General Medical Council

Regulating Anaesthesia Associates and Physician Associates

Consultation on our proposed rules, standards and guidance

This consultation also covers our fitness to practise decision-making principles that will apply to doctors, anaesthesia associates and physician associates.

This publication is available in Welsh on our website, at www.gmc-uk.org.
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Regulating anaesthesia associates and physician associates: consultation on our proposed rules, standards and guidance.

(This consultation also covers our fitness to practise decision making principles that will apply to doctors, anaesthesia associates and physician associates)

Part 1 – Introduction

In July 2019, the UK Government asked the General Medical Council to regulate two additional professional groups, anaesthesia associates (AAs) and physician associates (PAs).

The Anaesthesia Associates and Physician Associates Order (AAPAO or 'the Order'), drafted by government and laid in Parliament on 13 December 2023 establishes a legislative framework for the regulation of these two professions. Within this consultation, we've set out our proposed approach to implementing the requirements of the AAPAO through a combination of rules, guidance, and standards.

- The rules describe the processes and procedures that will deliver the legislative duties and powers set out in the AAPAO.
- The guidance supports decision makers to make fair, proportionate, and transparent decisions within those processes and procedures.
- The standards set out the professional values, knowledge, skills, and behaviours that we expect those we regulate to have, deliver or demonstrate under our framework.

Taken together, our rules, guidance and standards will establish an effective and efficient regulatory framework for AAs and PAs that will benefit patients and registrants alike.

The General Medical Council

We're 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 patient safety, or the public's confidence in doctors, may be at risk, and take action where needed.

From 2024, our role will expand to accommodate the statutory regulation of AAs and PAs (collectively referred to as 'associates' in this consultation document) – for whom we'll also undertake these functions.

What we're consulting on

We're consulting on the draft rules and standards that are required to implement the legal duties and powers within the AAPAO, and bring AAs and PAs into statutory regulation later this year.

We are also consulting on fitness to practise policy principles that will inform the content of guidance that will govern our regulation of AAs, PAs and doctors (and questions on these can be found in Part 5 – Fitness to Practise). We are proposing to introduce new and updated guidance for doctors based on these principles at the same time as introducing guidance for AAs and PAs, so that they too can benefit from the more streamlined, clear and accessible decision making framework that our guidance will provide.

We have grouped our rules, standards, and guidance by regulatory function, in the order that AAs and PAs are likely to encounter them across their career. These functions are:

Education and training for AAs and PAs – covering:

- the outcomes that must be met by student associates to obtain an approved AA or PA qualification
- the standards that must be met by providers of education and training to award those qualifications
- our processes for approving and quality assuring the education and training provided.

(Questions 1–5)

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

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

(Question 6)

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

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

(Questions 7–8)

Removal from the register of AAs and PAs– covering:

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

(Questions 9–11)

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

- our processes for assessing, investigating, and adjudicating a concern
- our process for taking action because of a fitness to practise concern by issuing a warning or imposing a measure (restriction) on an AA or PA'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 AAs, PAs, and doctors).

(Questions 12–20)

Changing and challenging our decisions – covering:

- our process for revising specified GMC decisions
- the process for internal appeals against GMC decisions.

(Questions 21–22)

Fees – covering:

- our approach to charging fees for our functions.

(Questions 23–24)

Towards the end of the consultation document, we also ask questions 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 want to hear a variety of perspectives before we finalise our rules, standards, and policy principles to inform the content of guidance, so we encourage respondents to complete as many questions as possible.

What this consultation is not about

In 2017, government consulted on whether AAs and PAs 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.

In 2019, government asked the GMC to regulate both professions and the legislation to enable this to happen (the AAPAO) was laid in parliaments in December 2023 and is now law.

Therefore, we're not consulting on:

- whether AAs and PAs should be brought into statutory regulation, or whether they should be regulated by the GMC – those decisions have already been made by the UK Government, with the support of the Scottish Government
- the content of the Anaesthesia Associates and Physician Associates Order, which includes the professional titles of 'anaesthesia associate' and 'physician associate' – this has already been laid in parliaments
- the scope of an AA and PA's practice - it isn't the role of the regulator to determine what tasks individual professionals can safely carry out once they are registered with us, because that depends on their individual skills and competence, which develop over time. We won't determine scope of practice for AAs and PAs beyond initial qualification competencies, just as we don't determine it for doctors. We know that NHS leadership, employer bodies and royal colleges have begun looking at how AA and PA scope of practice may develop over time. We welcome those developments and encourage involvement of the AA and PA professions in them also.

An introduction to anaesthesia associates and physician associates

Anaesthesia associates and physician associates work with doctors. They each belong to a defined professional group and hold complementary skill sets to doctors.

PAs work under the supervision of doctors across a range of specialties, in both hospitals and general practice; taking histories, examining, diagnosing, managing, and treating patients. They also form part of the multidisciplinary team, which consists of different healthcare professions working together to make decisions regarding the treatment of patients. Presently there are around 4,000 PAs on the Faculty of Physician Associates (FPA) voluntary register and 1,800 students.

AAs work within the anaesthetic team and support the delivery of general anaesthesia and critical care. They perform pre- and post-operative assessments and interventions under the supervision of a consultant anaesthetist or other autonomously practising anaesthetist, and work as part of an anaesthetic team. Presently there are around 180 AAs practising across England, Wales, and Scotland.

AAs and PAs will provide much needed additional clinical resource to the UK medical workforce – helping to improve patient care for all.

The benefits of regulation

Although the numbers of AAs and PAs are relatively small at present, they are expected to grow in number over the next few years. This is in line with the ambition set out within the long term workforce plan in England, and in line with the commitment to take a gradual and evidence based approach to their expansion in Scotland. There are currently 37 PA courses and three AA courses in the UK, provided across 38 higher education institutions.

The scale and speed of expansion of AA and PA roles is a workforce issue and not a matter for the GMC or this consultation. However, in view of the expected expansion, it is important that AAs and PAs are brought into statutory regulation as soon as possible.

Regulation will help assure patients, colleagues and employers that AAs and PAs are appropriately educated and qualified, can contribute safely and appropriately to the care of patients and can be held to account if serious concerns are raised. This is the underlying purpose of regulation, for doctors, for other healthcare professionals and, in the future, for AAs and PAs too.

We recognise that as the number of AAs and PAs working in the healthcare system grows, there are wider questions being asked about their role and their place in the healthcare team. Many of these questions are not fundamentally about regulation and they are for others to address, though we continue to work with the relevant organisations to inform discussions where they intersect with our regulatory role.

What the regulatory framework for AAs and PAs will cover

How we regulate AAs and PAs will be similar to how we regulate doctors. As such, the AAPAO will enable us to:

- quality assure education and training for student AAs and PAs
- establish a register for AAs and PAs
- establish processes for AAs and PAs to be entered and removed from the register
- set professional standards for AAs and PAs
- establish processes to assess whether AAs and PAs continue to meet the standards that we set
- establish processes for investigating concerns about AAs and PAs, and take action where we consider there is a risk to public protection.

However, although the regulatory functions will be similar to those for doctors, the AAPAO will enable us to regulate in a more flexible, responsive, and efficient way than is currently possible under the Medical Act 1983 (as amended)* for doctors.

Reforming regulation for all

As part of its move to bring AAs and PAs into statutory regulation, the government also committed to introducing wider reforms to the regulation of existing healthcare professions. These wider reforms will be based on the legislative framework that's been created for AAs and PAs.

We've long called for wider reform to professional regulation. The laws that govern how we regulate doctors have not kept pace with the changing needs of the healthcare systems in which the professions work, and with society's expectations of modern regulation. Some of our legislation has its origins in the 19th century. And, although it has been updated at various times, the result is a regulatory framework that is complex, overly prescriptive, and slow to adapt to change.

As individual healthcare professionals increasingly work together as part of wider multidisciplinary teams, the differences and disconnections between the way that each profession is regulated have become all too apparent. This lack of consistency and co-ordination has hampered regulators in their efforts to protect the public and support those we regulate in delivering great care.

* The Medical Act 1983 is also referred to as 'the Medical Act' in this consultation document.

Therefore, the introduction of a new, modern regulatory framework for AAs and PAs represents a critical first step in delivering wider reform for all healthcare professions, enabled by greater legislative consistency across the different regulators.

The provisions set out within the AAPAO provide a foundation to help us deliver tangible benefits for patients, associates, employers, providers, educators, and trainers. They'll also, in time, address many of our longstanding concerns about the complex and overly prescriptive legal requirements that have governed our regulation of doctors.

The purpose of our consultation

There are two purposes of this consultation.

First, we're seeking views on our proposed approach to regulating AAs and PAs, through inviting comments on our draft rules – and where appropriate, supporting standards and guidance.

The UK Government has determined that the AAPAO will act as the basis for reforming the existing legislative framework for doctors and other healthcare professions. While separate legislation will be brought forward to enable this, we anticipate that the AAPAO will provide the basis for the statutory functions, legal powers, and duties for doctors – with additional provisions that are specific to this profession where appropriate.

For this reason, we expect that the rules and guidance for AAs and PAs described in this consultation will be broadly similar to those which will be introduced for doctors once the new legislation is laid. For example, we anticipate that the legislation will introduce accepted outcomes, as described in part 5 of this document, for doctors as part of fitness to practise proceedings. We will consult separately on the rules and proposed changes to guidance for doctors in due course. However, we welcome an initial view from doctors now on the clarity, fairness, and proportionality of our proposals for AAs and PAs. This will in turn influence our development of rules for doctors in future.

Second, we're also seeking comments on our proposed policy principles to inform the content of decision-making guidance, which we'll be introducing for AAs, PAs, and doctors at the same time. One of these pieces of guidance will replace our existing *Sanctions guidance for members of Medical Practitioners Tribunals and for the General Medical Council's decisions makers* for doctors.

Future related consultations

The rules we're consulting on here are the ones that we need to have in place for the start of AA and PA regulation.

Later, we'll consult on additional rules for those areas of the AAPAO that are not covered here and are not needed for the start of AA and PA regulation. These will include rules relating to our proposed revalidation model for AAs and PAs.

We will also consult on the rules required to implement a reformed regulatory framework for doctors – once the government has laid the relevant legislation. We expect that the government will consult on and introduce equivalent legislation for the medical profession as soon as possible.

Who should respond to our consultation

We welcome responses from AAs, PAs, AA and PA students, doctors, the public, patient representative groups, and any other individuals or organisations who are likely to be affected by, or use, our processes governing the regulation of AAs and PAs.

To help individuals respond to our consultation questions, we've:

- created a glossary of key terms in Annex A
- highlighted how proposals covering AAs and PAs compare with our existing regulatory approaches for doctors and medical students.

We also welcome the views of doctors, AAs, and PAs on our fitness to practise policy principles, which will inform the content of our decision-making guidance.

We will introduce new guidance for doctors at the same point that we introduce it for AAs and PAs (please see Part 5 for further details).

How do I take part?

You can respond to the consultation in several ways.

- You can complete our online survey which can be found here or you can email your response to us at AAPAconsultation@gmc-uk.org
- Alternatively, you can send printed responses to AAPA Consultation, Regulation Policy Team, General Medical Council, Regents Place, 350 Euston Road, London NW1 3JN
- If you need the consultation document in other languages, or another format, email us at gmc@gmc-uk.org

The consultation closes at 23:59 on **20 May 2024.**

What will happen next

Once the consultation closes, we'll analyse the results, taking into account both the level of agreement with our proposals and the supporting reasoning provided by respondents. We will also draw on the results of separate commissioned research that will capture views of members of the public on our proposals.

We'll then publish a report with conclusions of the consultation and summarise any changes to our rules, standards, and guidance in the light of the feedback we received.

The amended rules will then need to be approved by our governing Council once the AAPAO comes into force and statutory regulation commences for AAs and PAs. We anticipate that this will begin in late 2024.

Part 2 – Education and training

Education and training

For AAs and PAs our role in education and training will be to:

- set the learning outcomes, which establish the knowledge, skills, and behaviours that AAs and PAs must meet to qualify
- set the standards for each AA and PA curriculum
- approve each curriculum for AAs and PAs
- set the standards that course providers must meet in order to deliver AA and PA courses and award AA and PA qualifications
- approve AA and PA courses
- carry out quality assurance checks to make sure that education organisations are meeting the standards that we set.

What we're consulting on

We're consulting on:

- two sets of draft education and training standards.
- the rules that will govern our processes for regulating AA and PA pre-qualification education and training.

We welcome comments on any aspect of our proposed rules and standards, particularly comments on:

- the proposed content of our education and training standards
- our proposed approach to approving and quality assuring each AA and PA curriculum, and AA and PA courses
- the extent to which our rules establish clear, proportionate, and fair processes for the regulation of AA and PA pre-qualification education and training.

Before reviewing our proposed rules and standards, which can be found via the links above, we encourage you to first read Part 2 of the consultation document, which provides further details on the purpose and scope of these documents.

What our standards cover

We expect the education and training provided to AA and PA students to meet our standards. Just as good AA and PA students and professionals make the care of their patients their first concern, so must the organisations that educate and train them.

We're consulting here on two sets of education standards:

- standards for PA and AA pre-qualification curricula (our 'curricula standards')
- standards for the delivery of PA and AA pre-qualification education (our 'course standards').

Each UK-wide curriculum provides detailed requirements on what should be taught to AAs and PAs. Our expectations for each curriculum are set out in our curricula standards, which must be met for each curriculum to be approved.

There'll be one curriculum for AAs, owned by the Royal College of Anaesthetists (RCA) and one curriculum for PAs, owned by the Faculty of Physician Associates (FPA). Both the RCA and FPA consulted key stakeholders on the development of each curriculum in line with our regulatory requirements. Both organisations will retain an ongoing responsibility for designing and developing each curriculum in a way that meets our standards. They are referred to below as 'the curriculum developer'.

The course standards set out our expectations for course providers that deliver AA and PA pre-qualification education and training in the UK. Course providers must use the relevant UK-wide curriculum when developing the content for their course. This will help ensure consistency in the knowledge, skills, and behaviours expected of newly qualified AAs and PAs.

The education standards complement the PA and AA generic and shared learning outcomes. The learning outcomes set out the knowledge, skills, and behaviours that we expect newly qualified AAs and PAs to demonstrate. Each curriculum incorporates these shared learning outcomes but also set out profession-specific outcomes. Course providers are expected to ensure that AA and PA students have opportunities to achieve the outcomes within a supportive learning environment.

From September to November 2021 we sought feedback on these learning outcomes and each draft curriculum and published the *Physician associate and anaesthesia associate pre-qualification education framework: engagement report*.

When AAs and PAs come into regulation, they'll be expected to meet our standards of patient care and professional behaviour, which already apply to doctors: *Good medical practice*.

We've developed guidance for AA and PA students on how the principles and standards in *Good medical practice* apply to them while they are learning: *Achieving good medical practice: interim guidance for physician associate and anaesthesia associate students.*

We developed guidance for course providers on what to do if there are concerns about a student's ability to meet the standards expected of them. We worked with stakeholders including AA and PA bodies, groups that represent doctors, and employers to draft this.

We'll be approving each curriculum and all AA and PA courses against the standards set out above, using the processes described in rules.

Once approved, we'll place the curricula and courses in a cycle of regular quality assurance to make sure standards are being maintained. If each curriculum or individual course falls below our standards, then we'll take action.

What our education and training rules cover

The rules contain the following sections:

- curricula approval – the process we'll use to approve each curriculum against our standards
- course approval – the process we'll use to approve courses against our standards
- monitoring and quality assurance – how we'll undertake regular monitoring and quality assurance to make sure that curricula and courses continue to meet our standards
- measures – how we'll take action if a curriculum or course falls below our standards
- notification of decisions – our process for notifying an organisation of a decision regarding their application for curriculum or course approval or a decision that affects their approval status.

We've set out below how each of these processes will operate.

Curricula approval (rule 3)

As mentioned above, there will only be one curriculum for each of the associate professions, which will apply on a UK-wide basis. We've worked closely with the curriculum developers to support the development of each draft curriculum.

Through this process we:

- provided advice on what is required to meet our standards
- gathered feedback from stakeholders at a formative stage of each curriculum's development
- commissioned a review by independent experts.

When we begin the approvals process, we'll assess whether each curriculum meets our standards. For us to do this, the curriculum developers must submit an application that includes a summary of their draft curriculum. They must provide evidence that demonstrates how our standards and requirements have been addressed in the design and development of the proposed curriculum.

We will approve a curriculum where we're satisfied that it meets our standards. The curriculum developer will need to make sure that, once approved, their curriculum continues to meet our standards. If the curriculum developer wishes to make changes in the future, they'll need to reapply for approval, setting out how these meet our standards.

Course and qualification approval (rules 4 and 5)

After regulation commences, organisations who wish to deliver AA or PA pre-qualification education, including establishing a new AA or PA course, will need to apply for approval of their course.

In developing their course, each provider must ensure that it meets our course standards. Providers must:

- demonstrate that they have incorporated into their course the high-level learning outcomes set out in the relevant UK-wide curriculum
- confirm they have degree awarding powers
- provide evidence to demonstrate how the course meets our course standards.

We'll guide the organisation on the nature and scope of the evidence that they must submit as part of their application. In some scenarios, we may need more information from the organisation to support their application.

We'll review the evidence submitted by the organisation, including any extra evidence we've requested, and undertake quality assurance activities, such as visits to the organisation, as appropriate.

Where we're satisfied that the course meets our standards, we'll approve it.

Where a course does not fully meet our standards, we may, in some circumstances, grant conditional approval, subject to the course provider undertaking identified steps. Conditional approval of this kind will only be granted where the course is delivering the approved curriculum and where students are being supported to meet the professional standards in *Good medical practice*.

When a course is approved, the qualification awarded upon successful completion of the course is also approved.

Where we decide to either grant conditional approval, or refuse approval, we'll explain our reasons for doing so to the organisation.

Transitional approval processes for AA and PA courses that already exist

The education and training rules describe how we'll approve new AA or PA courses once regulation comes into effect. However, there are existing AA and PA courses that are already running, and their providers will also need to seek approval of these courses once regulation starts.

Our approval process will work in the same way described above (see Course approval, rule 4), but we've made additional arrangements to prepare providers that deliver these courses for regulation.

There are currently 37 PA courses and three AA courses in the UK, provided across 38 higher education institutions. Over the last three years, we've worked closely with these organisations to help them prepare for regulation.

Each organisation engaged with a voluntary version of our quality assurance process and our quality assurance team:

- undertook additional quality assurance activities
- reviewed the evidence gathered
- provided written and verbal feedback.

To minimise any delay in existing courses being able to award approved AA and PA qualifications, we plan to issue approval of existing AA and PA courses shortly after regulation begins, provided they meet the six criteria we've set to inform these decisions.

Where we're not satisfied that our criteria are met, we'll either grant conditional approval, or refuse approval.

Monitoring and Quality assurance (rule 6)

Once courses are approved, they enter our rolling cycle of quality assurance to ensure that they maintain our standards.

As part of this, we'll take both proactive and reactive quality assurance action, which allow us to check that courses are meeting our standards. These replicate the activities we currently undertake to quality assure programmes of education and training for medical schools and postgraduate training programmes for doctors.

Proactive quality assurance activities include:

- asking course providers to complete an annual self-assessment questionnaire (which we'll review and provide feedback on)
- visiting the organisation
- observation
- document reviews.

We'll publish an annual quality assurance summary for each organisation, which details the quality assurance we've undertaken over the year for their courses.

If an issue is raised, we'll carry out reactive quality assurance activities to make sure that standards are not compromised. This may include taking action to promote and ensure local management of the concerns by the relevant organisation (for example, the Royal College or Faculty).

Our quality assurance framework provides more details about these activities and how they are carried out.

In the case of curricula, we expect the curriculum developers to make sure that the curriculum maintains our standards. We're currently considering our approach to quality assuring postgraduate curricula for medical education and training—learning from this will inform our approach to quality assuring each curriculum for AAs and PAs accordingly.

Taking action: measures (rules 7, 8 and 9) and notifications (rules 10 and 11)

We'll work collaboratively with organisations to make sure that they understand our standards and know what information they need to provide to demonstrate that they meet them. However, if a course is not meeting our standards, we may take action by imposing a measure against their approval status. This may include setting conditions, which a course provider must ensure the course complies with, or revoking approval from their course entirely.

We'll impose conditions when they are necessary for patient safety or learner wellbeing. For example, a condition could require that a provider not use clinical placement settings where supervision can't be provided, or to submit urgent evidence that all appropriate learning outcomes are being met.

If we propose to set a condition, we must first notify the course provider of our intention to do so. The provider will then have an opportunity to make representations (provide us with written comments) about our proposed approach. This may involve the provider commenting on our proposed approach and/or providing further information/evidence if they believe this isn't justified. Once we've considered any additional evidence, we'll make our final decision.

We will monitor compliance with the conditions set. They'll be amended, if required, or removed if they are no longer necessary.

We'll work with organisations to drive improvements where our standards are not being met. We'll use our powers to revoke approval only as a last resort, having explored all other options to drive improvement, and where we consider this to be the only remaining option to ensure AAs and PAs are appropriately qualified and to protect patients and/or learners. Again, the provider will be notified of this proposal and have the opportunity to provide comments before we make a final decision. If we revoke our approval of a course, our approval of the qualification awarded upon successful completion of that course is also revoked.

How our proposals compare to our current approach for doctors

Much of our approach is similar to how we currently regulate education and training for doctors.

- We set standards that we expect curriculum developers, and education and training providers to meet.
- We also set the outcomes that we expect newly qualified doctors to know and be able to meet, and which we expect education and training providers to deliver.

The Medical Act gives us different powers in the undergraduate sector from the postgraduate sector. That means that the way we approve and quality assure each of those sectors is different.

Undergraduate medical education

We maintain a list of approved medical schools that can award a primary medical qualification. To grant approval, we subject these bodies to an extensive period of quality assurance. We do not approve individual courses, nor do we approve undergraduate curricula used by the courses. However, we quality assure the courses in line with our standards.

We also specifically quality assure elements of their final exams to make sure that they are meeting the requirements set out in our Medical Licensing Assessment framework. In future, doctors will need to pass the Medical Licensing Assessment (MLA) as part of their degree programme before they can join our register. And while it won't form part of their course, PAs and AAs seeking to register with the GMC will need to pass the PA registration assessment (PARA) and AA registration assessment (AARA) respectively to be eligible for registration with the GMC.

Postgraduate medical education

We approve curricula developed by the Royal Colleges and we maintain a list of approved postgraduate programmes and sites. We also approve individual postgraduate trainers and the locations in which education and training takes place. After approval, we undertake a rolling cycle of quality assurance to make sure that our standards are maintained.

As set out above, we intend to follow these processes for pre-qualification education and training for AAs and PAs.

AAs and PAs

We intend to approve individual AA and PA courses, rather than entire education and training institutions. This means that, when we have concerns about a course, we can take proportionate and targeted action more suited to the needs of that course rather than taking action that will affect all courses run by that organisation.

This will be particularly beneficial in the context of AA and PA education because organisations may run several courses – for example, undergraduate entry courses, postgraduate entry courses or apprenticeship courses. Being able to approve and quality assure each individual course will ensure that we're providing a granular level of scrutiny and support as the course requires.

Consultation questions – education and training

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? (Agree / Disagree / Neither agree nor disagree or don't know)

Please provide a reason for your answer.

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? (Agree / Disagree / Neither agree nor disagree or don't know)

Please provide a reason for your answer.

3 To what extent do you agree or disagree with our proposed approach to approving pre-qualification education and training, as described within our rules? (Agree / Disagree / Neither agree nor disagree or don't know)

Please provide a reason for your answer.

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? (Agree / Disagree / Neither agree nor disagree or don't know)

Please provide a reason for your answer.

5 To what extent do you agree or disagree with our proposed approach to attaching conditions to or withdrawing our approval of pre-qualification education and training, as described within our rules? (Agree / Disagree / Neither agree nor disagree or don't know)

Please provide a reason for your answer.

PART 3 – Establishing a register of AAs and PAs

The register

For AAs and PAs our role will be to make sure that:

- we establish and maintain a single register for AAs and PAs, with one part for AAs and one part for PAs
- the register contains all the information that we're required to collect
- the register, and the entries within it, remain accurate and up-to-date
- we publish information from the register that is necessary for the protection of the public.

What we're consulting on

We're consulting on the following sets of rules:

- form and keeping of the register rules – describing our approach to establishing and maintaining a register.

We welcome comments on any aspect of our proposed rules, particularly comments on:

- our proposed approach to maintaining the register, and the extent to which our processes are clear, fair, and proportionate.

Before reviewing our proposed rules, which can be found via the links above, we encourage you to first read Part 3 of the consultation document, which provides further details on their purpose and scope.

What our form and keeping of the register rules cover

These rules set out:

- the format of the register
- the information that will be contained within the register about each associate
- our process for amending entries in the register.

The information we'll collect and record in the register is set out in rule 4. This will include:

- the associate's name
- their GMC reference number (which will include a prefix to distinguish AAs and PAs from doctors)
- the date of their most recent registration and registration history
- their contact details
- their relevant qualifications
- their fitness to practise history (if any).

We'll collect most of this information as part of the AA / PA application for registration.

Rule 5 enables us to update or correct information where necessary—allowing us to add relevant information over time, such as fitness to practise history and appeal decisions.

Other information (rule 4)

The AAPAO allows us to record other information in the register. We've not yet identified further information we would want to record about associates on the register. If we decide to collect other categories of information in future, we'll first consult on our proposals and reasoning for doing so.

Publication of register information

Publishing information is an important aspect of being an open and transparent regulator. It gives assurance to employers, patients, and the public that all registrants have demonstrated the standards that are needed to practise as an AA and/or a PA in the UK.

Some information that we record on the register will not be published (for example, contact details)—separate provisions within the AAPAO determine what we must publish and what we can choose to.

For each registered associate, we're required to publish their name, reference number and date of most recent registration, together with the part of the register that they are registered in. Where an individual has been subject to a warning or a restriction on their registration because of impaired fitness to practise, we'll also publish this information on our website, alongside the outcomes of any appeals.

We will also publish details of each registered associate's relevant qualification used to apply for registration, the date of their first registration, and dates of all subsequent changes to their registration status.

How our proposals compare to our current approach for doctors

The rules set out the information that we're required to collect and record in the register for AAs and PAs. We will not include the collection of gender information or method of paying the annual retention fee as a requirement in the AA and PA register. This is because these are not specified in the overarching legislation, and there is no clear public protection argument for the AA/PA rules to require this information as part of the registration process.

This is different from the equivalent legislation and current regulations for doctors which allow more flexibility in the information we can decide to record on the register. To achieve consistency between the requirements for AAs and PAs and those for doctors, we plan in future to update the Form and Content of the Register Regulations for doctors to no longer require gender information to be recorded on the register for them.

However, although our rules won't require us to collect gender information for registration purposes, we will continue to collect it on a voluntary basis as part of our routine diversity monitoring data collection. We will publish this as part of wider demographic reporting, but not for individual associates.

Consultation questions – form and keeping of the register

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? (Agree / Disagree / Neither agree nor disagree or don't know)

Please provide a reason for your answer.

Part 4 – Gaining entry to and removal from the AA and PA register

Gaining entry to the register

For AAs and PAs our role will be to:

- assess whether applicants meet our standards of registration, and enter applicants who meet our standards and are fit to practise on to the register
- assess whether AAs and PAs who want to re-enter the register have met the required registration standards and are fit to practise.

Removal from the register

For AAs and PAs, our role will be to:

- remove an associate's entry from the register in the circumstances required by the AAPAO
- decide whether to remove an associate's entry from the register in circumstances where the AAPAO gives us the discretion to do so.

What we're consulting on

We're consulting on our proposed registration rules. These cover:

- registration and re-entry procedure and evidence—describing the evidence requirements for an application, the processes for applying for registration and re-entry, and the circumstances in which we'll grant or refuse this
- procedure for removing entries from the register.

We welcome comments on any aspect of our proposed rules, particularly comments on:

- our proposed procedure for an application for registration and the extent to which this is clear, fair and proportionate
- our proposed procedure for re-entry, including our proposal to take into account the length of time an associate has been off the register – and the extent to which this offers a clear, fair and proportionate process

- our proposed approach to removing entries from the register – and the extent to which our processes described in rules are clear, fair and proportionate
- whether our removals rules strike the right balance between setting clear expectations over when we'll remove entries from the register and allowing us to adapt our requirements to the circumstances of the individual associate, where possible
- our proposed approach to handling requests for voluntary removal where there are outstanding fitness to practise concerns
- our proposed approach for when a decision to remove an entry from the register should take effect.

To help aid interpretation, we have included a brief explanatory statement at the start of these rules. We are considering how best to use these statements and we welcome feedback on whether they help to improve the clarity and accessibility of the rules.

Before reviewing our proposed rules, which can be found via the links above, we encourage you to first read Part 4 of the consultation document, which provides further details on the purpose and scope of these documents.

What our registration procedure and evidence rules cover

These rules set out:

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

Our procedure for registration (rule 4)

The rules set out the procedure for making an application and the evidence that must be provided. By providing this evidence, all AAs and PAs entering the register will demonstrate that they've met the required standards of education, training, knowledge, skills, experience, performance, conduct, ethics, and English language to be registered and practise in the UK. We will grant registration to applicants who have met both the standards and requirements, and paid the registration fee.

Our evidence requirements (rules 3-4)

Rule 4 also sets out the categories of information that we require AAs and PAs to provide as part of their application. The rules are intended to provide flexibility in relation to how applicants can demonstrate that they have met those requirements based on their individual circumstances. We've published information about our registration requirements for prospective applicants. And we'll publish guidance on the types of evidence that will be accepted in advance of the start of regulation.

UK-qualified individuals will need to provide evidence of a relevant qualification at the level of postgraduate diploma or above. Under rule 3, non-UK qualified individuals will need to provide information about their AA or PA qualification for us to assess whether it is acceptable to practise as an associate in the UK.

Applicants are also required to provide evidence of completed training and assessments, and experience. For most applicants this will be a recent pass in the registration assessments for their profession. However, existing associates who are employed in those roles at the point of regulation won't be asked to re-take an assessment as long as their work history provides ongoing evidence to demonstrate that they meet the knowledge and skill requirements. We will set out our policy on this in due course.

Applicants will also be required to sign declarations confirming their insurance and indemnity arrangements, that they are fit to practise, and provide details of their employment history as an AA or a PA (where applicable).

Verification and assessment (rule 5)

We will verify the accuracy and authenticity of the information submitted by applicants and may request further details where necessary.

All applicants seeking registration will be required to meet the same standard of ID verification. This is to make sure that we reduce the risk of identity theft and fraud to maintain the integrity of the register. Registration will only be granted if we can verify an applicant's identity.

All applicants will also need to have their relevant qualification verified as it's important that we provide the public with the confidence that registrants have the necessary knowledge and qualifications to provide safe patient care – as well as ensuring that qualifications are authentic.

Rule 5 sets out the circumstances in which an application will be refused, which include, for example, cases where we're not satisfied that the standards for registration have been met.

Applications will be closed where applicants have failed to provide the information we require, or where they have not paid the registration fee.

Notifications (rule 6)

We will notify applicants of a refusal decision or closure within five business days. Where we've refused or closed an application for registration, we'll explain our reasons for doing so. Where an application has been refused, we'll inform applicants of their ability to appeal our decision within 28 days (please see Part 6 for more details on our appeals framework).

How our proposals compare to our current approach for doctors

The development of registration rules is a requirement under the AAPAO which does not exist in the Medical Act. The rules framework is new but in designing it we've aimed for flexibility and proportionality to allow us to adopt many of the same policy approaches to registration that we have in place for doctors.

Putting the details of our procedures and approach in rules will also strengthen transparency and provide certainty to associates about how our processes will operate.

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

What our re-entry rules cover (rules 19 – 23)

Where an AA or PA has requested removal or been removed from the register, our re-entry rules set out the process for applying to re-enter the register. The rules set out the process and proportionate evidential requirements to assess whether an associate meets the standards for registration and that they are fit to practise.

The re-entry rules set out:

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

The procedure for applying to re-enter the register (rule 19)

This rule covers the procedure for applying to re-enter the register that will apply for most applicants. It sets out the evidential requirements that applicants must demonstrate when they want to re-enter the register.

We require the same registration standards to be met at the point of re-entry, but the evidential requirements are tailored to the amount of time an AA or PA has been off the register. This will allow us to consider the length of time that different types of evidence remain valid for. For example, if an individual has only been removed for a short period of time, we will not require further evidence of English language capability. This is based on our assessment that evidence of English language capability should remain valid for a two-year period.

This rule also sets out the circumstances in which an associate will not be eligible to apply to re-enter the register through this route. This is where we've removed an associate due to a fraudulent application or where we made an error in putting an associate on the register.

The rules propose other restrictions for re-entry applications where an associate was automatically removed because they committed one of the serious criminal offences listed in the AAPAO or because a tribunal or case examiner imposed a final measure of removal. In these circumstances, associates are not permitted to apply for re-entry until at least five years have passed, or until the end date of any sentence for a criminal conviction has passed. This reflects the seriousness of the circumstances resulting in their removal from the register and the need to ensure public confidence in the professions. To provide a fair and proportionate approach to handling applications for re-entry in these cases, we also propose to limit the number of applications that an individual can make to three.

In all cases where we've refused an application for re-entry because we're not satisfied that the applicant's fitness to practise is not impaired, we've included a time limit of 12 months for submitting a further application (i.e. a further application cannot be submitted until 12 months have passed). This allows applicants time to gather further relevant evidence and ensures we're able to deal with repeated re-entry applications in a proportionate manner.

Our general procedure for re-entry applications and general approach to assessing a re-entry application (rule 20)

To decide on a re-entry application, we may need to make further enquires or request further information.

Where we receive further information about an individual's fitness to practise, the rules require us to share that information with the applicant and give them the opportunity to comment within 28 days.

This rule also sets out the circumstances in which applications for re-entry will be closed and no decision on re-entry will be made. This is where an associate fails to provide the information we require or fails to pay the required registration fee.

Our procedure for assessing re-entry applications where the applicant was removed following a fitness to practise final measure (rule 21)

Where an applicant applies to re-enter the register after having been removed for a fitness to practise final measure, there are two parts to our decision on whether to grant or refuse their application.

- A tribunal at the Medical Practitioners Tribunal Service (MPTS) will decide if they are satisfied that an applicant's fitness to practise is not impaired. The applicant will be notified of the referral to a tribunal and a hearing will be held to review the applicant's evidence of their fitness to practise (the procedure for the hearing is set out in our Adjudication rules – please see Part 5 for further details).
- We'll also assess whether the applicant meets the standards for registration.

Subject to the outcome of these two decisions, the Registrar will then grant or refuse the application.

Our procedure for assessing re-entry applications following removal for any other reason (rule 22)

All applicants must demonstrate that they meet the standards required for registration that are included in rule 4. In some cases, applicants must also demonstrate that their fitness to practise is not impaired – those include where an applicant:

- was automatically removed – including where their criminal conviction was subsequently quashed
- had a fitness to practise condition or suspension in place at the time they left the register
- had an open fitness to practise investigation at the time they left the register
- has had a concern about their fitness to practise raised since the date their entry was removed from the register
- has declared a fitness to practise concern as part of their application.

We'll notify the applicant that they are required to demonstrate that their fitness to practise is not impaired and that they have the right to make written representations within 28 days. If no written representations are made, we may proceed to make a decision on the information we hold.

We'll set out in our guidance what information applicants may provide to support their application.

The rule sets out that the Registrar can either grant or refuse an application for re-entry and the circumstances in which an application can be refused.

How we'll notify individuals of our re-entry decision and serve decisions (rules 23 - 24)

Our rules set out the timeframes and process for communicating our decisions to applicants. Where we close an application because it is incomplete, or a fee has not been paid, we will explain our reasons. Where we refuse an application, in addition to explaining our reasons, we'll notify applicants of their right to appeal our decision and any limitations on making further applications (please see Part 5 for details of our appeals framework).

How our proposals compare to our current approach for doctors

Unlike the current arrangements for doctors, in the case of AAs and PAs we'll be able to ask for evidence of the steps taken by applicants to maintain their knowledge and skills during their time off the register. We believe this will provide greater assurance to the public that individuals remain up-to-date and are safe to practise.

Currently we can indefinitely suspend a doctor's right to apply for re-entry (which doctors can apply to have lifted). We do not have this ability under the AAPAO and will instead limit the number of applications that an AA or a PA can make to three (for cases where an associate is applying for re-entry following automatic removal or removal by a final measure). We believe this provides greater clarity regarding the circumstances in which individuals can apply for re-entry.

What our removal rules cover (rules 7 – 18)

Our rules set out the steps that we'll take when removing an associate's entry from the register or in response to a request from an associate to remove themselves from the register. They also provide powers for us to request information from an associate or make other enquiries necessary to decide about whether to remove an associate from the register.

Fitness to practise final measure

To note: this process is covered by the Fitness to Practise rules rather than the removal rules (Please see Part 5 for further details).

Where we've given an associate a final measure of removal following fitness to practise proceedings, we'll remove the associate from the register as soon as reasonably practicable, as this is required by the AAPAO.

Notification to the associate of the final measure outcome and their right to appeal that decision will have already been made through the fitness to practise proceedings. Please see part 5 for more information.

Automatic removal from the register (rule 7)

The rules reflect the requirement in the AAPAO to remove an associate who was convicted of a listed offence from the register as soon as reasonably practicable. This is because these offences are of such seriousness that they are incompatible with registration as a healthcare professional. Requiring us to remove individuals in such circumstances will enable us to take swift and decisive action to protect the public.

Once we've removed an associate for a listed offence:

- we'll notify them within five business days of the removal (including the date that the removal took effect) and their right to appeal the decision to remove them from the register based on the automatic removal duty
- we'll also notify anyone the associate was employed by or had an arrangement with to provide services and any other regulatory body they were registered with.

Removal of an entry for failure to pay a required fee (rule 15), Removal of an entry for failure to maintain adequate insurance and indemnity (rule 16), Removal of an entry for failure to maintain an effective means of contact with the Registrar (rule 17)

In these circumstances we'll notify the associate of the proposed removal, the reasons for it and the actions that the associate can take within a period that we specify to prevent this. For example, these actions could be to pay any required fees or to obtain the necessary insurance or indemnity cover.

If further action is not taken, the Registrar (a specific person, working for the regulator, with responsibility for a particular decision) can then remove the associate from the register. Once we've decided, we will:

- notify the associate within five business days
- remove the associate from the register once we've served this notice.

Removal of an entry which was procured fraudulently or made incorrectly (rule 14), and failures to comply with an evaluation (rule 13) or provide information (rule 18)

An evaluation in this context refers to an evaluation of an individual's performance, health or language, or an evaluation of the extent to which an individual meets our standards.

In these circumstances we'll:

- notify the associate of the proposed removal
- explain the reasons for it and of their right to provide additional information, within a specified period, for us to consider further – this is referred to in the rules as making representations.

Following receipt of representations from the individual, or in the absence of any representations, the Registrar has the power to remove the associate from the register. The removal will take effect at the point the associate is notified of the removal. We'll notify the associate within five business days of this decision.

Associate's request to be removed from the register (voluntary removal) (rules 9 – 12)

Our rules are drafted to provide a straightforward process for associates to leave the register if they no longer wish to practise in the UK. For example, if they intend to retire, take a career break or practise in another country. We think it is right that associates who don't have any outstanding fitness to practise concerns should be able to easily remove themselves from the register if they wish to do so.

Where an associate wishes to be removed from the register, they must apply in writing. Applications will usually be granted provided there are no unresolved fitness to practise concerns. Where the application is granted, we will notify the associate and the removal will take effect from the date the notification is served on them.

If the application is incomplete or the associate has not provided the necessary information, we may refuse to make a decision and close the application, with the associate then informed of this closure and our reasons for doing so. This is set out in rule 9.

Where there are ongoing fitness to practise proceedings, the decision maker for the application will depend upon the stage that's been reached in those proceedings. The Registrar will consider the application if the case has not yet been referred to the case examiner to consider. Where it has already been referred, the case examiner will consider the application. And if the case has been referred to a tribunal, then the case examiner or tribunal can consider the application if the tribunal has not yet reached the stage described in rule 42(1)(b)(iii) of the Adjudication Rules. If the case has reached this stage then the tribunal will consider the application. This is set out in rules 10 and 11.

Where a decision has been made about an application for removal, we will notify the associate of that decision within five business days whether it has been granted or refused (together with reasons for any refusal) and, if granted, the date it will take effect. We'll also notify them of their right to appeal the decision. This is set out in rule 12.

How our proposals compare to our current approach for doctors

The requirement to automatically remove associates convicted of the offences listed in Schedule 2 of the AAPAO is a new duty and does not currently exist for doctors under the Medical Act.

For doctors, we're still required to demonstrate that a doctor's fitness to practise is impaired on the basis that they've been convicted of serious criminal offences.

Our proposed approach to considering associate requests to be removed from the register, where there are no outstanding fitness to practise concerns, offers a swift and proportionate process for these professions.

Consultation questions - Gaining entry to and removal from the AA and PA register

7 To what extent do you agree or disagree with our proposed approach to registration, as described within our rules? (Agree / Disagree / Neither agree nor disagree or don't know)

Please provide a reason for your answer.

8 To what extent do you agree or disagree with our proposed approach to re-entry, as described within our rules? (Agree / Disagree / Neither agree nor disagree or don't know)

Please provide a reason for your answer.

9 To what extent do you agree or disagree with our proposed approach to removal, as described within our rules? (Agree / Disagree / Neither agree nor disagree or don't know)

Please provide a reason for your answer.

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? (Agree / Disagree / Neither agree nor disagree or don't know)

Please provide a reason for you answer.

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? (Agree / Disagree / Neither agree nor disagree or don't know)

Please provide a reason for your answer

Part 5 – Fitness to practise proceedings

Fitness to practise

For AAs and PAs, our role will be to establish and operate a process for dealing with concerns that are raised with us about an associate's fitness to practise – this will include the following stages.

- **Initial assessment** – where we'll determine if regulatory action is likely to be required.
- **Accepted outcomes** – where a case examiner will consider whether the associate's fitness to practise is impaired. And if they decide that it is, the case examiner will propose appropriate restrictive action (a final measure). Where they don't find impairment, they may issue a warning.
- **Adjudication** – where an associate rejects an outcome proposed by a case examiner, or where a case examiner otherwise refers a case to a hearing, for example if they cannot reach a decision on impairment, a tribunal will consider the case. If the associate's fitness to practise is found to be impaired by a tribunal, they may impose appropriate restrictive action (final measure). Where they do not find impairment, they may issue a warning.
- **Review of final measure** – where a case examiner or tribunal will consider whether the associate's fitness to practise is impaired and determine whether a measure is still needed to protect the public, and if so, what that measure should be.

We will also establish and operate a process for referring a concern to an interim measures tribunal during fitness to practise proceedings and to consider whether interim regulatory action is required (an interim measure).

The Medical Practitioners Tribunal Service (MPTS) will arrange and operate tribunals for AAs and PAs. The MPTS currently runs hearings for doctors and is independent in its decision making, operating separately from the investigatory role of the GMC.

What we're consulting on

We're consulting on our proposed rules for fitness to practise . These cover:

- initial assessment
- interim measures and interim measure reviews
- accepted outcomes
- adjudication
- final measure reviews.

We're also consulting on the following principles that will form the content of decision-making guidance—this will be introduced for AAs, PAs, **and doctors** once regulation starts for AAs and PAs.

- *Principles for impairment guidance*. A finding of impairment can only be made where an AA, PA or doctor is assessed to pose a current and ongoing risk to one of more parts of public protection. The principles outline the approach and key factors relevant to assessing this risk.
- *Principles to inform guidance on restrictive action*. Restrictive action is put in place to address the current and ongoing risk to public protection posed by an AA, PA or doctor. The principles outline the approach and key factors relevant to deciding what type of restrictive action is a proportionate regulatory response.
- *Principles to inform guidance on warnings*. Warnings are put in place as a formal response to indicate to an AA, PA or doctor that any given behaviour or poor performance represents a departure from the professional standards expected and should not be repeated. The principles outline the approach and key factors relevant to deciding if a warning is a proportionate regulatory response.

We welcome comments on any aspect of our proposed rules and the principles that'll form the content of decision-making guidance, but would particularly welcome comments on:

- our rules for how we will exercise our statutory powers and comply with our statutory obligations set out in the AAPAO in relation to fitness to practise and the extent to which our processes are clear, fair and proportionate
- our proposed approach for accepted outcome decisions to be made by a single case examiner – selected from a team of case examiners
- our proposed principles that will inform the content of our decision-making guidance, which we will introduce for AAs, PAs and doctors once we begin regulation for AAs and PAs.

Before reviewing our proposed rules and decision-making principles, which can be found via the links above, we encourage you to first read Part 5 of the consultation document which gives more details on the purpose and scope of these documents.

Initial assessment (rules 3 – 5)

What the rules cover

We will open an initial assessment where a question arises about whether an associate's fitness to practise is impaired. Initial assessment is used to determine whether regulatory action is likely to be needed to protect the public.

Our initial assessment rules describe:

- our powers to investigate concerns to determine whether regulatory action is likely to be required
- the action we must take at the conclusion of an initial assessment
- when we'll notify individuals of decisions made during this process.

Our powers of investigation (rule 3 and 5) and the action we must take at the conclusion of an initial assessment

Where we consider that a question has arisen about the possible impairment of an associate's fitness to practise, we will undertake an initial assessment to consider whether it's likely that regulatory action is required to protect the public (referred to in our rules as the 'test for onward referral'). This is based on an assessment of risk to public protection and the factors that we'll consider in reaching this decision are set out in our principles, which will inform the content of our decision-making guidance.

Where we decide that a concern meets the test for onward referral, our rules states that we must refer the concern to a case examiner for further consideration. We may wait for the outcome of an investigation by another body before deciding whether the test for onward referral is met. Where we decide the test is not met, we will close the concern.

To inform our decision-making, the rules enable us to undertake investigations at any stage of our fitness to practise proceedings. As part of our investigations, and to inform our decision-making, we may also direct the associate to undergo a relevant assessment of their performance, health or knowledge of English. The rules set out the information that we must give an associate when making such a direction. In line with the provisions of the AAPAO, they also set out the potential next steps that we'll take where an associate does not comply with a direction to undergo an assessment.

In such cases, and when considering whether or not the onward referral test is met, we may draw an adverse inference (which is a conclusion based on an individual's failure to do something). Alternatively, we may seek to remove the associate from the register under the provisions of article 9 of the AAPAO.

The rules apply similar provisions where an associate fails to comply with a requirement to give information or documentation. However, the AAPAO specifically excludes material produced for either the purposes of an associate's professional development or for the purpose of their personal reflection.

The AAPAO establishes that an associate can be found to be impaired by reason of:

- their inability to provide care to a sufficient standard
- misconduct.

The AAPAO does not provide for an associate to be found impaired by reason of health, which exists in our current legal framework for doctors. However, we'll need to consider the impact of an associate's health condition when deciding whether or not they are impaired for either of the two reasons set out above.

It's important to us that we, as we do for doctors now, treat cases where the health of an associate is a factor compassionately. We'll aim to design our processes to be as sensitive as possible to those with health concerns despite the lack of a specific reference to health in the AAPAO.

Our requirement to notify individuals of decisions made during Initial Assessment (rule 4)

Rule 4 makes provision for us to notify associates that we are carrying out an initial assessment of a concern raised about them. Before making a decision to refer a concern to a case examiner, we will notify the associate of why we consider the onward referral test may be met. We must give the associate 28 days to comment on this before reaching a decision on whether the concern should be referred to a case examiner. We must also inform them of their right to be represented. We will then notify an associate of our decision within five business days of it being taken.

We will update the person raising the concern of the progress of our initial assessment and give them opportunities to provide information about the concern, as well as informing them of the outcome.

How our proposals compare to our current approach for doctors

Under our current framework set out in the Medical Act, any case meeting the threshold for investigation must be referred on to a case examiner to decide whether regulatory action is likely to be required or whether the case can be closed.

This protracts the resolution of some cases, creating needless stress for the doctors concerned and can raise false expectations for those that have raised the concern with us. We believe that the increased discretion provided for by the AAPAO will enable us to investigate cases proportionately and take swift action to protect the public or close cases where regulatory action is not required.

Interim measures and interim measure reviews (rules 6 – 16)

What the rules cover

An interim measure is a temporary restriction on registration that applies to an associate's entry in the relevant part of the register. We will refer an associate to an Interim Measure Tribunal (IMT) if we consider that is necessary for public protection or if it's in the interests of the public or associate.

An interim measure allows us to take immediate action to protect the public while we complete our fitness to practise proceedings. There are two types of interim measures:

- conditions – which impose restrictions on the individual's practice and/or may require them to do something
- suspension – which prevents the individual from practising for a specified period.

These rules set out a high-level framework for determining whether an interim measure may be required. Our rules also provide a flexible framework for reviewing these measures. This enables the measures to be reviewed by a case examiner on the papers (where decisions are made on the basis of written submissions) without the need for a hearing where the associate consents, or through a tribunal hearing where the associate requests one or we determine that a hearing is needed.

The rules cover:

- the procedure for referring a case to an Interim Measure Tribunal (IMT)
- how the IMT will operate
- our procedure for reviewing interim measures
- our procedure for notifying individuals of the decision of an IMT.

Procedure for referring a case to an IMT (rule 6)

We'll notify the associate of:

- a referral to an IMT
- our reasons for referring
- any evidence relevant to the consideration of whether an interim measure should be imposed.

The rules also allow us to withdraw a referral to the tribunal where we consider that an interim measure is no longer necessary.

Procedure for an Interim Measure Tribunal (rule 7)

Rule 7 describes the procedure for an IMT. The tribunal must consider evidence put forward by the parties and give them the opportunity to make submissions before making its decision.

Evidence can only be given orally if the tribunal considers it necessary to reach its decision. If an interim measure is imposed, it will come into effect immediately and we will notify the associate of this decision. We will also notify their employer, other regulatory body (if appropriate), and the person who raised the initial concern.

Reviewing interim measures (rule 8 - 16)

We can start a review of an interim measure at any point prior to its expiry. Under the terms of the AAPAO, we must do this before the end of six months from when the interim measure came into effect or from the date of any previous review.

An associate can also request a review. If we refuse this request we must notify the associate of our reasons for doing so.

When we initiate a review of an interim measure, we must refer it to either a case examiner or an IMT. We will notify the associate of the referral and our reasons for doing so, together with any evidence that is relevant to the matters under review.

Where the case is referred to a case examiner, the case examiner will first consider whether an interim measure remains necessary, taking into account written information provided by us and any written information (representations) from the associate. If an interim measure is no longer necessary, the case examiner must revoke the existing measure and we will then notify the associate of this decision.

If an interim measure remains necessary, the case examiner will decide whether the existing interim measure should be extended, varied or revoked, and replaced with a different measure. We will then notify the associate of the case examiner's proposal.

The associate may either accept the proposal or request a hearing. If the associate does not respond to the proposal or request a hearing within a specified timescale, the case examiner may impose the interim measure or may ask us to refer the matter to an IMT, which will then review the case using the procedure described above for interim measures (rule 16).

The case examiner can also allow an existing measure to continue when considering a review. This could be used for example, where there's a concern that the associate failed to comply with an existing measure but on further consideration, the case examiner decides that no change is needed to the existing measure.

How our proposals compare to our current approach for doctors

The process and test for imposing and reviewing interim measures is similar to the current approach that we use for doctors under the Medical Act. The main difference is that under the Medical Act, reviews of interim measures carried out without a hearing must be carried out by either an Interim Orders Tribunal (IOT) or by the tribunal chair acting alone.

The AAPAO makes provision for the Regulator to carry out reviews of interim measures and we propose to delegate this decision to either a case examiner to conduct reviews or to a tribunal to conduct a hearing. We believe that this will provide for a more proportionate mechanism for determining reviews of interim measures. As with doctors now, associates will retain the right to have their review considered at a hearing, which will be conducted by an IMT.

Accepted outcomes rules (rules 17 – 25)

Our accepted outcomes rules set out a high-level framework for determining how we'll handle concerns that are referred to a case examiner when the onward referral test is met.

Our intention is to introduce a clear, fair and proportionate process that's focused on reaching agreement with associates. And where possible, one that is focused on identifying the restrictive action (conditions, suspension or removal) that we'll take where an associate poses a current and ongoing risk to public protection – meaning their fitness to practise is impaired.

The accepted outcome process has the potential to enable us to take quicker action to protect the public and minimise the number of tribunal hearings that we are required to hold.

Given the adversarial nature of hearings, this will reduce potential stress for associates, complainants, and witnesses who would otherwise need to provide evidence at a hearing. Fewer tribunal hearings will also reduce the impact on health service employers in having to release witnesses who are staff members to attend.

The AAPAO gives powers to a case examiner to make accepted outcome decisions. We propose that accepted outcome decisions are made by a single case examiner who is selected from a team of case examiners – with cases allocated to the next case examiner with availability.

Case examiners have been carefully selected, trained, and rigorously inducted to support quality decision-making in all case types. They'll be supported by ongoing training and decision-making discussions. We will have a rigorous assurance framework, including internal and external audit, to ensure quality and consistency of decisions. We will also publish these decisions together with our underpinning reasoning (excluding any confidential details).

The rules describe how we propose to deliver this process, and:

- require a case examiner to consider information relevant to their consideration of the case, including written representations from the associate
- provide a case examiner with an ability to request further information where relevant and appropriate to do so
- require a case examiner to consider if the associate's fitness to practise is impaired

- set out the action a case examiner may take when they decide an associate's fitness to practise is not impaired
- set out the action a case examiner may take when they decide an associate's fitness to practise is impaired
- provide clarity on when a final measure or warning will take effect
- require a case examiner to notify associates of decisions that are made during the accepted outcomes process.

Where appropriate to do so, we expand on these areas in the following sections.

Our rules are supported by our principles that will form the content of our decision-making guidance. This will inform case examiner decisions on:

- impairment
- when to issue a warning (when an associate's fitness to practise is not impaired)
- what final measure to propose (when an associate's fitness to practise is impaired).

Accepted outcomes process – where a case examiner considers that the associate is impaired (rules 19-20, 22 and 25), When measures will take effect (rule 21)

Following referral to the accepted outcome stage, the rules require the case examiner to consider information that is relevant to the case. This would include for example, information provided by the person who raised the concern initially, as well as information provided by the associate, both of whom will have had the opportunity to provide their perspective and input during the initial assessment stage. The case examiner will then reach a decision on whether the associate's fitness to practise is impaired. Where appropriate to do so, the case examiner may also refer the matter on to a tribunal.

Where a case examiner determines that an associate's fitness to practise is not impaired, they may issue a warning or take no further action. In cases where the case examiner decides to impose a warning, it will take effect when the notice of this decision has been served on the associate.

Where the case examiner determines that an associate's fitness to practise is impaired, they can propose an appropriate final measure. A final measure is a restriction that can be imposed by a case examiner or tribunal – and will apply to an associate's entry in the register.

Final measures include conditions, suspension or removal from the register; they can restrict an associate's practice, stop them from practising for a period of time or remove their right to practise entirely.

When a case examiner proposes an outcome, we'll notify the associate of:

- the case examiner's findings on the case
- their decision on impairment
- details of the proposed final measure, including the duration that it will apply for.

Taken together, these three points represent the 'terms of the proposed outcome' (also referred to as 'terms' in this document), and they are informed by the individual circumstances of the case. As such, the decision on impairment and the proposed measure are not open for negotiation. The associate will have 28 days to accept or reject the proposed terms.

Where the case examiner becomes aware of new information relevant to their consideration of the case, the terms of the proposed outcome may be withdrawn.

Where there's been a withdrawal, the case examiner can re-consider the case and take any of the steps set out in the accepted outcome process; this includes reaching a decision on impairment, imposing a warning, proposing an outcome, or referring a case to a tribunal.

Under the AAPAO, a final measure of removal must take effect as soon as reasonably practicable after its been imposed. A final measure of conditions or suspension will take effect from the point that we serve notice of the case examiner's decision to impose it. All final measures will stay in force during the appeal period and any subsequent appeal process. This is to make sure that the public is protected while an appeal of a decision is carried out and concluded.

Where an associate rejects the terms of the proposed outcome, the case examiner will refer the case to a tribunal for consideration and decision. This is to make sure that an associate has a right to a full hearing if they would prefer their case to be concluded through this process.

Where an individual does not provide a 'reasoned response' by accepting or rejecting the proposed outcome within 28 days, the case examiner may impose the final measure that was proposed under the terms or refer the case to a tribunal.

We will develop guidance to support case examiners to reach fair and consistent decisions on how to exercise this discretion. This will include guidance on what constitutes a 'reasoned response'. However, we anticipate that a response will be 'reasoned' if the associate explicitly states that they either accept the full terms of the proposal, or they do not.

A case examiner may extend the period that an associate has to respond to a proposed outcome where they consider it's reasonable to do so.

Notifications of our decisions (rules 21, 23 and 24)

The rules set out when we'll notify individuals of our decisions. When a case examiner agrees or imposes a warning or a final measure, the rules require us to notify the associate and several third parties of the decision.

The third parties we must inform include the complainant (if applicable), the associate's employer (where known), and any other regulatory body with whom the associate is registered (where known).

We'll also notify associates of their right to appeal the decision (please see Part 6 for further details of our appeals framework) and that we have the ability to revise the case examiner's decision where appropriate (please see Part 6 for further details of the revisions framework).

How our proposals compare to our current approach for doctors

While our current legislation for doctors doesn't currently reference case examiners, our current rules, introduced in 2004, require two case examiners to make a decision at the end of an investigation into a doctor's fitness to practise. This restriction will not apply under our new legislative framework for AAs and PAs. Our proposed approach offers greater flexibility to develop a more modern, streamlined decision making model to reflect how decisions are made about matters of significant concern to individuals and the public by single decision makers in modern adjudication systems including judges, coroners, ombudsmen, and regulatory adjudicators.

Under the AAPAO, case examiners will also have greater decision-making powers and will be able to decide if an associate is impaired (a finding of impairment), which for doctors can only currently be made by tribunals. Following a finding of impairment, they'll be able to propose a wider range of restrictive action to associates than is currently permitted under our legislative framework for doctors.

Currently, for doctors, sanctions imposed on a doctor's registration will come into force after the subsequent appeal period has expired. If an appeal has been made, the sanction will only come into force after that appeal has been heard and if it's not successful. To address any gaps in public protection during this period, tribunals can put an immediate order of conditions (requiring a doctor to stop doing certain things, to work only while supervised or to retrain) or suspension in place – while the appeal is considered and concluded.

The AAPAO does not provide the same framework for AAs and PAs. It does not provide powers to impose immediate orders to manage public protection risks while an appeal is considered and concluded. Therefore, under the AAPAO, a final measure of removal must take effect as soon as reasonably practicable after it's been imposed. For a final measure of conditions or suspension, we propose that these measures should come into effect immediately on service of notice and stay in force during the appeal period and any subsequent appeal, or until the measure otherwise expires.

Adjudication rules (rules 26 – 55)

The adjudication process will be used to reach outcomes in cases that are not resolved by case examiners through the accepted outcome process.

The range of regulatory action available to a tribunal will be the same as for case examiners; they'll be able to impose a warning or put in place restrictive action of conditions, suspension, or removal.

Adjudication will also be used to:

- determine if an interim measure is needed – and where an interim measure is in place, adjudication will be used to carry out a review in certain circumstances
- review an existing final measure of conditions or suspension in certain circumstances
- decide, in cases where an associate was removed from the register because of a final measure and is now seeking re-entry – if the associate is fit to practise.

The adjudication process for AAs and PAs will be run by the MPTS.

Our adjudication rules set out our proposed framework for managing cases that have been referred to a tribunal. The rules include the process for running hearings and communicating outcomes to associates and third parties as appropriate. Our intention is to establish a fair, just, and efficient adjudication process for associates which protects the public.

When a case is referred to a tribunal, the adjudication model enables:

- A case manager (an individual appointed by the MPTS for the purpose of managing cases referred to a tribunal for a hearing) to give directions to the parties (the associate and the GMC) about the approach we'll take to get the case ready for hearing.
- Any preliminary legal arguments to be made, such as an application for the identity of a witness to be anonymous or in relation to the admissibility of evidence. These arguments will be determined by a case manager in advance of the hearing or will be considered by a tribunal at a preliminary hearing.
- A tribunal to be convened to determine any facts that are disputed between the parties and to decide if the associate's fitness to practise is impaired. If the tribunal considers that an associate's fitness to practise is not impaired, it may issue the associate with a warning. Where it finds that the associate's fitness to practise is impaired, the tribunal can impose a final measure of conditions, suspension or removal.

The adjudication rules aim to deliver this model through:

- Describing the approach to case management and setting out the consequences where a party to the proceedings fails to comply with the adjudication rules and/or directions given by a case manager or tribunal.
- Setting out that we can group allegations of impaired fitness to practise against a single associate or group the cases of multiple associates – where it is appropriate to do so.
- Outlining that hearings may be held in person or be conducted using audio or video conferencing facilities.
- Confirming that for all hearings, the MPTS must serve notice of a hearing (and setting out the timeframe in which it must be sent and what the notice of hearing content must include).
- Providing for case managers to postpone a hearing, and for tribunals to adjourn a hearing.
- Setting out an associate's right to be represented at a hearing, while providing the tribunal with the ability to proceed in the absence of an associate and/or their representative if certain criteria are met.
- Providing for case managers and tribunals to determine preliminary legal arguments in advance of a hearing.
- Confirming that hearings must be held in public unless the tribunal is considering an interim measure or the health of an associate – or where a case manager or tribunal decides that the individual circumstances of the case outweigh the public interest in holding the hearing in public.
- Setting out the approach to admitting evidence and the approach to supporting vulnerable witnesses to provide evidence at a hearing.
- Describing the procedure that a tribunal will follow to reach a decision on a case.
- Requiring the MPTS to notify the associate and the GMC at various points in the adjudication process – seeking representations from these parties at those stages set out in the AAPAO (as described in our rules).

The adjudication rules also set out the procedure to be followed by a tribunal when deciding if an applicant's fitness to practise is impaired for the purpose of re-entry to the register. This applies to circumstances where the applicant was removed from the register because a case examiner or tribunal imposed a final measure of removal.

Tribunals will also be supported in their decision-making through guidance. Our decision-making principles that will inform the content of this guidance are set out in the following documents:

- *Principles for impairment guidance*.
- *Principles to inform guidance on restrictive action*.
- *Principles to inform guidance on warnings*.

We expand on certain aspects of our adjudication procedure below.

Case manager directions (rule 26)

We propose that a case manager can give directions to the parties about the approach to take when getting the case ready for hearing. This is to support the just and expeditious management of a case to ensure that the hearing runs fairly and efficiently. While case management directions will often need to take account of the individual circumstances of a case, another way that case managers can support effective case preparation is by issuing standard practice directions. Standard practice directions are case management directions that apply to every case or type of case, for example, a direction covering the preparation of evidence bundles for the hearing.

Supporting vulnerable witnesses (rule 38)

The rules propose the circumstances in which a witness must be treated as vulnerable. They also provide case managers and tribunals with a broad discretion to direct that a witness should be treated as vulnerable, when considering the interests of the witness and all the circumstances of the case. In both instances, a witness can confirm if they do not wish to be treated as vulnerable.

We'll provide guidance on how to decide if a witness should be treated as vulnerable and on the types of measures that can be put in place to support them. For example, we'll take into account whether the witness is under the age of 18 at the hearing, whether they have a mental or physical disability, and whether they've previously complained of intimidation.

Our guidance will also cover the measures that can be put in place for a vulnerable witness – for example, introducing video links or screens, using pre-recorded evidence, having an interpreter or an intermediary or hearing their evidence in private.

Evidence (rule 39)

The standard of proof that applies to proceedings before a tribunal is the same as for civil proceedings – the balance of probabilities. This means that when deciding disputed facts, a tribunal will need to be satisfied that an event is more likely to have occurred than not. In other words, it needs to be more than 50% likely.

A tribunal may admit any evidence that they consider fair and relevant to the case before them. Where an associate has committed a criminal offence, a certificate of conviction will be treated as conclusive evidence of the offence committed.

Equally, a certificate of determination by a regulatory body (outlining a decision taken by the regulatory body) will also be treated as conclusive evidence of the facts found proved in relation to that determination. This means that in both instances, we will not need to reprove the underlying facts at the hearing.

Rule 39 proposes that the main evidence is provided to the tribunal by way of a signed witness statement. The witness can give their main evidence orally if both of the parties agree to this, or if a case manager or tribunal decides that it should be provided in this way. Where a witness' main evidence is submitted in writing, they can still be required to attend the hearing to answer questions that the other party, or tribunal, has for them. This is in line with the usual approach to witness evidence taken in civil court and tribunal proceedings.

Preliminary hearing (rule 41)

The rules describe our proposed procedure for convening a preliminary hearing to determine preliminary legal arguments. For example, this might include hearing applications relating to the disclosure of, or admissibility of evidence, or whether a hearing should be held (fully or partially) in private.

Deciding these issues separately and in advance allows the parties to prepare for the main hearing with greater certainty and reduces the risk of avoidable adjournments.

Constitution and appointment of tribunals (rules 50-52)

Tribunals will consist of three tribunal members, including a chair. The AAPAO requires tribunals to consist of at least one individual who was either:

- previously registered as an AA or PA or
- has an approved qualification suitable for registration as an AA or PA or
- is a current registrant member (a doctor, AA or PA)

and one lay member who does not satisfy any of these requirements.

The rules set out that the MPTS must appoint and maintain a list of people who are eligible to act as tribunal members. In doing so, they will set and publish criteria which a person must satisfy for initial and continued appointment. As the MPTS operates separately from the investigation function of the GMC, the rules specify that a tribunal member cannot hold any other position with the GMC, except as a member of the MPTS.

The MPTS runs most hearings by appointing a legally qualified chair. Where the chair is not legally qualified, the MPTS must appoint a legally qualified person to advise the tribunal on questions of law and on the drafting of decisions.

How our proposals compare to our current approach for doctors

The adjudication process for associates largely replicates the process we currently have for doctors. However, to deliver our aim of establishing a fair, just, and efficient adjudication process for associates, which protects the public, we've used the increased discretion provided for under the AAPAO to extend the powers of case managers under the rules.

This is an important step as it allows case managers to resolve a wider range of issues in advance of the hearing, where appropriate for them to do so. The benefit is that this gives clarity to the parties and witnesses on key issues and allows the hearing itself to be focused solely on the issues which continue to be the subject of dispute between the associate and the GMC.

The ability for case managers to be able to issue practice directions is also new. It is intended to be consistent with achieving the expeditious management of cases referred for a hearing.

As is currently the case for doctors, rule 38 establishes the circumstances in which a witness must be treated as vulnerable for the purpose of being eligible for special measures. However, for associates, we've replicated the protection provided by the Domestic Abuse Act 2021, to enable special measures to be available to a witness where the alleged behaviour against the witness amounts to domestic abuse. This takes into account the significant impact that this type of behaviour can have on a witness, on their ability or willingness to engage in a hearing and on the quality of their evidence.

For doctors, the Medical Act provides that a sanction of conditions, suspension or erasure will come into force after the expiry of the appeal period or, if an appeal is lodged, when that appeal is determined if it's not successful.

However, under powers contained in the Medical Act, tribunals can put an immediate order of conditions or suspension in place while the 28 day appeal period runs, and where an appeal is lodged, while it is considered and concluded.

The AAPAO does not provide the same framework for associates. As with a final measure of removal imposed by a case examiner, under the AAPAO, a final measure of removal imposed by a tribunal must take effect as soon as reasonably practicable after it's been imposed.

For a final measure of conditions or suspension put in place by a tribunal, we propose these measures should come into effect immediately on service of notice and stay in force during the appeal period and any subsequent appeal, or until the measure otherwise expires. The rules also make provision for a tribunal to direct that a final measure of conditions or suspension will take effect immediately – where it considers there would be a risk to public protection if it did not do so.

Final measure reviews (rules 56 – 67)

Once a final measure has been imposed, the AAPAO enables us to undertake reviews of measures at any time to determine if an associate remains impaired, and if they do, to take the necessary action to address the current and ongoing risk.

In drafting the rules, our intention is to provide a fair and proportionate approach to undertaking reviews – which protects the public and supports associates in returning to unrestricted practice where they no longer present a risk to public protection.

Our rules propose a flexible framework for reviewing measures. This enables measures to be reviewed by a case examiner on the papers without the need for a hearing or through a tribunal hearing where the associate requests one or we determine a hearing is needed.

Our framework also provides for situations where a new concern arises about an associate who already has a final measure in place. Our framework enables the new concern to be considered alongside the existing measure when determining what regulatory action is needed to address any current and ongoing risk.

Our rules set out an approach that reflects our accepted outcome and adjudication processes, as set out above. Supported by our decision-making principles (*Principles for impairment guidance, Principles to inform guidance on restrictive action, Principles to inform guidance on warnings*) our rules enable:

- an associate to request a review of their final measure
- further investigations to be undertaken to consider the issues under review and to inform our decision of the review's outcome
- consideration of when final measures should take effect if imposed during the review
- notification of associates and relevant third parties of the outcome of our review.

What the rules cover

Directing the review of a final measure (rule 56)

When imposing a final measure of conditions or suspension, a case examiner or tribunal may direct that the measure should be reviewed prior to its expiry.

We may also direct a review at any stage, if an associate requests it or if we choose to do so of our own volition. If we refuse a request by an associate to carry out a review, we must inform them of the reasons for our refusal.

Referral of a review (rule 57)

Where a review has been directed, we can refer it to either a case examiner or to a tribunal. Referral to a case examiner will enable:

- reviews to be carried out proportionately without the need for a hearing
- measures to be put in place more swiftly where needed to protect the public
- a swifter return to unrestricted practice where the associate's fitness to practise is no longer impaired.

The associate will still be able to request a hearing if they would prefer. We may also refer the review directly to a tribunal – for example, if there's a new concern which has already been referred or a case examiner considers that the review should be heard by a tribunal.

Consideration of information by a case examiner (rule 58), No failure to comply with a requirement of a final measure (rule 59)

Case examiners will consider the information that we provide to them, and any representations received from the associate. In circumstances where the review has been directed because we have received evidence that the associate failed to comply with an existing measure, the case examiner will consider whether the associate has in fact failed to comply.

Where they determine that there's been a failure to comply, or where the review has been directed for other reasons, the case examiner will go on to consider whether or not the associate remains impaired. If they find that there's still impairment, they'll decide whether to extend the existing measure, vary an existing measure of conditions, or impose a different measure. They may also decide to allow the existing measure to continue where this is the most appropriate action.

If the case examiner determines that there's been no failure to comply, they must allow the existing measure to continue, and we must notify both the associate and relevant third parties of this decision.

No impairment (rule 60)

Where a case examiner determines that the associate is no longer impaired, they must either revoke the existing measure or allow that measure to expire.

We will allow the measure to expire where its imposition was necessary for the promotion of public confidence in the profession. And we'll notify the associate of the reasons for the decision and also inform relevant third parties of the decision.

Proposed outcome and the associate's response (rules 61 - 62)

In circumstances where a case examiner determines that the associate's fitness to practise remains impaired and they consider the existing measure should be extended, varied or replaced with a different measure, the case examiner will propose an outcome to the associate.

The associate will have 21 calendar days to respond to say whether they agree to the terms of the proposed outcome or whether they request a tribunal hearing. If they don't respond, then the case examiner may impose the proposed outcome or may refer the matter to a tribunal. The timescale for the associate's response is one week shorter than the timescale for outcomes proposed under the accepted outcomes process because in general terms, the review is considering existing matters rather than new concerns. However, the case examiner may extend this period where appropriate to do so.

Where the case examiner becomes aware of new information relevant to the case, they may withdraw the proposed terms. Where there's been a withdrawal, the case examiner can reconsider the case and take any of the steps set out in the review process.

Notification of outcome of review (rule 63)

We must notify an associate of the outcome of a review decision within five business days, setting out:

- the reasons for the decision
- information about when a measure will take effect
- whether a subsequent review has been directed
- details of appeal rights.

We must also inform relevant third parties of the decision.

Power to request further information (rule 64)

Rule 64 enables the case examiner to request further information from us where it's relevant to their consideration of the review.

Where we provide further information, we must disclose that information to the associate and give them the opportunity to make representations if they wish to do so.

Provisions relating to the consideration of a review by an associates tribunal (rule 66)

Where a review has been referred to a tribunal for consideration, we may withdraw that referral if appropriate.

This may be because further information was received which requires consideration or because it's become possible for a case examiner to conclude the matter through a proposed outcome without a hearing. We must notify the associate of any withdrawal decision and the reasons for it.

The rules propose a procedure that the tribunal must follow when considering a review of a final measure. These largely mirror the provisions in the rules dealing with adjudication. In addition, where the review solely relates to non-compliance with an existing measure, and the tribunal determines that the associate has in fact complied, they must allow the existing measure to continue.

As with case examiner reviews, where a tribunal determines that the associate is no longer impaired, they must either revoke the existing measure or allow that measure to expire. Where they consider the associate remains impaired, they must decide whether to extend, vary or replace the existing measure or allow it to continue.

The case examiner will also determine whether the measure should take effect on expiry of the existing measure or at the point that notice of the decision is served. The tribunal can also direct the measure to take effect immediately where it considers there would be a risk to public protection if it did not do so.

Procedure for the review of a final measure where a new concern has been raised (rule 67)

Where a new concern about an associate who is already subject to a final measure of conditions or suspension is referred to a case examiner or tribunal for consideration – the rules propose that a review is referred to the same case examiner or tribunal so that the matters can be considered together. The case examiner or tribunal must first consider the new concern and then go on to review the existing measure, taking into account their findings on the new concern when determining the appropriate action to take.

How our proposals compare to our current approach for doctors

Our proposed approach largely mirrors our current approach for reviewing final measures for doctors under the Medical Act. The main difference is that under the Medical Act, reviews carried out without a hearing must be carried out by either a Medical Practitioners Tribunal or by the Tribunal Chair.

The AAPAO makes provision for us to carry out reviews of final measures and we propose to delegate this decision to either a case examiner to conduct reviews or to a tribunal to conduct a hearing.

We believe that this will provide for a more proportionate mechanism for deciding reviews of final measures where matters can be resolved by a case examiner without the need for referral to a tribunal for a hearing. As it is currently the case for doctors, associates will retain the right to have their review considered at a hearing, which will be conducted by a tribunal.

Consultation questions – Fitness to Practise proceedings

12 To what extent do you agree or disagree with our proposed approach to initial assessment, as described within our rules? (Agree / Disagree / Neither agree nor disagree or don't know)

Please provide a reason for your answer.

13 To what extent do you agree or disagree with our proposed approach to interim measures and interim measure reviews, as described within our rules? (Agree / Disagree / Neither agree nor disagree or don't know)

Please provide a reason for your answer.

14 To what extent do you agree or disagree with our proposed approach to accepted outcomes, as described within our rules? (Agree / Disagree / Neither agree nor disagree or don't know)

Please provide a reason for your answer.

15 To what extent do you agree or disagree with our proposed approach to adjudication, as described within our rules? (Agree / Disagree / Neither agree nor disagree or don't know)

Please provide a reason for your answer.

16 To what extent do you agree or disagree with our proposed approach to final measure reviews, as described within our rules? (Agree / Disagree / Neither agree nor disagree or don't know)

Please provide a reason for your answer.

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? (Agree / Disagree / Neither agree nor disagree or don't know)

Please provide a reason for your answer.

18 To what extent do you agree or disagree with our proposed decision-making principles for impairment guidance? (Agree / Disagree / Neither agree nor disagree or don't know)

Please provide a reason for your answer.

19 To what extent do you agree or disagree with our proposed decision-making principles for guidance on what restrictive action is required? (Agree / Disagree / Neither agree nor disagree or don't know)

Please provide a reason for your answer.

20 To what extent do you agree or disagree with our proposed decision-making principles for guidance on warnings? (Agree / Disagree / Neither agree nor disagree or don't know)

Please provide a reason for your answer.

Part 6 – Challenging our decisions

Revisions and appeals

For AAs and PAs, our role will be to:

- revise decisions, where there's been an error or where circumstances have materially changed
- operate an internal appeal process for individuals who wish to challenge decisions that we've made.

What we're consulting on

We're consulting on the following sets of rules:

- revisions
- appeals.

The AAPAO introduces a new framework for challenging or changing specific decisions. There are two procedures under which this can happen.

- The first is where we can swiftly amend or correct a decision where we agree it was wrong or where the circumstances have materially changed since it was made. This procedure is referred to as 'revisions'.
- The second is where an individual can challenge decisions that we've made on the basis that they're wrong or unjust. This procedure is referred to as 'appeals'.

Revisions

Taking revisions first, the AAPAO provides the GMC with a new power to revise decisions. The AAPAO requires us to specify in the rules which decisions can be revised in this way.

The revision power may be used where certain grounds are met – either where there's been:

- an error of fact or law
- a material change in circumstances since that decision was made.

The AAPAO sets out the grounds for revision that must be met for different decisions. For example, certain fitness to practise decisions can only be revised on the ground of error of fact or law.

We can choose to revise our own decision, provided these grounds are met. However, in some instances, certain individuals (as set out in the rules on revisions) will also be able to request that we revise a certain decision. We provide further details on these decisions below – see *Requests to revise certain decisions (rule 6).*

Appeals

The AAPAO also grants a right of appeal for certain decisions about fitness to practise, registration, removal from the register, and re-entry to the register.

For most decisions, individuals will appeal to a panel convened by the GMC or MPTS, either as a written appeal or through an oral hearing where requested. If permission to appeal is refused, or the appeal is not upheld, individuals have a further right of appeal to the courts depending on the decision appealed.

Certain decisions are appealable directly to the courts and do not require an appeal to be made first to an internal panel. This applies to some fitness to practise decisions made by tribunals and automatic removal decisions.

Where a person appeals to the GMC against a decision, we'll consider whether that appeal should proceed – through granting or refusing permission. At this stage, we may also decide that we can revise that decision without proceeding to a full appeal. This will allow us to resolve contested decisions or correct errors more swiftly – where appropriate to do so. Where permission for appeal is granted, the appeal will continue through our internal appeal process.

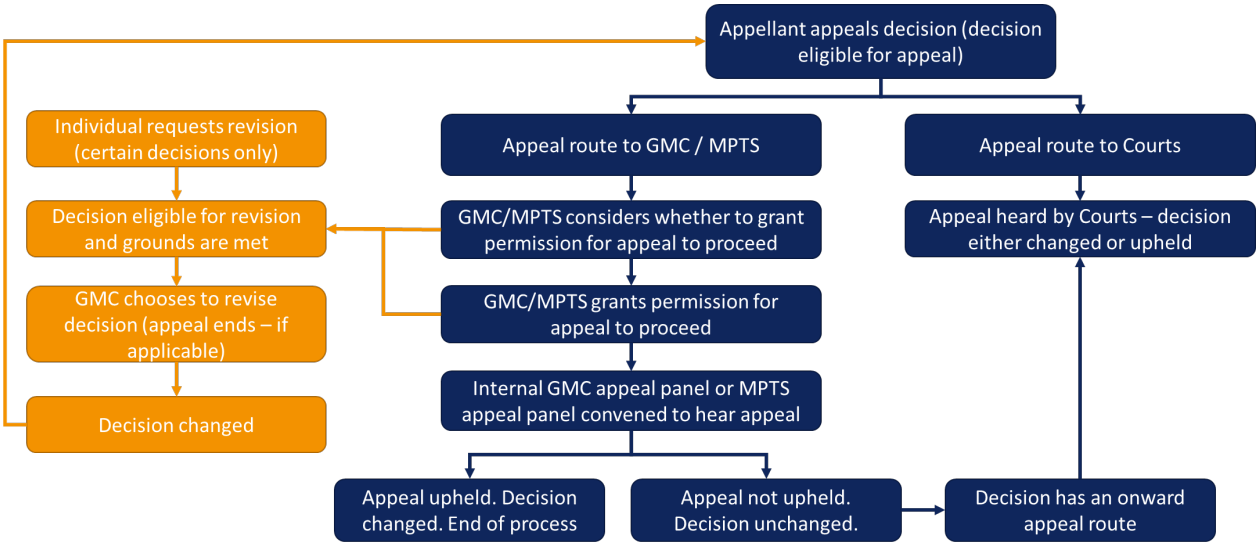
Revisions and appeals

The table below outlines which decisions are appealable and revisable:

Decision	Who is the decision appealable to in the first instance?	Is the decision revisable?	Does the decision have an onward right of appeal and if so to who?
To register an applicant	Internal GMC appeal panel	Yes	Yes - County Court and equivalent
To re-enter an applicant to the register (following removal for Fitness to Practise reasons)	High Court and equivalent	No	No
To re-enter an applicant to the register (following removal for non Fitness to Practise reasons)	Internal GMC appeal panel	Yes	Yes - High Court and equivalent
To remove an associate's entry from the register (does not include removal decisions where it is indicated that the associate has died, removal decisions relating to the imposition of a final measure, or removal decisions due to the associate's conviction of a listed offence in the AAPAO)	Internal GMC appeal panel	Yes	Yes - County Court and equivalent
To remove an associate's entry from the register where it is indicated that the associate has died	County Court and equivalent	Yes	No
To remove an associate's entry from the register due to their conviction for a listed offence in the AAPAO	High Court and equivalent	Yes	No
Decision to refer or not refer a concern to a case examiner following initial assessment	No appeal right provided by the AAPAO	Yes	No appeal right provided by the AAPAO
Decision of case examiner to take no further action, to issue the associate with a warning or to impose a final measure on the associate including specifying the length of time that a final measure will remain in effect for	Internal GMC appeal panel	Yes	Yes - High Court and equivalent
Decision of a tribunal to take no further action, issue the associate with a warning or impose a final measure on the associate	High Court and equivalent	No	No

Decision of a tribunal to impose an interim measure on the associate and to specify the time it will remain in effect for	High Court and equivalent	No	No
Decision of a case examiner to extend, vary or revoke an existing interim measure	Internal GMC appeals panel	No	Yes – High Court and equivalent
Decision of a tribunal to extend, vary or revoke an existing interim measure	MPTS appeal panel	No	Yes – High Court and equivalent
Decision of a case examiner to extend, vary or revoke an existing final measure	Internal GMC appeals panel	No	Yes – High Court and equivalent
Decision of a tribunal to extend, vary or revoke an existing final measure	MPTS appeal panel	No	Yes - High Court and equivalent

The flow chart below summarises how these two processes will operate alongside each other.



Before reviewing our proposed rules, which can be found via the links at the beginning of this section, we encourage you to first read part 6 of the consultation document, which provides more details on the purpose and scope of these documents.

Revisions rules

Revisable decisions (rule 4)

We've set out in rule 4 the decisions that are eligible for revision.

We're not including decisions made by tribunals in the list of revisable decisions. The MPTS is operationally separate from the GMC, and we consider the appropriate route of challenge for a tribunal decision is to the court on appeal.

We've also excluded education decisions on the basis that the decision-making process in this area is collaborative – giving education providers multiple opportunities to submit evidence and make representations before a final decision is reached. Our education powers already enable approval decisions to be amended, for example, through restricting or withdrawing approval we've granted. Providers can also submit a new application if circumstances have changed.

Timescales (rule 4)

Rule 4 also specifies the period within which we must receive a request for a decision to be revised. Equally, where we're considering whether to revise a decision of our own volition, we must also begin that process within the same period.

- We'll consider revising a decision to remove an associate from the register if that decision was made less than three months beforehand.
- This is similar to our rules for re-entry to the register, which require applicants to provide additional evidence to demonstrate that they meet registration standards when they've been off the register for longer than three months.

In these two circumstances listed above – it would be more appropriate for the associate to apply for re-entry to the register instead.

- For decisions made by case examiners to close a fitness to practise case, either with a warning or without any further action – or where they've imposed a final measure of conditions, suspension or removal on the associate – the time limit for beginning our consideration (of whether to revise) is also three months.

This is because we don't consider it to be appropriate or fair for there to be uncertainty about the outcome of the fitness to practise process for a longer period. Furthermore, such decisions can only be revised on the ground that there's been an error of fact or law – which would have already occurred by the time the decision was made.

- For all other decisions that are eligible for revision – we'll only consider revisions within 12 months of the decision having been made.

For decisions about registration and re-entry to the register – 12 months reflects the period when most of the evidence provided in the original application will no longer be valid – so it'll be easier for the applicant to reapply instead.

For initial assessment decisions in fitness to practise, a time limit of 12 months balances:

- sufficient time for the provision of new information which might indicate an error of fact has occurred
- sufficient time to consider any material changes in circumstances
- fairness to the registrant.

Grounds for revision (rule 5)

Rule 5 confirms which grounds can be used to revise the decisions set out in rule 4.

Revision of decisions (rule 6)

Rule 6 explains the process for revising a decision, the actions that might follow, and the sources of information that we'll draw on to inform our consideration.

Where we choose to revise a decision, the revision will take effect at the point when the individual (to whom the decision relates) is served notice of our decision.

If we decide, following a revision, that a certain action should not have been taken – for example, imposing a fitness to practise measure or removing an individual from the register for non-fitness to practise reasons – we'll remove any reference to that action.

For example, the fitness to practise measure would no longer appear in the associate's fitness to practise history. However, any gap in a person's registration history because of this action cannot be retrospectively changed and would therefore remain.

Requests to revise certain decisions (rule 7)

There are three routes through which we'll consider a revision:

- as part of an appeal
- for certain decisions, as set out in the rules, where we receive a request to revise that decision
- where we've not received a request or an appeal – but decide to revise our own decision.

Rule 7 confirms that a revision can be formally requested for the following decisions (decisions one, two, three, and four).

- Decision one – to remove an entry from the register for conviction of an offence listed in Schedule 2 of the AAPAO
- Decision two – to remove an entry from the register for non-payment of fee
- Decision three – to refer, or not refer, a complaint to a case examiner
- Decision four – of a case examiner to close a case with no further action or with a warning or to impose a final measure of conditions, suspension or removal.

For the first two decisions listed (decisions one and two), that relate to removal from the register, a revision may be requested by the associate whose entry was removed.

For the last two decisions listed (decisions three and four), that relate to fitness to practise, a revision may be requested by the associate who is the subject of that decision, or a person who we've decided has an interest in that decision. For example, this could include a complainant, another person connected to that decision or the Professional Standards Authority.

Rule 7 also proposes that a fee may need to be paid when requesting a revision, but this would only apply to decisions one and two – and so would be paid by the associate.

Representations (rule 8), Enquiries and further information (rule 9)

Rules 8–9 propose that, depending on the nature of the decision that's revised, we can make further enquiries and request additional information as required to inform our consideration.

The rules also propose that we can invite written representations from the person to whom the decision relates.

Our rules also make clear that if we don't receive any representations, or we don't receive the additional information that we requested as part of our enquires, we may still revise the decision.

Notifications (rule 10)

When we revise a decision, we'll notify associates of our decision within five business days of doing so. We'll also notify the person who is the subject of the decision, together with anyone who was notified of the original decision when it was first made.

If the person who is the subject of the decision does not wish to accept the revision, they may be able to appeal that decision within 28 days. The person would be permitted to do this if the original decision being revised is listed as appealable in the AAPAO (see appeals section below).

How our proposals compare to our current approach for doctors

Under our current legislative framework for doctors, we can revise certain decisions. This is referred to as our rule 12 process. This allows existing registrants, complainants, and interested parties to request a review of initial assessment decisions and case examiner decisions to close a case, issue a warning or agree undertakings (which are similar to conditions) without referral to a tribunal.

The AAPAO also allows us to revise these decisions for AAs and PAs – although in this instance, we can also revise case examiner decisions to impose a wider range of measures (beyond agreeing conditions).

However, the grounds for revising a decision under the AAPAO, set out in rule 5, are different to our existing grounds for our rule 12 process, which focus on whether:

- the decision is materially flawed
- there's new information which might have led to a different outcome
- a review is necessary for the protection of the public, the prevention of injustice to the doctor or necessary in the public interest.

The time limit for considering rule 12 requests is two years under our current rules. Our proposed approach in these rules limits this to 12 months for initial assessment decisions, and three months for case examiner decisions.

As well as enabling a registrant to challenge a decision, the revision mechanism provides an important mechanism for complainants and other interested parties to challenge our decisions where public protection concerns arise. It's essential therefore that this is maintained for concerns relating to AAs and PAs.

There are some decisions that we don't currently have explicit powers to revise but will have the power to do so under the AAPAO for AAs and PAs. These include decisions relating to registration and removal from the register. Therefore, the power of revision provides additional flexibility to change or make a new decision in such cases and expedite the appeal process to deliver a swifter outcome for the appellant.

Appeals

What our appeals rules cover

The AAPAO allows associates to appeal certain registration and fitness to practise decisions. There are no appeal rights in the AAPAO for decisions relating to our regulation of education and training.

The appealable decisions are set out under articles 16 and 17 of the Order. Our rules set out the process for appealing decisions under article 16 to internal appeal panels run by the GMC and MPTS – they do not cover appeals to the courts.

The rules set out that an appeal against a decision made by a tribunal will be dealt with by an MPTS appeal panel. The AAPAO requires an associate to appeal any decision relating to a final or interim measure review to an internal appeals panel, rather than directly to the courts. Ensuring that these appeals will be dealt with by an MPTS appeal panel will preserve the operational separation between the MPTS and the GMC.

Notice of appeal (rule 3), Permission to appeal (rule 4)

Rule 3 sets out the information that must be provided as part of the notice of appeal. This must be received by the GMC within 28 days of the decision that is being appealed.

For decisions that are appealable to a GMC appeals panel, upon receipt of the notice of appeal, we'll decide whether to grant permission for the appeal to proceed within 28 days.

- If we decide during this period that the decision can be revised, we'll proceed through the revision process and the appeal will end.
- If the decision is not eligible for revision or we decide not to revise the decision—provided there is a real prospect of the appeal succeeding (for example, clear reasoning has been provided as to why the decision may be wrong or unjust), we'll give permission for the internal appeal to proceed.

Having granted permission for the appeal to proceed, if new information subsequently comes to light which suggests that the decision can be revised, we'll revise it through the process described above in the revisions section. In this instance the appeal would end.

When deciding whether to grant permission for an appeal against a tribunal decision, a legally qualified person appointed by the MPTS must consider whether:

- the hearing took place without the associate being present and, if it did, whether there is compelling new evidence that it was unjust for the hearing to do so
- there is any other exceptional circumstance that requires permission to be granted.

If the associate participated in their hearing, we consider that they have already had the benefit of a tribunal hearing their case and so, unless there are exceptional circumstances, the nature of their appeal is best considered by the courts rather than an MPTS appeal panel. In this instance, permission is unlikely to be granted and the appeal would end.

Appeals (rule 5)

Rule 5 proposes that the focus of the appeal should be limited to a review of whether the decision was wrong or unjust. For the decisions set out in rule 5 (3), we propose that the focus of the appeal should be limited to considering other specified factors.

For example, for those decisions where the associate has either:

- agreed to a final measure being imposed (as part of the accepted outcomes process)
- agreed to a proposal to vary or extend an existing interim or final measure as part of the review process
- not provided a reasoned response and had a final measure imposed on their registration

the appeal will only consider:

- the circumstances under which the associate agreed to the terms of the proposed outcome (see accepted outcomes section in Part 5)
- why we decided that the associate did not provide a reasoned response to the terms of the proposed outcome within the required time limit.

Withdrawing an appeal (rule 6)

Rule 6 proposes that a person can withdraw their appeal at any stage of the process. However, where an appellant chooses to do this, they will not be permitted to appeal the same decision again. If the appeal is withdrawn, the appellant will also forfeit any onward right of appeal to the courts.

We can postpone or adjourn the appeal hearing where the appellant has a good reason or where it's not just or fair to proceed. In such cases, the appellant would not need to withdraw their appeal.

Appeal case management (rule 7), Failure to comply with rules or directions (rule 8), Postponement (rule 9), Adjournment (rule 10)

Rules 7–10 describe how we'll manage the appeal process, including appeal case management and the issuing of standard case management directions, with the ability to hold a case management meeting if needed. They also set out the circumstances in which we'll postpone or adjourn a panel hearing.

These rules also set out the process for inviting submissions from the parties, and the consequences if a party fails to comply with any of the requirements we've set out in rules or directions that we've issued as part of this process.

Where the requirements in the rules or case management directions are not complied with, the panel may draw adverse inferences (which is a conclusion based on an individual's failure to do something) or may refuse to admit evidence where our rules or directions relate to that evidence.

Evidence (rule 11), Written appeals (rule 12), Oral appeals (rule 13), Witnesses (rule 14), Procedure at an oral appeal hearing (rule 15)

Rules 11–15 provide more information on the evidence that will be admitted by the appeal panel and how:

- written and oral appeals will operate
- submissions will be sought
- information will be disclosed
- appellants and interested parties will be kept informed throughout the process (through notifications).

As Rule 11 sets out, evidence will generally be admitted if the appeal panel considers it to be fair and relevant to the case before them.

The rules provide for appeals to be made in writing, unless the appellant requests an oral hearing.

The rules also provide for the appellant to call on witnesses to give evidence at the oral hearing – provided the evidence relates to the issues on appeal.

Representation at an oral appeal hearing (rule 16)

Rule 16 proposes that the appellant may be represented by a solicitor, legal counsel, or other suitable individual at an oral appeal hearing.

Appeal panel (rule 22)

Rule 22 describes the proposed make-up of appeal panels. All appeal panels will consist of three people.

For fitness to practise decisions, the AAPAO requires appeal panels to consist of at least one individual who either:

- was previously registered as an AA or a PA
- has an approved qualification suitable for registration as an AA or a PA
- is a current registrant member (a doctor, AA or PA).

and one lay member who does not meet any of these requirements.

All appeal panel members will be given the same training and guidance to enable them to discharge their duties effectively and fairly.

For MPTS appeal panels, Rule 22 provides that a person must not sit on an appeal panel where that person has previously sat on a tribunal dealing with an interim or final measure in the same case.

Panel decisions (rule 18)

Rule 18 proposes that decisions of an appeal panel will be taken by a simple majority.

After the decision has been made, we'll notify the appellant of the Panel's decision on their appeal with reasons—and of their right to appeal to the court where applicable.

We'll inform the appellant within five business days of the appeal panel notifying us of their decision and let them know that they can appeal the decision to the courts – where eligible to do so.

Where an appellant decides to appeal the decision of a GMC appeal panel to the courts, we can choose to revise that decision – provided it's eligible for revision and meets the grounds set out in the AAPAO. In this instance, the onward appeal to the courts would end.

How our proposals compare to our current approach for doctors

Under the Medical Act, certain decisions relating to registration, removal, and re-entry can be appealed to an internal GMC appeal panel, and MPTS decisions are directly appealable to the courts. However, where we decide not to restore a doctor's entry to the register, there is currently no right of appeal.

Under the Medical Act, appellants are required to appeal to internal appeal panels within 28 days. However, while there's no legislative requirement to first seek permission for the appeal to proceed, we have the power to strike out appeals that don't have merit.

Under the AAPAO, a wider range of decisions can be appealed to an internal appeals panel, including those relating to accepted outcomes. Appellants who wish to appeal their decision must now seek permission for their appeal to proceed. And as noted above, when a person appeals to the GMC against a decision, we now have the power to revise that decision without the need to proceed to a full appeal. This will allow us to resolve contested decisions or correct errors more swiftly – where appropriate to do so.

Consultation questions – Revisions and Appeals

21 To what extent do you agree or disagree with our proposed approach to revisions, as described within our rules? (Agree / Disagree / Neither agree nor disagree or don't know)

Please provide a reason for your answer.

22 To what extent do you agree or disagree with our proposed approach to internal appeals, as described within our rules? (Agree / Disagree / Neither agree nor disagree or don't know)

Please provide a reason for your answer.

Part 7 – Fees

Fees

For AAs and PAs, our role will be to:

- develop a framework for setting and charging fees for the delivery of our functions – which will include our approach to adjustments, refunds, and exceptions to charging where appropriate.

What we're consulting on

We're consulting on the following sets of rules:

- fees rules.

Before reviewing our proposed rules, which can be found via the links above, we encourage you to first read part 7 of the consultation document, which provides more details on their purpose and scope.

To support our rules, we will also publish in due course, further guidance on the circumstances in which we'll adjust, waive or refund fees.

Our current funding arrangement for AAs and PAs

At the point regulation starts we anticipate that the income generated from fees paid by associates will not be sufficient to cover the cost of regulating those professions, because there will initially be too few of them to do so. We have a funding agreement with DHSC that provides continuing subsidy until the point when we anticipate fees paid by AAs and PAs will fully cover the costs of their regulation.

The development cost of bringing associates into regulation is being met by the Department for Health and Social Care (DHSC).

What do the rules cover?

The rules do not set out the individual fees that we'll charge, but do set out the proposed principles that will inform our approach to deciding fees. Once we have finalised our rules following this consultation, we'll publish a schedule of fees on our website, informed by these principles.

Our principles for setting fees are set out at rule 4. When developing these rules and the level of the annual fee, our over-arching financial principle is that associates and doctors should pay for the cost of their own regulation, therefore registration and annual fees paid by different registrant groups are expected to differ.

We will publish a schedule of fees which will set out the nature and amount of our fees and we'll update this on an annual basis. Where we choose to vary the fees, we'll do so in accordance with the principles at rule 4. We will report on the potential impact of any fee changes on associates in our annual report.

These measures will promote transparency and assurance over our approach to fee setting, while providing us with the flexibility to amend our fees where required (for example, to accommodate changes to the cost of our activities).

The AAPAO requires us to set our fees while making sure that, as far as possible, our fee income doesn't exceed our expenditure when averaged out over a number of years. For this requirement, our expenditure can also include an amount that's set aside to build and maintain our reserves—enabling us to fulfil our obligations as a charity. What this means is that in any given year, there may be a surplus or deficit in our overall budget.

Our fees will be set with a view to make sure that they can fully cover the cost of delivering our functions for AAs and PAs. Where certain associates engage with particular functions – for example, overseas applicants for registration, we'll charge a fee linked to the cost of that separate process. We believe that this will provide a fairer approach for all.

Rule 3 allows us to charge a fee to education organisations for approval and quality assurance, which we only intend to use to recover costs incurred from quality assuring any future AA or PA training that takes place overseas.

Rule 6 permits us to refund, adjust, suspend or waive a fee. As noted above, we'll produce separate guidance on the circumstances in which we'll do this – but by way of illustration, and drawing on the approach we currently use for doctors, we have provided three examples below.

- In the case of an associate taking voluntary removal from the register, we'll refund the annual fee for the period they were unregistered.
- To support specific groups of registrants, we may charge a reduced fee. For instance, this could include supporting those with refugee status (although we have not yet finalised where and when we'll apply this exemption).
- In the case of an associate who's been suspended from the register following a fitness to practise measure, we may suspend billing for the duration of that measure.

Rule 7 sets out the potential consequences of the failure to pay a fee, which may lead to the removal of an associate's entry from the register.

Consultation questions – Fees

23 To what extent do you agree or disagree with our proposed approach to setting and charging fees, as described within our rules? (Agree / Disagree / Neither agree nor disagree or don't know)

Please provide a reason for your answer.

24 To what extent do you agree or disagree with our proposed principles for setting and varying fees in future? (Agree / Disagree / Neither agree nor disagree or don't know)

Please provide a reason for your answer

Part 8 - Equalities considerations and our Welsh Language Standards obligations

The public sector equality duty requires us to consider the implications of our proposals on individuals who share protected characteristics.

In consulting on our proposed rules, guidance, and standards for AAs and PAs, the duty requires us to consider the extent to which they:

- eliminate discrimination, harassment, victimisation, and any other conduct that is prohibited by or under the *Equality Act 2010*
- advance equality of opportunity between persons who share a relevant protected characteristic and those who do not
- foster good relations between persons who share a protected characteristic and persons who do not share it.

We've set out how our rules, guidance, and standards address these considerations – focusing on AAs, PAs and members of the public – in a separate *Equality Impact Assessment* (EqIA).

As noted in part 1 of the consultation document, we'll be consulting again on the application of rules, guidance, and standards for doctors when new legislation has been brought forward to replace the Medical Act. To accompany that consultation, we'll develop an additional equality impact assessment which will consider the additional effect of our proposed changes on doctors who share protected characteristics. However, for now, we've provided an initial summary view below of the potential effects on this group, and we'll add to these as part of our ongoing work to introduce equivalent reforms for doctors.

Many of the positive effects of our rules and guidance on AAs, PAs and members of the public will also apply to doctors who share protected characteristics. Doctors who graduated overseas or are from an ethnic minority group are typically disproportionately impacted by our processes. The introduction of new rules and guidance gives us an opportunity to address their differential experiences and deliver more equitable and inclusive regulatory services for all.

- Our proposal to introduce a flexible registration framework that's based on the version described in this consultation document for AAs and PAs will provide for a more consistent approach to the assessment of UK graduates, and those who graduated overseas, seeking registration. It will also support system-wide work to address and eliminate differential professional outcomes for doctors who graduates overseas and doctors from an ethnic minority group.

- Changes to our fitness to practise processes will present opportunities to improve outcomes for doctors who share protected characteristics, who are typically overrepresented in fitness to practise processes.
    - For example, initial assessments will enable us to take a more proportionate approach to determine when to investigate – reducing the stress and time that registrants are involved in our processes, particularly where no action is needed.
    - The introduction of processes like accepted outcomes and expanded pre-trial case management will streamline processes that are complex to navigate – leading to better outcomes for doctors who are less likely to be formally represented.
    - And while streamlining our fitness to practise processes through the introduction of accepted outcomes will bring about much-needed modernisation and flexibility, it's essential that doctors don't feel pressured into accepting a proposal (particularly where they are not represented). Doctors who are not represented are typically those who graduated overseas or are from an ethnic minority group. We would propose to mitigate this through making clear in our communications to doctors (as we are proposing to do for AAs and PAs) that the process is entirely voluntary and that the doctor has a choice to refuse the proposal.

Changes in the way we approve medical education and training will also provide the opportunity to influence equality standards in medical education and training, particularly in the undergraduate sector where we'll be able to approve individual courses rather than institutions. We'll be able to quality assure at a more granular level and consider how to use our regulatory levers to address equalities issues that may arise, such as discrimination or toxic cultures in education, training or working environments.

There may, however, be some changes that could have a negative effect, or changes that we can't yet assess. For example, it's important that additional evidential requirements introduced as part of our re-entry rules and guidance do not have a disproportionate impact on doctors who take breaks in practice (such as those taking maternity leave or a break for ill health, or due to caring responsibilities). We'll aim to mitigate an impact like this through our guidance, ensuring that our decision makers consider these cases in a fair and proportionate manner.

As we develop our rules, guidance and standards for doctors following the laying of further legislation, we'll undertake further work to understand the impact of our proposals on doctors who share protected characteristics. We will use our data, together with feedback collected through future consultations, to understand the possible implications of our proposals, so that any equality considerations and opportunities are addressed. Where we identify potential negative impacts, we'll revise our proposals to mitigate the risk of these occurring and where we see opportunities to be more equitable and inclusive we will also build these into our proposals for reform for doctors.

Consultation question – Equalities considerations

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? (Agree / Disagree / Neither agree nor disagree or don't know)

Please provide a reason for your answer

Welsh language

As a regulator for medical professionals across the UK, we are committed to making sure that our decisions consider the effects, if any, on opportunities to use the Welsh language, and on treating the Welsh language no less favourably than the English language.

Standards issued by the Welsh Language Commissioner 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 Welsh language, and to introduce any measures required to either mitigate any negative influence as well as bolster any positive influence.

Drawing on the responses to the questions below, we'll highlight any relevant impacts, and our proposed response to these, within our report on the findings of this consultation.

Consultation questions – Welsh language

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? (Agree / Disagree / Neither agree nor disagree or don't know)

Please provide a reason for your answer

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? (Agree / Disagree / Neither agree nor disagree or don't know)

Please provide a reason for your answer

How we will use your response

We'll carefully consider the responses we receive before finalising our rules, standards, and guidance. We are committed to evaluating the potential effect of any changes we make on all those who may be affected. This includes the effect our proposals could have on groups who are protected under the *Equality Act 2010*.

We'll analyse and respond to the issues raised in line with our principles for conducting consultation analysis. These specify that we do so in a way that's balanced, consistent, responsive, and transparent.

We'll publish the outcomes of the consultation exercise on our website. We will not include any personally identifiable information in these reports but may include illustrative anonymised quotes from consultation responses – unless you ask us for your response to remain confidential.

We will process your data in line with the UK General Data Protection Regulation. Our privacy and cookies policy explains how your data will be used, how cookies will be set, and how to control or delete them.

Your response to this consultation may be subject to disclosure under the Freedom of Information Act 2000, which allows public access to information we hold. This doesn't necessarily mean your response will be made available to the public as there are exemptions relating to information given in confidence and information to which the UK General Data Protection Regulation applies.

Would you be happy for us to publish anonymous quotes from your response?

- Yes, I would be happy for you to publish anonymous quotes from my response.
- No, I would prefer that you treat my response as confidential.

Annex A - Glossary

AA	Anaesthesia Associate.
AAPAO	The Anaesthesia Associates & Physician Associates Order 2024.
Adjudication	The process of deciding a matter or case by listing and conducting a tribunal hearing. Tribunal hearings relating to associates are run by the MPTS.
Annual fee	The fee that individuals who are regulated by the GMC pay every year to remain on the GMC register.
Approved AA/PA qualification	A AA/PA qualification which has been approved by the GMC as meeting the education and training standards necessary for the purposes of GMC registration.
Associate	Collective term for anaesthesia associates and physician associates.
Case Examiner	A senior decision maker appointed by the GMC to carry out the functions specified in Articles 10 and 13 of the AAPAO in relation to considering whether an AA's or PA's fitness to practise is impaired.
Case Manager	An individual appointed by the MPTS 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 determining certain preliminary legal arguments made by a party to the proceedings and postponement applications.
Conditional approval	The approval by the GMC of a course of AA/PA pre-qualification education and training, subject to certain conditions being met, usually within a specific time period.
Court	“Court”, except in the term “county court”, means in the case of a person whose registered address is, or would be if they were registered (i) in Scotland, the Court of Session, (ii) in Northern Ireland, the High Court of Justice in Northern Ireland, and (b) in any other case, the High Court of Justice in England and Wales.
Final measure	A restriction imposed on an associate's registration by a case examiner or a MPTS tribunal where that associate's fitness to practise has been found to be impaired.

Good medical practice (GMP)	Good medical practice is the GMC's core guidance describing what's expected of all registered doctors/AAs/PAs. See further details at: https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/good-medical-practice
Interim measure	A temporary restriction which may be placed on an associate's registration if this is considered necessary for the protection of the public or is otherwise in the interests of the public or the associate.
Medical Act	Medical Act 1983 is the primary legislation which governs the GMC's regulation of doctors. It sits alongside the AAPAO, which will govern the regulation of AAs and PAs.
Medical Practitioners Tribunal Service (MPTS)	An adjudication service established under the Medical Act to run tribunal hearings. The MPTS makes independent decisions and operates separately from the investigatory role of the GMC.
PA	Physician Associate
Panel	Appeals can be made to an internal GMC appeals panel against certain decisions made by the GMC or to an internal MPTS appeals panel against certain decisions made by MPTS tribunals.
Register	The list of AAs and PAs registered to practise in the UK. A separate register exists for doctors.
Registrant	An associate or doctor who is registered with the GMC.
Registrar	A specific person, working for the regulator, with responsibility for a particular decision (for example, whether or not to grant an application for re-entry to the register).
Representations (making representations)	The process of providing written or oral comments on a proposed decision.
Revalidation	Revalidation is the process through which doctors are required to demonstrate to the GMC on a periodic basis that they remain up to date and fit to practise. A similar process is being developed for AAs and PAs.
Rules	Rules describe the operational processes and procedures through which the GMC will carry out its functions in relation to education, registration, fitness to practise, revisions of decisions and appeals, and the setting and charging of fees.

Statutory functions	The GMC's regulatory functions as set out in the Medical Act 1983 and the AAPAO 2024.
Statutory regulation	The regulation of a profession in accordance with legal requirements (including under the Medical Act and AAPAO).
Tribunal	A group of three decision makers appointed by the MPTS, and constituted under rules made by the GMC, to make certain decisions where a question has arisen about an associate's fitness to practise.
Warning	A formal regulatory response where an associate's fitness to practise is not impaired which indicates that any given behaviour or poor performance represents a clear and specific departure from the professional standards expected and should not be repeated.

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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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