals) commented on the role of the decision maker, and the composition of interim measure tribunals. Respondents argued that PAs and AAs should not be able to sit on panels or make decisions about practising associates.

Interim measures

Respondents who supported our proposed approach, covering most respondent groupings, cited as the reasons for doing so:

- the perceived alignment with our current processes for doctors
- the fairness and proportionality of our approach
- that our approach seems to strike an appropriate balance between public protection and safeguarding the rights of individual associates.

Other respondents called for greater clarity in our criteria for imposing interim measures, with one doctor noting the need for 'detailed criteria and clear examples in the rules that specify the conditions under which interim measures may be applied'. A doctor organisation asked us to clarify the threshold that would need to be met for a case to be referred to an interim measure tribunal, as well as whether, and if so when, a referral could be withdrawn from the tribunal.

Interim measure reviews

Within our consultation document, we proposed that reviews of existing interim measures could be undertaken by a single case examiner. We received mixed views about this proposal. Several respondents – both individuals and organisations – expressed concern over this approach on the basis that it gave too much power to a single person. One organisation noted that this represented a significant change to our current approach for doctors, for whom interim order tribunals are used to review interim measures (referred to as 'interim orders' for doctors). Another organisation felt that the proposals did not deliver adequate separation in our decision making, with the regulator (in this case the case examiner) acting as both investigator and decision maker.

Many respondents, irrespective of whether they agreed or disagreed with our proposals, queried how we would ensure consistency in decision making. They argued that decision makers must be sufficiently trained and have 'necessary tools and clear processes' (Organisation, software company) to undertake this role. A regulatory body further noted that 'this increased flexibility needs to be balanced by ensuring fundamental procedural safeguards'.

Several respondents commented on our proposed approach to enable the PA or AA to either agree to a new or changed interim measure (after review) when proposed by the case examiner, or to request a hearing at a tribunal. Although some respondents supported the ability of the associate to request a hearing if they disagreed with a decision maker's proposed outcome, a doctor organisation noted that associates may lack the confidence to request a hearing. This respondent thought that all interim measure reviews should be heard by a tribunal instead.

One regulatory body did not consider that it was necessary for the PA or AA to agree a proposed interim measure and that a case examiner should be able to impose it, highlighting that there was a right of appeal if the associate did not agree. They went on to note that the involvement of case examiners at this stage could lead to an 'unnecessarily protracted' process should the associate then request a hearing if they refuse the case examiner's proposed terms. Another respondent noted:

'Different levels of scrutiny and decision-making standards could lead to unequal treatment of similar cases, affecting fairness and transparency.' (Doctor)

A regulatory body also queried the fairness of our power to refuse a request from a PA or AA for a review of their interim measure. They felt that we should be:

'required to hold a review when the associate's request is supported by evidence of a material change of circumstances and representations as to why the measure should be varied, replaced or revoked'. (Organisation, regulatory body)

Timeliness – interim measures and interim measure reviews

Some respondents referred to the timeliness of the interim measures process, including the procedure for interim measure referrals and tribunal hearings – arguing that we needed to take swifter action to protect the public. Several respondents called for us to set out clear timescales for each part of the process. A regulatory body also queried our approach to notifying third parties of the outcome of interim measure reviews, and our timeframe for doing so.

Respondents made some drafting suggestions for the rules. For example, a regulatory body commented that the wording of the provision relating to withdrawing an interim measure was overly restrictive and suggested an alternative.

Our response

Interim measures

In response to the feedback requesting greater clarity on the thresholds for imposing an interim measure, the test of whether an interim measure is needed is set out in Article 11 of the AAPAO. We will set out in guidance, as we do now for doctors, the considerations that decision makers should take into account when deciding whether that test is met, and an interim measure should be imposed. As with question 15 on adjudication, and question 22 on appeals, we received a large volume of feedback about the composition of tribunals, in this instance, interim measure tribunals. The AAPAO requires us to establish interim measure tribunals for PAs and AAs (referred to as panels in the AAPAO). The AAPAO also requires that interim measure tribunals are made up of at least one registrant and one lay member.[*]

Although the AAPAO gives us some discretion as to whether the registrant panel member is a doctor, PA, or AA, it remains our long-term position for doctors, PAs, and AAs to be eligible to serve as registrant panel members for fitness to practise tribunals, and appeals, in cases relating to PAs and AAs. We do not agree that doctors must sit on every panel in cases involving PAs or AAs, or that PAs and AAs should be excluded from involvement in the regulation of their own professions by denying them a role on panels. We believe that it should be possible for PAs and AAs to serve as panel members for those cases focusing on the practice of an individual PA or AA.

[*] A lay member is anyone who isn't a registrant, didn't used to be a registrant, and is not eligible to apply for registration in future.

However, in the period immediately after regulation begins it's likely that there won't be enough registered and appropriately experienced PAs and AAs to serve on interim measure tribunals. Therefore, we expect that for practical and operational reasons, during this period, interim measure tribunals for PAs and AAs will need to include doctors. The rules we've prepared give us the necessary flexibility to accommodate this.

Interim measure reviews

We've also amended our rules to give further clarity on how different aspects of the interim review process will work. These changes include:

- clarifying that a case examiner may allow an existing interim measure to continue, without any changes to this, following an interim measure review; an associate who does not agree with the existing interim measure continuing will be able to request a tribunal hearing
- clarifying that a case examiner may request that we obtain further information, not already held by us, to inform their review of the interim measure
- clarifying that, subject to their expiry date, interim measures remain in effect during, and following, the appeal process
- removing the ten-day timeframe for notifying third parties of the outcome of an interim measure review; feedback from our consultation queried our inclusion of this, suggesting that it may prevent us from notifying third parties outside of this period.

In response to the feedback about our decision to delegate reviews of interim measures to a single case examiner, we continue to hold the view that it is appropriate and more efficient to allow a case examiner to review existing interim measures 'on the papers', without needing to convene an interim measures tribunal (unless the associate requests this). We currently operate a process of reviews on the papers for doctors where a review is undertaken by a single decision maker, usually a legally qualified tribunal chair, with the agreement of the registrant.

For PAs and AAs, these decisions will be taken by case examiners with appropriate guidance, training, audit, and quality assurance of decision making. Associates will be able to request a tribunal if they wish. We, and the case examiners, can also refer a review directly to a tribunal – to address those situations where a review needs to be done urgently.

We note the regulatory body's feedback that we should not be able to refuse an interim review request where that request is supported by evidence of a change in circumstances. Although we agree with this in principle, we still believe that this power is needed to refuse clearly inappropriate requests, particularly as we've not included any limitation on how soon after an interim measure has been imposed a review can be requested. However, we'll set out in guidance the circumstances in which we would typically accept or refuse a request.

Timeliness – interim measures and interim measure reviews

We've noted the feedback about the timeliness of the interim measure and interim measure review processes. Although we cannot set out in rules how long each part of the process will take, we'll aim to complete our considerations swiftly – balancing the need for prompt action to protect the public with fairness to the associate.

Box 10: Interim measure and interim measure review rules – the changes we've made

- Removed time limits for notifying employers and third parties of the outcome of an interim measure review (rule 16).
- Amended rules to clarify that a case examiner can, upon review, allow the existing interim measure to continue without any change (rule 14).
- Amended rules to clarify that, subject to their expiry date, interim measures remain in effect during, and following, the appeal process (rules 9, 16, and 19).
- Amended rules to clarify that a case examiner can request that we obtain further information, not already held by us, to inform their interim measure review (rule 17).
- Amended drafting of rule 8 on withdrawal of an interim measure referral following feedback that the existing drafting was overly restrictive.
- Made technical drafting changes to improve the clarity of rules.

Accepted outcomes

Question 14: To what extent do you agree or disagree with our proposed approach to accepted outcomes, as described within our rules?

What we heard

Overall responses		Responses from individuals					Responses from organisations	
			Total	Public	Doctors	PAs/AAs		
Total responses	2,551	Total responses	2,488	369	1,587	369	Total responses	63
Total comments	704	Total comments	674	100	489	31	Total comments	30
Agree	31% (796)	Agree	31% (760)	37% (135)	14% (221)	95% (350)	Agree	57% (36)
Disagree	53% (1,349)	Disagree	54% (1,336)	51% (189)	67% (1,063)	1% (5)	Disagree	21% (13)
Neither agree nor disagree or don't know	16% (406)	Neither agree nor disagree or don't know	16% (392)	12% (45)	19% (303)	4% (14)	Neither agree nor disagree or don't know	22% (14)

Of the 3,011 individuals and organisations that responded to the consultation, 2,551 (85%) responded to this question. Of these:

- 796 (31%) agreed
- 1,349 (53%) disagreed
- 406 (16%) neither agreed nor disagreed or did not know.

Analysis of comments – accepted outcomes

Across all responses to the question, the most common themes to emerge related to the appropriateness, reasonableness, and proportionality of the procedure for accepted outcomes. Some respondents felt that the process was inadequate and needed revision. Whereas others took an opposing view, perceiving the process to be appropriate, proportionate, and reasonable.

Some respondents felt that the accepted outcome approach fails to adequately protect the public or would not be suited to some types of cases. For example, a doctor organisation proposed that accepted outcomes were not suited to more complex cases focusing on issues of bias, disputed facts, systemic issues, and cultural factors. And another doctor organisation sought clarity on whether, and if so in what circumstances, we would refer a concern directly to a tribunal without first proposing an accepted outcome.

Respondents raised concerns over the consistency and quality of decision making, with some respondents noting that clear criteria, guidance, and training were needed, together with robust quality assurance of resulting decisions. As one doctor noted:

> *'any outcomes should be reviewed by an independent EDI (equality, diversity and inclusion) examiner who examines whether the processes of the case and the outcomes are discriminatory based on the individuals protected characteristics. This should also be compared to the outcomes of similar cases or where no similar cases are available it should be compared to cases which have had similar outcomes.' (Doctor)*

Respondents also sought further clarity on some aspects of the process, including, for example, our power to withdraw a referral to a tribunal, and the circumstances in which we'll use this.

How a PA or AA responds to the proposed outcome

Some respondents focused on the case examiners' terms of the proposed outcome – which detail:

- the case examiners' findings
- their decision on impairment
- the proposed final measures – as well as how PAs and AAs should respond to these.

Respondents asked whether the PA or AA would have to agree to all three elements of the proposed terms, or whether it would be enough to simply accept the proposed measure without the findings on impairment. We can confirm that they will have to accept all three, that is, the case examiners' findings about the case, their finding of impairment, and the proposed final measure.

Several respondents also commented on the extent to which the accepted outcome process will permit representations to be made by parties to the case. A regulatory body and patient organisation both called for these to be sought from the complainant.

Other respondents suggested that PAs and AAs should also be permitted to give their views on the proposed terms and make 'sensible requests' to change the measure when appropriate to do so, for example, where these relate to 'conditions'. A doctor organisation further suggested that the accepted outcome process be split into two stages – so that the case examiner is required to first seek representations on the allegations, before proposing an appropriate final measure.

Some respondents commented that PAs and AAs may feel pressured or coerced into accepting a proposed outcome. As one organisation noted:

> *'There is emphasis placed on those being investigated to display insight. However, this is often interpreted as being required to admit to something that they do not believe that they did, and that if they do not do this it will be seen as prejudicial to them.' (Organisation, professional association)*

One organisation argued that where the PA or AA rejects the proposed terms, this should not be disclosed to the tribunal – in case it's used as evidence of restricted insight on the part of the associate. Another organisation suggested that, to support a swifter hearing, the rules should require associates to confirm the basis upon which they reject the case examiners' proposal.

Some respondents also disagreed with our proposal to impose a measure in the absence of a reasoned response from the PA or AA, who has 28 days to respond to the proposed terms – although these can be extended by the case examiners. One respondent noted that decisions in the criminal justice system are not made without the accused being present. A medical defence organisation suggested that we should first consider the circumstances that might have prevented a PA or AA from giving a reasoned response – rather than impose a measure as soon as the 28-day period passes.

Respondents also suggested that we consider introducing a condition within the rules for us to refer a case straight to tribunal in the absence of a response and/or extend the 28-day period – to allow associates to seek professional or legal advice. In contrast, a small number of respondents suggested that this timescale should be halved. And the process expedited, given the potential negative effects that the process might have on the mental health and livelihood of PAs and AAs.

When accepted outcome decisions and warnings take effect

In our rules, we proposed that warnings and accepted outcome decisions would take effect once notice of the decision has been served. Although some respondents agreed with this proposal, others provided a counter view. For example, a doctor organisation noted that the publication of a warning can have a significant effect on practising privileges for private practice. They queried why we would impose these before any appeal period has passed. A regulatory body made a similar point, contrasting our proposals with our current approach for doctors:

> *'The current process for doctors seems fairer where tribunal can add conditions to protect the public whilst the appeal decision is made. By imposing final outcome immediately before appeal could potentially mean a person has a period of suspension/conditions that applied when not needed if appeal upheld.' (Organisation, regulatory body)*

However, it should be noted that the AAPAO prevents us from imposing immediate interim conditions while the appeal is heard, in the way described by this respondent.

Respondents made additional drafting suggestions. These included:

- amending the rules to make clear that an interim measure will be revoked when a final measure is agreed or imposed
- changing terms within the rules to make clear that the case examiner is setting out their assessment of the allegation rather than their findings on the case
- amending the rules to make sure that we notify PAs and AAs of any disclosure or notification to a complainant or third party.

Public research findings

The full research report is included in **Annex C**.

Research participants were provided with information about our existing investigation process before moving on to the accepted outcomes process. A case study was shared to illustrate how a concern would be resolved through this process.

The research found that, in general, participants supported our reforms to fitness to practise, viewing them as logical, fair, and progressive. On the accepted outcomes process specifically, participants focused more on the type of final measure that would be imposed – with many wishing to see more 'punitive' action taken. Some participants welcomed a swifter process that removes the need for a tribunal hearing – they believe it'll reduce stress for patients, family members, and other complainants. Others suggested that a swifter process was important as it would allow us to prioritise our resources for dealing with the most serious incidents.

Participants shared mixed views on when it was appropriate for a case examiner to make a decision, and when a case should be referred to a tribunal. Although some participants welcomed that PAs and AAs could choose to have their case heard by a tribunal, they felt that a tribunal was only likely to be of interest where associates seriously disagreed with a case examiner's findings, or who felt they had been wronged somehow. However, others felt that the accepted outcome process would deny the complainant 'justice', would be viewed as 'an admission of guilt' on the part of the associate, or would not be fairly administered by us.

Our response

We've considered the comments and suggestions, and we note the recurring themes about appropriateness, reasonableness, and proportionality. Regarding the feedback about the consistency and quality of decision making, there will be detailed guidance for decision makers on assessing whether an associate's fitness to practise is impaired, and if so, what action to take. There will also be appropriate training, auditing, and quality assurance.

Whether some types of cases should be excluded from the accepted outcomes process

We note the feedback suggesting that some types of case should be excluded from the accepted outcomes process and should be referred directly to a tribunal. We don't support introducing any form of constraint that limits the power of case examiners to reach decisions on impairment and propose outcomes. Such limitations would be at odds with the more proportionate, less adversarial fitness to practise process that the AAPAO seeks to create. This would also undermine the benefits of the accepted outcome process which are intended to:

- reduce the stress on complainants and witnesses, who would otherwise have to give evidence at a public hearing
- reduce the stress for associates who choose to accept the terms of the proposed outcome
- allow cases to be concluded more quickly where the associate accepts the findings on impairment and the final measure proposed at the accepted outcome stage – enabling swifter action to protect the public.

However, the AAPAO does permit case examiners to refer cases directly to the tribunal where they think that is the appropriate course of action, and we'll provide guidance for case examiners on the exercise of this discretion. One example of where this might be necessary is where the case examiners consider that they cannot reasonably resolve conflicts of evidence.

Negotiating the proposed terms and representations

It is important to stress that the accepted outcome process is not a negotiation – if the associate disagrees with any of the terms of the proposed outcome (the case examiners' findings, their decision on impairment, and the proposed final measure), then the case will be referred to tribunal.

We do not support any change to enable the PA or AA to propose an alternative outcome. We are not required under the AAPAO to seek representations from the associate on the terms of the proposed outcome but must instead seek their agreement with the outcome that the case examiners propose. The associate and complainant will have been given the opportunity to provide information and views on the concerns as part of our initial assessment and investigation of the concern. The rules also ensure that the associate can make representations about the case against them before our decision to refer the case to case examiners.

We have, however, included a provision in the rules to enable case examiners to withdraw an offer of proposed terms where they become aware of new relevant information. Where this happens, the case examiners may then proceed to take account of the new information in determining the appropriate action to take. This may be to close the case with no action, impose a warning, or put forward alternative proposed terms to the associate.

No response to the proposed terms from the PA/AA or rejection of the proposed terms by the PA/AA

In response to the feedback we received about the imposition of an outcome in the absence of a reasoned response (a response that states whether the PA or AA is agreeing or disagreeing with the proposed terms), we'll set out in guidance the circumstances in which it may be appropriate for case examiners to impose a measure, and when it may be more suitable to refer the case to a tribunal. But we add that case examiners may permit the 28-day limit to be extended where they consider it is fair and proportionate to do so, for example, if the associate cannot respond during this time because of poor health.

Where the associate rejects the proposed terms, the case will be referred to a tribunal. We've noted the feedback suggesting that this rejection should not be made known to the tribunal in case this be viewed as a lack of insight. An associate has the right to reject an offer and request that the case is referred to tribunal. We'll make clear in guidance that this is not a relevant consideration for a tribunal, who should determine the case independently of an associate's response to the case examiners' proposed terms. We do not consider that the terms of a proposed offer by case examiners should generally be disclosable by either party to a tribunal.

When should measures take effect

We continue to hold the view that final measures agreed or imposed through the accepted outcomes process should take effect on service of notice, rather than following the period of appeal. This approach ensures continued public protection while any appeal is undertaken and concluded – preventing the associate from returning to unrestricted practice during this period. Unlike the *Medical Act* for doctors, the AAPAO does not permit us to put in place immediate orders to restrict practice until we've concluded the appeal.

Drafting suggestions

We received feedback that our drafting in relation to the revocation of interim measures when final measures are imposed implied that there were circumstances when this would not take place. There are in fact circumstances where it might not be appropriate to revoke an interim measure if there is another unresolved concern about the same associate under assessment. However, we agree that the original drafting could be improved, and we've amended to say that case examiners must determine whether any action is needed in respect of an interim measure. This mirrors wording we've used for tribunals. We've also added in a provision to ensure that this action must be taken in cases which conclude with no action or with a warning.

We've also amended our rules to clarify that case examiners can request that we obtain further information, not already held by us, to inform their accepted outcome decision.

Box 11: Accepted outcomes rules – the changes we've made

- Amended rules to clarify that case examiners must consider what action is needed in respect of any interim measure in place at the point they close a case with no action, or impose a warning or a final measure (rules 22 and 24).
- Amended rules to clarify that, subject to their expiry date, final measures remain in effect during, and following, the appeal or revision process (rule 25).
- Amended rules to clarify that case examiners can request that we obtain further information, not already held by us, to inform their accepted outcome decision (rule 29).
- Made technical drafting changes to improve the clarity of rules.

Adjudication

Question 15: To what extent do you agree or disagree with our proposed approach to adjudication, as described within our rules?

What we heard

Overall responses		Responses from individuals					Responses from organisations	
			Total	Public	Doctors	PAs/AAs		
Total responses	2,560	Total responses	2,497	366	1,598	370	Total responses	63
Total comments	814	Total comments	783	114	526	82	Total comments	31
Agree	31% (783)	Agree	30% (748)	36% (133)	14% (219)	94% (346)	Agree	56% (35)
Disagree	54% (1,392)	Disagree	55% (1,378)	51% (187)	69% (1,098)	2% (8)	Disagree	22% (14)
Neither agree nor disagree or don't know	15% (385)	Neither agree nor disagree or don't know	15% (371)	13% (46)	18% (281)	4% (16)	Neither agree nor disagree or don't know	22% (14)

Of the 3,011 individuals and organisations that responded to the consultation, 2,560 (85%) responded to this question. Of these:

- 783 (31%) agreed
- 1,392 (54%) disagreed
- 385 (15%) neither agreed nor disagreed or did not know.

Analysis of comments – adjudication

Composition of panels

As with question 13, one of the most common themes to emerge focused on the constitution and appointment of tribunals, and the view that the registrant member of the panel must always be a doctor. Some went further, noting that doctors should be involved in decision making at every stage of the adjudication process. However, a minority of respondents held a different view, with some noting that PAs and AAs should be represented on the panel, and others suggesting that PAs and AAs should not be permitted to sit on panels until their professions have 'matured and become settled into the healthcare workforce' (Organisation, doctor organisation).

Fairness and transparency

Several respondents focused on issues of fairness and transparency. Of those who disagreed with our proposals, one doctor noted that it was 'inappropriate' that we only need to prove our case on the balance of probabilities, whereas a second expressed concern over a lack of access to adequate legal representation or support for associates. A third commented on our proposal to accept certificates of conviction as proof of fact, noting:

> *'… I cannot object more strongly to the rule that a certificate of conviction be treated as fact. The police and the criminal justice system are plagued with serious errors and miscarriages of justice. It is absurd, and frankly, frightening, for their evidence to be exempt from scrutiny by a defence solicitor.' (Doctor)*

The Health Act 1999 requires the standard of proof in our fitness to practise proceedings to be on the balance of probabilities, so we do not have the discretion to adopt a different approach.

Of those who neither agreed nor disagreed, one individual noted, in the interest of transparency, the need for timely updates at each stage of the process, and a requirement to 'resolve cases at each stage within a deadline' (Doctor).

A doctor organisation also held this view and suggested that case managers should have the discretion to extend these 'where the interests of justice and fairness require it'.

Respondents who agreed with our proposals (including doctors, PAs and AAs, members of the public, and some organisations) felt that the process was both fair and appropriate. However, they made a few suggestions for further improving this. These included:

- including decision-making criteria within the rules
- providing guidelines for when, and how, hearings will be held in public (and how security/privacy will be ensured when holding hearings online)
- introducing measures to support PAs and AAs throughout the adjudication process.

Adjudication procedure

A small number of comments focused on our expanded role for case managers. Some respondents welcomed this approach and the increased flexibility it offers. But others expressed concerns that case managers would be given too much power – and that there should be provisions, set out within the rules, for directions to be challenged. A medical defence organisation suggested that case manager directions could be challenged at either a direction meeting or a preliminary legal arguments hearing.

Specific drafting suggestions included requiring case managers to invite submissions before issuing directions and ensuring that PAs and AAs receive directions at least seven days before any pre-hearing meeting.

As with question 14, there were mixed views over our proposal for final measures to take effect when we serve notice of our decision, or immediately when imposed at the direction of a tribunal. Some welcomed this proposal, whereas others suggested that there should be a choice to delay these in some circumstances – for example, where the associate needs time to make arrangements to comply with conditions.

Several respondents commented on costs, which tribunals may award following a hearing – respondents questioned their purpose and limitations. For example, one organisation felt that:

> *'costs should not be awarded against those who are appearing in front of a Tribunal'. (Organisation, professional association)*

Other respondents queried the level of training that case managers would receive to effectively assess costs.

Respondents made further detailed drafting suggestions to improve the clarity and workability of the adjudication rules. Additionally, a doctor organisation noted that individuals should not be required to seek approval from us or the tribunal for their choice of legal representative – and that the PA or AA should make this decision.

Support for witnesses

Within our consultation document, we set out how we intend to support vulnerable witnesses. Responding to these points, two organisations (both regulatory bodies) suggested we extend this support to all witnesses.

Our response

We've made minor drafting amendments to clarify the rules and make sure they have the intended effect. We've also set out in guidance the decision-making principles that will inform decisions on impairment, appropriate restrictive action, and warnings as addressed in questions 18–20 below. We will also set out in guidance the factors that will inform our decision making on whether to hold a tribunal hearing in private.

We've already set out our response to feedback on the composition of tribunals in our response to question 13. But to reiterate, it remains our long-term position for doctors, PAs, and AAs to be eligible to serve as registrant panel members for fitness to practise tribunals in cases relating to PAs and AAs.

Fairness and transparency

In response to the feedback we received about only needing to prove our case on the balance of probabilities, it is important to clarify that this is the standard of proof that we are legally required to apply. We've no discretion in the matter. We've amended our rules to make clear that we are required to do this under the Health Act 1999.

Regarding certificates of conviction, we maintain that it is reasonable for us to treat these as conclusive evidence of the offence committed. It would not be appropriate for us to seek to go behind the proven fact of the criminal conviction.

Case managers

In response to the feedback we received about case managers, and case manager directions, we'll provide further details on the case manager role, and the practice directions that they may issue in operational guidance. We also note the feedback about the status of practice directions and whether they can be challenged. We envisage that practice directions will address common

issues applicable to most hearings, such as requirements relating to hearing bundles and documents provided to tribunals. The rules already permit tribunals to not be bound by any case management direction(s) where they decide it is in the interests of justice or there's been a material change in circumstances.

We note the feedback suggesting that we must first seek submissions from parties before issuing case management directions. However, there may be circumstances where case managers need to issue directions – for example, to direct parties to respond to queries. It would be disproportionate and inefficient to require the case manager to first seek submissions on their intention to direct parties to respond in this way.

With regard to costs, the awarding of costs is quite rare, and applies only in scenarios where the tribunal is satisfied that a party (either the associate facing allegations or us) did not comply with a rule or practice direction and behaved unreasonably in the conduct of the proceedings. A tribunal may decide to award costs in such cases, and a case manager will then assess the amount that should be paid. We'll continue to provide guidance and training to case managers to support them to accurately assess costs.

Witnesses and support

Two organisations suggested that we should either offer equivalent support to all witnesses or consider all witnesses as 'vulnerable' (thereby enabling us to put additional special measures in place, including permitting evidence to be given by telephone or video link).

It would not be appropriate to categorise all witnesses as 'vulnerable'. Some witnesses may not wish to be categorised in this way, and we must strike a balance between supporting witnesses to give clear and objective evidence and ensuring the associate's right to a fair hearing. Case managers and tribunals will be able to designate a witness as 'vulnerable' and will have guidance to help them decide whether to do so.

Representation

Some respondents questioned our ability to approve an associate's choice of representative for tribunal hearings (where the representative is not a solicitor or barrister). We currently have this power in respect of fitness to practise tribunals for doctors and it supports the efficient and effective conduct of proceedings. As we do now for doctors, we'll set out in guidance who can and can't represent a PA or AA at a tribunal hearing and the factors relevant to assessing who is a suitable individual to provide representation.

Box 12: Adjudication rules – the changes we've made

- Amended rules to clarify that the civil standard of proof is applied in associate tribunals – as required by Section 60 A(1) Health Act (rule 44).
- Made technical drafting changes to improve the clarity of rules.

Final measure reviews

Question 16: To what extent do you agree or disagree with our proposed approach to final measure reviews, as described within our rules?

What we heard

Overall responses		Responses from individuals					Responses from organisations	
			Total	Public	Doctors	PAs/AAs		
Total responses	2,541	Total responses	2,478	365	1,584	366	Total responses	63
Total comments	669	Total comments	643	104	464	25	Total comments	26
Agree	31% (790)	Agree	30% (754)	37% (134)	14% (221)	95% (347)	Agree	57% (36)
Disagree	53% (1,340)	Disagree	54% (1,328)	52% (188)	66% (1,053)	2% (6)	Disagree	19% (12)
Neither agree nor disagree or don't know	16% (411)	Neither agree nor disagree or don't know	16% (396)	12% (43)	20% (310)	4% (13)	Neither agree nor disagree or don't know	24% (15)

Of the 3,011 individuals and organisations that responded to the consultation, 2,541 (84.3%) answered this question. Of these:

- 790 (31%) agreed
- 1,340 (53%) disagreed
- 411 (16%) neither agreed nor disagreed or did not know.

Analysis of comments – final measure reviews

For those respondents who disagreed or selected don't know/neither to this question, several themes emerged. Some felt that the process for final measure reviews was not sufficiently clear, robust, or comprehensive, with a suggestion it should be more punitive. There were also calls for the rules to mandate a more frequent cycle of reviews given perceived concerns over the practice of PAs and AAs. Some felt that the 'vagueness' of the procedure could lead to inequitable or unfair decisions. And there was some support for more detailed criteria for reviewing final measures and for determining whether a change is required. A few respondents also suggested that complainants and other interested parties should have an opportunity to submit their views to the review.

For those respondents who agreed, many felt the procedure seemed fair, appropriate, and reasonable. They supported regular reviews to make sure that the measures remain relevant and proportionate, with the flexibility to change these over time as required.

Several respondents (doctors, a member of the public, and an organisation) objected to our proposal to delegate final measure reviews to case examiners. They cited concerns over the consolidation of power in a single individual, and uncertainty over whether case examiners have the necessary 'credentials' to undertake this role. Other respondents noted that there needed to be robust training for case examiners, including training focused on EDI. They also highlighted the importance of quality assuring case examiner decision making, and guidance on when reviews should be referred to a tribunal.

Drafting suggestions

A medical defence organisation made a few suggestions for improving the final measure review process, which are summarised below.

- We should confirm in guidance that the ability of associates to request an early review of their measure should not have any effect on the duration of the measure that is agreed or imposed at the outset.
- Where we seek to change an imposed measure and the PA or AA concerned does not provide a reasoned response to what we proposed, we should first consider the circumstances that might have prevented them from doing so, rather than impose any amended measure as soon as the 21-day period for accepting or rejecting the amended measure elapses. A doctor organisation made a similar point, arguing that 21 days was too short a period to respond.
- We should have the discretion to consider written representations from associates when these are provided beyond the permitted timescale.

Other comments

A doctor organisation also questioned the fairness of allowing final measures to run their course when, following review, we consider that the PA or AA is no longer impaired.

Respondents also made further drafting suggestions to make sure that a final measure review is not delayed if there is a new, but unrelated, fitness to practise concern about that associate. Within our consultation document, we suggested that this new concern be dealt with first. Our draft rules require decision makers to consider the issues raised by any new case first and then determine the action needed in relation to the new case and the review together.

Our response

We've made some minor drafting amends to clarify the rules and make sure they have the intended effect. This includes clarifying within the rules that case examiners may request we obtain further information, not already held by us, to inform their review of the measure.

With regard to the concerns expressed in feedback about the fairness, consistency, and robustness of decisions, there will be detailed guidance for decision makers on assessing whether an associate's fitness to practise is impaired, and if so, what action to take on review. There will also be appropriate training, auditing, and quality assurance.

We've retained the provision which enables decision makers to decide whether to revoke a measure or to allow it to expire in cases where they have found no impairment. This is because there are situations where a previous tribunal may have determined that a measure of a particular length was needed to promote and maintain public confidence in the profession, and it would not be appropriate for a review to override that decision. We'll provide guidance to decision makers on the exercise of this discretion.

Many of the points raised in response to question 16 mirrored those we received for question 12 on interim measures and interim measure reviews. In response to the feedback about our decision to delegate reviews of final measures to a single case examiner, we continue to hold the view that it is appropriate and more efficient to allow case examiners to review final measures 'on the papers', without needing to convene a tribunal (unless the PA or AA requests this). We currently operate a process of reviews on the papers for doctors, where reviews are done by a single decision maker, usually a legally qualified tribunal chair, with the agreement of the registrant. These decisions will be taken by a case examiner with appropriate guidance, training, audit and quality assurance of decision making. Associates will be able to request a tribunal if they wish. However, we've decided that, where a review includes consideration of a new case alongside the issues raised by the review, the outcome of the review should be decided by two case examiners.

In response to the specific drafting suggestions proposed by the medical defence organisation, we make the following comments.

- The AAPAO prevents us from imposing any measure beyond 12 months. As now, decision makers will have guidance on the appropriate restrictive action to impose, taking into account all the circumstances of the case. We consulted on the principles that will inform this guidance and our response to the feedback we received is set out below for question 19. The ability of a PA or AA to request a review of their measure is not a relevant factor when considering the length of this sanction.
- We'll set out in guidance the factors and considerations that case examiners will need to take into account when they decide whether to impose a new final measure – should the associate fail to respond to our proposal within 21 days. This will also cover when it may be more suitable to refer a case to tribunal. But we add that case examiners may permit the 21-day time limit to be extended where they consider it is fair and proportionate to do so, for example if the PA or AA cannot respond during this time because of poor health.
- We've amended the rules to clarify that case examiners can extend the timeframe for associates to make written representations on further information that we've disclosed to them during the review.

Box 13: Final measure review rules – the changes we've made

- Amended rules to clarify that a case examiner can request that we obtain further information, not already held by us, to inform their review (rule 70).
- Amended rules to clarify that case examiners can extend the time available for someone to make written representations following disclosure of further information (rule 70).
- Made technical drafting changes to improve the clarity of rules.

Single case examiner

What we proposed

The AAPAO gives powers to a case examiner to:

- determine if the fitness to practise of a PA or AA is impaired
- impose a final measure through the accepted outcomes process (see question 14).

Case examiners are senior decision makers appointed by us to carry out some functions that are set out in articles 10 and 13 of the AAPAO.

Within our consultation document, we also proposed that accepted outcome decisions should be made by a single case examiner, who is selected from a team of case examiners – with cases allocated to the next available case examiner. Within this section, we set out the feedback we received on this specific proposal, together with our response to that feedback.

Question 17: To what extent do you agree or disagree with our proposed approach for accepted outcome decisions to be made by a single case examiner, selected from a team of case examiners?

What we heard

Overall responses		**Responses from individuals**					**Responses from organisations**	
			Total	**Public**	**Doctors**	**PAs/AAs**		
Total responses	2,553	Total responses	2,490	366	1,590	368	Total responses	63
Total comments	938	Total comments	898	132	583	113	Total comments	40
Agree	26% (670)	Agree	26% (641)	34% (123)	11% (177)	82% (300)	Agree	46% (29)
Disagree	60% (1,533)	Disagree	61% (1,510)	55% (203)	74% (1,172)	10% (35)	Disagree	37% (23)
Neither agree nor disagree or don't know	14% (350)	Neither agree nor disagree or don't know	14% (339)	11% (40)	15% (241)	9% (33)	Neither agree nor disagree or don't know	17% (11)

Of the 3,011 individuals and organisations that responded to the consultation, 2,553 (85%) answered this question. Of these:

- 670 (26%) agreed with our proposed approach
- 1,533 (60%) disagreed with our proposed approach
- 350 (14%) neither agreed nor disagreed with our proposed approach, or did not know.

Analysis of comments – single case examiner

Respondents who disagreed with our proposals gave several reasons for doing so.

Consistency of decision making

Some respondents noted the challenge of maintaining consistency in decision making when relying on a single individual, and suggested there was an increased potential for bias, injustice, and error. This view was held by doctors, PAs and AAs, members of the public, and some organisations. A regulatory body asked why the potential for bias was not referenced in our Equality Impact Assessment. And a doctor organisation highlighted concerns over the potential for adverse effects on unrepresented associates in particular. As one patient organisation noted:

> *'There are obvious risks attached to only having one case examiner in terms of patient safety and achieving the right outcome. This will include issues such as the quality of the investigation, any potential bias, limitations of an individual's knowledge base and experience, potential impact of workload, and the fact that this represents a completely new cohort of FTP [fitness to practise] cases for the GMC with all the complexities around the wide range of roles these registrants will be undertaking alongside all the contextual issues that are likely to arise.' (Organisation, patient organisation)*

Related to this point, respondents (in particular doctors, PAs and AAs, and some members of the public) mentioned that decisions of such importance should be subject to collective decision making – given the variability of cases, and potential gaps in knowledge about a PA or AA's scope of practice. A doctor organisation noted that a lay and medical case examiner working in tandem were more likely to reach a balanced view.

> *'While the consultation document asserts that case examiners undergo thorough selection, training, and induction processes, it remains doubtful that a single case examiner could possess the requisite breadth of knowledge and experience to assess every case effectively. The practice of allocating cases based on case examiner availability raises concerns that relevant expertise may be overlooked if cases are not assigned to case examiners with specific knowledge and experience relevant to the case at hand.' (Patient)*

Given these factors, some respondents cautioned that the efficiency supported by a single case examiner decision-making model should not come at the expense of quality and fairness of decision making. Some respondents questioned the comparisons we had drawn with the judicial system. As one organisation set out:

'While we welcome movement to a more streamlined single decision maker model, noted in the consultation documentation as being in line with other similar investigatory processes, it will be important to ensure that every effort is made to reduce the risk of unconscious bias. The consultation documentation notes single decision makers are common in the justice system, however, 2022 research by the University of Manchester shows evidence of racial bias in the judiciary.' (Organisation, membership body)

A second case examiner

Irrespective of whether or not respondents supported our proposal, many argued that a second case examiner could be used for some types of case. These included complex cases or those based around particular protected characteristics or, in specific circumstances, where more restrictive sanctions were likely to be needed. In their response a regulatory body noted the findings of their recent consultation, in which 80% of respondents agreed that more than one case examiner may be required in some cases.

Decision maker

Respondents also commented on the recruitment of case examiners, with some (largely doctors and members of the public) noting that PAs and AAs should never be eligible to be case examiners because they should not be 'self-regulating'.

'Given MAPs are dependent workers who rely on supervision from a doctor any outcome decisions must involve review by medical doctors rather than MAPs.' (Doctor)

A smaller number of respondents felt that senior PAs and AAs could be eligible if we changed our approach and decided to use two or more case examiners.

Knowledge, skills, and training

Those respondents who agreed with our proposed approach caveated their view by highlighting the skills, knowledge, and expertise that case examiners must hold to perform their function.

Some respondents, typically PAs and AAs, referenced familiarity with PA and AA education and training (including curricula standards), professional standards, and scope of practice as a pre-requisite for eligibility. Some associates also felt that they should be eligible to serve as case examiners, provided they have at least five years' full-time-equivalent post-qualification experience.

Respondents also noted that, irrespective of the number of case examiners used, transparency of decision making through the publication of decisions, external review and audit, and training and supporting guidance was required to make sure that decision making is robust and free from error and bias.

Our response

We've carefully considered the feedback that we received on this issue. Although there was some support for a single case examiner decision-making model, this was significantly

outweighed by support for two or more case examiners – with mixed views on whether this should apply to every case or some types of case only.

We believe there are benefits and disadvantages to using both the single and two case examiner decision-making models. But having listened to the feedback, we've now changed our approach.

We'll use two case examiners for all decisions made under Article 10 of the AAPAO. This includes:

- decisions on whether fitness to practise is impaired
- decisions on the proposed outcome
- decisions to impose a warning when there is no impairment
- decisions to take no further action when there is no impairment
- decisions to impose an outcome when no response is received from the associate
- decisions to refer a case to a tribunal.

Where the two case examiners cannot agree on the decision – that is, whether the associate's fitness to practise is impaired, whether to issue a warning (if no impairment is found), the proposed final measure, or whether to grant voluntary removal – the case will be referred to a panel of three case examiners for a decision.

We've updated our rules to reflect this.

Box 14: Single case examiner proposal – the changes we've made

- Amended our rules to confirm that we'll use two case examiners for all decisions made under Article 10 of the AAPAO (which includes accepted outcome decisions).

Decision-making principles

What we proposed

As we note above, our decision-making principles will inform guidance on how we'll make decisions as part of our fitness to practise proceedings. The resulting new guidance for PAs and AAs will take effect from 13 December 2024. Updated guidance for doctors will now take effect in early 2025 following a transition period. We've pushed back the introduction of the guidance for doctors to allow sufficient time to train our staff on how to apply this (taking into account the volume of doctor cases going through our fitness to practise procedures).

Question 18: To what extent do you agree or disagree with our proposed decision-making principles for impairment guidance?

What we heard

Overall responses		**Responses from individuals**					**Responses from organisations**	
			Total	**Public**	**Doctors**	**PAs/AAs**		
Total responses	2,538	Total responses	2,475	363	1,582	368	Total responses	63
Total comments	680	Total comments	652	96	478	25	Total comments	28
Agree	31% (784)	Agree	30% (750)	35% (128)	14% (222)	94% (346)	Agree	54% (34)
Disagree	52% (1,327)	Disagree	53% (1,314)	50% (183)	66% (1,044)	1% (5)	Disagree	21% (13)
Neither agree nor disagree or don't know	17% (427)	Neither agree nor disagree or don't know	17% (411)	14% (52)	20% (316)	5% (17)	Neither agree nor disagree or don't know	25% (16)

Of the 3,011 individuals and organisations that responded to the consultation, 2,538 (84%) responded to this question. Of these:

- 784 (31%) agreed
- 1,327 (52%) disagreed
- 427 (17%) neither agreed nor disagreed or did not know.

Analysis of comments – decision-making principles for impairment

Several respondents (largely doctors, some members of the public, and other individuals) who disagreed with the draft principles suggested changes to the content.

Assessing seriousness

Within the principles, we stated that some types of behaviour or poor performance may represent such a significant departure from the professional standards expected that they indicate a high level of seriousness. These included instances where a doctor deliberately misled patients or others about their licensing status. Respondents felt that these behaviours should also include PAs and AAs who are:

- falsely claiming to be doctors
- working as equivalent to doctors in any context
- misleading anyone about their status.

One organisation noted that in assessing seriousness, we should not conflate patient risk with the extent of an individual's departure from our professional standards, noting that different specialties will be dealing with different risk profiles.

Criminal convictions, dishonesty, and public confidence

Some respondents asked for clarity on how 'seriousness' should be interpreted for different types of case. One respondent noted that a failure to declare conflicts of interest, or allowing these to affect decisions, should increase the level of seriousness. This respondent also felt that the gravity of the misconduct should be greater in cases of criminal convictions and dishonesty – where these either demonstrate impaired judgement or create a plausible risk of harm to an individual.

Some respondents suggested that we should review our guidance for doctors who are subject to custodial sentences for non-violent action relating to, for example, climate change. These respondents suggested that such behaviours should be treated as having a lower level of seriousness. One respondent went further, requesting guidance on what constitutes professionalism when acting on grounds of conscience.

Respondents asked for more clarity on how we'll assess 'public confidence' and how registrants should approach situations when the decision-making principles are in conflict with each other. As one respondent put it:

> *'The three principles underpinning decision making in this guidance can certainly conflict with each other e.g. a doctor may have to decide whether to break the law to save lives, or let people die and follow the law.' (Doctor)*

Whether our principles are set at the right level and focused on the right areas

There were mixed views on whether we've set the principles at the right level and/or focused on the right areas. Some respondents (largely doctors and members of the public) felt that our principles were not stringent enough in terms of how they will apply to PAs and AAs, were too complicated to understand, were poorly defined because of the absence of standards, or should be the same as those used for doctors. One individual noted:

> *'I feel that there needs to be a list of particular situations that may cause concern and which are unacceptable.' (Individual, other)*

Other respondents (doctors, PAs and AAs, and other individuals) felt the principles focused on the right areas. One respondent added that any assessment of impairment should also consider views from a diverse range of stakeholders to give a holistic view of the practitioner's impairment and implications. This respondent also felt that the principles should address what happens after a decision on impairment has been made – particularly for those registrants who may need to be supported through treatment or other intervention.

One organisation further asked whether the principles should also address instances of practitioners working outside of their scope of practice and under appropriate levels of supervision.

Decision making

Respondents also asked for more clarity on how we'll use the principles to make decisions in a consistent manner, as well as confirmation on who will make those decisions. Other comments focused on how we'll train decision makers to apply the principles and how unconscious bias would be mitigated in fitness to practise cases. Lastly, one respondent noted that the failure to comply with a condition should be treated as a separate complaint and should not be used as an opportunity to review the initial decision that led to that condition.

Our response

Assessing seriousness

In response to the feedback about the types of behaviour or poor performance that, as a starting point, should be treated as having a high level of seriousness, we've added to the list of examples cases where a PA or AA deliberately misled others about their registration status.

We also note the feedback suggesting that in assessing seriousness we should not conflate the magnitude of patient harm with the scale of the departure from our professional standards (noting that different specialties will be dealing with different types of risks daily). Although reference has been made to this within our decision-making principles, we've made changes to clarify this point further.

We've noted the feedback about custodial sentences and the views that our approach should be different where a registrant received a sentence for engaging in a non-violent protest, and that we should provide more detail about different types of criminal offences.

Our policy approach was developed to support us to meet out legal duty to protect the public. This means acting in a way that:

- protects, promotes, and maintains the health and wellbeing of the public
- promotes and maintains public confidence in the professions
- promotes and maintains proper professional standards and conduct.

It is not feasible for our policies and guidance to describe every scenario that may result in a fitness to practise concern. However, although the framework set out in the principles provides direction for our decision makers, it still allows for decisions to be made on a case-by-case basis –

to consider the individual circumstances. Where necessary, we'll provide training to our decision makers on how to deal with specific case types (as we currently do for cases relating to doctors) and consider if further supplementary guidance is required.

However, our current policy position is that behaviour resulting in a custodial sentence indicates a higher level of seriousness. This is due to the impact of this on public confidence in the professions, even though there may not be a current risk to patient safety. Our decision-making principles (for impairment) distinguish been criminal convictions for minor offences dealt with by way of a fine or discharge, and those that result in a custodial sentence or other action. Accordingly, they can then be treated as indicating different levels of seriousness.

We plan to separately review our approach to assessing public confidence and will give an update on this in 2025.

Decision making

Regarding the feedback about our approach to decision making more broadly, our suite of fitness to practise guidance will explain the different decision makers involved at each stage of the fitness to practise process. We'll also provide training to our decision makers to explain how they should assess impairment, which, as described in the principles, is based on considering whether a doctor, PA, or AA poses any current and ongoing risk to public protection. As well as considering seriousness, this includes considering any relevant context and how the doctor, PA, or AA has responded to the concern.

We've reviewed the section on relevant context to clarify the impact it has on the assessment of current and ongoing risk. We've made it clear that where external system or interpersonal factors have had an impact on a doctor, PA, or AA's behaviour, performance, or health, and those factors have since been addressed or mitigated, the risk they currently pose to public protection is likely to decrease, especially if the working environment, support, and/or level of supervision have since improved.

We've updated wording used in our list of behaviours or poor performance that indicate a low or high level of seriousness – to reflect changes made in our existing *Guidance for decision makers when violence and dishonesty may represent a lower risk to public protection (2024).*

Additional comments

We've also made various additional changes to our principles.

- We've updated our description of 'undermining collaborative working' to remove references to 'good faith'. This is because Part IVA of the Employment Rights Act 1996, which gives effect to the protections of the Public Interest Disclosure Act, now requires disclosures to be made 'in the public interest' rather than in 'good faith'.
- We've added text to explain that if a doctor, PA, or AA in a leadership role exhibits behaviour or poor performance that negatively affects others in the working environment, or could reasonably have affected others, it will typically increase the risk to public protection. Stepping down from the role will not reduce this risk unless the issue was tied solely to their leadership duties.

- We've further clarified our approach to assessing how the doctor, PA, or AA has responded to the concern, noting that evidence of insight and remediation will inform our assessment of risk at all stages of the fitness to practise process.
- We've added text to explain the relevance of a doctor, PA, or AA keeping their knowledge and skills up to date.

Box 15: Decision-making principles (impairment) – the changes we've made

- Added in a section to confirm that some issues do not fall within the spectrum of seriousness of matters that could give rise to a question of impairment, which is based on us assessing if there is any current and ongoing risk to public protection.
- Expanded the list of behaviours that indicate a high level of seriousness to include cases where a PA or AA has deliberately misled patients or others about their registration status.
- Made drafting changes throughout to clarify or expand some aspects of the decision-making principles.

Question 19: To what extent do you agree or disagree with our proposed decision-making principles for guidance on what restrictive action is required?

What we heard

Overall responses		Responses from individuals					Responses from organisations	
			Total	Public	Doctors	PAs/AAs		
Total responses	2,532	Total responses	2,469	365	1,576	365	Total responses	63
Total comments	662	Total comments	636	97	465	23	Total comments	26
Agree	31% (789)	Agree	30% (753)	37% (134)	14% (218)	94% (344)	Agree	57% (36)
Disagree	53% (1,334)	Disagree	54% (1,325)	51% (185)	67% (1,056)	1% (5)	Disagree	14% (9)
Neither agree nor disagree or don't know	16% (409)	Neither agree nor disagree or don't know	16% (391)	13% (46)	19% (302)	4% (16)	Neither agree nor disagree or don't know	29% (18)

Of the 3,011 individuals and organisations that responded to the consultation, 2,532 (84%) responded to this question. Of these:

- 789 (31%) agreed
- 1,334 (53%) disagreed
- 409 (16%) neither agreed nor disagreed or did not know.

Analysis of comments – decision-making principles for restrictive action

There were mixed views on the clarity and fairness of our proposed principles. Although some respondents (doctors, PAs and AAs, other individuals, and some organisations) felt the process was clear, robust, fair, and proportionate, other respondents (largely doctors, members of the public, and other individuals) took a different view.

Some of those who objected to our proposals felt that there was a risk that the principles could create further ambiguity about the role and status of PAs and AAs, given that our principles do not recognise the fundamental differences in training and qualifications between the different professions. Others focused more on the suitability of restrictive action for associates. Views on the restrictive action varied, from the need for this to be punitive, to scepticism over the effect of regulatory action:

'Furthermore, there are doubts about the effectiveness and appropriateness of applying restrictive actions to individuals in these roles. Given their limited training and expertise, critics argue that PAs and AAs may not possess the necessary skills to safely and effectively perform certain tasks or procedures. Implementing restrictive actions without addressing the underlying issues surrounding the existence of these roles may result in inadequate care for patients and compromise patient safety.' (Doctor)

Some respondents (largely doctors and members of the public) requested clarity on whether any decision to take regulatory action against a PA or AA would have any implications for their supervising doctor. These respondents were clear that there shouldn't be any repercussions for the supervising doctor. Additional calls for clarity focused on how decisions are made and evaluated. One respondent suggested that we should include scenarios with examples of appropriate regulatory action within the guidance.

A few respondents, although supporting our proposals, argued that 'removal from the register' should never be used as a restrictive action where the concern stems from the health of the registrant:

'Although removal due to a health condition is feasible under the AAPA Order, there should be robust procedures in place to ensure that this power is not used inappropriately given it is a marked departure from the current legal framework. Some health conditions can take a long time to get better or overcome (years in some cases), and it would seem unfair to remove a registrant if they are still engaged with treatment in the hope of getting better. Suspension or conditions (if feasible) would be far more proportionate.' (Doctor)

Drafting suggestions and points of clarification

Respondents made several drafting suggestions. Some of these focused on redrafting the guidance to additionally cover interim measures, or to change points of emphasis. For example, they suggested we clarify that restrictive action may not be required following a finding of impairment – given that a tribunal may choose not to take further action. Respondents felt that our decision-making principles are drafted to imply that some form of action will always follow.

We've summarised further drafting changes that respondents proposed below.

- We should include references to relevant case law to support our views on what is likely to be appropriate regulatory action in some circumstances. However, a respondent noted that the principles should emphasise 'the importance of individual case assessments to ensure that decisions are tailored to specific circumstances rather than solely relying on precedents' (Doctor).
- We should clarify that we do not need to verify testimonials if these are already verified by the individual's legal representative.
- We should clarify that any time already spent under an interim order may be taken into account when deciding upon an appropriate final measure.
- The final measure imposed must be proportionate to the PA or AA's actions and should prioritise patient safety.

- We should set out how the views of the complainant or patient will be considered when deciding what restrictive action is needed.
- Alongside imposing restrictive action, we should include supportive measures, such as recommendations for professional development or remedial training – to help the doctor, PA, or AA address gaps in practice, enhance rehabilitation prospects, and promote patient safety.

Our response

Several respondents requested further clarity on how our decision-making principles for restrictive action compare with our existing *Sanctions guidance* for doctors. The content of the principles to inform guidance on restrictive action is different from the current *Sanctions guidance* in the following ways.

- Some content that appears in the *Sanctions guidance* sits within the principles to inform impairment guidance instead of the principles to inform guidance on what restrictive action is required, such as information about insight and remediation. This is because this type of evidence is directly relevant to deciding whether a doctor, PA, or AA poses any current and ongoing risk to public protection – and so should first be considered at that stage of decision making. The decision maker's view on current and ongoing risk then informs our regulatory response to close a case with no action, issue a warning, or impose restrictive action. We don't currently have separate impairment guidance for doctors but will introduce this as part of implementing the principles into guidance.
- We've changed the structure to more clearly set out the key considerations that will inform decisions on which type of restrictive action is required.
- For some types of case, including sexual misconduct, dishonesty, violent or abusive behaviour, discrimination, clinical cases, and health, we've provided further details on when a particular form of restrictive action is likely to be necessary.

Interim measures/orders

Respondents queried how we'll take into account existing interim measures/orders when making decisions on restrictive action.

We've expanded our original text on this issue to reflect the current Medical Practitioners Tribunal Service (MPTS) guidance *Taking interim orders into account* more closely. We've clarified that interim measures/orders differ from substantive sanctions because they are not conclusive findings and follow a separate test. We've added that where a decision maker might be considering imposing restrictive action of suspension on a doctor, PA, or AA's registration:

> *'time spent under an interim order/measure of suspension may be relevant when determining the proportionate period of suspension purely on the grounds of public confidence. In many of these cases, given the different purposes of interim and substantive measures/orders, a previous interim measure/order of suspension is unlikely to have a significant impact. Nevertheless, it must still be considered.'*

We've also amended the decision-making principles to confirm that if there's an interim measure/order in effect at the point restrictive action is being put in place, it should usually be revoked. The exception is where the interim measure/order relates to other concerns that have not yet been fully investigated or adjudicated.

We can also confirm that the decision-making principles do not apply to decisions to impose an interim measure/order. We will produce separate guidance to support decision making on interim measures for PAs and AAs and already have guidance on interim orders for doctors.

Supervision

Respondents asked questions about the effect of a concern being raised about a PA or AA's behaviour or performance on their supervising doctor. A concern being raised about a PA or AA will not automatically lead to a concern about their supervising doctor's behaviour or performance. As with other professionals that doctors currently supervise and work alongside in multidisciplinary teams, doctors are not accountable for their actions or decisions, provided doctors have delegated responsibility to them in line with our professional standards *Delegation and referral* and any other relevant detailed guidance. However, if we do receive information about the behaviour or performance of a PA or AA's supervising doctor, we are legally required to consider if the information raises a question about their fitness to practise.

Health conditions

Some respondents asked how the decision-making principles for restrictive action would deal with cases relating to a registrant's health.

Our explanatory publication *What we mean by fitness to practise* and the principles to inform impairment guidance included in the consultation explain that having a health condition does not, in or of itself, mean that a doctor, PA, or AA will pose any current and ongoing risk to public protection. However, there could be a risk to patients where the health condition has an effect on the doctor, PA, or AA's ability to practise safely. Where this is the case and a doctor, PA, or AA's fitness to practise is impaired, the principles to inform restrictive action will apply. The principles consulted on included a specific case type section for health. We stated that removal from the register will not usually be appropriate where the sole concern relates to the effect of a PA or AA's health condition. Under the legal framework for doctors, where the current and ongoing risk to public protection relates solely to the effect of a health condition, erasure from the medical register is not an option.

Once we've implemented into guidance the principles we consulted on, we'll produce additional guidance for deciding what approach to take when restrictive action is reviewed. This will include further direction on the approach to take in health cases.

Additional comments

Respondents critiqued that we constructed the principles with the presumption that some form of restrictive action will always be needed when there is conclusion that a doctor, PA, or AA poses a current and ongoing risk to public protection.

In the principles we consulted on, we referred to how under both legal frameworks (the *Medical Act* and AAPAO), the ability to take no action lies exclusively with MPTS tribunals. Where case examiners have found a PA or AA to be impaired, the AAPAO does not permit them to take no action. However, we'll consider how to fairly present the possibility of an MPTS tribunal taking no action when the principles are implemented into decision-making guidance.

Regarding other drafting suggestions proposed we've done the following.

- We've updated the text to enable verification of testimonials to be undertaken by the doctor, PA, or AA's legal representative – which reflects our current approach for doctors. We've also expanded the examples of reasons why an adverse inference should not be drawn from the absence of a testimonial/reference to include where the doctor, PA, or AA recently changed employer or is working on a locum basis.
- We've added clarification that where a doctor, PA, or AA has evidence to show that a specific condition is not workable, and alternative conditions can be identified that adequately address the current and ongoing risk to public protection posed by the doctor, PA, or AA, consideration can be given to putting those in place instead. However, where alternative conditions are not appropriate or proportionate, the conditions considered necessary to protect the public in a timely way should be imposed.
- We've removed reference to individuals being entitled to practise 'medicine' to reflect the different practising entitlements between doctors, PAs, and AAs.

Box 16: Decision-making principles (restrictive action) – the changes we've made

- Explained in more detail the relevant considerations where a doctor, PA, or AA provides evidence that a specific condition is unworkable.
- Amended our decision-making principles to clarify how interim measures/orders affect our decisions on what restrictive action is required.
- Drafted changes throughout to clarify and expand some aspects of our decision-making principles.

Question 20: To what extent do you agree or disagree with our proposed decision-making principles for guidance on warnings?

What we heard

Overall responses		Responses from individuals					Responses from organisations	
			Total	Public	Doctors	PAs/AAs		
Total responses	2,515	Total responses	2,451	360	1,562	367	Total responses	64
Total comments	640	Total comments	612	94	444	24	Total comments	28
Agree	32% (806)	Agree	31% (769)	37% (132)	14% (225)	96% (352)	Agree	58% (37)
Disagree	52% (1,301)	Disagree	53% (1,292)	50% (181)	66% (1,028)	2% (6)	Disagree	14% (9)
Neither agree nor disagree or don't know	16% (408)	Neither agree nor disagree or don't know	16% (390)	13% (47)	20% (309)	2% (9)	Neither agree nor disagree or don't know	28% (18)

Of the 3,011 individuals and organisations that responded to the consultation, 2,515 (83.5%) responded to this question. Of these:

- 806 (32%) agreed
- 1,301 (52%) disagreed
- 408 (16%) neither agreed nor disagreed or did not know.

Analysis of comments – decision-making principles for warnings

Of those who answered disagree or neither to this question, some respondents felt that the principles were not clear enough and lacked detail. Some respondents also felt that the principles were open to interpretation – and their lack of specificity could affect the consistency with which they are applied, and lead to biased decision making.

Some respondents felt that more detailed guidelines were required to mitigate this, particularly when dealing with warnings in clinical cases and for those cases where there's no finding of impairment. As one respondent noted:

> *'Could give more examples of scenarios and what would constitute a verbal warning vs written warning and implications of these.' (Organisation, higher education Institution)*

Some respondents (largely doctors and members of the public) felt that the principles should be more punitive or stringent for PAs and AAs. Conversely, other respondents across nearly all categories felt that the principles were appropriate, reasonable, and fair.

Other respondents expressed contrasting views about when a warning should or shouldn't be considered. Some felt they should be used only when there's a clear risk to patient safety, rather than for 'minor infractions unrelated to patient care' (Doctor). Others felt that these should also be used to uphold public trust.

A few respondents felt that warnings should never be considered a sufficient regulatory outcome for a PA or AA who works outside of their defined scope of practice. A doctor went further by suggesting that a warning may be suitable for supervising doctors who repeatedly pressure or permit associates to act beyond their agreed scope of practice.

A regulatory body asked whether a warning would be appropriate in cases where concerns stemmed from ill health.

Additional suggestions included that we:

- clarify and specify within the guidance which of the two grounds for action the warning relates to (misconduct or inability to provide care to a sufficient standard)
- consider opportunities for seeking representations from complainants on whether to issue a warning.

A medical defence organisation queried how far we would take into account warnings that had been issued previously for similar conduct:

> *'a proportionate approach should, in our view, take account of the age of the warning and whether there have been any other similar incidents until the issue at hand; that an associate was given a warning in the past should not in and of itself mean that a subsequent case cannot be concluded with a warning'. (Organisation, medical defence organisation)*

Several respondents suggested that we monitor and quality assure our use of the principles to make sure these are used consistently and appropriately. A few respondents also suggested that we give additional, targeted follow-up support for registrants who have received a warning, and identify further training to reduce the risk of similar concerns arising again.

Our response

When a warning should be imposed

Some respondents argued that our decision-making principles to inform guidance on warnings needed greater clarity and specificity to leave less room for interpretation.

There is, inevitably, a balance that needs to be struck between producing guidance which allows each case to be considered on the basis of its individual circumstances, and guidance that is too specific and prescriptive, such that it risks restricting decision making. However, the principles are clear that a warning should only be considered in cases where a doctor, PA, or AA falls just short of posing a current and ongoing risk to public protection. Our decision-making principles on impairment provide a framework for assessing this risk, and that assessment will determine if a warning is an appropriate regulatory response.

Some respondents wanted our decision-making principles to be more punitive. However, the purpose of regulatory action is not to punish a doctor, PA, or AA but to protect the public (through protecting and promoting patient safety, maintaining public confidence, or upholding professional standards). Any action we take to achieve this aim must be fair and proportionate. Warnings are not used to respond to a current and ongoing risk to patient safety. Instead, they are appropriate when regulatory action is needed to maintain public confidence or to uphold professional standards, and to highlight that some behaviour or poor performance is not acceptable and should not be repeated. We've amended our decision-making principles to make this clearer.

Where there is a conclusion that a doctor, PA, or AA poses a current and ongoing risk to public protection – ie their fitness to practise is impaired – restrictive action in the form of conditions, suspension, or removal/erasure from the register will usually be imposed. The legal framework for doctors, PAs, and AAs does not permit us to impose warnings where we found a person to be impaired. Therefore, warnings cannot be linked to an individual 'ground for action' or 'head of impairment' as suggested.[*]

Some respondents felt that a warning would not be appropriate where a PA or AA was found to have impersonated a doctor. We've amended our decision-making principles to make it clear that such behaviour has a high level of seriousness and so carries an associated high level of risk to public protection as a starting point. This means that evidence of relevant context or insight and remediation (that typically decreases risk) will carry less weight in our assessment of whether the PA or AA poses any current and ongoing risk to public protection. As a result, there is more likely to be a finding of impairment. And consequently, a higher likelihood of some form of restrictive action against the PA or AA – such as conditions, suspension, or removal from the register. However, every case must be assessed based on its individual circumstances.

Fitness to practise history

As part of our assessment of whether a doctor, PA, or AA poses any current and ongoing risk to public protection, we can take into account any relevant fitness to practise history – which includes previous warnings that have been issued. If the concern raised is similar in nature to the concern that previously resulted in a warning, that will usually increase the seriousness of the current concern and our view on current and ongoing risk. This means that the doctor, PA, or AA may be more likely to be found impaired and so a further warning is not an appropriate regulatory response.

Additional comments

Patient and complainant views are important. They are gathered during the initial assessment/investigation stage of the fitness to practise process and inform our assessment of whether the doctor, PA, or AA poses any current and ongoing risk to public protection. We do not separately seek patient (or registrant) views on whether a warning should be issued where the

[*] Heads of impairment for doctors are equivalent to the grounds for action for associates. There are six heads of impairment for doctors, and at least one of these must be met for us to investigate a doctor's fitness to practise.

doctor, PA, or AA's fitness to practise is not impaired, or on the type of restrictive action that should be taken following a finding of impairment. This is because our legal role is to protect the public rather than to provide recourse to any individual.

In terms of support for registrants, we already have information available to doctors who are subject to our fitness to practise processes. We'll be signposting to the support that's available to PAs and AAs too on our website. This will be modelled on the resources that we currently produce for doctors.

Regarding the other drafting suggestions proposed, we've clarified in the 'specific case types' section the circumstances in which a warning will often be appropriate, including for clinical concerns.

Box 17: Decision-making principles (warnings) – the changes we've made

- Amended our principles to confirm that warnings will typically be issued in cases where regulatory action is needed to maintain public confidence or to uphold professional standards, and to highlight that some behaviour or poor performance is not acceptable and should not be repeated.
- Made drafting changes throughout to clarify some aspects of our decision-making principles.

Changing and challenging our decisions

What we proposed

The AAPAO introduces a new framework for challenging or changing some specified decisions in relation to registration, re-entry, removal, and fitness to practise. There are two procedures under which this can happen.

- The first is where we can swiftly correct a decision when we agree it was wrong or where the circumstances have materially changed since it was made (revisions). Within our rules, we set out our proposals for how we intend to operate a revisions process. This included setting out which decisions can be revised, who can request a revision, and how decisions will be revised.
- The second is where an individual can appeal decisions that we've made on the basis that they're wrong or unjust (appeals). The AAPAO defines which decisions can be appealed, who can lodge an appeal, and who they can be appealed to (ie to an internal GMC panel or directly to the courts). Within our rules, we proposed an approach for establishing and running an internal appeals function. We also included a power to revise a decision without needing to hold an appeal – to resolve contested decisions or correct errors more swiftly.

We consulted on our rules for revising and appealing decisions that we make.

Question 21: To what extent do you agree or disagree with our proposed approach to revisions, as described within our rules?

What we heard

Overall responses		**Responses from individuals**					**Responses from organisations**	
			Total	**Public**	**Doctors**	**PAs/AAs**		
Total responses	2,415	Total responses	2,355	351	1,490	362	Total responses	60
Total comments	706	Total comments	681	95	511	23	Total comments	25
Agree	31% (752)	Agree	30% (717)	36% (128)	13% (193)	96% (346)	Agree	58% (35)
Disagree	54% (1,315)	Disagree	55% (1,305)	(49%) (172)	71% (1,052)	2% (7)	Disagree	17% (10)
Neither agree nor disagree or don't know	14% (348)	Neither agree nor disagree or don't know	14% (333)	(15%) (51)	16% (245)	2% (9)	Neither agree nor disagree or don't know	25% (15)

Of the 3,011 individuals and organisations that responded to the consultation, 2,415 (80%) responded to this question. Of these:

- 752 (31%) agreed with our proposed approach
- 1,315 (54%) disagreed with our proposed approach
- 348 (14%) neither agreed nor disagreed with our proposed approach or did not know.

Analysis of comments – revisions

Across all responses to the question, one of the most common issues identified by respondents focused on how revisions would be determined. And specifically, who would make the final decision – several respondents argued for doctors to be involved in the decision-making process.

From those who commented specifically on the wording of the rules, several themes emerged.

Clarity of rules

There were mixed views over the clarity of the rules – although a minority of doctors and members of the public felt the rules weren't sufficiently clear, this was balanced by others (mainly organisations) who felt they were both clear and proportionate. Some respondents also called for greater clarity on how the process would operate.

Further comments focused on both the terminology that we used within the rules – with requests for further explanation of what particular terms mean – and drafting changes to improve their clarity and effectiveness. For example, a doctor organisation queried our definition of 'eligible person' for rule 2 – those that are entitled to request a revision – noting that:

> *'as currently drafted, "eligible person" is so broad in scope that it creates an obligation on the regulator to review a decision at the request of a broad range of people [which] needs to be considered when looking at the length of time when something can be revised'. (Organisation, doctor organisation)*

Time limits

Some respondents commented on our proposed time limits for considering a revision. We proposed that these should be either three or 12 months, depending on the decision. Several respondents noted that the revision process needs to be swifter to support more timely decision making. Whereas others felt that the time limits for some specified decisions, particularly for revising case examiner decisions, were too short:

> *'Timelines for decision revision requests should follow current rules which allow 2 years. Reducing this to 3 months, in the case of case examiner decisions could limit the likelihood of reaching a fair outcome.' (Organisation, doctor organisation)*

Other respondents adopted a compromise, suggesting that the rules should give the flexibility to extend these time limits where necessary. It should be noted that the rules already provide us with the ability to extend these where we consider it to be in the public interest to do so.

List of revisable decisions

Some respondents (including doctors, members of the public, other individuals, and several organisations) focused on our proposed list of revisable decisions, arguing that a wider range of decisions should be revisable. For example, a regulatory body said that education decisions should also be revisable. They also queried why the following decisions were revisable:

- decisions to grant registration given we have the powers to remove an individual where registration was granted in error
- any decision that a PA or AA can both request a revision for and appeal to our internal appeal panel. It was queried why an associate would want to request a revision if they can appeal that same decision.

Some respondents suggested that some decisions should be revisable on both grounds set out in our rules (where there's been an error of fact or law and a material change of circumstances) or that additional grounds should be considered because the existing ones were too narrow. It should be noted that the AAPAO defines the grounds that each decision can be revised under.

Additional comments

We also received a small number of responses about the transparency of the process. Several respondents commented on the need to make sure that all decisions made as part of the revision process (including decisions not to revise) are published with an accompanying rationale for why the decision was made. A regulatory body emphasised the importance of giving rationales for any decision that we choose to revise on our own initiative.

Two additional themes emerged from respondents' comments. They:

- suggested that we review our approach to notifications – with comments focusing on how we notify individuals of our revision process and decisions made through this process, who we notify of decisions, and when that notification should take place
- disagreed over our proposed approach to charging fees for revising and appealing decisions covered by the registration rules.

We've grouped our response to this question with our response to question 22 on appeals.

Question 22: To what extent do you agree or disagree with our proposed approach to internal appeals as described within our rules?

What we heard

Overall responses		Responses from individuals					Responses from organisations	
			Total	Public	Doctors	PAs/AAs		
Total responses	2,386	Total responses	2,326	344	1,468	360	Total responses	60
Total comments	666	Total comments	639	94	468	22	Total comments	27
Agree	31% (745)	Agree	31% (711)	37% (126)	13% (193)	96% (345)	Agree	57% (34)
Disagree	54% (1,294)	Disagree	55% (1,282)	51% (174)	70% (1,024)	1% (5)	Disagree	20% (12)
Neither agree nor disagree or don't know	15% (347)	Neither agree nor disagree or don't know	14% (333)	13% (44)	17% (251)	3% (10)	Neither agree nor disagree or don't know	23% (14)

Of the 3,011 individuals and organisations that responded to the consultation, 2,386 (79%) responded to this question. Of these:

- 745 (31%) agreed with our proposed approach
- 1,294 (54%) disagreed with our proposed approach
- 347 (15%) neither agreed nor disagreed with our proposed approach or did not know.

Analysis of comments – appeals

The most common reason that respondents gave for disagreeing or answering 'neither' to this question related to the composition of appeal panels. This view was held largely by doctors, together with several members of the public and other individuals. Most of these felt that appeal panels should always include at least one doctor – as one individual noted:

> *'It is entirely inappropriate for the proposal to not explicitly include a provision that a medical doctor must be part of any appeal panel/tribunal to ensure appropriate fitness to practise standard setting for PAs/AAs within their scope and roles as supervised dependent practitioners working under the supervision of doctors.' (Medical student)*

The next most common theme to emerge focused in general terms on the fairness of the appeal process. Some respondents commented on the subjectivity of an internal process and expressed concern over the perceived lack of separation between the original decision maker and the decision maker(s) assessing the appeal. It should be noted that the AAPAO permits individuals to appeal to the courts if they do not agree with the outcome of their internal appeal.

The focus of the appeal

Of those respondents who focused on the wording and detail of the rules, several themes emerged.

Some respondents expressed concern over our proposal to focus internal appeals on reviewing the appealed decision, to assess whether it was wrong or unjust, rather than rehearing the case, which would involve reconsidering all the facts to reach a new decision. Respondents argued that this would narrow the scope of an appeal and would limit the likelihood of its success. One respondent went further, suggesting that a review would prevent new evidence from being admitted.

There were mixed views over our proposal to narrow the scope of what can be appealed. Although some individuals and organisations felt that the scope of an appeal should be limited – either in particular defined circumstances or to prevent inappropriate appeals from continuing – others took a different view.

> *'There should be no exceptions to the right of appeal to the registrant at all stages. This is an essential component of a just regulatory system.' (Organisation, doctor organisation)*

Transparency, independence, and support for individuals

Respondents also gave mixed views over the transparency of the process. With several members of the public and 'other' individuals calling for all appeals to be held in public to build confidence in the process. In contrast, a doctor organisation argued that the rules do not sufficiently recognise the need for privacy where appeals focus on the health of the appellant.

Commenting on issues of fairness, some respondents questioned our proposal to charge a fee for registration appeals and our proposal for individuals to seek permission for their appeal to be heard. It should be noted that the requirement to seek permission to appeal is set out within the AAPAO.

One individual made a link between this and the independence of the process, noting:

> *'in the interests of self preservation the regulator will more often than not either refuse the appeal or construct a process that will satisfy there being an appeals process while not giving that process appropriate independence of power to be meaningful'. (Individual, other).*

Respondents also queried how we would support individuals who are engaging with the appeals process. A regulatory body argued that the supportive measures we proposed for vulnerable witnesses should apply to all types of witness so that all can provide 'their best evidence'.

Clarity of approach

As with the revision rules, there were mixed views over the clarity of our proposed approach.

Some respondents felt that the rules gave insufficient detail or that the process appeared to be too lenient. Some of these went further, linking this to a general point about our processes failing to distinguish between doctors, PAs, and AAs. Others commented more on our use of specific terminology, and on how we would implement the process. For example:

- a medical defence organisation queried what we mean by a 'real prospect of success'
- a doctor organisation said that appellants should not be required to give all supporting information, including details of their witnesses, at the outset, but should be able to give this at a later point in the process, where appropriate
- another doctor organisation said that appellants, who may choose to be represented by a third party, should not be required to seek approval from us for their choice of representative
- an individual doctor queried how we would control for variability in our decision making.

Those who supported the process commented favourably on the clarity of our proposed approach. A trade union body welcomed our ability to revise decisions without needing to undertake the entire appeal process.

Public research findings

The full research report is included in **Annex C**.

Research participants were provided information on our proposed approach to revising and appealing decisions. A case study was also shared with participants to illustrate how the revisions process would operate. The case study focused on a hypothetical scenario whereby a complaint was reported to us and we, following investigation, decided that the test for onward referral had not been met. The complainant then decided to challenge our decision by requesting a revision.

The research noted, in summary, that the revisions process appeared to be 'sensible, fair and suitable for all roles'. However, further consideration highlighted concerns about the impartiality of decision makers, with the suggestion that we would favour the interests of registrants over those of patients, and some distrust over our ability to 'judge [our] own decision making'.

With regard to appeals, although supporting the concept of internal appeals, the research identified mixed views over the introduction of the permission stage, and noted similar concerns over the impartiality of the internal appeal process – with queries raised over who would adjudicate the appeal, and how far removed they would be from the original decision maker.

Our response

Revisions and appeals

Decision making

The consultation feedback for both questions 21 and 22 focused on who would make revision and appeal decisions.

The AAPAO gives us the power to revise decisions. Revision decisions will be made by decision makers who are independent of the original decision maker and have the appropriate skills and training.

For appeals, the AAPAO requires us to establish panels to determine each appeal. Although the AAPAO provides us with some discretion as to the composition of these panels, it remains our long-term position for doctors, PAs, and AAs to be eligible to serve as registrant appeal panel members in cases relating to PAs and AAs. We do not agree that a doctor must sit on every internal appeal involving PAs or AAs, or that PAs and AAs should be excluded from involvement in the regulation of their own professions by denying them a role in internal appeal panels. We believe that it should be possible for PAs and AAs to serve as internal appeal panel members for those cases focusing on the practice of an individual PA or AA.

However, it is important to emphasise that the *Medical Act* prevents PAs and AAs from serving as registrant members on internal appeal panels for doctors. Further, in the period immediately after regulation begins, it is likely that we won't have enough registered and appropriately experienced PAs and AAs to populate PA and AA internal appeal panels. Therefore, we expect that for practical, operational reasons, internal appeal panels for PAs and AAs will predominantly include doctors for some time.

Charging for revisions and appeals

The AAPAO prohibits us from charging additional fees for fitness to practise proceedings (which includes internal appeals for fitness to practise decisions). We only propose to charge a fee for revising or appealing decisions relating to registration and removal of entries outside of fitness to practise proceedings. We will refund appeal fees where the appeal is upheld.

Clarity of process

The consultation feedback identified areas where respondents sought additional clarity on both the revisions and appeals process – which we believe are better set out in guidance or information on our website, rather than rules. Examples of these include providing further detail on:

- how the revision process will operate, and when we'll seek representations from the person to whom the decision relates
- when we'll permit revisions outside of the timescales set out in the rules
- how the appeals process will work
- the scope of an appeal
- what constitutes 'a real prospect of success'
- information for appellants and the support we'll provide to witnesses for individual appeals.

Revisions – general

We agree that amendments to the rules would help to improve their clarity and help PAs and AAs understand how our processes will operate.

We agree that it is disproportionate and potentially confusing to establish multiple, overlapping processes for PAs or AAs to challenge decisions, and believe that there should be a single process for challenging decisions. We've removed the additional route for PAs or AAs to request a revision of a decision outside of an internal appeal process.

We've also reflected this change within our definition of 'eligible person', which we agree is too broad as currently drafted. We've amended this to 'a person who, in the opinion of the Regulator, has sufficient interest in the decision, other than the person to whom the decision relates'.

We've also excluded decisions to grant registration from the list of revisable decisions on the basis that if registration was fraudulently obtained or granted in error, their entry can be removed from the register through our removal processes.

However, as per our consultation proposals, it will continue to be the case that education decisions are not revisable. This is because the approval process will give education providers multiple opportunities to submit evidence and make representations before we make a final decision.

We agree that it is important to explain why we've revised a decision. We will notify the person who the decision relates to of the revised decision and the reasons for this. And when an eligible person requests a revision, and we determine that the decision should not be revised, we'll explain the reasons for our decision. We will set out our approach to publishing revised decisions in our publication and disclosure policies.

We note the feedback suggesting that timescales for revising some decisions should be extended beyond those set out in our rules. However, in setting the timescales for different types of decisions, we've sought to balance fairness to the PA or AA through:

- minimising the period in which further action might be taken against them
- providing enough time for errors in the original decision to come to light, or for circumstances to change. The rules permit us to extend the time limits in exceptional circumstances and we'll provide further detail on these in guidance.

For decisions about registration and re-entry, we've also set the timescale to take into account the period of validity for evidence provided as part of the original registration application.

Appeals – general

We've amended the rules to clarify that an appellant should only have to provide details of their witnesses as part of their notice of appeal if they are known at this stage. The rules already permit further documentary evidence to be provided at a later stage, and this will enable appellants to provide details of witnesses at a later point too.

In response to the comments around the independence of the internal appeal process, externally appointed individuals (both lay and registrant) will make up our internal appeal panels. The decision over whether to grant permission for the appeal to proceed will be made by decision makers who are independent of the original decision maker and have the appropriate skills and training.

We continue to hold the view that an appeal should be a review of the decision appealed and believe that this provides a proportionate mechanism for responding to an appeal. Where the appellant disagrees with our internal appeal decision, they may appeal this to the courts, provided the AAPAO permits this. A review will not prevent new evidence from being heard. New evidence can be provided where it supports why the decision was wrong or unjust, and where

the internal appeal panel considers the evidence to be relevant to the issues in the appeal, and it is fair to admit it.

We note the suggestion that we should not be able to approve an appellant's choice of representative (where the representative is not a solicitor or barrister). However, retaining this flexibility is important to support efficient and effective internal appeal panel hearings and processes. We currently have this power in respect to fitness to practise tribunals for doctors, and as we already do for them, we'll set out in guidance who can and can't represent a PA or AA at an appeal hearing.

Box 18: Revisions and appeals rules – the changes we've made

- Clarified our definition of eligible person in our revision rules (rule 2) to make clear that it is a person with a sufficient interest in the decision and to exclude the PA or AA from being able to request a revision.
- Excluded decisions to grant registration from the list of decisions that can be revised (rule 4).
- Changed our appeals rules to clarify that appellants can provide details of witnesses at a later stage of the appeal and not just as part of their notice of appeal (rule 3).
- Made technical drafting changes to improve the clarity of rules.

Fees

What we proposed

Once regulation comes into force, our role will be to develop a framework for setting and charging fees for the delivery of our functions. This will include our approach to adjustments, refunds, and exceptions to charging where appropriate.

We consulted on draft fees rules for PAs and AAs. They set out:

- in what circumstances the GMC can charge a fee
- overarching principles for setting the fee amount
- payment of fees, including when a PA, AA, or applicant must pay a fee and when the GMC must notify a PA or AA of the amount of the fee due
- the ability for the GMC to adjust, refund, waive, or suspend a fee payment
- consequences of failure to pay a fee.

We did not consult on a proposed fee value, as there is no requirement within the AAPAO to include the fee levels within the rules. We published indicative fee levels separately on 21 November 2024 and a full schedule of fees will be confirmed 13 December 2024. We did, however, highlight that the principles contained within the rules will underpin the fee structure.

We also noted that we anticipate the fee income generated by PAs and AAs will not initially cover the cost of regulation, and so we entered into a funding agreement with the DHSC that fully funds the costs of bringing PAs and AAs into regulation. This also provides transitional funding to support our fee income while the number of PA and AA registrants remains low.

Question 23: To what extent do you agree or disagree with our proposed approach to setting and charging fees, as described within our rules?

What we heard

Overall responses		Responses from individuals					Responses from organisations	
			Total	Public	Doctors	PAs/AAs		
Total responses	2,692	Total responses	2,627	376	1,700	370	Total responses	65
Total comments	1,466	Total comments	1,425	163	1,036	115	Total comments	41
Agree	18% (485)	Agree	17% (456)	9% (34)	12% (202)	50% (185)	Agree	45% (29)
Disagree	60% (1,615)	Disagree	61% (1,603)	53% (199)	76% (1,291)	3% (10)	Disagree	18% (12)
Neither agree nor disagree or don't know	22% (592)	Neither agree nor disagree or don't know	22% (568)	38% (143)	12% (207)	47% (175)	Neither agree nor disagree or don't know	37% (24)

Of the 3,011 individuals and organisations that responded to the consultation, 2,692 (89%) responded to this question. Of these:

- 485 (18%) agreed
- 1,615 (60%) disagreed
- 592 (22%) neither agreed nor disagreed or did not know.

Analysis of comments – setting and charging of fees

Across all responses to the question, the most common response focused on what the fee should be, and how this should compare with equivalent fees for doctors. Linked to this, respondents also made suggestions to change the rules and principles, which included calls for fees to be salary or means tested.

Principles for setting fees

From this feedback, the following factors were highlighted as considerations when setting fees.

- Fees should consider registrant income, means, and costs. Many respondents (largely doctors, members of the public, and some organisations) noted that PA and AA salaries are often higher than doctors' salaries in the first few years of a doctor's career, and that doctors face higher costs, so it would be unfair for PA and AA fees to be lower. One doctor said:

'This is not just about covering the cost of regulation/DHSC funding. It's about being fair to doctors who pay a large sum of money for regulation. PAs get paid more than doctors and if doctors are paying more for regulation, there will be a huge level of disagreement with this.' (Doctor)

- There is strong support, across respondents, for the principle that our fees cover the cost of regulating professions. However, some respondents wanted to see stronger assurances that doctors will not subsidise PA and AA regulation. As one doctor noted:

  'the rules should be explicit that the regulation of each profession should be entirely self-funding with no cross-subsidy'. (Doctor)

- Some respondents went further and commented on future changes to fees. For example, some respondents (largely doctors) indicated that they expected to see higher volumes of fitness to practise concerns for PAs and AAs because of the absence of a defined scope of practice and that this may require fees to be higher. But counter to this, some PAs and AAs noted that as 'dependent practitioners' there are likely to be lower costs to regulate them.
- Some respondents (PAs and AAs and a PA organisation) wanted to see us take into account the current fee to be on the Faculty of Physician Associates' voluntary register – which covers both professional body support and registration.
- Some respondents did not want consideration of the DHSC subsidy to be part of our overarching principles for setting fees. Instead, respondents wanted to see the fee reflect the actual cost of regulation of PAs and AAs to make sure that PA and AA fees do not suddenly increase when the subsidy ends.
- Others noted the importance of ensuring that effort is made to minimise and streamline our expenditure, with fees kept as low as reasonably practical – with some wanting to see a cap on fees.

Transparency and notifications

Respondents were keen to see greater transparency surrounding our fees and how these are calculated and spent. There were also calls to understand how shared resources such as staff and office space are costed. One doctor suggested that:

'detailed reports on how fees contribute to regulatory functions could help practitioners understand the value derived from their financial contribution'. (Doctor)

Where respondents did engage directly with our draft rules, the following points were raised.

- We should not charge fees for revisions of, and internal appeals for, registration and removal decisions.
- A trade union body wanted to see the rules clarify when we can review the schedule of fees, to make it clear fees cannot change at any time and only following the annual review.
- Respondents, including a PA organisation and trade union body, called for PAs and AAs to be given reasonable notice before fees are charged. In the rules, we said we would give PAs and

AAs five working days' notice of the fee due. But we received feedback this was too short and should be extended to 28 days or a calendar month. As one organisation noted:

> *'A minimum of five business days is completely inadequate and would likely result in many associates falling foul of the rules.' (Organisation, trade union body)*

A PA said:

> '*I don't believe an Associate should be removed from the register after one failed payment. There should be a time frame where this can be remedied with no impact on the register status of the Associate.' (PA)*

- Some respondents also wanted to see the rules require stakeholder consultation before fees can be changed. A doctor said we should:

> *'regularly engage with stakeholders, including practitioners, when reviewing or adjusting fee structures. This consultation process should assess the impact of fees on practitioners and ensure that changes are fair and justifiable.' (Doctor)*

Additional comments

We also received comments that didn't relate to the content of the rules themselves, but more to how we would apply the rules in practice. This included questions about:

- what should happen if a PA or AA fails to pay their fee
- how PAs and AAs should be able to pay their fee, such as by direct debit
- the circumstances in which we should offer a reduced fee to PAs and AAs, including whether this should mirror what we currently offer to doctors. One organisation suggested, for example, that socio-economically disadvantaged groups should be eligible for discounted fees.

Respondents also expressed views about aspects of our approach which we are not consulting on, for example, the DHSC subsidy or our current funding model of charging fees to registrants.

Finally, respondents wanted some additional information on what the fees will be. This included how the principles will be used to set fees; the circumstances in which we'll refund, reduce, or waive a fee; and how the DHSC subsidy will operate in practice.

We've grouped our response to this question with our response to question 24 below on fee principles.

Question 24: To what extent do you agree or disagree with our proposed principles for setting and varying fees in future?

What we heard

Overall responses		Responses from individuals					Responses from organisations	
			Total	Public	Doctors	PAs/AAs		
Total responses	2,615	Total responses	2,550	372	1,635	369	Total responses	65
Total comments	1,056	Total comments	1,023	131	704	110	Total comments	33
Agree	17% (456)	Agree	17% (428)	9% (34)	12% (191)	45% (167)	Agree	43% (28)
Disagree	56% (1,467)	Disagree	57% (1,454)	49% (183)	71% (1,163)	5% (18)	Disagree	20% (13)
Neither agree nor disagree or don't know	26% (692)	Neither agree nor disagree or don't know	26% (668)	42% (155)	17% (281)	50% (184)	Neither agree nor disagree or don't know	37% (24)

Of the 3,011 individuals and organisations that responded to the consultation, 2615 (87%) responded to this question. Of these:

- 456 (17%) agreed
- 1,467 (56%) disagreed
- 692 (26%) neither agreed nor disagreed or did not know.

Analysis of comments – principles for setting and varying fees in future

Among those who agreed or disagreed with our proposals, the most common reason for their response focused on the perception that doctors might subsidise the regulation of PAs and AAs. The most common response from those that answered 'neither agree nor disagree or don't know' referred to the need to ensure we consult on fees.

Taking into account all responses to this question, feedback either focused on our principles, including the considerations that should inform the setting of fees, or the need for transparency in how these fees are set.

There was a strong argument against doctors funding the regulation of PAs and AAs, with a particular emphasis on this from individual doctor respondents. As one organisation expressed:

> *'Regardless of the regulatory body, as previously stated, it is also important that any costs of the regulation of PAs must not be transferred to doctors.' (Organisation, doctor organisation)*

As with the feedback provided to question 23 above, several respondents (largely doctors and members of the public) felt that fees should have regard to registrant income, means, and costs. Various respondents provided a similar response to that of a doctor organisation, noting that:

> *'AFC [Agenda for Change] band seven pay scale is in excess of many doctors' basic pay and therefore [we] suggest that fees should be at least equal to that of doctor holding full registration'. (Organisation, doctor organisation)*

Doctors and members of the public in particular expressed support for the proposal that the income we get from fees should not exceed the cost of regulation. There was also support for the principle that our fees should reflect the cost of the administration to regulate PAs and AAs and should mirror the 'real-time' costs incurred from registering and regulating them. Additionally, some respondents linked their answer to the DHSC subsidy, stating they wanted to see the UK government subsidy extend to all fees, including doctors' fees. However, others were opposed to this, with one respondent stating that they did not agree with taxpayer money being used in this way.

Transparency

Respondents were keen to see greater transparency surrounding our fees, including both the way in which we calculate the final fee value and how much it costs to regulate these professions. Two further points were raised related to this.

First, some respondents, particularly PAs and AAs, argued that we should have to consult on fee levels.

> *'Any future adjustment of the fee for physician associates should be subject to prior consultation of physician associate registrants and the professional membership body for physician associates.' (PA)*

And second, some respondents wanted to see more information about our proposals in our consultation document to answer the question. One doctor organisation in particular called for greater detail and transparency on how fees are set, particularly where these differ between doctors, PAs, and AAs.

Our response

Principles for setting and varying fees

We saw a lot of support for our proposal to set a fee structure that is based on us recovering the cost of regulatory functions from registrants. This approach ensures that doctors will not incur additional costs through their annual fees for the ongoing regulation of PAs and AAs.

Although there was feedback suggesting we link fees to income levels, the most appropriate basis for calculating fees is based on the cost of activities that relate to the regulation of PAs and AAs. In developing our methodology to calculate fees, we sought independent review from PwC (PricewaterhouseCoopers), who have extensive experience in financial modelling and who considered our approach to be reasonable and proportionate.

We anticipate that the registration and annual fees we'll set for PAs and AAs will be higher than the current fees charged by the Faculty of Physician Associates for their voluntary register. This is due to the forecast cost of regulating PAs and AAs in line with the requirements of the AAPAO. Additionally, there are discrete activities that only some cohorts of potential or existing registrants engage with, and therefore it is right to charge a fee where these activities generate costs.

With regard to the proposal that we consult on fee changes, the AAPAO does not require this, and it is not an approach that we currently take for doctors. As the true cost of regulating PAs and AAs becomes clearer over time, we'll review our fees annually to understand if there's any evidence for us to make adjustments in the future. Where we need to make changes to our fees, the AAPAO requires us to consider and report on the effect of those changes on the PA and AA professions, and to subsequently publish revised levels in our schedule of fees as set out in the rules.

Regarding the feedback on the DHSC subsidy, we entered into a funding agreement with the DHSC that:

- fully funds the costs of bringing PAs and AAs into regulation
- provides transitional funding to support our fee income while the number of PA and AA registrants remains low.

We'll charge a fee which reflects the costs of regulation over the medium term, and we'll continue to receive a subsidy from the DHSC to cover some additional costs during the transition phase. Therefore, although we don't expect there to be a significant change in fee level for PAs or AAs when the subsidy ceases, this will depend upon the number of registered PAs and AAs, and the volume of their regulated activities.

Fees rules

We'll continue to charge for some revisions and appeals. Although we received a small number of comments objecting to this proposal, charging in this way supports our principle of setting fees to cover the cost of regulatory activities. Where PAs or AAs engage with particular functions – for example, overseas applications for registration, appeals, and revisions – we'll charge a fee linked to the cost of that separate process. We believe that this will provide a fairer approach for all.

Respondents wanted assurances that the fees cannot change at any time. As the true costs of regulating PAs and AAs becomes clearer over time, we'll review fees annually to understand if there's any evidence for us to make adjustments. This will take into account the impact of inflationary changes to our cost base. This is the same process we currently follow for doctors. Typically, fees are agreed by Council in December and take effect from 1 April, thereby giving PAs and AAs enough notice of upcoming fee changes. However, it is important that the rules provide us with the flexibility to change fees in response to exceptional circumstances – thereby ensuring that the costs of regulation can continue to be met by PAs and AAs.

Respondents wanted more clarity about notice periods. Our original rules proposed a minimum notice period of five days for informing PAs and AAs that payment of a fee is due. However, we agree that this does not give a sufficient notice period and so we've now extended this to ten

days. However, in practice the notice that we give to the PA or AA of the fee that is due will be consistent with that provided to doctors, which is currently 31 days before the fee is due.

The fee rules also set out the requirement for PAs and AAs to pay an annual fee to maintain their registration, when this fee is due, and the notice we will provide that payment is required. When the fee is not paid, the PA or AA may be removed from the register, and our procedure for establishing this is set out within our registration and removal rules. However, removal is not instant and where we are considering this, we will provide PAs and AAs with notice of our intention to remove their entry, no fewer than 28 days beforehand. Should individuals provide payment within this period, they will not be removed from the register.

Although we'll not be offering income discounts at this stage to PAs and AAs, we will review the fee structure and potential for discounts once we have sufficient information on the numbers of PAs and AAs, their demographics, and the costs of their regulation.

Additional comments

We received requests for clarity on a few other matters which we've summarised below.

- The rules set out the requirement to pay a fee and the requirements of when a fee is due to be paid. Details on how to pay fees will be provided on our website and in fee related communications to PAs and AAs. Payment methods will be the same as those offered to doctors, including the ability to pay the annual fee by direct debit, in monthly and quarterly instalments.
- The rules set out the ability to refund, waive, or adjust fees. As we noted in our consultation document, we'll provide further details on the circumstances in which we'll do this in guidance.

Box 19: Fees rules – the changes we've made

- Amended the rules to extend the minimum notice period, that a fee must be paid, from five to ten days (rule 5).
- Further drafting changes after internal consideration to improve clarity of the rules.

EDI and the Welsh language

What we proposed

The public sector equality duty requires us to consider the implications of our proposals for individuals who share protected characteristics. In our Equality Impact Assessment (EQIA), we outlined how our rules, standards, and guidance address these considerations, focusing on PAs, AAs, and members of the public. We appreciate that our proposals may also affect doctors and we are considering those impacts separately and on an ongoing basis.

In relation to the Welsh Language (Wales) Measure (2011), we consulted on the effects of our proposals on opportunities to use the Welsh language. This included checking that our proposals will not treat the Welsh language less favourably than the English language. This is in accordance with the *Welsh Language Standards* (WLS) issued by the Welsh Language Commissioner. The WLS require us to:

- identify and consider the effects of our proposed policy positions – as set out in our rules, standards, and guidance – on the use of the Welsh language
- consider introducing measures to mitigate negative, or bolster positive, effects.

Question 25: Referring to our separate EQIA, to what extent do you agree or disagree that we have identified all relevant impacts (for AAs, PAs and members of the public) for our proposed rules/guidance/standards as currently drafted?

What we heard

Overall responses		**Responses from individuals**					**Responses from organisations**	
			Total	**Public**	**Doctors**	**PAs/AAs**		
Total responses	2,117	Total responses	2,060	317	1,276	334	Total responses	57
Total comments	532	Total comments	503	77	307	81	Total comments	29
Agree	20% (430)	Agree	19% (398)	11% (34)	14% (176)	47% (156)	Agree	16% (9)
Disagree	39% (820)	Disagree	39% (811)	39% (123)	50% (637)	1% (2)	Disagree	28% (16)
Neither agree nor disagree or don't know	41% (867)	Neither agree nor disagree or don't know	41% (851)	50% (160)	36% (463)	53% (176)	Neither agree nor disagree or don't know	56% (32)

Of the 3,011 individuals and organisations that responded to the consultation, 2,117 (70%) responded to this question. Of these:

- 430 (20%) agreed
- 820 (39%) disagreed
- 867 (41%) neither agreed nor disagreed or did not know.

Analysis of comments – EDI impacts

Respondents had mixed views on whether the EQIA fully identified all relevant impacts on groups with protected characteristics.

Although some respondents felt that we had identified all the impacts, others raised additional areas for us to consider, including the impact of our proposals on PAs and AAs working part time, disabled PAs or AAs, those for whom English is not their first language, and those who qualified overseas. It was also suggested that we take into consideration the possibility that many PA students may come from lower socio-economic backgrounds, may have families, and may have caring responsibilities.

A regulatory body also argued that our EQIA omitted the possible risk of bias that might stem from using single case examiners. A doctor organisation made a similar point. They noted that some registrants already at risk of disproportionate outcomes because of their ethnicity may accept more serious measures in the absence of a panel hearing. In doing so, they drew parallels to the current experience of doctors in fitness to practise proceedings. They suggested that the increased risk of bias, stemming from a single case examiner decision-making model, might further worsen this risk.

Other respondents supported this view, noting that the experience of PAs and AAs who qualified overseas may mirror the experiences of international medical graduates and black and minority ethnic doctors. These are groups that are disproportionately affected by our processes, and are less likely to have legal representation.

Several respondents (largely doctors and some members of the public) noted that the EQIA did not explicitly acknowledge the effect of the proposed reforms on doctors more generally. This was particularly so for those in training, and those who would be required to supervise PAs and AAs.

Some respondents (largely doctors and members of the public) also noted that we had not considered the impact of our proposals on members of the public, as recipients of the care and treatment provided by PAs and AAs. One respondent stated:

> *'there appears to be a lack of rigorous analysis on how these rules might affect patient safety, access to care, and the overall quality of healthcare delivery'. (Doctor)*

Respondents raised a recurring concern that members of the public will be unable to distinguish between doctors, PAs, and AAs. One respondent noted:

> *'I think vulnerable persons and those with disabilities are less likely to correctly identify clinicians as PAs and more likely to assume they are as trustworthy and knowledgeable as doctors.' (Doctor)*

Respondents identified actions that we could take to mitigate adverse effects on individuals with protected characteristics. They recommended that we:

- make sure we capture and record demographic data to better understand the impact of our proposals on different groups on the register (some felt this should be included on the register)
- review potential impacts of our proposals on groups with protected characteristics in a few years' time, by which point the effect will have become apparent
- provide guidance and documents in multiple languages
- consider discounted fees for disadvantaged groups
- clarify whether the registration assessments for PAs and AAs will allow for reasonable adjustments for disabled individuals
- provide more information on how we will tackle unconscious bias.

Our response

We recognise the importance of monitoring the impacts of our proposals over the coming years once regulation has started. The EQIA is a dynamic document that identifies possible impacts we will need to continue to monitor. As part of this, we will continue to capture and record, on a voluntary basis, demographic data relating to various PA and AA cohorts (potentially including additional characteristics like socio-economic status) and review our approach to doing this to ensure it is as effective as possible. This will help us understand the impact of our proposals and make adjustments as necessary.

We note that some feedback drew upon EDI issues that are known to exist in relation to doctors – for example, in relation to the risk that registrants who have qualified overseas may be disproportionately represented within our fitness to practise processes. We understand that PAs and AAs differ in terms of scale and diversity, so we will need to monitor data once regulation starts to understand how relevant these EDI themes are for the PA and AA cohorts in the longer term.

We also acknowledge the concern that several respondents raised that patients and the public need to be able to distinguish between doctors, PAs, and AAs, and know who is treating them. We've expanded further on this point in Part 3 of this report. And as we set out in our response to question 6, we've taken steps to clearly distinguish PAs and AAs from doctors on our online registers. We'll also use 'easy read' documents and materials to help make the distinction clearer.

Across all our questions, consultation feedback identified potential impacts on, and considerations for, some groups with protected characteristics. We have summarised some of these below, together with our response to those themes.

Education and training

Examples of feedback we received include the following.

- Both the curricula and course standards need a stronger focus on EDI.
- Diverse voices should be used to shape the development of the curricula as part of the standards.
- Education and training providers must make sure reasonable adjustments are put in place for learners.
- We should consider the impact of the proposed reforms on doctors, including those in training or those who will be required to supervise.

In responding to this feedback, we note the following.

- Our curricula standards require organisations to demonstrate that they meet their legal obligations under equality legislation and that they've considered equality, diversity, and fairness in the development of the curriculum (CS2.6).
- We have produced guidance on reasonable adjustments and our *Welcome and valued* guidance focuses on disabled learners.
- As part of our work to monitor the ongoing impacts of PA and AA regulation, we will explore its interaction with doctors' training and supervision.

Registration and removal

Examples of feedback we received include the following.

- We received mixed views on the collection and publication of gender data – although it was generally felt that the approach to collecting and publishing gender data of PAs and AAs should also apply to doctors.
- A single registration standard for all applicants (irrespective of where they qualified) will be fairer for overseas graduates (who are more likely to be black or from an ethnic minority).
- Decisions to remove an associate must be based on a fair, equitable, and objective process.

In responding to this feedback, we note that we'll continue to collect gender information on a voluntary basis as part of our routine monitoring. We intend to update the Form and Content of the Register Regulations for doctors to introduce a similar approach for doctors in future.

Responding to concerns (fitness to practise)

Examples of feedback we received include:

- concerns about fairness and risk of bias in the single case examiner model, which could be addressed by robust EDI training

- concerns that accepted outcomes may disproportionately and adversely affect associates from ethnic minority or lower socio-economic groups, particularly if using a single case examiner.

In responding to this feedback, we will:

- provide guidance, training, quality assurance, and ongoing evaluation to promote consistency in fitness to practise decision making
- use two case examiners for accepted outcome decisions.

Fees

An example of feedback we received was to consider introducing discounted fees for registrants from disadvantaged groups.

In responding to this feedback, we plan to use data to analyse the equalities implications of our fees scheme and review this at the end of the transitional period.

Question 26: In your opinion, could the proposals have either positive or negative effects on opportunities for people to use the Welsh language and on treating it as no less favourable than English?

What we heard

Overall responses		Responses from individuals					Responses from organisations	
			Total	Public	Doctors	PAs/AAs		
Total responses	2,070	Total responses	2,015	306	1,252	331	Total responses	55
Total comments	338	Total comments	315	53	170	65	Total comments	23
Agree	24% (491)	Agree	24% (481)	38% (116)	9% (118)	68% (225)	Agree	18% (10)
Disagree	20% (414)	Disagree	20% (409)	21% (64)	25% (319)	2% (6)	Disagree	9% (5)
Neither agree nor disagree or don't know	56% (1,165)	Neither agree nor disagree or don't know	56% (1,125)	41% (126)	65% (815)	30% (100)	Neither agree nor disagree or don't know	73% (40)

Of the 3,011 individuals and organisations that responded to the consultation, 2,070 (69%) responded to this question. Of these:

- 491 (24%) agreed that the proposals would have a positive or negative effect
- 414 (20%) disagreed that the proposals would have a positive or negative effect
- 1,165 (56%) neither agreed nor disagreed or did not know.

Analysis of comments – proposals' impact on opportunities to speak Welsh

Across all responses to the question, the most common request was for us to provide documents, services, and processes in Welsh. One example provided focused on ensuring that witnesses at fitness to practise proceedings can give written and oral evidence in Welsh if they request to do so. Further suggestions included the following.

- Ensuring that our standards and/or hearings are offered in Welsh and that further opportunities exist for bilingual communication. However, some respondents noted that it may be appropriate to limit such provisions, for example by considering the time or cost involved in producing a translation or securing an interpreter.
- Ensuring that PAs and AAs receive relevant language, cultural, and competency training to enable them to communicate effectively with Welsh-speaking patients. As one respondent noted:

'If PAs and AAs are integrated into healthcare settings where the predominant language is Welsh, there may be an indirect impact on language accessibility and inclusivity. In such cases, ensuring that PAs and AAs are proficient in Welsh or that translation services are readily available could be important factors in maintaining language equality in healthcare delivery.

Conversely, if there are barriers to PAs and AAs accessing training or employment opportunities due to language requirements, this could inadvertently limit opportunities for Welsh speakers. It's crucial for the regulatory framework to consider these factors and ensure that language considerations do not inadvertently disadvantage any group.' (Doctor)

Some respondents noted that a failure to provide services, processes, and documents in Welsh would have negative effects for patients, PAs, and AAs:

'Unless communications and the work of tribunals are offered to be conducted in Welsh as a choice then patients or PA/AA practitioners could potentially be disadvantaged if their first language is Welsh.' (Organisation, NHS or Health and social care organisation)

Other respondents were either not sure about the potential impacts or felt that our proposals would have no obvious negative or positive effect on opportunities for speaking Welsh.

We've set out our response to this question below, under 'Our response: questions 26 and 27'.

Question 27: Could the proposals be revised in any way to increase opportunities for people to use the Welsh language and to help treat it as no less favourable than English?

What we heard

Overall responses		Responses from individuals					Responses from organisations	
			Total	Public	Doctors	PAs/AAs		
Total responses	2,050	Total responses	1,995	305	1,241	327	Total responses	55
Total comments	322	Total comments	300	54	150	69	Total comments	22
Agree	12% (240)	Agree	12% (233)	8% (24)	8% (100)	28% (90)	Agree	13% (7)
Disagree	20% (418)	Disagree	21% (412)	20% (60)	26% (317)	4% (12)	Disagree	11% (6)
Neither agree nor disagree or don't know	68% (1,392)	Neither agree nor disagree or don't know	68% (1,350)	72% (221)	66% (824)	69% (225)	Neither agree nor disagree or don't know	76% (42)

Of the 3,011 individuals and organisations that responded to the consultation, 2,050 (68%) responded to this question. Of these:

- 240 (12%) agreed
- 418 (20%) disagreed
- 1,392 (68%) neither agreed nor disagreed or did not know.

Analysis of comments – increasing Welsh language opportunities

Across all responses to this question, the most common observation focused on the need for documents, services, and processes to be available in Welsh. Respondents repeated the suggestions they made in question 26 above in their answers to question 27. However, they suggested that we take the following additional actions.

- Clarify how we would respond if a complaint was received in Welsh and how the 'active offer' (providing a service in Welsh without someone having to ask for it) would be enabled. A postgraduate body asked if digital technology could be used regarding Internet Protocol addresses to ensure active communication in Welsh for those in Wales, or clear guidance on how to access services in Welsh.
- Develop patient-facing resources (for example, consent forms and educational materials) in Welsh and ensure they are available in all relevant healthcare settings.

- Ensure that regulatory information and communication are available in both Welsh and English.
- Provide Welsh language training to staff, particularly those involved in direct communications with the public or those based in Wales, to facilitate better engagement with Welsh-speaking associates and patients.
- Establish language proficiency standards for PAs and AAs working in Welsh-speaking communities.
- Provide bilingual training materials and resources to support PAs and AAs in their education and professional development.
- Actively encourage the recruitment and retention of Welsh-speaking PAs and AAs, potentially partnering with educational institutions providing relevant training.
- Actively promote the use of the Welsh language within educational settings and the healthcare profession.
- Implement language support services, such as translation and interpretation.
- Engage with Welsh-speaking communities and stakeholders to gather feedback and insights on how the proposals can better support the use of the Welsh language.

Our response

We note that some of the suggested areas of action are included in our existing offer to Welsh speakers. Our professional standards, including *Good medical practice*, are available bilingually.

Information on how we comply with the WLS, and how people can access our Welsh language services, is available on our website and the MPTS website. This includes how we offer doctors, PAs, and AAs the opportunity to use Welsh in parts of our fitness to practise procedures. They are able to communicate with us in Welsh, including submitting forms and documents, and giving evidence at hearings.

We have also developed processes to make sure we make the active offer of providing a service in Welsh without a doctor, PA, or AA having to ask first when we make initial contact with a registrant based in Wales.

We note that some of the suggested areas of action are more appropriate for consideration by employers and providers of services, rather than the regulator.

Some of the points raised also have implications for our approach to regulation more broadly. We will need to reflect further on the feedback and consider the implications of this for our corporate policy approach to the WLS once regulation starts.

Annex A: Our methodology

Consultation – collecting and processing responses

Our consultation ran from 26 March 2024 to 20 May 2024. We accepted responses from our online survey, hosted on the platform Smart Survey, as well written responses submitted to us either by email or by post. We made our consultation available in both English and Welsh, and, where we received Welsh language responses, translated these before analysis.

Our consultation was made up of 27 substantive consultation questions. We also included a series of 'about you' questions, which gave us information about the breakdown of respondents, set out in **Annex B**.

Some respondents did not address the specific questions asked in our consultation or submitted generic responses. We saved and analysed these generic answers separately from the question responses. This ensured that this feedback was still considered and analysed, despite not following our consultation question format.

We then prepared the data for analysis, removing any blank responses. We defined a blank response as one in which there was no response to any of the 27 questions contained in the online survey or other substantive comment – even though the respondent completed the 'about you' section of the survey. There were several hundred responses in this category.

After data clean up, the final consultation response total was 3,011 responses.

Public research

We commissioned Shift Insight to undertake dedicated research with patients and the public. Further details on this research, including the methodology followed, can be found in **Annex C**.

The research involved in-depth focus groups and one-to-one interviews with 58 people from a broadly representative sample of people across the four countries of the UK. Because our consultation was technical and detailed, we designed the research to present our proposals to members of the public in an accessible and engaging way.

- Rather than share the draft rules and decision-making principles, we created a pre-read that mirrored the structure of our consultation, but at a higher level. This included real-life scenarios that took participants through a registrant's journey with us, from their education to joining the register to what happens if a fitness to practise concern arises.
- The researchers then used slides to present this information visually during the focus groups.
- We provided extra information about our current and future role that facilitators used to answer questions or provide clarity throughout the discussions.
- We also asked the researchers to adapt their approach to the needs of the groups, to make sure we heard from people with a range of health conditions as well as those less likely to engage with us. The researchers offered 1-1 telephone interviews for those who preferred to engage with the researchers through this format.

Analysing responses

We have carefully considered all the responses we received, a proportion of which appeared to be based on template responses prepared by representative bodies to guide their members' responses. In doing so we have paid particular attention to the feedback from individuals and organisations most directly affected by the different elements of our proposals.

We analysed the quantitative data for each question (whether an individual agreed, disagreed, or answered neither/don't know) together with demographic data provided by each respondent, using the software packages Power Bi and Excel.

We analysed free text comments using the software package NVivo. We reviewed every response and 'coded' it to assign a particular theme, or themes, to that response. Drawing on guidance produced by the Consultation Institute, we developed a coding framework to guide this process. Analysts were encouraged to identify additional codes as they reviewed responses to make sure that our coding system better reflected the responses we received.

We split codes into two categories.

- **Blanket codes** – these applied to all questions and ensured our analysis was consistent where we encountered repeated feedback or themes. A lot of feedback about wider issues not covered by our consultation fell into this category.
- **Question specific codes** – these were specific to the subject matter of our consultation questions. Although we provided a starter list of codes, we did not expect this list to be exhaustive and asked analysts to add to this as they came across new themes.

Each analyst's coding was subject to an internal quality assurance (QA) process, where a cross check was undertaken for a sample of completed coding to validate the codes that were used and to make sure that our analysts approached this task consistently.

Additionally, our external auditor, BDO, reviewed our proposed approach to analysing the consultation findings, and we refined our approach to take into account their feedback.

Drawing out the viewpoints of different audiences

To understand how free text and quantitative themes varied by audience, we grouped some respondents together to facilitate this analysis. We grouped respondents in the following way.

For individuals

Audience group	Who this includes
Doctors	All respondents who answered 'individual' to Q34 and 'doctor' to Q35
PAs and AAs	All respondents who answered 'individual' to Q34 and any of the following to Q35: 'physician associate', 'anaesthesia associate', 'physician associate student', 'anaesthesia associate student'
Public	All respondents who answered 'individual' to Q34 and any of the following to Q35: 'patient', 'carer/relative or advocate', 'member of the public'
Other healthcare professionals	All respondents who answered 'individual' to Q34 and 'other healthcare profession' to Q35.
Lay GMC/MPTS associates	All respondents who answered 'individual' to Q34 and 'lay GMC/MPTS associate' to Q35.
Other individuals	All respondents who answered 'individual' to Q34 and either 'other – please say what' to Q35, or left Q35 blank

For organisations

Audience group	Who this includes
Educators	All respondents who answered 'organisation' to Q34 and either 'higher education institution (including medical school)' or 'postgraduate body' to Q47
Employers	All respondents who answered 'organisation' to Q34 and either 'independent healthcare provider' or 'NHS/health and social care organisation' to Q47
Doctor membership bodies/organisations	All respondents who answered 'organisation' to Q34 and 'doctor organisation' to Q47
PA and AA membership bodies/organisations	All respondents who answered 'organisation' to Q34 and either 'physician associate organisation' or 'anaesthesia associate organisation' to Q47

Audience group	Who this includes
Patient organisations	All respondents who answered 'organisation' to Q34 and 'patient organisation' to Q47
Regulatory bodies, UK government departments, and public bodies	All respondents who answered 'organisation' to Q34 and either 'regulatory body', 'UK government department', or 'public body' to Q47
Other organisations	All respondents who answered 'organisation' to Q34 and either answered 'other (please say what)' to Q47 or did not answer Q47

Reporting our consultation findings

Once an analyst had read and coded all their free text consultation responses, they were able to write up their findings.

We prepared a report template for analysts to complete, one for each question, to make sure that we had a standardised way of presenting the consultation data and analysis findings.

The first half of the template consisted of key quantitative data and the second half was a narrative of the qualitative data. The qualitative data was structured by the responses to the consultation question, in majority order (from the most answered option to the least). Analysts used queries in NVivo to split their coding against these options and report themes from most raised to least raised per answer.

We also asked analysts to identify whether some types of respondents were more likely to raise particular themes or arguments, using the stakeholder groupings identified above.

Like our approach to coding, our reporting was subject to an internal QA process. QA analysts reviewed draft reports and checked queries in NVivo to make sure that we had correctly reported the data and our findings.

We then used these reports and the patient research findings to identify, discuss, and agree changes to our rules, standards, and guidance.

Annex B: Respondent breakdown

As part of our consultation, we asked questions to understand the demographic profile of our respondent population, for respondents who indicated that they were responding as an 'individual' rather than as an 'organisation'. The results for these questions are set out below. The category 'not known' was used for any individual who left a particular demographic question blank.

Table 1 sets out the age breakdown of individuals who responded to our consultation, with most falling into the 25 to 34 age category.

Table 1 – Number of respondents by age category

Age category	Number of respondents
0 to 18	2
19 to 24	133
25 to 34	1,110
35 to 44	571
45 to 54	459
55 to 64	288
65 and older	141
Prefer not to say	148
Not known	78
Total	**2,930**

Table 2 provides a breakdown of individual respondents by gender. Most of the individuals who responded to our consultation were male. In a separate question, 11 individuals said that their gender is different from their birth sex, and 2,395 individuals answered to say it is the same.

Table 2 – Number of respondents by gender

Gender	Number of respondents
Male	1,418
Female	1,059
Prefer not to say	326
Not known	127
Total	**2,930**

A small proportion of individuals who responded to our consultation reported that they are disabled, as set out below in table 3.

Table 3 – Number of individuals reporting that they are disabled

Disability	Number of respondents
Yes	270
No	2,193
Prefer not to say	351
Not known	116
Total	**2,930**

Table 4 provides a breakdown down of responses from individuals by ethnicity, with most of the respondents reporting that they belonged to the white ethnic group, followed by Asian or Asian British.

Table 4 – Number of individual respondents by ethnicity

Ethnicity		Number of respondents
Asian or Asian British	Indian	214
	Pakistani	95
	Bangladeshi	16
	Chinese	35
	Any other Asian background	69
Black or Black British	Caribbean	10
	African	71
	Any other black, African, or Caribbean background	7
Mixed	White and Black Caribbean	15
	White and Black African	12
	White and Asian	31
	Any other mixed or multiple ethnic background	38
White	English, Welsh, Scottish, Northern Irish, or British	1,365
	Irish	81
	Gypsy or Irish Traveller	4
	Roma	2
	Any other white background	161
Other ethnic group	Arab	27
	Any other ethnic group	27
Prefer not to say		488
Not known		162
Total		**2,930**

Table 5 provides a breakdown of individuals by religion, with most indicating that they had no religious affiliation, followed by respondents who answered they belonged to a Christian denomination.

Table 5 – Number of individual respondents by religion

Religion	Number of respondents
Buddhist	14
Christian (including all Christian denominations)	674
Hindu	130
Jewish	19
Muslim	176
Sikh	12
Other	46
No religion	1,142
Prefer not to say	548
Not known	169
Total	**2,930**

Table 6 provides a breakdown of individuals by sexual orientation, with most respondents answering 'heterosexual/straight' followed by 'prefer not to say'.

Table 6 – Number of individual respondents by sexual orientation

Sexual orientation	Number of respondents
Bisexual	91
Lesbian/Gay	132
Heterosexual/straight	1,779
Other	52
Prefer not to say	663
Not known	213
Total	**2,930**

Table 7 provides a breakdown of individuals by country of residence. Most of the respondents were from England, with smaller numbers reporting that they were from Northern Ireland, Scotland, and Wales. Some respondents reported that they were currently living overseas.

Table 7 – Number of individual respondents by country of residence

Country of residence	Number of respondents
England	2,384
Northern Ireland	60
Scotland	170
Wales	91
Other (European Economic Area)	10
Other (rest of the world)	31
Prefer not to say	2
Not known	182
Total	**2,930**

Annex C: Research with patients and the public (Shift Insight)

Exploring public views on the implementation of regulatory reform

July 2024

Matthew Wood, Isadora Rackham and Jane Powell, Shift Insight

1. Contents

Introduction

The General Medical Council (GMC) is the independent regulator of doctors in the UK. It works with doctors, patients, and other stakeholders to support good, safe patient care across the UK. The remit of the GMC has changed significantly following the passing of the Anaesthesia Associates and Physician Associates Order (AAPAO). This will allow physician associates (PAs) and anaesthesia associates (AAs), also known as medical associate professions (MAPs), to be regulated for the first time. It is expected that reform of legislation governing other healthcare professionals (including doctors) will follow. These reforms will allow the GMC to respond more quickly and flexibly when patient safety is at risk, and better support good practice.

This report outlines findings from research exploring public views on how PAs, AAs and, in due course, doctors will be regulated following the GMC's reforms. The research aimed to collect qualitative input from members of the public, whose views may not have been fully captured in the GMC's consultation on this topic.

The work reported here ran alongside a larger public consultation, which gathered views from PAs, AAs, doctors, members of the public, representative bodies and other organisations, on the proposed rules, standards and guidance needed to bring PAs and AAs into regulation. This research is designed to supplement this more detailed consultation process, capturing the public voice in a more accessible way, from a diverse and broadly representative group of members of the public.

While we consider the project to have been successful in meeting the GMC's aims, we are also aware of the research limitations (explored later in this report) – particularly related to understandable gaps in public knowledge around details of the GMC's role and governance, which could not all be covered in a pre-read document. In some cases, it was possible to mitigate these limitations by adapting our approach. In other cases, it was harder to mitigate gaps in understanding of the GMC's remit, but these situations provided insight into the potential source of certain reactions to case studies and stimulus.

This report should not be read as proof of strong public support for or opposition to regulation of PA and AA roles *by the GMC*, when compared to other potential regulators, or as support or opposition to the introduction of these roles more generally. While we found that many participants had concerns making them strongly supportive of the regulation of these roles, many others were not aware of them prior to this research. It was not the intention of the project to explore these issues in detail.

2. Executive summary

Our approach

The GMC ran a technical consultation on the proposed rules, standards and guidance that set out how PAs and AAs will be regulated. The GMC was keen to hear the voices of members of the public to supplement the wider spring 2024 consultation. The consultation has gathered views from doctors, PAs, AAs, and representative bodies and other organisations, to inform the development of the GMC's final rules and policy positions.

The GMC was also keen to hear public voices as it prepares to make changes to the way it regulates PAs and AAs, and doctors in due course.Shift Insight were commissioned to capture insights from a range of individuals whose voices were perhaps less likely to be heard as part of GMC's consultation response. The project's overall purpose was to explore the views of a broadly representative group of members of the public around the proposed changes to how the GMC regulates and perspectives on the reforms more generally.

We conducted six focus groups and 14 online in-depth interviews with members of the public across the UK, for a total of 58 participants. A full breakdown is provided in the appendix.

The groups were split by age band, on the basis of our previous work with similar samples, including work for the General Optical Council. This experience led us to note in this GMC study that groups of similarly aged participants were more likely to feel comfortable sharing their thoughts, while having more experiences in common – leading to more detailed discussion. The study highlighted generational differences that may exist partly due to differing experiences of the healthcare system. While the focus was not on differences by age, we have indicated where there were strong findings from each of these bands, with such stark differences not noticeable for other demographic characteristics.

Interviews were conducted with vulnerable participants, including the long-term unemployed, those experiencing multiple long-term health conditions, and minority or minoritised groups, alongside those from demographic segments not represented in the focus groups. Fieldwork took place in late March to April 2024.

We provided all participants with a pre-read document, which set out a simplified overview of the changes across four areas:

- Education.
- Joining/leaving the register.
- Complaints/concerns.
- Challenging the GMC's decisions.

This document was co-produced by Shift and the GMC's policy teams. The GMC provided an illustrative example for each area, featuring a fictional person and situation. Some of the examples focused on PAs and AAs, while others focused on doctors. We aimed to capture thoughts about the proposals illustrated by each example, rather than about specific roles

or groups, given that the GMC is expecting to have consistent processes for all registrants following regulatory reform.

The reforms span all areas of the GMC'S operations and, in full, are lengthy and complex. We had to balance the detail provided to participants with the time we could reasonably expect them to engage with the pre-read document, and to discuss this in focus groups and interviews. This led to the creation of an eight-page document focusing on the higher-level detail of each area. The text summarising the changes shown to participants is provided as an appendix to this document.

The vast majority of participants described having a high degree of confidence in their understanding of this document, finding it logical and comprehensible, though some were left with questions they hoped to answer in the research session. At the end of each focus group and interview, we asked participants how much they felt able to contribute – scores largely fell between 7 and 10, with most at the higher end.

Key findings by research objective

Please note that the term 'proposed changes' has been used in reference to doctors, reflecting the upcoming reforms to the way in which they are regulated. We have used the term 'proposals' and 'proposed approach' when referring to PAs/AAs, reflecting the fact that these approaches are new, with the GMC not having previously regulated these roles.

RO1 **What are the initial reactions to the proposed changes to the way the GMC regulates doctors?**

Are the changes seen to be clear? Are the changes seen to be logical?

To what extent are they seen to be an improvement, if at all?

Participants broadly showed support for the proposed changes to the regulation of doctors. The majority felt that the processes and procedures described had improved, appearing more efficient and less bureaucratic. They could understand why the GMC would want to make these changes, though not always how they would work in practice.

The changes, as presented in simplified form via our pre-read, were consistently said to be clear and logical by participants. Proposed changes related to joining, leaving and rejoining the register were perhaps the best understood and received. These seemed straightforward and uncontroversial.

Many participants were glad to see the GMC taking an active role in making updates, believing that healthcare was changing all the time and that regulators needed to keep ahead of oncoming challenges. There was often an assumption that these changes were part of a continuous process, and a pragmatic sense that they could never be truly perfect. Participants also accepted that there would always be unforeseeable issues, in particular around fitness to practise, and that the GMC could not prevent all of these.

Almost all participants told us that talking through the changes in the group or interview had increased their level of understanding of the roles, the GMC, and both regulation and reforms – all of which often started from a very low level.

RO2

To what extent are the proposed changes considered fair, compassionate and proportionate?

Are the proposed changes considered equally fair, compassionate and proportionate for doctors and members of the public?

The proposed changes and approaches were generally seen as fair – balancing the needs of registrants, the public and society. Several proposals, including the introduction of accepted outcomes, were expected to reduce the duration of cases, which was viewed as compassionate and stress-reducing for all parties. The idea of one consistent standard for joining the GMC's registers was seen as fair, consistent, and efficient. Similarly, leaving and rejoining the registers was seen as quicker, fairer and easier for all registrants.

Participants largely focused on whether the proposed changes and approach were fair and compassionate for members of the public. Broadly, the alignment of regulation between doctors and PA/AA roles was viewed as fairer and more proportionate for members of the public, who could feel confident that all roles would be held to account should anything go wrong. Those who liked the idea of accepted outcomes identified what they saw as a focus on learning lessons, which was seen as reducing the chances of future similar incidents. However, misconceptions highlighted how accepted outcomes needed to reflect the traumatic lived experience of the patient.

The revisions process was initially seen as sensible, fair and suitable for all roles. However, there were suspicions about the level of oversight the GMC held over the appeals process, with concerns it could refuse appeals it disagreed with. Overall, the proposed changes were met with support, but areas for clarification and improvement were highlighted.

RO3

To what extent were there seen to be any potential issues with the proposed changes?

How could these potential issues be remedied, if at all?

There were consistent perceptions that the GMC would tend to find in favour of registrants during complaints, appeals and revisions processes. Many of the issues identified pointed to a lack of contextual knowledge about the GMC and its governance structures, as well as the finer details of the changes.

Participants wanted to know more about how the accepted outcomes and appeals/revisions processes would work, suggesting that these areas are more difficult to understand.

There were some doubts about the real-life implementation of these changes in some cases. This was partly because participants viewed any change in the context of what they saw as overstretched health services – as well as a lack of trust in both regulation overall and in non-clinical managers whose support they felt was required for implementation, but some perceived them as more interested in self-preservation than patient care.

RO4 **To what extent are the changes considered robust enough to protect the public interest?**

In what ways do they impact confidence in the GMC?

The changes discussed were seen as being robust enough to protect the public interest, both in the sense that they would protect against unsafe practice, and that they would not take large numbers of registrants out of work at a time of great need.

There was some discussion about how "bad apples", as termed by participants, might be able to use the changes to their advantage, such as someone with something to hide leaving the register before a complaint could be raised. However, many participants felt that a small number of cases like this were inevitable and were realistic in their expectations of what the GMC could routinely prevent. They trusted registrants to abide by the rules, drawing a parallel with the trust they put in healthcare professionals when undergoing a procedure.

Very few participants had heard of the GMC, and those who had knew little more than the name and, on occasion, a link to doctors. As such, a baseline level of confidence and any change in this was difficult to measure. Many participants felt confident in the GMC's ability to regulate and enact the changes in the future based on the pre-read and discussion.

Participants often told us that their confidence in the GMC was strengthened through discussion of the changes and regulatory mechanisms in place, though this tended to be from an initially low knowledge base.

RO5 **To what extent are there different views on how PAs/AAs are regulated, as opposed to doctors?**

To what extent are the public aware or familiar with PAs/AAs?

Participants generally wanted all registrants to be treated equally, no matter their role, level of seniority, or other differentiators. There was consistently strong backing for these roles to be highly regulated. Many participants felt that doctors, PAs and AAs should comply with the same professional standards, to avoid public confusion. It was described as reassuring that PAs and AAs will be open to the same level of oversight and scrutiny as doctors. Some were concerned that these roles could otherwise be treated more leniently than doctors and evade "justice" for any mistakes that impinged on patient safety.

There was relatively little recognition of PAs and AAs – the majority of participants simply hadn't heard of them, including the entirety of the first focus group of 18- to 39-year olds. Broadly, we found there was low awareness amongst younger participants, which became higher in older age groups, some of whom had seen stories about PAs/AAs in the media.

There was a perception from participants that these roles are currently under-regulated and that bringing them under the GMC's regulatory remit was logical and an improvement on the current situation, given the tasks they understood PAs and AAs to undertake.

Given their lack of awareness of these roles in general, it is perhaps not surprising that they seemed unaware of, or at least did not raise spontaneously, arguments against GMC regulation of these roles. It should be noted that we did not prompt them with any suggestions for alternative arrangements. Support for regulation and positive reaction to the GMC's reforms as presented to participants should not be read as wider, informed support for or opposition to the GMC taking on this role.

Key findings by GMC policy area

Participant understanding of PAs and AAs

- ✓ There was a consensus across all age groups that GMC regulation was appropriate and necessary, and that these roles should be regulated in a similar way to doctors.
- X Awareness of PAs and AAs was low, requiring us to introduce these roles and their responsibilities to support discussion of the proposed regulatory approach.
- X There was low awareness of the GMC's statutory requirements, even after information was provided.

Education

- ✓ Participants had a highly positive reaction to the example provided.
- ✓ There was a consensus that checking both content and teaching was the right approach.
- ✓ Regular checks were felt to better reflect the pace of change in the subject.
- X There was some concern about exam burden for students, additional admin work for universities and replication of higher education regulators work.
- X Participants were unclear whether clinical placements would also be checked by the GMC – they felt they should be.
- X Some participants were sceptical of the GMC having the necessary resources.

Joining the register

- ✓ Participants had a generally positive reaction.
- ✓ Standardisation was felt to be fair to all applicants.
- ✓ Standardisation led to increased perceptions of trustworthiness and more confidence in the quality of International Medical Graduates – closing any "loopholes".
- X Some participants had concerns around a perception of increased burden of evidence for UK students.
- X Some had a general mistrust in some global medical education systems.

Leaving and rejoining the register

- ❖ Mixed reaction, with some participants divided on leaving the register.
- ✓ Felt to be quicker, fairer and easier for registrants.
- ✓ Outstanding FTP cases would identify any doctors attempting to "flee".
- ✓ General agreement that the level of evidence needed to rejoin would depend on time spent away and what they were doing.
- X Participants discussed how lower-level concerns from employers might still be important yet not be aired.
- X They also felt some could be leaving the register to avoid recrimination.
- X The proposed approach is less stringent – participants queried if there is an easier way of checking in with employers whilst also remaining efficient.

Complaints and concerns

- ✓ Most supported reforms and the proposed approaches, viewing them as logical, fair and progressive.
- ✓ Reductions in time, stress and cost outlay were seen as beneficial.
- ✓ Others liked the lessons-learned approach, which they thought would benefit society more widely.
- X There was some callsfor greater levels of punishment for non-compliant registrants, with this seen as part of being “fair” and providing “justice”. Punishment was seen as integral to the GMC’s role.A minority were sceptical about the GMC’s independence and the internal nature of the processes.

Challenging the GMC’s decisions

- ✓ For many, the changes to the appeals process sounded less cumbersome and more efficient overall.
- ✓ The revisions process was initially seen as sensible, fair and suitable for all roles.
- X These attitudes sometimes changed when working through the example of a revision. This led to heated discussion of the GMC’s perceived lack of impartiality, with participants again feeling they would favour registrants over patients.
- X This could speak to wider issues around a lack of trust in public bodies. It also led participants to reappraise their thoughts about the appeals process, looking more critically at the GMC’s role in this.

Conclusions and other considerations

The study found that participants generally reacted positively to the proposed changes and approach, viewing them as a logical step forward for patients, doctors, PAs and AAs. The approach to regulation of PAs and AAs was particularly well received, with participants expressing confidence in the proposed checks to ensure patient safety. The GMC’s active role in implementing updates was also appreciated, with participants acknowledging that healthcare is constantly evolving and regulators need to stay ahead of challenges.

However, there were some tensions and contradictions. While participants wanted the GMC to actively police compliance and, in some cases, punish offenders, many also expressed distrust in the GMC, questioning its independence and suspecting bias towards registrants. This scepticism seemed to be part of a broader issue of mistrust in public bodies rather than

any specific grievances with the GMC, given the lack of knowledge participants had of the organisation.

Participants consistently expressed a desire for all healthcare professionals to be subject to the same regulation, viewing this as fair and necessary given the trust placed in them. They were concerned about potential leniency towards PAs and AAs and wanted to ensure that these roles would be subject to the same level of oversight and scrutiny as doctors. Participants emphasised the need for justice, fairness, and visible checks and balances.

Participants made recommendations and considerations for the GMC, collected at the end of this report.

3. Background and research objectives

3.1. Background

The General Medical Council (GMC) w*orks with doctors, patients, and other stakeholders to support good, safe patient care across the UK. They set the standards doctors and those who train them need to meet and help them achieve them. If there are concerns these standards may not be met or that public confidence in doctors may be at risk, the GMC can investigate, and take action if needed.* The GMC's remit will change significantly following the passing of the Anaesthesia Associates and Physician Associates Order (AAPAO). This will allow physician associates (PAs) and anaesthesia associates (AAs), to be regulated for the first time. It is expected that reform of legislation that governs other healthcare professionals (including doctors) will follow. These reforms will allow the GMC to respond more quickly and flexibly when patient safety is at risk, and better support good practice.

In response to this, the GMC have conducted a public consultation on the various sets of rules, standards and guidance needed to implement the regulation of PAs and AAs. The consultation provided stakeholders with the opportunity to comment on the proposed rules, standards and guidance.

The GMC were also keen to hear the voices of members of the public as it prepares to make changes to the way it regulates. To supplement its wider spring 2024 consultation, it commissioned Shift Insight to capture the public voice from a range of individuals whose voices were perhaps less likely to be heard as part of GMC's consultation response.

The project's overall purpose was to explore the views of a broadly representative group of members of the public on the proposed changes to how the GMC regulates. The research objectives were framed in relation to doctors and therefore used the term 'proposed changes', but these are all-new approaches for the previously unregulated PA and AA roles.

3.2. Research objectives

This work explored five core research objectives, built around the key requirement for research that appropriately evaluated the proposed changes/approaches:

1. What are the initial reactions to the proposed changes to the way the GMC regulates doctors?
    a. Are the changes seen to be clear?
    b. Are the changes seen to be logical?
    c. To what extent are they seen to be an improvement, if at all?
2. To what extent are the proposed changes considered fair, compassionate and proportionate?
    a. Are the proposed changes considered equally fair, compassionate and proportionate for doctors and members of the public?
    b. What would make the proposed changes more fair, compassionate or proportionate?

3. To what extent were there seen to be any potential issues with the proposed changes?
    a. How could these potential issues be remedied, if at all?
4. To what extent are the changes considered robust enough to protect the public interest?
    a. In what ways do they impact confidence in the GMC?
5. To what extent are there different views on how PAs/AAs are regulated, as opposed to doctors?
    a. To what extent are the public aware or familiar with PAs/AAs?

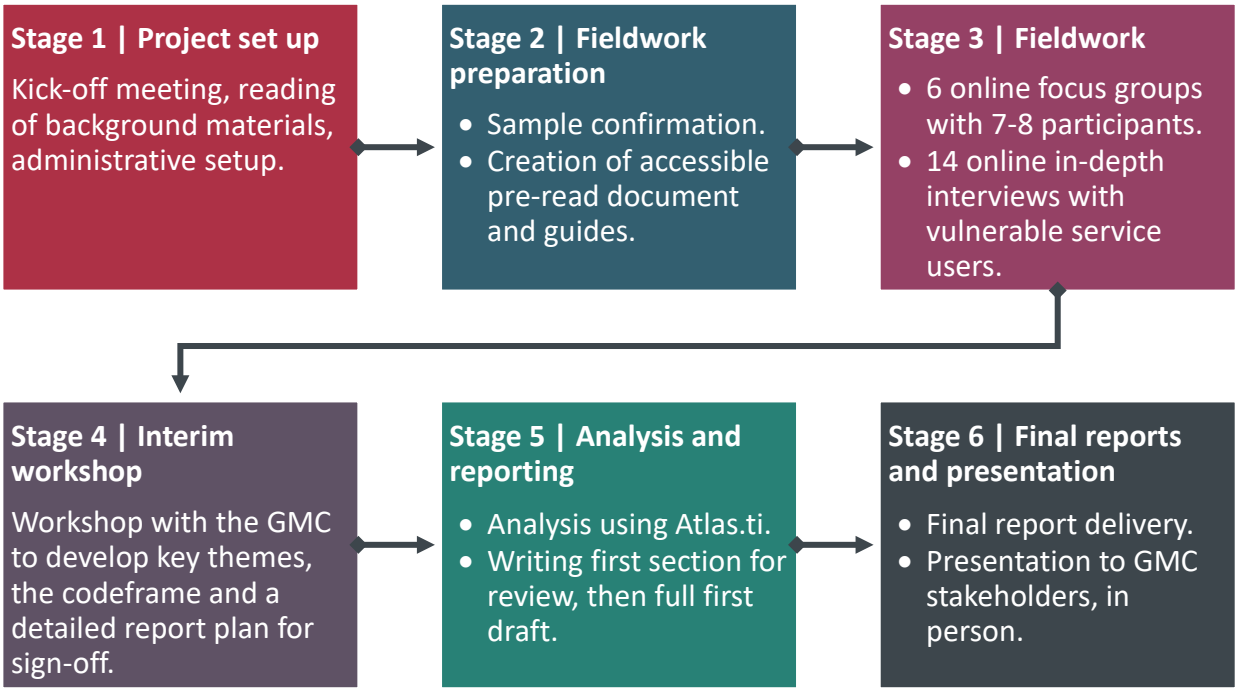
3.3. Methodology

Our overall approach

A qualitative approach was felt to be best suited for this research, due to the depth of insights required and the necessity to ensure members of the public have their say in a format other than online surveys.

- **Online focus groups** allowed for a diverse sample, but also the use of sophisticated and engaging questioning techniques and activities, to ensure participants had a good basis for providing their views.
- **Online individual interviews** were also conducted with specific underrepresented groups to ensure they had an appropriate opportunity to have their say.

Our approach was organised over six stages, as shown below:



The pre-read

Ensuring participants understood the suggested changes was essential to this project. To do so, we created a brief and accessible pre-read that was distributed prior to each interview or focus group, as well as being presented in a scaffolded way during the sessions.

Within this pre-read, which is included as an appendix to this document, research participants were provided with accessible information under the following headings:

- What does regulation mean?
- About the General Medical Council (GMC).
- About the changes to how the GMC regulates.
- About physician associates and anaesthesia associates.

The document outlined potential changes to regulation in the following areas:

- Education.
- Joining and leaving the register.
- Complaints and concerns.
- Challenging the GMC's decisions.

For each, the changes were outlined alongside a fictional case study of this change in action, bringing to life the difference between the current situation and what might occur in future:

André, aged 55, has worked as a GP in Devon for over 25 years. He is taking early retirement from the NHS and moving to Portugal with his partner. He might decide to practise medicine part-time in Portugal but hasn't decided yet. For now, he wants to finish work and give up his GMC registration.

Figure 1: text from example 2 – leaving the register

The pre-read was tested for clarity prior to being sent out to participants, with adaptations made. The document aimed to balance depth and comprehension - *we simplified the technical, 70-page consultation to facilitate discussion.* It would be unrealistic to ask our sample to engage with a longer or more detailed document, with subsequent conversations lacking in focus. Our document aimed to enable wide-ranging conversations about a complex topic without overburdening participants.

Conducting interviews and focus groups

These areas of the pre-read then formed the basis of a semi-structured topic guide for both the interviews and focus groups, with participants discussing both the change in general terms and the case study via a guided discussion.

Groups and interviews were all conducted by fully trained members of the Shift Insight team, who were given the freedom to divert from the script in order to follow up interesting lines of enquiry. Sessions were recorded and then transcribed for analysis.

In the main, the pre-read and its examples formed a useful basis for discussions. It appeared to have been read and well understood by participants, most of whom rated their understanding of the document at 7 or 8 out of 10. Where comprehension issues arose, we adapted the materials slightly – see the limitations section of this report for further details. Where participants' understanding of the issues was partial, we have noted this in the appropriate section of this report.

Sampling and respondent profiles

Ensuring the research captured a range of voices was seen as important to understanding different perspectives that are dependent on an individual's experiences or background. For this reason, participants were carefully selected to be representative. Groups were organised by age (18-39, 40-59 and 60+), which was successful in highlighting generational differences that may exist partly due to highly varied experiences of the healthcare system.

Interview participants were chosen to reflect groups that research suggests are often underrepresented in consultations (Owen et al., 2022; Macdonald, 2023; and Bécares, 2020), including younger people, the long-term unemployed, those experiencing multiple long-term health conditions, other vulnerable participants, and minority or minoritised groups. A breakdown of the sample by quota is included in an appendix to this document.

Care was taken to exclude those with a close connection to the healthcare sector, so as not to bias groups. For this reason, we excluded:

- Current and retired doctors.
- Current and retired PAs and AAs.
- Other healthcare professionals (current and retired).
- Patients with experiences of GMC's Fitness to Practice procedures as a complainant or those who had been closely associated with a complaint through friends or family.

4. Participant understanding of PAs/AAs

4.1. Summary

- ✓ There was a consensus across all age groups that GMC regulation was appropriate and necessary, and that these roles should be regulated in a similar way to doctors.
- X Awareness of PAs and AAs was low, requiring us to introduce these roles and their responsibilities to support discussion of the proposed regulatory changes.
- X There was low awareness of the GMC's statutory requirements, even after information was provided.

4.2. Awareness

Awareness of the roles

There was relatively little recognition of these two roles – the majority of participants simply hadn't heard of them, including the entirety of the first focus group of 18- to 39-year-olds. Broadly, we found there was low awareness within the younger groups, and that this became higher in older groups.

I don't know who they are. I was going to try and say I do. I don't.

18-39, England

Participants aged 40 and above were both more informed about PAs/AAs and more nervous about being treated by them. Those in the 60+ groups seemed most aware. This knowledge tended to come from media reports – which tended to focus on lapses in patient safety – or from direct experience in a healthcare setting. The small number of younger participants who had heard of the roles told us that this had been from social media:

They were all over the news for quite a while. There was a lot of kick up on social media, particularly X, about doctors being upset that people were being allowed to do their jobs with what they considered not enough training. It's from that really.

18-39, Wales

PA and AA responsibilities

Those who said they were familiar with PAs and AAs lacked knowledge of their responsibilities. Even after being provided with the pre-read document and engaging with

the research, there was a great deal of confusion regarding their tasks and responsibilities. Discussions revealed a range of misapprehensions and assumptions. For example:

- One 60+ group member stated "in my experience PAs are usually senior nurses" – despite the pre-read providing clear information on routes into these roles. A 40- to 59-year-old interviewee connected them with nurse practitioners.
- A 40- to 59-year-old participant told their group that these roles existed already, "probably senior nurses, senior whatever", but had recently been given a new title to appear more impressive to service users.
- One 60+ participant's reading was that PAs and AAs are effectively doctors who have chosen to not be regulated.
- Another younger participant's instincts were that PAs were receptionists or administrators.

Participants were worried they wouldn't be able to tell the difference between PAs/AAs and doctors. Many participants felt this way, not just those who regularly or recently accessed healthcare. Some thought back to recent interactions with health professionals and suspected they had probably been speaking to a PA rather than a doctor – which they hadn't realised at the time. Participants, particularly in the older groups, raised concerns over PAs/AAs' level of autonomy and the critical, clinical nature of many tasks. Some were most concerned about AAs. This unease was rooted in a lack of trust in PAs' and AAs' abilities, and framed in the context of struggling healthcare systems.

They want to get in cheaper doctors, probably, not the GMC, but the NHS where it is now… so they'll get less trained… less experienced.

60+, England

We didn't test out understanding of what other members of multidisciplinary teams do, so findings here should not be taken as a conclusion that PA and AA roles are particularly obscure in comparison to other roles.

4.3. Attitudes to regulation

There was widespread surprise about the current lack of consistent regulation for AAs and PAs – participants felt it was sorely required. The idea of an independent body overseeing PAs' and AAs' education and day-to-day practice was extremely well received, with perceived benefits for patients and the healthcare system more widely. Participants consistently expressed a desire for these roles to be treated in the same way as doctors and subject to the same regulation, viewing this as fair and necessary given the trust they placed in these professionals. They were concerned about potential leniency towards PAs and AAs and wanted to ensure that these roles would be subject to the same level of oversight and scrutiny as doctors.

They're basically doing what a doctor does. I think the more checks there are, it's got to be something that's good and much better. I'm still in shock at what they can do.

40-59, Scotland

I think it will provide a fair bit of reassurance to the public that PAs and AAs are open to oversight and scrutiny just like doctors are.

40-59, Wales

I hope it makes things easier for both patients and GPs because everyone is under pressure.

18-39, England

Once again, this positivity was tempered with doubt that regulatory reforms could be effectively rolled out in the current health service context:

- The idea of supervision and the form it would take across tasks and settings was unclear for participants.
- Participants were also apprehensive about how the roles would be managed before a point of concern arises – especially given the well-publicised pressures on doctors.
- Participants also questioned whether supervisors would have time to properly check work, feeling that PAs in particular would end up doing many tasks without adequate supervision.

While participants' understanding of the regulatory landscape was limited, the GMC appeared to them as well placed to provide this.

I'm really glad the GMC exists because we put our lives in doctors' and PAs' and AAs' hands, and we have to know there's a body there making sure they are reaching certain standards in their work.

60+, England

Given their lack of awareness of these roles in general, it is perhaps not surprising that they seemed unaware of, or at least did not raise spontaneously, arguments against GMC regulation of these roles. It should be noted that we did not prompt them with any suggestions for alternative arrangements. As such, support for regulation and positive reaction to the GMC's reforms should not be read as wider, informed support for the GMC taking on this role, or opposition to it.

However, we did hear a consistent view that PAs and AAs should be regulated in the same way as doctors.

5. PA/AA Education

We provided an example of how the GMC will oversee a PA studying a Physician Associate Practice MSc – demonstrating thorough, formal quality assurance processes. This represents the GMC expanding what they currently do for doctors to PAs and AAs.

5.1. Summary

- ✓ Participants had a highly positive reaction to the example provided.
- ✓ There was a consensus that checking both content and teaching was the right approach.
- ✓ Regular checks were felt to best reflect the pace of change in the subject.
- X Participants were unclear whether clinical placements would also be checked by the GMC – they felt they should be.
- X Some participants were sceptical of the GMC having the necessary resources.
- X There was some concern about exam burden for students, additional admin work for universities and replication of higher education regulators work, though these largely stemmed from misunderstandings.

A summary of the proposed approach discussed in this area can be found in the appendix.

5.2. Initial reactions to the proposed approach

The proposed approach to quality assurance of PA and AA education was generally well received – participants felt it was hard to disagree with greater checks. They thought the components of the approach described were hands-on, able to ensure quality in the long term and sufficient for a trustworthy education. Participants told us that knowing a PA or AA had been through this system would make them feel more confident and comfortable. They felt the thorough nature of GMC procedures would also support efficiencies and reductions in checks once they were practising. Some participants noted they would like to understand more about the practical nature of the checks and queried the possibility that in-person checks of teaching or conversations with tutors may not reflect the true nature of courses – some participants compared this with Ofsted inspections in education.

However, the proposed approach to regulation of registrants' education had the most generally positive reaction overall – queries were raised about practicalities more than any genuine concerns or objections to the proposition.

5.3. Positive reactions to the proposed approach

Participants had a generally positive reaction to the proposed approach to regulation of PA and AA education. In particular, participants noted that the quality of a course could vary substantially depending on factors outside its content, so the proposed approach could appropriately identify areas of sub-par performance.

Checking the quality of teaching as well as content was seen as vital. There was an assumption that regular checks would detect issues early, stopping them before they became established, and reducing the impact on students. Several younger participants viewed the approach as fair and helpful in light of COVID-19's impact, alongside wider disparities in education – drawing on their own negative experiences of university education. For example, one participant drew a comparison to their engineering degree, in which some cohorts did not meet accreditation requirements, preventing access to the Institute of Mechanical Engineers.

Other positive reactions related to the regularity and depth of checks proposed by the GMC. Some participants flagged that year to year, the quality of a course could change:

I'm glad to see more regular and more thorough checks, and that they will be regularly checking in rather than just at the start of the course because things can change course to course, year to year. Even the style of teaching can make a huge difference, and tutors can drop out or change quite regularly in some places.

18-39, Wales

Several participants were also positive about the inclusion of student voices in the GMC's proposed approach, with students felt to be best placed to tell the GMC where the course may be lacking:

I particularly like the second point where they're visiting the university, speaking with their students and the tutors. It's brilliant. It's communication opening up. I think it's really important.

60+, England

Overall, the approach was felt to be sufficiently rigorous to protect the public interest, with a positive impact on participants' trust in the quality of education received by PAs and AAs.

5.4. Potential issues identified with the proposed approach

Whilst the overall reaction to the proposed approach to PA and AA education was generally very positive, some participants did have some queries around the practicalities and noted some potential drawbacks.

The depth and breadth of the checks themselves were queried – some participants felt that additional checks may be more surface level, not truly getting to the bottom of the quality of a course and its teaching, and may end up being more casual "data collection":

It didn't sound major… it sounded a bit like more of the same. If they just want to collect some more data, they can email them a little questionnaire or something… get [the provider] to fill that out, and then measure the results from there.

18-39, England

Other participants queried how regular the checks would actually be, given the level of resource they assumed this would take from the GMC. One participant also wondered if this was the most effective use of GMC resources – they suggested that other governmental bodies may be reviewing the quality of education already, as well as the providers themselves reflecting on the quality of their own provision.

Concerns generally related to the impact the proposed approach may have on staff and students within providers. For example, some participants flagged that GMC checks may take up valuable time at the provider and lead to added anxiety or stress for staff and students. A small number of participants noted the proposed approach had greater similarity with Ofsted inspections, which they believed greatly contributing to stress for school educators. Some participants had a misunderstanding around the implication of the proposed change on exams, with a query around the potential doubling up of a registration exam. A common theme emerged here – while the proposed approach looked positive on paper, some participants were unsure if it would effectively translate to reality.

Participants felt that the proposed approach to education would increase their trust in a PA or AA, but some also noted that there was little the GMC could do around education that would fundamentally change their mistrust of all roles they interacted with in healthcare.

6. Joining the registers

Background information was provided to introduce participants to the medical register for doctors, and the GMC's plan to keep a separate register of PAs and AAs who meet GMC requirements. Participants were told about the evidence a PA or AA who applies to join the GMC registers will need to provide, or currently needs to provide in the case of doctors.

We provided an example of how the GMC will deal with new PA/AA registrants via a case study of a graduate from a PA postgraduate course needing to provide evidence of his qualification, a declaration about his fitness to practise, and proof that he is insured to join the register, in addition to sitting an exam that has been developed by the GMC.

Participants were informed that PAs who have studied outside of the UK will need to provide the same evidence and sit the same exam as UK graduates. This represents the GMC expanding what they currently do for doctors to PAs and AAs.

6.1. Summary

- ✓ Participants had a generally positive reaction.
- ✓ Standardisation was felt to be fair to all applicants.
- ✓ Standardisation led to increased perceptions of trustworthiness and more confidence in the quality of International Medical Graduates – closing any "loopholes".
- X Some participants had concerns around a perception of increased burden of evidence for UK students.
- X Some had a general mistrust in some global medical education systems.

A summary of proposed approaches discussed in this area can be found in the appendix.

Participants were broadly aware of the existence of a doctors' register, though not necessarily who administered this or which roles it applied to. A majority felt that the proposed approach was generally positive, with alignment of regulation between doctors and PA/AA roles felt to be fairer to all applicants.

Participants, especially those in the 60+ groups, suggested that standardising checks on international applicants in particular would contribute to a greater sense of security around the quality of registrants – some recalled anecdotal media stories of people having been found to practise without appropriate qualifications. Despite the perceived fairness of the proposed approach applying across all countries, some participants contrastingly felt that some countries and providers (e.g. those receiving accreditation from Harvard in the US) may not need to be subject to the same high standard of checks, as the quality of the teaching, education and qualifications may be of a higher standard.

6.2. Initial reactions to the changes and proposed approach

Awareness of the existing GMC register was very low, and the future register of PAs and AAs non-existent. However, the broader concept of a register was well understood by participants. Most participants were aware of the concept of a doctors' register, largely through media stories or the concept of being "struck off", but this was in name only, and there was low awareness of the GMC register itself or what joining the register would actually entail.

I knew they had a register. I didn't know what hoops they had to jump through to join.

40-59, Scotland

The proposed changes and approach were met with general support. To participants, the idea of a single standard for joining seemed fair, consistent and more efficient for both the GMC and applicants. They also approved of PAs and AAs being required to follow a similar process when they join the register, whilst providing different types of evidence, as doctors Consistency was associated with trustworthiness and was felt to reduce the possibility of falsified qualifications or poor-quality applicants.

6.3. Positive reactions to the changes and proposed approach

The idea that all applicants from across the world will have to show they meet the same standards for registration, no matter where they're from, was approved of in principle.

The changes seem positive and necessary… especially the one with doctors coming from abroad. When I was reading the current approach, it was like 'really?' And with the changes, you're like yes, that was needed.

18-39, England

Some participants had concerns around registrants educated overseas falsifying documents to work in the UK. There was a perception that this change would put an end to people "sneaking in" as one participant put it, which made participants feel more secure. The proposed approach was felt to close any potential "loopholes" to joining the register unfairly. However, participants were unable to cite evidence when pressed for information on specific cases or sources of information for these lapses and loopholes. There was very little knowledge of GMC processes around the verification of documents and other checks. We suggest that these might represent misconceptions, rather than a reflection of current issues.

Other positive comments linked the standardisation in the proposal to positive outcomes for healthcare more generally – with some participants believing that the proposed change would make patients feel more confident in the level of care they could expect to receive from any registrant.

It's vital to have the same standards. It's not right that people from different countries with different levels of education should have to satisfy different criteria. It's patients who matter and the patient care has to be standardised. The future approach is correct. Everybody should have the same standards and the same skill sets.

60+, England

One participant, aged 18-39, thought that the proposed change to joining the register may positively impact the efficiency of the application process for international applicants, to make the UK a more desirable location to practise medicine:

If the UK is struggling to get doctors, especially junior doctors, and they hope people from other countries will register, then it's probably good for them [the GMC] if they're making it [joining the register] simpler and making the whole system work more efficiently.

18-39, Northern Ireland

6.4. Potential issues identified with the changes and proposed approach

A minority of participants questioned the need for graduates from what they termed "trustworthy" education providers in countries such as the USA to "jump through hoops", suggesting that someone educated within a framework they deemed similar to the UK might not need to go through the full process. There was, however, sometimes a lack of trust in the medical education systems of some less wealthy countries.

There maybe should be some exceptions if the approach is similar in different countries. Some exemptions could apply… There could be some modifications to that [proposed approach] just to account for similarities, if there are some… It could show a recognition of standards met somewhere else, or similar frameworks, just showing they have already reached certain competencies.

18-39, England

Other concerns again revolved around the potential practical limitations to the proposals, and reflected some misconceptions of these:

The GMC will have a lot of work on their hands… I assume when they say check individual PAs, it would have to be individual spot checks. I don't think they'll check everyone.

60+, England

We also heard questions and misunderstanding about the use of exams to check potential registrant's knowledge. A small number queried if the registration exam for doctors replaced their university final exams, or if it was an addition, with some worried about a potential duplication of requirements. This arose from concern about there being an

increased exam burden on young UK registrants, suggesting universities and the GMC integrate regulation requirements into UK qualifications for fairness. However, where possible, we reassured participants that this would not be the case.

7. Leaving and rejoining the registers

Here we provided information on registrants being removed from the registers because they are retiring, moving to work in another country, wanting to stop working as a doctor, PA or AA, or if they do not meet GMC standards. We outlined how the way that the GMC will manage the register for PAs and AAs and the register for doctors in the future, will be slightly different to the current process in three ways:

- Currently, registration requirements for doctors vary depending on where in the world someone got their qualification and the type of registration they are applying for. In future, all applicants will have to show they meet the same standards for registration, no matter where they're from.
- There will be a simpler process for removing individuals from the register. If someone wants to leave the GMC register and there are no current concerns about their practice, it will be quicker and easier to do so.
- If a professional wants to rejoin the register, they will need to meet the same standard as registration, but the specific evidence they need to provide will depend on how long they have been off the register.

We provided the example of a GP taking early retirement from the NHS and moving overseas. This contrasted the current and future approach. At present, the registrant would fill out a form that would be reviewed by the GMC, who would then get evidence that there are no ongoing or outstanding issues with his fitness to practise. Following reform, the GMC will not need any additional evidence from employers. Registrants wishing to leave will fill in a form declaring that there are no outstanding fitness-to-practice issues as well as the GMC conducting internal checks to ensure sure that there are no further concerns, making the process faster and simpler for the registrant. Discussion focused on doctors, but we also probed for reflections on PAs and AAs and if views were different.

7.1. Summary

Key perceptions included:

- ❖ Mixed reaction, with some participants divided on leaving the register.
- ✓ Felt to be quicker, fairer and easier for registrants.
- ✓ Outstanding FTP issues would identify any doctors attempting to "flee".
- ✓ General agreement that the level of evidence needed to rejoin would depend on time spent away and what they were doing.
- X Participants discussed how lower-level concerns from employers might still be important yet not be aired.
- X They also felt some could be leaving the register to avoid recrimination.

- X The proposed approach is less stringent – participants queried if there is an easier way of checking in with employers whilst also remaining efficient.

A summary of the proposed approach discussed in this area can be found in the appendix.

7.2. Initial reactions to the changes and proposed approach

If you're not going to practise, there wouldn't be much point in paying to be on the register.

18-39, Northern Ireland

There were few concerns about the changes and proposed approach to leaving the GMC registers for doctors, PAs and AAs, though some participants pointed out that the information provided to them was not very detailed and consequently hard to argue with. Participants thought the changes should be applied consistently across all roles, with one bar for all. Participants generally felt that registrants should be able to leave the registers with little difficulty, suggesting that those wanting to move, retire or no longer practise medicine should be able to do so quickly and efficiently.

A small minority of participants did flag some concerns around what appeared to them to be a less stringent approach to leaving the registers, with the potential for some grievances or issues only known to employers not to be aired. Other participants also noted this, but felt that given the registrant was leaving the register anyway, any minor outstanding issues were likely not to be of concern.

7.3. Positive reactions to the changes and proposed approach

Leaving the register: positive reactions

A simple declaration saying I have no outstanding issues and I'd like to leave the register would be sufficient. In my opinion it should be a quick process. Coming back on is another matter, but why make life difficult for people?

60+, Scotland

Participants generally agreed that registrants should be able to leave the registers quickly and efficiently, with speeding this up by removing steps in the process felt to be positive.

Several noted how they placed a high level of trust in doctors to practise to a high standard, so taking back this trust when they're simply trying to leave the register seemed at odds with how patients currently relate to them.

If we trust a doctor to do heart surgery, he can decide if he wants to finish. There's got to be a point where you say 'Yes, I trust your judgement'.

60+, England

Some participants recognised that they may feel differently about this process if the registrant was leaving the UK to practise medicine elsewhere, and queried if and how appropriate information such as minor concerns might be passed on about registrants between countries. Generally, however, there was a sense that generic employment processes could sufficiently fill any gaps to which the proposed approach may lead.

One participant noted that employers themselves, who will no longer be consulted when a registrant applies to leave the register, may have been biased against the departing registrant for potentially small or personal reasons, ultimately making it harder to leave the register when a registrant should be entitled to do so. Depersonalising the process to increase efficiency therefore made sense to this participant.

Rejoining the register: positive reactions

For many participants, their level of comfort with the proposed change was due to the example flagging that the registrant was likely not leaving to practise medicine elsewhere. Some participants pre-emptively queried what this would mean for rejoining the register and, while there were differing ideas about the level of evidence applicants should offer when applying to rejoin the register, there was a general consensus that this could be relative to the time spent off the register.

Participants noted that the fast-paced nature of medicine meant practice could be different one year to the next, and those applying to rejoin the register needed to be able to prove they were still qualified.

While the example provided didn't focus on rejoining the register, we separately prompted participants about this part of the process. Most reflected that there would likely be a difference in the level needed for those who had left to practise elsewhere, compared with those who had perhaps stopped practising for some time. Participants felt that registrants who had been practising elsewhere should have to supply evidence from employers about their time working there:

How difficult is it to contact the employers… that is the normal practice when you get a job, when you're going for any job, that his record for the GMC when he first registered might be nice and clean, but what could have happened in between in the years he's been working is unknown to them.

60+, England

Some participants had a slightly more rigorous approach to rejoining the register, suggesting that even those only off the register for a short time should have to go through the process again fully and take the registration exam again:

You have to prove you're still fit to practise. I know people have to have ongoing development and ongoing training, so if you want to return to being a doctor, you have to sit the exam that everybody else sits to prove you can still do it, regardless of how many years' experience you've got.

40-59, Scotland

7.4. Potential issues identified with the changes and proposed approach

The small number of negative reactions largely centred on a perceived risk of "bad apples" being able to leave unnoticed. While public safety may not be compromised in these cases, participants worried about, in their words, a lack of "punishment" for outstanding issues and some reflected on the possibility of registrants potentially leaving to practise medicine elsewhere. This reflected misconceptions that the requirements for registration are different for public and private practice, as well as a perception that regulation may not be as robust in nations outside of the UK.

I suppose it is slightly [different if registrant is leaving to not practise], but how do we know he's telling the truth? He might take up medicine. He might not for a couple of years, but he might go into private practice after a while.

60+, England

These were often described as "borderline" cases – those that didn't merit contacting the GMC, but where there had been underlying concerns within an employer. A minority felt that the old system may have been preferable here, offering a greater ability to flag issues that fell below the GMC's thresholds, or the complainant's understanding of these. These participants had some suggestions around the possibility of still including a check with employers, but automating this to a simple checkbox if the employer did not have any issues to flag. There was a perceived mismatch between other proposed approaches which saw the GMC collecting more data.

Participants noted that the lack of detail provided around rejoining the register meant they were limited in what they could say. They mentioned residual questions here, the answers to which may affect the possibility of them raising issues. For example:

- How would the rules change, depending on what else registrants had been doing? If they had been practising overseas, would different countries be treated differently?
- What are the thresholds here? There was a strong suggestion that these should be clear and their rationale transparent.
- Would there be different requirements based on particular specialities versus general practice?

The final question, relating to differentiated requirements based on specialty, was also noted by some participants in relation to roles. A small number of participants flagged that they felt PAs would perhaps need to provide less evidence when rejoining the register than, for example, a specialist heart surgeon. The nature of their role, whilst felt to be fairly extensive, was also not seen as needing the same high standard of evidence for rejoining. We also heard questions and misconceptions relating to requirements around shorter absences, including maternity leave, which would not be relevant.

8. Complaints and concerns

For this area, we provided information on the current GMC investigation process, introducing tribunals and their make-up and the potential for this to lead to a doctor being removed from the medical register. We then discussed how, once regulation starts, PAs and AAs will need to follow guidance that sets out the principles of good practice, just as doctors do now, and the potential for PAs and AAs to be investigated when serious concerns are raised. We then focused on the new 'accepted outcomes' process, which will initially apply to PAs and AAs, but in future will also apply to doctors. This covered two key points:

- The GMC will be able to focus on concerns that pose a bigger risk to patient safety or public confidence in doctors, PAs and AAs, and to close cases that don't need action from the regulator.
- There is potential for more cases to close without a tribunal, such as when the doctor, PA or AA agrees with the action the GMC says is needed, which would be a quicker process for patients, families and professionals.

We provided the following case study and example of the future approach:

Mary, aged 47, from Aberdeen, has complained about the treatment her husband Derrick received from Sonia, a surgeon. Sonia performed a heart surgery on Mary's husband. Mary is concerned that Sonia did not discuss all the surgery risks with them before the procedure. She also did not listen to the family when they were worried that Derrick was getting worse every day after his surgery and unfortunately died a few days after the procedure.

The future approach:

The GMC will still investigate Sonia and will still liaise with the hospital where she works. However, the case examiner, following the outcome of the investigation can propose a measure to Sonia who now has two options:

- Accept the outcome of the GMC's investigation and the proposed measure to repeat training while she stops working as a doctor for three months. Sonia cannot negotiate the measure with the case examiner.
- OR request a tribunal and let an independent group of three decision-makers decide what action is required to protect the public.

Mary will be updated about whether Sonia accepts the outcome or requests a tribunal, and she is offered a meeting with the GMC to discuss the case.

8.1. Summary

- ✓ A majority supported reforms and the proposed approaches, viewing them as logical, fair and progressive
- ✓ Reductions in time, stress and cost outlay were seen as beneficial.
- ✓ Others liked the lessons-learned approach, which they thought would benefit society more widely.
- X There was a call for greater level of punishment for non-compliant registrants, with this seen as part of being "fair" and providing "justice". Many seemed to feel that punishment was integral to the GMC's role.
- X A minority were sceptical about the GMC's independence and the internal nature of the processes.

A summary of changes discussed in this area can be found in the appendix.

8.2. Initial reactions to the proposed approach and changes

Discussions with participants consistently highlighted anxieties about fitness to practise issues, across all roles. When prompted, participants in the focus groups and interviews strongly felt that the complaints and investigation process as a whole should be the same for doctors, PAs and AAs, given what they knew about the nature of PA/AA roles and responsibilities.

In addition, participants raised the idea that the supervisor should also be culpable to some degree in most cases, given their responsibility to oversee PA/AA roles. This was raised independently, rather than discussed as a potential option by moderators. While we did prompt for differences by role, many participants were quick to voice their support for doctors, PAs and AAs to be required to follow the same principles of good practice.

These feelings were explored through the case study, which focused on accepted outcomes. The proposed reforms outlined here felt sensible to participants, many of whom made the assumption that retraining would focus on specific areas of need determined by the case examiner. In the example provided, it appeared to participants that the heart surgeon's mistakes were to do with communication rather than clinical practice. There was widespread support for what looked like improved levels of communication with the patient and their family.

While many initially agreed with the proposed changes, there was some scepticism when applied to the pre-read example. We repeatedly heard participants discuss the complaints procedure in terms of "justice", both for the complainant and registrant. Many across the sample viewed the GMC as having a punitive role. For them, justice could not be done without some amount of punishment for the registrant.

There needs to be some consequence. They can't just say 'I'll re-train and I won't make the same mistake'. It is like a crime. If you commit a crime, you can't say 'I won't do it again, just let me go'.

18-39, England

It should be noted that only one outcome was provided in the example, with a lot of feedback relating to the specifics of retraining rather than the concept of accepted outcomes as a whole. This led to participants describing the specific example as "lenient", conflating this with the option of an accepted outcome as a whole. We suspect that the nature of the patient outcome – first presented as a death, then adjusted to serious complications for later sessions – led to anchoring bias, in which participants' decision-making focusing on this information. Had we talked about a harsher outcome for the registrant or a less serious case, or perhaps provided more context, results may have been different. We would not suggest that our study found the principle of accepted outcomes to be perceived as more lenient than the current approach.

Lastly, some felt that the process didn't feel as straightforward and efficient as they had imagined, in terms of the time a case could take to reach an outcome.

8.3. Positive reactions to the proposed changes

If you're sorting it out among the GMC, the doctor, and the patient's family and everybody is happy with the outcome then it saves time, stress and resources. If lessons are learnt… then going to tribunal isn't going to make much difference… it's best to give the GMC the power to close it there.

18-39, England

Most participants ultimately agreed that the reforms in this area were a positive step forward. While many expressed a desire for a more punitive process, this was tempered with a pragmatic attitude towards patient safety, the needs of health services and wider society. Older participants often called upon their own experiences of workplace complaints or tribunals and empathised with registrants in this position. The instigation of the accepted outcomes process was characterised as a common-sense approach that would reduce time, stress and cost.

My opinion is the future approach is a legal system. You either plead guilty and accept option one… or you say 'I didn't do anything, I'm not guilty,' and you go down the tribunal. If somebody has found you negligent, that's like being given a charge, and you say I hold my hands up. I agree that would be beneficial. Or you say I totally disagree, and it gives you that second option to appeal.

40-59, Scotland

Participants identified training, set as the condition in the example, as important to their rationale. Focusing on training would help ensure the same mistakes weren't made in future by the individual registrant. There was also a wider lessons-learned element raised here, avoiding similar errors being made by others. However, specificity of conditions was important for participants, particularly around the length of time they would take to meet.

Overall, the system was viewed as rigorous but compassionate to the needs of registrants and the public. There were perceived benefits for all involved:

Stakeholder	Perceived key benefits
Registrants	• Participants generally agreed that re-training was the likely outcome of most investigations, and that offering this upfront following an initial investigation made sense. • They noted that it would ultimately be the registrant's career that is at risk, and it was right that they had some agency in determining the course of action.
Complainants	• A reduction in stress for patients, family members and other complainants who would have to wait for a long time for closure from a tribunal. • Perceptions that communication would be improved, with updates and meetings between the GMC and the patients' families seen as a positive step forward – acknowledging them and giving them agency.
Society	• A shorter process felt like it would be less costly for the NHS and devolved health services, both financially and in terms of taking doctors out of circulation at a time of great need. • Perceived to reduce the risk of ongoing patient harm.
The GMC	• A small minority of participants suggested that it was important that the GMC could close cases more quickly, saving resources for the most serious incidents.

Figure 2, Key benefits to the accepted outcomes process as identified by participants

The cost of going through a tribunal is enormous, not to mention the stress for everyone involved, and I'm not just talking about [the registrant]. I'm talking about the relatives and witnesses. This would be hanging over people for years, so I can see a lot of benefits.

60+, Scotland

Reduced time and stress

Several older participants described how, in their experience, tribunals could be an extremely lengthy and involved process that had the potential to be incredibly stressful. Any alternative was felt to be good. These individuals drew on their own negative experiences in different sectors here – including education, local government and private employment. These had been highly taxing, both for individuals who had been subject to investigation and those who had played another role in the process. One Scottish participant recalled how their own experience had required them and others to travel to Edinburgh and London many times, using public funds. There was a great deal of anxiety about the potential for costs to build up, with taxpayers footing the bill – in this context but also more generally when discussing the reforms.

There was also widespread agreement that long periods of time waiting for a final outcome would likely be traumatic for already stressed complainants. It was beneficial to all to find resolution as quickly as possible.

My immediate thought is that's a really good thing. Anything that simplifies things [and] takes the stress out of it, that's a good thing.

18-39, Scotland

Lessons-oriented

Participants who supported the idea of accepted outcomes liked how they appeared to focus on learning lessons, perceiving this as helping to reduce the chances of something similar happening in the future, such as improved communication as addressed in the example. This was understood as fair, with the proposed changes seen as able to adapt to the context and content of the specific complaint. These participants were more likely to trust in doctors, PAs and AAs and their clinical abilities. They described a pragmatic view, in which it was counterproductive to remove highly skilled professionals from the system. These participants valued the GMC as a body that could signpost support and training. There does not appear to be any strong correlation between these views and any demographic factors.

Doctors are human. Mistakes do happen. In the long run, what good does punishing a doctor do? I think retraining and getting them back into work is the best way forward, unless obviously it's a really dangerous situation.

40-59, Wales

I think that doctors generally have enough concerns without this [a lengthy complaints process] as well.

18-39, Wales

The process was also seen as supporting whistleblowers to raise complaints with the GMC without the guilt of costing the registrant in question their job:

With the old approach it's quite serious and it goes to tribunal, and it could mean they lose their job, whereas the new approach could mean it doesn't go to tribunal, but they get the support they need.

40-59, Scotland

There was a divide between those who were willing to put their trust in the case examiner, and those who felt that this would not be sufficient. Participants who trusted the GMC's ability to make an accurate decision without the need to go to tribunal noted the level of evidence used, including employer records and interviews. For them, there was likely to be little more that could be gleaned from a tribunal. It was felt that the full process was only likely to be of interest to registrants who seriously disagreed with a case examiner's findings, or who felt they had been wronged somehow. It was seen as beneficial to have this avenue available should it be required, providing agency for registrants and the ability for them to put across their own side of the story – have their "day in court" as numerous participants called it. Ultimately, it was felt that most cases would not merit this level of scrutiny and it was better to resolve them and move on.

8.4. Potential issues identified with the proposed changes

This seems geared around protecting the doctor, and, as we've seen many times over the years, the institution pulls rank. They protect each other, so Mary [the complainant] needs to be protected as well.

40-59, Northern Ireland

There were also some criticisms of the changes, often from the same participants who held the favourable views described so far in this section – making this a key area in which participants held multiple, conflicting viewpoints. Broadly, more critical views represented initial emotional reactions, while more positive attitudes emerged after some discussion. We would suggest this is a finding, rather than a limitation. We probed participants in depth, looking to understand their own impressions, as well as what they thought was fair for registrants and complainants – observing sentiments changing throughout discussions.

These multi-dimensional viewpoints were particularly apparent when discussing accepted outcomes. This may be a result of the example used, which presented a serious case, resulting in a death. This was adjusted after the second group to 'serious complications', but findings remained consistent, with strong demand from many participants for the GMC to apply punitive measures. Rationales related to:

- The risk of complainants being denied "justice".

- A lack of trust in the GMC.
- An accepted outcome being viewed as an "admission of guilt".
- A lack of clarity around the process, including timescales.

A perceived lack of "justice"

The idea of outcomes being "fair" for all parties drove a desire for punitive measures. Participants expected the GMC to ensure registrants were punished for mistakes, often describing this as being "fair" or providing "justice" to patients who had experienced a lapse in safety. Many participants wanted to see mistakes punished, especially for more serious issues. It was felt that suitable punishments would be in proportion to the patient outcome rather than the actual error made by the registrant.

It's about proportion. You don't want to see a doctor dragged through court for months and being stressed for something relatively minor, but on the other hand, if it's a serious matter, you would want to see justice done.

60+, Scotland

Based on the information available, participants generally perceived accepted outcomes to be less punitive than those that might come from a tribunal. The example case study resulted in a training condition and the pre-read did not show that case examiners can also propose suspension or removal through the accepted outcomes process. This may have led participants to assume that accepted outcomes are less punitive, whereas in reality the sanctions available to case examiners will be the same as those in a tribunal.

Consequently, participants tended to focus on the specifics of the example rather than the overall accepted outcome process. For instance, they had concerns about the 3-month retraining window, which they felt this was too short and might not have a significant impact on behaviour – meaning the registrant might revert to old habits afterwards. We heard concerns about further risk of patient harm, with participants referring to the Lucy Letby case and others, where they felt that harm could have been reduced if initial concerns had been acted on. In terms of accepted outcomes, participants felt the "punishment" did not reflect the traumatic lived experience of the patient or their family.

I think, if I can imagine myself being in this situation, from a family's perspective, the emotions attached to this, you would want more justice.

18-39, England

This suggests a misunderstanding of the GMC's role, abilities and statutory duty. Still, this sentiment cannot be discounted, given the potential impact it may have on future GMC communications. We heard the term "struck off" time and time again, especially from those 40+. Being removed from the register was, alongside the GMC making referrals to the police, an extreme option that many expected to be part of the regulatory toolkit. Similar opinions were heard from participants from a diversity of backgrounds, suggesting that

these are concerns that may carry weight for a wide range of individuals. Participants spoke of cases potentially "falling through the cracks", if registrants took what was seen as the easy option of accepting an outcome.

A lack of trust in the GMC

Participants were sometimes sceptical of what they saw as the overly internal nature of the complaints and accepted outcome process, questioning the independence of GMC stakeholders. In many cases, they believed that outcomes would be lenient. This aligned with concerns that the GMC would favour registrants over patients:

It seems like it's more protecting the doctor and the PAs and AAs, as opposed to protecting the public, and the public should always come first, especially the NHS. In this case, the man is dead. That's as worse as it can get, but the doctors get to continue with their career… It doesn't seem like the person who's suffered is getting any justice.

18-39, Scotland

Several were cynical of the GMC's motives in enacting reforms, feeling that the process had just been streamlined to protect registrants and reduce any burden on them after a dispute.

I don't know any other industry or career where your work can kill someone, and they'd be like just go and retrain for three months and you can come back. That's ridiculous.

18-39, England

We also heard some more conspiratorial thinking – linking to the wider theme of a lack of trust in public bodies. One younger participant speculated that the GMC's hidden rationale was to retain as many doctors as possible in the workforce. Others were generally wary of internal procedures:

I'm a cynic when it comes to councils. You never know the inner workings of them. It's like the masons.

60+, Wales

As throughout this study, a lack of knowledge around the GMC's external oversight led participants to feel that there was insufficient scrutiny from external, independent bodies. However, we did not hear any concerns that doctors would attempt to negotiate with the GMC for beneficial outcomes, despite some scepticism about the process.

Forces the "innocent" to assume "guilt"

Participants were concerned that some registrants might accept outcomes to avoid the drawn-out hassle of a tribunal, regardless of whether they agreed with the case examiner's

findings. For most participants, accepting an outcome meant the registrant would have no voice in the process and equated to assuming guilt and responsibility for the incident.

Recommendation of a tiered approach

The desire for appropriate retribution was voiced by many who also supported the accepted outcomes process. While these two viewpoints might seem contradictory, participants explained how they thought the level of "punishment", i.e. the outcome determined by the GMC, should be dependent on the severity of the case.

In most cases, they expected complaints to be minor and rectifiable by training. However, in more serious cases, they held the expectation that there would be long-term consequences for registrants, as redress for the harm they had caused patients.

Some participants suggested that there should be a tiered approach, where the punishment reflected the patient outcome. For example, if it resulted in a death, it should always go to tribunal. While participants did not want people being dragged through a long process for something small, they also didn't want serious cases to avoid full scrutiny and appropriate conditions, including some form of punishment or penalty where appropriate. Questions over how these thresholds would be set were not resolved in the groups.

I don't want to see a doctor suffer unnecessarily… but I think there are times when they're going to have to take the time to do it all properly, and this may result in their suspension.

60+, Scotland

Further factors

Other concerns related to a perception that processes becoming less rigorous could result in the GMC becoming less well respected over time. This was a minority view.

Timescales for investigating and determining outcomes were not provided in the pre-read example, and participants felt there should be guidelines on when a step should happen and how long it might last. Several participants had been involved in a tribunal in an unrelated field[1] and described this as a long and extremely challenging time. For them, knowing that a complaints process would be over more quickly via an accepted outcome would be a key determining factor in which option to choose, and believed that GMC registrants would think the same.

[1] Note that we did not probe into the details of these situations given the public nature of the groups, but did screen out any participants with links to the GMC, roles under consideration, and the wider medical/healthcare sector)

9. Challenging the GMC's decisions (appeals and revisions)

Information was provided detailing new processes in which more of the GMC's decisions on raised concerns could be challenged or changed in two ways:

- **A revision:** The GMC can swiftly modify a decision if it is incorrect or outdated. Revisions can be: requested by case participants; initiated by the GMC upon identifying errors or changes in circumstances; or applied to appealed decisions to avoid lengthy, stressful procedures.
- **An appeal:** Individuals can contest a decision via a GMC appeals panel if they believe it's wrong or unfair. The appeals process is expanding to include more types of decisions. Notably, more GMC decisions can now be appealed internally, and individuals must seek GMC's permission to appeal, which will only be granted if the appeal has a potential for success.

The example dealt with a revision to a decision made about an AA:

> The case study described a member of the public making a complaint to the GMC after finding that an AA had shared a photo on social media in which a patient's name was clearly visible. After considering this concern, the GMC decided this one-off incident wasn't a risk to patient safety or public confidence in health professionals and closed the case. The complainant was not satisfied with this. They then found out that the same AA had multiple social media accounts posting similar content, including videos showing him performing a procedure on a patient.
>
> The member of the public put in a request for the GMC to change their original decision. When the GMC were considering this request, they indicated that they would share the information they had provided with the AA and ask for their comments.
>
> The member of the public wanted to know whether the GMC would proactively gather more evidence and investigate the AA's social media usage when considering their request. They also wanted to know whether they should send more information to the GMC to support his request.

Some participants struggled with the complexity of this case, leading us to take them through one step at a time and prompt on each element in turn, before a final discussion.

9.1. Summary

- ✓ For many, the changes to the appeals process sounded less cumbersome and more efficient overall.
- ✓ The revisions process was initially seen as sensible, fair and suitable for all roles.
- X These attitudes changed when working through the example of a revision. This led to heated discussion of the GMC's perceived lack of impartiality, with participants again feeling they would favour registrants over patients.
- X This could speak to wider issues around a lack of trust in public bodies. It also led participants to reappraise their thoughts about the appeals process, looking more critically at the GMC's role in this.

A summary of changes discussed in this area can be found in the appendix.

9.2. Appeals

Positive reactions to the proposed changes

Positive reactions to the proposed changes were pragmatic. The process was described as similar to a legal court of appeal. These participants understood that the GMC could not play the role of police, prosecutor and judge.

Participants described several factors behind the process marking an improvement, to do with both a reduction in time and cost outlay for complainants:

Avoiding the courts

There was a perception that it was time-consuming and expensive to go through the courts, which would be highly stressful for those wanting to make an appeal. Under the old system, participants believed that hiring a solicitor and taking time off work would come at personal cost to complainants, with this burden removed under the reforms.

A minority of participants noted that UK courts are currently over-loaded, and the system as a whole would benefit from any reduction in demand for court time and space.

Asking permission from the GMC

Participants assumed that the appeals process would be popular, but only a relatively small number of cases would actually see a significant change in their outcome. As such, it appeared sensible to save time and effort by cutting the process short for cases that were highly unlikely to see a successful appeal. Participants with these views did express some concern there may be instances of cases being "unjustly" excluded from appeal, but they felt the amount of time saved made it worth the risk.

I feel it only feels fair that you should be able to appeal, regardless, but at the same time, would everybody not just appeal, whether or not they would be successful in the end, so how much time does that waste if they're going to go through the appeals process and it's still going to be the same outcome?

18-39, Scotland

A minority of participants felt, correctly, that an individual could always go to court if they fundamentally disagreed with the GMC's decision.

Potential issues identified with the proposed changes

However, others were suspicious of the level of oversight the GMC held over the process. A key trigger for this unease was the sense that the GMC could refuse appeals they disagreed with for political reasons. One participant stated:

If the individual wants to appeal, they must be able to appeal, and it's not for the GMC to say 'You can't appeal, sorry.' I don't agree with that, I have a problem with that.

60+, England

This was another instance of the reforms being understood as "unfair" and being ineffective at addressing unjust treatment:

Everybody should have the right to appeal if they feel they've been unfairly judged.

18-39, England

Participants identified what they saw as a conflict of interest. This prompted an emotional reaction for several and spoke to their instincts that the GMC may not be trustworthy.

It sounds a bit incestuous. They're applying to the GMC in the hope that they'll agree to appeal against the GMC, which will then be looked at by the GMC.

18-39, England

The majority of concerns we heard reflected what participants saw as a lack of external oversight, with internal panels described as troubling by a range of participants.

Anything that has an internal panel for me, is always a bit of an alarm… there should be an independent body within the independent body.

18-39, England

There was widespread support for a "neutral" third party who could oversee the appeals process, as evidenced by the following focus group discussion:

***Participant 1 (Northern Ireland)**: It nearly feels like the GMC have to have somebody regulating those decisions as well.*
***Participant 2 (Scotland)**: They've got a monopoly. They decide everything.*
***Participant 1 (Northern Ireland)**: They're skewing the decisions.*
***Participant 3 (England)**: It feels like it needs to go to a board of specialists in that industry or within that specific topic, and they need to analyse the decision made.*

18-39 Group

This scepticism could partly be explained by a lack of awareness about the make-up of the appeals panel, as this was not provided to participants. Several asked if this could be made up of the same people who made the original decision, if these groups might be known to each other, or if the panel knew the registrant and their family in a personal context. It was also unclear what options were available to those whose application had been denied.

As identified across this study, there were also more fundamental issues around a lack of trust in public bodies, including the GMC. While participants' rationale for holding these views was not always clear and fell outside the scope of this work, a minority of group members believed that the GMC could be "gatekeeping" via this reform. These participants felt that the GMC could be, consciously or unconsciously, biased in their decision-making, both in the first instance and as part of the appeals process:

We can't forget about bias, financial and political interests, social capital. There's a lot of factors that go into when a panel is making a decision for an appeal.

40-59, England

Others suggested that the GMC could be tempted to limit the number of appeals for internal financial or staffing reasons, making the availability of an alternative route all the more important.

9.3. Revisions

Participants tended to respond emotionally to the example, which they felt showed the GMC making the wrong call. Most viewed the lack of investigation and the case's closure in the first instance as unfair and not representing patient interests. They then read the example as the GMC failing to fully rectify this by collecting further evidence when given the opportunity. The nature of the example scenario used may have skewed results towards the negative, and to some extent supported existing feelings of mistrust towards the GMC. It may have also limited engagement with the finer details of the reformed approach.

Positive reactions to the proposed changes

It should be stressed that some participants were much more trusting of the GMC. On first being introduced to the idea that, under the reforms, the GMC could quickly change a decision if found to be wrong or no longer suitable because things have changed, reaction was largely positive. The fact that there was a clear process by which the organisation could address any oversights or mistakes was seen as comforting. As in many other areas of reform, the idea of shortening lengthy processes was well received, and this was seen as fairer and less stressful for all parties involved.

However, this changed when confronted with the example scenario, which started with the GMC deciding to close a case, finding that that this was a one-off incident that wasn't a risk to patient safety or public confidence in health professionals. The emotive nature of this example and the widespread sense that the GMC had made the incorrect initial decision perhaps meant that many ensuing reactions were much more critical.

Potential issues identified with the proposed changes

There were participants across the sample who didn't trust that the GMC could judge its own decision-making. For these already suspicious groups, this example demonstrated that they were correct to believe members of the public would be unlikely to see "justice" or "fairness" from the GMC, who they felt would be more likely to protect registrants.

"Why is Mo doing the work of the GMC? Their initial investigation was flawed. It was incomplete. Then who's regulating the regulator? They failed. There's a massive failure and a dereliction of duty by the GMC here."

60+, England

Again, this seemed to demonstrate a level of distrust in public institutions in general. Several participants were open about their lack of trust across a range of authority figures, including GPs, judges and members of what one participant called the "managerial class". Perhaps counterintuitively, those most vocal in their criticism felt strongly that the GMC should refer the registrant to the police, and factor the outcome of their investigation into their own decision-making. For them, the fact that the registrant appeared to have contravened the Data Protection Act, and other rules and regulations, made it more confusing that the GMC were not taking a more robust approach. One participant who worked as part of the police force was doubtful that any other authority would be equipped to conduct a thorough investigation, both in terms of having the necessary legal powers and technical expertise.

These reactions throw further light on participants' perceptions of the GMC's regulatory role as being to maintain patient safety via policing registrants.

Further feedback

We asked participants questions on two specific areas to gain feedback for the GMC to use in the development of their processes: the timelines for informing registrants; and complainants gathering additional evidence.

Timelines for informing registrants

Most participants felt the GMC should contact the registrant after they have collected evidence and built a case, otherwise evidence could be deleted or destroyed and the case could crumble. Some worried about the vulnerability of the complainant if registrants receive early warning that they are under investigation – feeling they might target complainants and pressure them into retracting their complaint.

A minority thought that being informed at this late stage would be unfair to doctors, who could be targeted by members of the public as part of a campaign against them, particularly if complainants use social media themselves to draw attention to perceived risks to public safety in addition to contacting the GMC. This smaller group of participants felt that the registrant should be contacted at the earliest possible opportunity. One suggestion was for the GMC to conduct some initial checks – such as verifying that the social media images referenced in the complaint are real and that there weren't other contextual factors in play – before deciding on the best course of action.

Additional evidence

Participants strongly felt it was unfair for members of the public to shoulder responsibility for investigating, providing evidence and navigating GMC processes, given their lack of expertise and overall involvement. They perceived that the onus was on complainants to gather evidence, without GMC support around what would be most effective or helpful.

There was general agreement that the GMC should take proactive steps in pursuing further evidence. Some held high expectations – for example, that the GMC would follow up on all emails from members of the public and collect evidence.

To some extent, this reduced concerns about the GMC being unable to dictate the nature of additional evidence.

Mo's job is to raise a concern and the GMC's is to investigate, that's what their resources are for.

60+, England

Several questioned the need for the case to go through the revisions process because of new evidence coming to light, rather than simply being raised as a new, distinct complaint. This felt overly bureaucratic and seemed to require more knowledge of GMC procedures than could reasonably be expected of members of the public.

I think the whole process should be as easy for the public as possible… if it's too laborious, the public won't do it and people will get away with things.

18-39, Northern Ireland

10. Regulation and the GMC

10.1. Awareness of the GMC

Awareness was mixed, with most participants unfamiliar with the GMC and its remit. Participants aged 40 and above were more likely to recall the GMC by name, most often from media stories involving malpractice or what several termed "things going wrong". Those aged 18-39 in our sample were more likely to be entirely unaware of the GMC as a specific public body, leading some to search online before speaking with us to provide them with some context. Awareness may have been overstated across the sample, given social desirability biases and the fact that we provided participants with an explanatory document to read before participation.

While awareness was low, the concept of the GMC and their work did not come as a surprise to participants – meeting their expectations that there would be a public body or regulator for most sectors.

It's the first time I've become aware of what the GMC was. It's not something that's advertised or shown on the news very often, or maybe I've not been watching the right news. I understand the regulatory stuff… it's just the name itself which was a bit of a new one to me.

18-39, Scotland

Others said it was simply that they had never had cause for complaint, or even just felt that the GMC and other public bodies lacked relevance to their life – they would seek them out if needed, on the assumption that there would be some kind of body in place.

After reflecting on the stimulus provided, which explained the role of the GMC, participants described how they understood the body as the medical equivalent of other national regulators, including OFCOM, Ofsted, the Advertising Standards Authority (ASA), the Food Standards Agency (FSA), the Financial Conduct Authority (FCA) and the Care Quality Commission (CQC). The concept of statutory regulators appeared well understood. Others drew parallels with professional associations and governing bodies, including the Law Society and the Football Association (FA). These varied understandings may be at the root of conflicting perceptions that the GMC exist to protect the public or registrants.

10.2. Reaction to the upcoming regulatory changes

When participants were asked to reflect on the reforms as a whole (across doctors, PAs and AAs), they expressed a lot of positive sentiment. There was broad support for the reforms, with efficiency, removing red tape and perceived cost savings for health services all showing as important for participants.

They're aiming for efficiency and cutting bureaucracy, and bringing in a lot of things under one umbrella.

60+, Scotland

The proposals for all roles were described as reflecting contemporary needs, with several participants making comments about the GMC "moving with the times":

I really liked it. I thought it felt very much as though they're bringing the regulatory requirements in to the 21st century, rather than what was needed in the 80s or 90s.

18-39, Wales

They also related these changes to those they expected them to carry out on a regular basis:

Hopefully it's an ongoing process, and every year or every five years they'll renew or review their processes and keep up to date.

60+, Wales

Many participants, including those who had previously been unaware of the roles, found it alarming that PAs and AAs are, in their perception, currently unregulated and lack an official register. The changes were in line with participant expectations of an ever-evolving regulator, adapting to current circumstances. Participants seldom referenced the statutory requirement for the GMC to regulate PAs and AAs, instead characterising them as the GMC addressing what looked to be a serious regulatory gap.

We heard many tensions and contradictions in participant responses. Sentiment around the GMC's reforms shifted throughout discussions – sometimes they were highly receptive, only to shift to less positive viewpoints, before coming back around to their original position. This was more than just individuals changing their minds – they often appeared to hold multiple contradictory viewpoints, especially where there was an underlying scepticism.

Straightaway, I thought anything that makes things simpler and also more thorough is a good thing… After that, I started thinking sometimes these things can end up making things more difficult, and in the end, they can end up the same as they were before, but under a different heading.

40-59, Scotland

While these tensions and shifts of opinion felt organic, and perhaps related to an evolving awareness of this topic, we also recognise that participants were subject to structured questioning by moderators who aimed to uncover deep and complex viewpoints. Participant

contradictions are explored in earlier sections of the report in the context of specific changes and topic areas.

While the reforms as a whole were well received, some were sceptical about what they would mean, for a variety of reasons, including that:

Perceived contextual difficulties would impair any attempt at reform, across roles.

- Participants were quick to point to an overstretched NHS (or devolved health service) and believed that staff in hospitals and GP practices would struggle to find the time to familiarise themselves with the reforms and develop any new approaches they might require.
- There was a lack of faith in hospitals, trusts, GP practices and other services more generally, with perceptions that corner-cutting and fire-fighting were routine. Participants referred to healthcare services they perceived to be "failing", not up to standard or otherwise in crisis, linking these to media stories.
- There was a further lack of trust in non-clinical managers within healthcare, who were portrayed by a minority as more interested in self-preservation than patient care. These participants were doubtful that these roles were interested in supporting regulatory reform, though it was not made clear how they would impede implementation.

Reforms wouldn't make material differences to their lives. We heard a degree of cynicism about what the proposals would mean in reality, including some doubt that they would have any positive effect on the public.

The introduction of PA and AA regulation provided further room for doubt. The level of supervision that participants expected, based on the pre-read, felt unrealistic to them, again based on the time pressures on doctors and a lack of trust in workplaces. The exact nature of supervision lacked clarity. Participants raised multiple questions here: *What would it actually look like? What would that mean for patients? Would it be evenly applied across all settings and contexts?*

Finally, there was a more fatalistic reaction from a smaller number of participants, who told us that they felt they had little agency in these kinds of decisions – stating "it is what it is" and "we get what we're given" when it comes to the NHS and devolved health services. This was prevalent across the sample, but heard most strongly from older (60+) participants.

10.3. Confidence in the GMC

In the eyes of those aware of it, the GMC were seen as a reputable and capable organisation – and part of the fabric of society, alongside other public bodies and regulators. Even those who were unfamiliar felt there would be a regulatory body in place. Nevertheless, there was scepticism that something good on paper might not work in practice.

Strong and meaningful regulation was seen as necessary to avoid fitness-to-practise issues, often citing news stories of serious cases (in many cases historical or outside of the GMC's remit, i.e. nurses and other roles), including Harold Shipman and Lucy Letby.

Levels of confidence in the GMC and its ability to effectively regulate and apply the upcoming changes differed by age of participant:

- Those aged 60+ appeared much less trusting than younger participants, often drawing on negative personal healthcare experiences or familiarity with press coverage of malpractice and serious cases – again, sometimes in contexts outside of the GMC's remit. These participants were more likely to be concerned that the GMC would always work to protect the interests of healthcare professionals over members of the public. This mindset led them to interrogate the examples provided in the pre-read more critically.
- Participants aged 18-39 were generally disengaged and unfamiliar with the GMC. They were more trusting and less opinionated. Nevertheless, some were still cynical about the GMC's motives, suggesting that some changes were cost-cutting exercises and others might increase payments to the GMC, e.g. those around sitting exams.

While there was majority support for the GMC acting as the regulator for PAs and AAs, a small number of participants described how it wasn't important to them which organisation played this role, simply that the process worked:

If they can set up another body to regulate the PAs and AAs, I don't think there's anything wrong with it, as long as they've got the same criteria. With the GMC, the fact that they work with doctors and they know what is required of doctors, and the fact the PAs and AAs work very closely with doctors… I'm neutral towards it… it all depends on their workload.

18-39, England

10.4. Regulation

Participant responses consistently displayed a tension between the necessity for regulation and a lack of trust in regulators and public bodies. Many participants supported the idea of regulation across many areas of public life, while also remaining highly sceptical about how these played out in reality.

We heard a general lack of trust in public bodies, with a feeling that the GMC will protect doctors, PAs and AAs ahead of patients. We heard the question "Who regulates the regulator?" several times. After discussion of this with the GMC, interviewers provided information on the Professional Standards Authority and accountability to parliament where relevant in the last five interviews. This somewhat countered negative perceptions of the GMC, providing reassurance that additional checks and balances were in place. Those with more deep-seated trust issues in regulators found this knowledge to be less convincing.

We obtained some useful insights into participants' conceptions of regulators, and their reference points from other sectors and situations. Negative sentiment or news regarding

the police, IPCC (Independent Office for Police Conduct) and CPS (Crown Prosecution Service) looks to have spread to other regulatory and national bodies. This led to a minority of participants being explicit in their perception that the GMC represented doctors policing themselves.

I relate it quite a lot to the police, they're meant to be independent and regulated, but it's more like the police policing themselves a lot of the time. My understanding is that this is the same, even though they're independent.

40-59, Scotland

Simultaneously, the desire to see the GMC dealing out punitive measures to registrants was a recurring theme. For many, effective regulation – in the interest of the public – meant decisive action. One older participant explained:

I always feel they don't have enough power. In the case of finding somebody guilty of the charges or accusations, if it's that serious… all they can do is kick them out. There's no recourse. They should be able to make legally binding 'you've got to pay that guy half a million'… as well as kicking them out.

60+, Wales

11. Conclusion

11.1. Overall perceptions

Overall, there was positive reaction to the reforms and proposed approach. To participants, these felt logical and like a step in the right direction for patients, doctors, PAs and AAs.

Regulation of PAs and AAs

In particular, more standardisation felt safer and fairer to participants. They were very pleased that PAs and AAs were being regulated – no one disputed the need for this. Proposals relating to these roles were received particularly well, with participants confident that there were appropriate checks in place to avoid compromising patient safety. For some, there was a direct link between regulatory reform and feelings of greater confidence in PA and AA roles. Participants would be happy to be treated by these roles once they are under GMC regulation. There were very few instances of participants drawing out differences between these two roles – treating them equally made sense to them. It should be said that there was a general mood of resignation that patients were happy to receive any attention in a difficult climate for UK health services. We heard the phrase "you get what you're given" more than once in relation to the NHS and devolved health services.

The GMC

Many participants were glad to see the GMC taking an active role in making updates, believing that healthcare was changing all the time and that regulators needed to keep ahead of oncoming challenges. There was often an assumption that these changes were part of a continuous process, and a pragmatic sense that they could never be truly perfect. Participants also accepted that there would always be unforeseeable issues, in particular around fitness to practise, and that the GMC could not prevent all of these.

Almost all participants told us that talking through the changes in the group or interview had increased their level of understanding of the roles, the GMC, and both regulation and reforms – all of which often started from a very low level.

While reaction to the changes was highly positive, there were older participants much less confident in PAs and AAs, and the ability of the GMC as a regulator to avoid serious incidents occurring in future. Others were sceptical of the rationale for the changes, reading efficiency as cost-cutting or a reduction in safeguards.

Regulation of different registrant roles

You have a duty of care. Your seniority or level of experience shouldn't matter.

18-39, England

Across the sample, there was a desire to see all registrant roles subject to the same regulation. This did not differ when talking through each topic. This consistency was seen as fair to both registrants and members of the public.

Participants explained how, as patients, they were asked to put their trust in all healthcare professionals, regardless of role, and wanted to see this repaid in a cohesive regulatory environment. Several queried whether nurses would be subject to the same guidelines and were surprised that there was not one standard. There was an expectation for one regulatory framework that could be researched by members of the public in times of need.

I would assume that everybody in the medical profession would be regulated by the GMC. I was surprised they weren't. I think they should be treated the same way.

40-59, Scotland

There was also a suspicion that, in practice, doctors or anaesthetists would rely on PAs or AAs to conduct many important tasks with a minimal level of supervision. The critical nature of PA and AA responsibilities made it sensible for the same regulation to apply to all roles.

It's almost having that level of responsibility, and, if they weren't governed the same, that would be worse than the doctors not having that level of governance because they're doing such important tasks that are what you'd expect the actual expert to be doing.

40-59, Scotland

Anyone who's got responsibility over people's lives all need to be held to the same standard.

18-39, Scotland

Multiple standards were deemed to be confusing for the public. It was described as reassuring that PAs and AAs will be open to the same level of oversight and scrutiny as doctors. Participants were worried that these roles would be treated more leniently than doctors and evade "justice" for any mistakes which impinged on patient safety.

They all have to be held to the same standards. Otherwise, life gets messy.

60+, Scotland

Participant tensions and contradictions

This study uncovered many seemingly contradictory attitudes. On one hand, participants consistently expressed a strong desire for the GMC to take an active role in policing compliance, ensuring that any "offenders" were severely punished. Yet they were also often distrustful of the GMC, expressing scepticism about its level of independence and feeling that outcomes were likely to be in the registrant's favour. While this idea of the GMC's role does not match its actual statutory duty, it is instructive. Justice and fairness were the watchwords for participants across every change, context and individual. Where these were seen as breached, participants became suspicious of the GMC's intentions and rationale.

Trust in public bodies

There appeared to be issues around a broader lack of trust in public bodies, which led some participants to believe that the GMC would always support registrants. The fieldwork took place at a time when many scandals involving public bodies and corporations were in the press, with the Post Office Horizon IT inquiry and TV dramatisation receiving a lot of public attention, alongside negative press involving the NHS, Ofsted and water companies. Much scepticism or mistrust relating to regulatory reforms connected to a similar sense of the GMC feeling opaque as an institution. Participants consistently raised the importance of sufficient external oversight or auditing of decisions. Without these, participants would be deeply concerned – they wanted to be assured of the checks and balances in place.

This may relate to a lack of knowledge – prior to the discussions, no participants had any understanding of the measures in place. This could not always be countered during groups and interviews. Concerns here seemed to be indicative of a deeper lack of connection between members of the public and the bodies that exist to protect them.

11.2. Recommendations from participants

We have collected participants' recommendations for the GMC. We do not suggest these are actionable or correct, only that they may be valuable in understanding their views.

Area	Participant recommendations
Education	Some participants felt it would be appropriate to have some kind of cooperation internationally to check PA/AA courses administered elsewhere.
Education	Ongoing oversight after education is done, i.e. keeping track of CPD hours or additional training and learning throughout careers. *I would expect there would be – especially the role they're doing dealing with vulnerable members of society and clinical environments – that there would be an ongoing… requirement to sign up to a specific register, and make sure they're clocking so many hours per year of CPD, and make sure they're consistently meeting that standard.* **18-39, Scotland**
Education	Recommendations for regularity of course checks ranged from yearly reviews to every 3 years.
Education	Introducing mentorship in courses to support PAs and AAs post-graduation, which the GMC could be looking for in its checks.
Rejoining	One participant suggested that those temporarily leaving the register for maternity leave should not need to go through the same rejoining processes, not realising that this is already the case.

	This led to wider conversations about the appropriate length of time a registrant could be off the register in relation to providing minimal evidence for rejoining.
Complaints and concerns	Many participants commented on communication between the NHS, or devolved health services, and patients or their families. Some suggested that the GMC might have a role to play in improving the nature of those communications. *I think the main problem for me, what I see in the NHS is really bad communication with patients and patients' relatives and you're often kept in the dark about what someone's treatment is, what's going on. And I think if the GMC can ensure that there is better communication between health professionals and patients, I think everyone would feel much happier with the service if they knew what was going on, what the next steps are.* **40-59, Wales**
Complaints and concerns	Some participants suggested the GMC should provide timescales to both the complainants and the registrant involved, around how long an investigation should take and when complainants should expect to hear from the GMC.
Complaints and concerns	Some suggested that there may be some instances where a case going to tribunal would always be appropriate, and that registrants involved in more serious cases perhaps should not be offered the chance to accept conditions such as training– this linked to some participants' desire to see a more punitive outcome. Related recommendations linked to a "tiered approach" for negotiating complaints and concerns, depending on the severity of the case.
Appeals and revisions	Some participants suggested that the appeals process be handled by an entirely separate third-party organisation. *Perhaps there could be an independent, smaller body to review appeal decisions so it's further removed or independent… Perhaps if there was any bias, or if it was the same people involved in the decision then there could be some sort of bias there, and just for a fairer appeal that's not going through the GMC again, but a separate body of it or a branch of it.* **18-39, England**
Appeals and revisions	Amongst some participants, it was seen as appropriate for the GMC to take on a more investigative role when seeking out evidence. Some participants reacted negatively to the scenario in which a GMC case was initially closed, suggesting that if the GMC had had the power to conduct more of an investigation initially, there would have been no need to re-open the case.
Appeals and revisions	A few participants felt the registrants involved in a case should be told they were being investigated again as soon as the GMC received additional evidence. But some were more hesitant around

	this, fearing that the registrant may be able to hide or delete any incriminating evidence.

Figure 3: participant recommendations by regulatory reform topic area

11.3. Limitations

While we consider the project to have been successful in meeting the GMC's aims, some issues and limitations are worth flagging. In some cases, it was possible to mitigate for these by adapting our approach. In other cases, this was not feasible, but often these situations themselves provided insight in terms of the potential source of some reactions to change.

Issue / limitation	Mitigation / impact
Lack of understanding of PA and AA roles – while care was taken to describe these roles in the pre-read, participants in the first focus group were still sometimes unclear about the tasks they might be expected to perform, or whether their role was largely clinical or administrative.	Following the first focus group, we amended stimulus materials to show participants a list of tasks, taken from the NHS Careers website, for both PAs and AAs, to support discussions. This was highly effective in enabling participants to understand these roles.
Misconceptions and lack of understanding around regulation and the GMC's role – despite the pre-read, in some cases, participant responses revealed gaps in their understanding of the GMC. In particular, some had the impression that it might have a representative function, and most were unaware that it was independent of the profession and subject to scrutiny itself.	After discussion of this with the GMC, moderators provided information on the Professional Standards Authority and accountability to parliament where relevant. However, this was late in the project. Some issues were inevitable when providing necessarily simplified and concise information about regulation and changes to regulation. While some of these are clearly misconceptions, it is useful perhaps to note that these misconceptions may be part of public responses to any change and to the GMC in general.
Complexity of the subject matter – the research sought public views on a sample of questions linked to the GMC's consultation. The consultation itself was technical, complex and lengthy at around 70 pages. This information had to be summarised and simplified to make the discussion accessible to the sample. **While the consultation focused on rules, standards and guidance for PAs and AAs, the research covered reform for all**	We took an approach aiming to balance depth and comprehension. Research tools, including the pre-read and discussion guides, were pitched at a user-friendly level to aid accessibility and better reflect the lack of knowledge we expected members of the public to have about the GMC. If the pre-read had been too long or had too much detail it would have been difficult to engage with, limiting participants' ability to contribute to discussions. The discussion guides covered a lot of ground during the

registrants, adding additional complexity for participants and researchers.	discussions and facilitated meaningful conversations about this complex topic. Wherever possible, we have detailed if findings apply only to doctors, PAs and AAs, or all registrants.
Timing of fieldwork – groups and interviews were conducted between late March and early April 2024, during and following a period of press attention to several high-profile public events related to regulation and public bodies, which were referenced by participants and may have impacted their responses to the GMC. These included the Post Office Horizon IT inquiry and TV dramatisation, the Lucy Letby case and criticism of water companies. In addition, there was substantial commentary in press and social media around PA and AA roles, some of which was noted by a small number of participants.	Recent events may have had an impact on perceptions of the GMC due to a general shift in public feelings towards regulators, which was not possible for the research to mitigate. The research shows that any changes will be viewed in the context of attitudes towards public bodies in general and highlights the importance of the GMC maintaining trust within this environment.

Finally, it is worth reiterating that this report should not be read as proof of strong public support for or opposition to regulation of PA and AA roles by the GMC, when compared to other potential options, or as support for or opposition to the introduction of these roles more generally. While participants were strongly supportive of the regulation of these roles, bringing them under the GMC's regulation was the only path presented to them. This was because the purpose of the study was to explore public views on how PAs and AAs, and in due course doctors, will be regulated after the GMC's reforms, following statutory legislation. No participants showed sufficient engagement with healthcare regulation to suggest other options themselves.

11.4. Bibliography

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12. Appendix

12.1. Summary of changes as provided to participants

Regulatory reforms were described to participants as follows as part of the document provided to them before they participated in the research.

Education

The GMC will undertake a more thorough, formal process of checking universities offering PA and AA postgraduate courses to ensure the teaching is meeting GMC standards, and that the course providers are preparing their students well to deliver safe patient care (quality assurance). They will collect more data, visit the university, and speak with students and tutors to make sure there are not any issues. If the GMC finds out there are issues, it can require the course provider to meet certain conditions to drive improvements in the quality of the course.

Joining and leaving the register

The way the GMC will manage the register for PAs and AAs (one register with two parts, one for PAs and one for AAs), and the register for doctors in the future, will be slightly different to the current process. Currently, registration requirements vary depending on where in the world someone got their qualification and the type of registration they are applying for. In future, all applicants will have to show they meet the same standards for registration, no matter where they're from.

There will be a simpler process for removing individuals from the register. If someone wants to leave the GMC register and there are no current concerns about their practice, it will be quicker and easier to do so.

In the future, the GMC will not need any additional evidence from employers as part of this process. Registrants will need to fill in a form declaring that there are no outstanding fitness-to-practise issues. Additionally, the GMC will check with its internal teams (such as the team in charge of fitness-to-practise investigations and the outreach team, a team meeting healthcare staff in the hospitals to help them with education and good practice) to make sure that there are no further concerns. It will be faster and simpler to leave the register for registrants.

If a professional wants to rejoin the register, they will need to meet the same standard as registration but the specific evidence they need to provide will depend on how long they have been off the register.

Complaints and concerns

To start with, the following will apply to PAs and AAs, but in future will also apply to doctors. The GMC will be able to focus on concerns that pose a bigger risk to patient safety or public confidence in doctors, PAs and AAs, and to close cases that don't need action from the regulator. There is potential for more cases to close without a tribunal, such as when the doctor, PA or AA agrees with the action the GMC says is needed, which would be a quicker and less stressful process for patients, families, and professionals while ensuring public protection.

The GMC will still investigate registrants who have been the focus of a complaint and will still liaise with the hospital where they work. However, the case examiner, following the outcome of the investigation, can propose a measure to registrants who would now have two options:

- Accept the outcome of the GMC's investigation and the proposed measure, which may be to repeat training while they stop working as a doctor for an agreed period of time. Registrants cannot negotiate the measure with the case examiner.
- OR request a tribunal and let an independent group of three decision-makers decide what action is required to protect the public.

Patients and complainants will be updated about whether the registrant accepts the outcome or requests a tribunal, and they will be offered a meeting with the GMC to discuss the case.

Challenging the GMC's decisions

At the moment, if a doctor, patient or someone else involved in the case is unhappy with a GMC decision on concerns raised, there are limited situations where they can ask the GMC to change the decision. For example:

- When there is new information about the case that could change the outcome of the decision
- When GMC made a significant mistake that could change the outcome of the decision

Under the new processes, more of the GMC's decisions on concerns raised could be challenged or changed:

Challenging a decision (an appeal)

Someone can appeal to a GMC appeals panel if they think the decision made about them was wrong or unjust. This is similar to how appeals already work, but people will now be able to appeal a broader range of decisions. Key changes are:

- More GMC decisions will be appealable to an internal panel. Currently, some of their FTP decisions are only available to be appealed to the courts, but an internal panel will now be able to consider appeals.
- Individuals now must ask for permission from the GMC to be able to appeal, and the GMC will only grant the appeal if they consider it has a chance of succeeding.

Changing a decision (a revision)

The GMC will be able to quickly change a decision if it is found to be wrong, or no longer suitable because things have changed since it was decided.

There are three routes for revising a decision:

- Those involved in the case can ask the GMC to revise certain decisions (similar to the current process).
- The GMC might spot an error, or that the situation has changed, and change the decision (similar to the current process).
- The GMC may revise an appealed decision to avoid the need for a long and stressful process.

If the GMC thinks the decision can be changed under the revision process, they will be able to request that.

Introduction

About the research

Thank you for taking part in our research – your feedback will be really useful. We are carrying out this research for the General Medical Council, or GMC for short. They are interested in your thoughts on how they plan to regulate certain health professionals. This document explains who they are and what they plan to change.

What does regulation mean? Regulators set rules for a profession, to make sure that the people working in that job know what they are doing, have the right skills, and behave properly. It helps to keep everyone safe and make sure things are done the right way.

About the GMC

The General Medical Council (GMC) is the independent regulator of doctors in the UK. This means they:

- **work with doctors, patients and others** to support good, safe patient care.
- **set the standards that doctors (and those who train them) need to meet**, while helping them achieve these standards. Their *Good medical practice* guidance sets out the standards of care and behaviour expected of all medical professionals.
- **make sure every doctor has the right knowledge, skills, qualifications and experience** to work across the UK by keeping an official list called the medical register.
- **investigate and take action when needed**, if there are concerns that patient safety or public confidence in doctors may be at risk.

About the changes to how the GMC regulates

We want to understand what you think about how the GMC is changing.

The GMC will soon be regulating two more professions: physician associates (PAs) and anaesthesia associates (AAs). After this, new laws affecting everyone on the GMC registers (doctors, PAs and AAs) will transform how the GMC works, allowing them to respond faster and better to the demands of 21st-century healthcare. This will mean the GMC can focus on supporting good practice and preventing harm, with benefits for both patient care and the well-being of everyone on their registers.

The GMC want your thoughts on how doctors, PAs, and AAs, which are collectively called *registrants*, should be regulated. Your thoughts and ideas will help the GMC make sure everyone is getting the care they need.

About physician associates and anaesthesia associates

In July 2019, the Department of Health and Social Care (DHSC) and the four UK governments asked the GMC to regulate two further professions: physician associates and anaesthesia associates.

- **Physician associates (PAs)** work with doctors and other healthcare workers in different places, such as hospitals, GP surgeries and in the community.
- **Anaesthesia associates (AAs)** work with the anaesthetic team and take care of patients before, during and after their surgery or procedure.

Neither PAs nor AAs are doctors, and they must always work under the instruction or supervision of a doctor. Currently, there are around 4,000 PAs and 180 AAs working in the UK, but these numbers are expected to grow in the next few years – with 36 UK universities running PA courses, and three running AA courses.

About this pre-read document

This pre-read document tells you about the topics that our focus-group discussion will cover:

1. Education
2. Entry to the registers
3. Complaints and concerns
4. Challenging the GMC's decisions

For each, we've given an example situation – featuring made-up people. In the focus group, we will ask for everyone's opinions on these topics and situations. Don't worry if there's something you don't understand – we are looking for your honest thoughts and will happily explain anything that's unclear.

1. Education

About this topic

The GMC has always worked to ensure the education that doctors get at medical school and their on-the-job training helps them to deliver good, safe patient care across the UK. They do this by assessing all medical school courses and postgraduate training programmes and by carrying out regular reviews. They also talk to medical students, doctors in training and educators to hear about their experiences.

Since 2021, the GMC has been making sure that universities teaching PAs and AAs are following the right standards by checking courses and requiring everyone to pass a final exam. The GMC quality assures the education provided to AAs and PAs by:

- requiring organisations to complete self-assessment questionnaires.
- visiting education and training providers.
- running feedback meetings or surveys with learners and educators.
- reviewing documents.

Example

Here is an example of how the GMC oversees the education of PAs and AAs. We will ask what you think about this in our discussion.

Lily, aged 30, from Preston, is currently studying the Physician Associate Practice MSc at the University of Central Lancashire. Lily already has an undergraduate degree in Biomedical Sciences. Her course takes two years to complete and will be taught at the university, with some clinical placements in various settings.

The current approach: The GMC has already checked that Lily's ***course*** meets their education standards and that what she's being taught covers the UK-wide curriculum and is preparing her to work as a PA after graduation. Lily will have to take the PA registration assessment at the end of her course.

The future approach: The GMC will undertake a more thorough, formal process of checking Lily's university to ensure the teaching is meeting GMC standards, and that the course providers are preparing their students well to deliver safe patient care (quality assurance). They will collect more data, visit the university, and speak with students and tutors to make sure there are not any issues. If the GMC finds out there are issues, it can require the course provider to meet certain conditions to drive improvements in the quality of the course.

2. Joining and leaving the register

About this topic

The GMC keeps an official list of every doctor who has the right knowledge, skills, qualifications, and experience to work in the UK. This is called the medical register. They will also start to keep a separate register of PAs and AAs who meet GMC requirements and can work in the UK, as part of the GMC's plan to start regulating these roles at the end of 2024. Doctors, PAs, and AAs on these registers are called *registrants.*

When a doctor, PA or AA applies to join the GMC registers, they will need to:

- show evidence that they have a relevant qualification and the knowledge, skills, and experience to provide good, safe patient care – which will usually be through passing an exam.
- show that they can speak English to a good level.
- declare that they are insured and fit to practise.

The GMC also has the power to remove registrants from the registers. This might be because a registrant is retiring or moving to work in another country or simply because they want to stop working as a doctor, PA or AA. It could also be done if they don't meet GMC standards, such as having proper insurance and paying their fee.

The way the GMC will manage the register for PAs and AAs (one register with two parts, one for AAs and one for PAs), and the register for doctors in the future, will be slightly different to the current process. For example:

- Currently, registration requirements vary depending on where in the world someone got their qualification and the type of registration they are applying for. In future, all applicants will have to show they meet the same standards for registration, no matter where they're from.
- There will be a simpler process for removing individuals from the register. If someone wants to leave the GMC register and there are no current concerns about their practice, it will be quicker and easier to do so.
- If a professional wants to rejoin the register, they will need to meet the same standard as registration but the specific evidence they need to provide will depend on how long they have been off the register.

Example 1

Here is an example of joining the register. We will ask what you think about this in our discussion.

Mark, aged 27, has just successfully completed a 2-year course to become a Physician Associate. In order to enter the GMC register, he will need to give evidence of his qualification, along with a declaration about his fitness to practice and proof that he is insured. He will also need to sit an exam, which has been developed by the GMC.

When PAs who have studied outside of the UK apply to enter the register, they will need to provide the same evidence and similarly sit the same exam as UK graduates do.

Example 2

Here is an example of leaving the register. We will ask what you think about this in our discussion.

André, aged 55, has worked as a GP in Devon for over 25 years. He is taking early retirement from the NHS and moving to Portugal with his partner. He might decide to practise medicine part-time in Portugal but hasn't decided yet. For now, he wants to finish work and give up his GMC registration.

The current approach:

André fills out a form on the GMC website. Someone from the GMC then reviews his application for removal. The GMC gets evidence from André's employer and others, that there are no ongoing or outstanding issues with his fitness to practice. The GMC grants André's request to leave and he is removed from the register on the date he requests. After this André is unable to do any work as a doctor in the UK.

The future approach:

In the future, the GMC will not need any additional evidence from employers. André will need to fill in a form declaring that there are no outstanding fitness to-practice issues. Additionally, the GMC will check with its internal teams (such as the team in charge of fitness to practice investigations and the outreach team (a team meeting healthcare staff in the hospitals to help them with education and good practice), to make sure that there are no further concerns. It will be faster and simpler to leave the register for André.

3. COMPLAINTS AND CONCERNS

About this topic

If serious concerns are raised with the GMC about a doctor's behaviour, health, or performance, they can investigate to see whether patient safety or public confidence in doctors, is at risk.

Following GMC investigations, some cases are heard in a meeting where their case will be assessed called a tribunal. This meeting is where independent decisions are made, which can include suspending or restricting a doctor from carrying out their duties. In very serious cases, the tribunals may remove a doctor from the medical register, meaning they can no longer work in the UK.

Once regulation starts, PAs and AAs will need to follow guidance that sets out the principles of good practice, just as doctors do now. When a serious concern is raised about a PA or AA, as with doctors, the GMC may need to investigate.

Reducing the impact of investigations

Over the last decade, the GMC has tried to make the way they investigate concerns faster, fairer and kinder.

However, GMC investigations can still be very stressful for everyone involved. The GMC needs the law to change so they can reduce this stress and so that those raising concerns and the professionals being investigated get faster decisions. To start with, the following will apply to AAs and PAs, but in future will also apply to doctors:

- The GMC will be able to focus on concerns that pose a bigger risk to patient safety or public confidence in doctors, PAs, and AAs, and to close cases that don't need action from the regulator.
- There is potential for more cases to close without a tribunal, such as when the doctor, PA or AA agrees with the action the GMC says is needed, which would be a quicker and less stressful process for patients, families, and professionals while ensuring public protection.

Example

Here is an example of a doctor being asked to accept the outcome of a GMC investigation. We will ask what you think about this in our discussion.

Mary, aged 47, from Aberdeen, has complained about the treatment her husband Derrick received from Sonia, a surgeon. Sonia performed a heart surgery on Mary's husband. Mary is concerned that Sonia did not discuss all the surgery risks with them before the procedure. She also did not listen to the family when they were worried that Derrick was getting worse every day after his surgery and unfortunately died a few days after the procedure.

The current approach

The GMC has investigated this complaint and decided action may be needed. The case has been referred for a case examiner decision. A case examiner is a senior member of GMC staff responsible for collecting and reviewing evidence.

The case examiner decided that that Sonia's actions did not meet professional standards and that she has not taken steps to avoid this happening again, so poses a risk to patients. The hospital where Sonia works contacted the GMC with similar concerns. After checking if Sonia agrees to get an assessment of her work, an expert checked her day-to-day work including her operations. This was to see if she was safe and competent for her role. It was decided that she does not meet the professional standards and is not fit to continue practising, but if she re-trains she can apply to come back to the register. Her case needs to be referred to the tribunal.

The future approach:

GMC will still investigate Sonia and will still liaise with the hospital where she works. However, the case examiner, following the outcome of the investigation can propose a measure to Sonia who now has two options:

- Accept the outcome of the GMC's investigation and the proposed measure to repeat training while she stops working as a doctor for three months. Sonia *cannot* negotiate the measure with the case examiner.
- OR request a tribunal and let an independent group of three decision-makers decide what action is required to protect the public.

Mary will be updated about whether Sonia accepts the outcome or requests a tribunal, and she is offered a meeting with the GMC to discuss the case.

4. CHALLENGING the GMC's DEcisions

About this topic

At the moment, if a doctor, patient or someone else involved in the case is unhappy with a GMC decision on concerns raised, there are limited situations where they can ask the GMC to change the decision. For example:

- When there is new information about the case that could change the outcome of the decision
- When GMC made a significant mistake that could change the outcome of the decision

Under the new processes, more of the GMC's decisions on concerns raised could be challenged or changed. For example:

- Changing a decision (a **revision**) – the GMC will be able to quickly change a decision if it is found to be wrong, or no longer suitable because things have changed since it was decided. There are three routes for revising a decision:
    - Those involved in the case can ask the GMC to revise certain decisions (similar to the current process).
    - The GMC might spot an error, or that the situation has changed, and change the decision (similar to the current process).
    - The GMC may revise an appealed decision to avoid the need for a long and stressful process (new process; see below).

- Challenging a decision (an **appeal**) – someone can appeal to a GMC appeals panel if they think the decision made about them was wrong or unjust. This is similar to how appeals already work, but people will now be able to appeal a broader range of decisions. Key changes are:
    - More GMC decisions will be appealable to an internal panel. Currently, some of their FTP decisions are only available to be appealed to the courts, but an internal panel will now be able to consider appeals.
    - Individuals now must ask for permission from the GMC to be able to appeal, and the GMC will only grant the appeal if they consider it has a chance of succeeding.
- If the GMC thinks the decision can be changed under the revision process, they will be able to request that (see above)

Example

Mo, aged 42, is a teacher and came across Johnni, an AA, sharing a photo on social media in which a patient's name is clearly visible. Mo complained to the GMC, as he was worried that Johnni was not protecting sensitive patient information (confidentiality). After considering this concern, the GMC decided this one-off incident wasn't a risk to patient safety or public confidence in health professionals and closed the case. Mo isn't happy with this decision. Since then, Mo realised that Johnni actually has multiple social media accounts on different

sites, and the photo mentioned in Mo's original complaint wasn't the only incident. In particular, around the same time the photo was posted, Johnni has posted some serious videos online on a different site showing him performing a procedure on a patient. GMC's rules state that Mo has 12 months to ask them to change this decision based on an error or a change of circumstances.

Mo then has to put his request in writing and provide evidence of Johnni's repeated behaviour for the GMC's consideration.

When the GMC was considering Mo's request to change the original decision, the GMC indicated to Mo that they would share the information provided by Mo with Johnni and ask for Johnni's comments.

Mo wanted to know whether the GMC would proactively gather more evidence and investigate Johnni's social media usage when considering his request. Mo also wanted to know whether he should send more information to the GMC to support his request.

Thank you, we look forward to speaking with you in our discussion group. Please do not hesitate to get in touch if you have any questions

Sample by quota area

Quota	Subquotas	n.
Nation	England	34
	Wales	8
	Northern Ireland	5
	Scotland	11
Age	Aged 18-24	3
	Aged 25-39	18
	Aged 40-59	19
	Aged 60 and over	18
Sex	Male	23
	Female	35
Gender	Male	24
	Female	33
	Non-binary or gender non-conforming	1
Household income	Low-income households / weekly household income under £400 per week or no regular income	13
	Weekly household income £400-£599	15
	Weekly household income £600-£999	15
	Weekly household income £1000-£1999	9
	Weekly household income: £2000 or more	5
	Prefer not to say	1
Ethnicity	White	29
	Asian	9
	Black	10
	Mixed	8
	Another ethnicity	2
Area	An inner-city area	14
	A suburban area	22

	A town	8
	A village	4
	A rural or countryside area	10
Employment status	Full-time	29
	Part-time	5
	Retired	17
	In education	1
	Not working	6
Religion	Buddhism	2
	Christianity (all denominations)	15
	Hinduism	4
	Islam	6
	Judaism	1
	Interfaith / Non-denominational	1
	No religion	27
	Other	1
	Prefer not to say	1
Marital status	Co-habiting or living with a partner	13
	Married or in a civil partnership	20
	Separated, divorced or civil partnership dissolved	3
	Single	22
Sexual orientation	Asexual	1
	Bisexual	3
	Gay / Lesbian	2
	Heterosexual / Straight	51
	Queer	1
Disability	Living with disability	15
Health conditions	Diagnosed with long-term health conditions	17
Pregnancy and maternity	Pregnant or had a baby in the last 12 months	3

TOTAL ACROSS GROUPS AND INTERVIEWS		58

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I ofyn am y cyhoeddiad hwn mewn fformat neu iaith arall, ffoniwch ni ar **0161 923 6602** neu e-bostiwch ni ar **gmc@gmc-uk.org**.

You are welcome to contact us in Welsh. We will respond in Welsh, without this causing additional delay.

Mae croeso i chi gysylltu â ni yn Gymraeg. Byddwn yn ymateb yn Gymraeg, heb i hyn achosi oedi ychwanegol.

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