ARDL RESPONSE TO:

DEPARTMENT OF HEALTH & SOCIAL CARE

REGULATING HEALTHCARE PROFESSIONALS, PROTECTING THE PUBLIC

ARDL

PREFACE TO ARDL RESPONSE

This response is submitted on behalf of the Association of Regulatory and Disciplinary Lawyers ("ARDL").

ARDL is the leading professional association for lawyers who work in the fields of regulatory and disciplinary law. ARDL's website may be found at www.ardl.co.uk.

The subject matter of the present consultation is highly relevant to the interests and expertise of ARDL members, hence ARDL has established a working group to prepare this response – see details of the working group below. We have also given ARDL's members the opportunity to contribute to this response via our website.

ABOUT ARDL

ARDL was established in 2002 in response to the rapid growth in professional regulation and the recognition that regulatory and disciplinary law has become a defined area of legal practice.

ARDL's purpose is to advance, foster and encourage amongst its members education, training and the exchange of information in all matters relating to the practice of regulatory and disciplinary law. ARDL now has approaching 1,000 members, who include barristers, solicitors, legal executives and trainee lawyers, at all levels of seniority in the respective professions.

ARDL holds regular seminars on relevant legal topics in London, Manchester and Edinburgh, given by distinguished speakers, as well as hosting networking and other events each year. Its *Quarterly Bulletin* provides a regular update of developments and cases in regulatory and disciplinary law.

ARDL members practice across a spectrum of professional discipline and regulatory areas, but with a strong representation in health and social care regulation. Our members are a mixture of lawyers in private practice and lawyers working in-house at regulatory or representative organisations. Members represent a cross-section of those who primarily act for regulatory bodies and those who regularly defend individual professionals before their regulators.

ARDL is led by a Committee of 18 elected and co-opted members who represent the diverse interests within ARDL's membership.

ARDL'S RESPONSE TO THE CONSULTATION

ARDL represents a broad cross-section of interests in professional discipline and regulation. ARDL members are likely to hold a range of different views on the questions raised in this important consultation on reform of healthcare regulation. We have therefore approached the preparation of this response by establishing a working group which represents a range of the membership's interests. However, we would ask that it be recognised that the views expressed in the response are those of the working group and may not be taken to represent a single, definitive view on behalf of the association or the views of any other party or body.

ARDL is not responding to the entire Consultation document; but rather the areas of most relevance and interest to its membership. ARDL's primary concern in responding to the consultation is the integrity of the healthcare regulatory scheme and as such, it will be seen that our responses reflect concerns regarding public protection and the confidence of the public in the healthcare professions and also the legitimate interests of registrants.

Our main concerns can be summarized as follows:

1. We consider that the Government has a legitimate role in professional regulation. It was unclear to the working group whether the Government's intention is to make changes to both existing substantive and secondary legislation under Section 60, or whether regulators will be able to make rule changes without Parliamentary oversight. We consider that both primary and secondary legislation, such as rules, are subject to Parliamentary oversight and approval.

2. In the event of a Unitary Board being established, we are concerned that the proposals for its constitution on appointment arrangements do not run counter to the requirement of transparency and accountability. Particular concerns are that unitary bodies generally do not allow for executives, whether full time or non-executive, to be held to account; and that the Chief Executive/Registrar may not effectively be held to account by the board because of a conflict of interests with his or her duties to the Council.

3. We consider that legislation and rules should provide that all decisions taken by the regulator including the decisions of case examiners should be appealable decisions with a right of appeal to a Fitness to Practise panel.

4. It seems to us that “lack of competence”, if such a term is to be introduced, should be limited to a failure to provide care to the required standard. It could arise from a single incident or by reference to a sample of the registrant’s work but which is not so grave as to be classified as misconduct.

5. We consider that it is not appropriate to include health and language skills within the term “lack of competence”. Moreover, impairment to practise through ill health is very much a separate and largely private process.

6. We do not consider “misconduct” should be an all embracing term that would include, but not limited to, a conviction or caution, and a determination by another regulatory body. The big picture here is whether the concept of “misconduct” as articulated by the courts in a series of cases at the highest level, should be replaced by the use of “disgraceful misconduct” as proposed by the Law Commissioners.

7. We consider that the “five year rule” should remain.

8. We have considerable reservations about the proposed enlarged powers of case examiners. Whilst there may be an argument for case examiners to have some increase in their existing powers, we have concerns about the overall extended powers envisaged in the Consultation document. In particular, we do not consider that case examiners should be able to determine that a registrant’s fitness to practise is impaired and have the full suite of measures available to conclude a case without oversight by a Fitness to Practise panel. Moreover, they should not impose an outcome on a registrant who has not responded to the case examiner’s offer of an accepted outcome.

9. We are also concerned at the lack of oversight of the decisions of case examiners. Whilst the Registrar is given the power to review case examiners’ decisions, and any other person, including the PSA, is given the right to request such a review, no person is given the duty of oversight. This seems to us to be a weakness.

10. Whilst we agree that publishing decisions (and measures) by case examiners and panels supports transparency of decisions made by regulators, this is not the issue. The regulator is exercising powers to further the over-arching statutory objective of the regulator for the protection of the public; see for example section 1(1A) and 1(1B) of the Medical Act 1983. The cardinal principle in the rules of all regulators is that hearings are to be held in public. For example, rule 41(1) of the GMC (Fitness to Practise) Rules, provides that, subject to well established exceptions, such as matters relating to health or that the particular circumstances of the case outweigh the public interest in

holding a hearing in public, all hearings shall be held in public. In proposing that case examiners may be permitted to close a case in private without a hearing the Consultation document appears to have lost sight of this vital factor.

11. The right of appeal should remain to the High Court (or Court of Session in Scotland or the High Court in Northern Ireland), from any decision of a Fitness to Practise panel. An appeal from a decision of a case examiner should be as of right to a Fitness to Practise panel rather than direct to the court.

Finally, the proposals in the Consultation document will have much greater impact on some regulators than on others – for example, the GCC and GOsC, whose schemes have never been modernised and are now very different from those of the other regulators. We support the principle of FTP processes being set out in rules, provided that the enabling provisions in the governing legislation clearly stipulate requirements for HR compliance and fair process. It is important to set out in legislation and rules, the appointment and decision making structures in the FTP process because of their impact on whether or not the scheme is HR compliant and protects minority interests.

WORKING GROUP

The working group has responded to Parts 1, 3 and 4 of the Consultation document, namely Governance and Operating Framework, Registration, and Fitness to Practise.

As stated above, we have not answered each and every Consultation question, but have responded to those in respect of which we believe we have the relevant experience and expertise to offer a useful contribution.

The members of the working group are:

- Kenneth Hamer, Henderson Chambers, Chairman of the Working Group and author of *Professional Conduct Casebook*
- Simon Eastwood, Senior Consultant, Hempsons
- Sarah Ellson, Partner and Co-Head of Regulatory Group, Fieldfisher, Manchester
- David Gomez, Author of *The Regulation of Healthcare Professionals*
- Tom Kark QC, QEB Hollis Whiteman Chambers
- Leigh Linton, Partner, Carson McDowell LLP, Belfast
- Paul Ozin QC, 23 es, Chair of ARDL
- Rosemary Rollason, Principal, RJ Rollason Law
- Vikram Sachdeva QC, 39 Essex Chambers
- Ian Stern QC, 2 Bedford Row
- Catriona Watt, Partner, Anderson Strathern, Edinburgh.

ARDL'S RESPONSE TO DEPARTMENT OF HEALTH AND SOCIAL CARE JUNE 2021

PART 1: GOVERNANCE AND OPERATING FRAMEWORK

Consultation question 3: Do you agree or disagree that regulators should be required to assess the impact of proposed changes to their rules, processes and systems before they are introduced? Please give a reason for your answer.

For the reasons stated in paragraphs 61 to 63 of the Consultation document, we agree that regulators should be required to assess the impact of any proposed changes to their rules before they are introduced. In addition to assessing the impact on stakeholders, we consider that regulators should consult, amongst others, the Department of Health & Social Care and recognised defence bodies of any proposed changes to their rules, giving adequate time for a response before any changes are implemented, and ensure that copies of any new rules or changes are freely made available to the public.

We consider that the Government has a legitimate role in professional regulation. In addition to overseeing and promulgating legislation the Government can and does undertake a more proactive role in securing reform of the regulators, often in response to specific crises. This is reflected historically in the setting up of public inquiries, such as the *Shipman Inquiry,* and more recently in the Reports and Inquiries mentioned in the Executive Summary.

We are concerned to ensure that Parliament is able to scrutinize any changes. Paragraph 39 of the Consultation document states that the Government intends to implement changes for each of the healthcare professional regulators through the procedures made under Section 60 of the Health Act 1999. We assume this to mean, for example, that the Medical Act 1983 might be replaced by a Medical Practitioners Order in the same way that the nursing and midwifery legislation was repealed and replaced by the Nursing and Midwifery Order 2001 using the arrangements under Section 60 of the Health Act, and the pharmacy legislation was replaced with the Pharmacy Order 2010, also by adopting Section 60.

Paragraph 45 of the Consultation document goes on to say that regulators will be provided with powers to set "more of their own operating procedures through rules or guidance that do not require the approval of Parliament or the Privy Council". It was unclear to the working group whether regulators will be able to make <u>all</u> rule changes without Parliamentary oversight or statutory

instrument. Presently, secondary legislation such as regulators' rules are implemented through the machinery of Section 60 of the Health Act 1999. For example, the General Medical Council (Fitness to Practise) Rules Order of Council 2004 was made in exercise of the General Council's powers under the Medical Act 1983 after first being laid before Parliament and coming into force thereafter under a statutory instrument. In contradistinction, the Fitness to Practise Rules 2019 of Social Work England, whilst made in accordance with regulation 3 of the Social Workers Regulations 2018, do not appear to have been laid before Parliament and appear to have been made without the check for secondary legislation provided by Section 60 of the Health Act 1999. Objection to proposed rules by the Secretary of State alone is not adequate.

In summary, whilst we agree with the need for regulators to assess the impact of any proposed changes to their rules, we are concerned that, in addition to consulting the public, stakeholders and the Secretary of State, the rules should be laid before Parliament in the same way, as example, the rules of the GMC, GDC, NMC and GPhC have Parliamentary oversight. The Fitness to Practise Rules of Social Work England would appear not to have gone through any Section 60 process or made by Order in Council. We wish to make clear that we do not consider that *guidance* issued by a regulator, as opposed to rules, need to go through a Section 60 process. However, we are concerned, in view of the Government's overseeing eye, and its legitimate role in professional regulation, that both primary and secondary legislation is made subject to Parliamentary approval.

Consultation question 4: Do you agree or disagree with the proposal for the constitution on appointment arrangements to the Board of the regulators? Please give a reason for your answer.

In the event of a Unitary Board being established, we are concerned that the proposals for its constitution on appointment arrangements do not run counter to the requirement of transparency and accountability. Particular concerns are:

a) unitary bodies generally do not allow for executives, whether full time or non-executive, to be held to account; and
b) the Chief Executive/Registrar may not effectively be held to account by the board because of a conflict of interests with his duties to the Council.

The corollary of transparency is accountability. Paragraph 66 of the Consultation document states that the Chief Executive/Registrar will sit as a board member with immediate effect, and paragraph 67 states that the Chair and Non-Executives Directors will appoint the Chief Executive to the Board.

Hence it would appear that the Chief Executive/Registrar is intended to play a role in the unitary board. We would suggest that steps would need to be put in place to avoid any conflict of interests and to ensure accountability and transparency.

Moreover, as stated above, it is important that all executive members of the proposed unitary board are held to account. As for the measures specifying the qualifications and experience required of effective board members, we draw attention to the report of Tom Kark QC and Jane Russell *Review of the Fit and Proper Person Test,* published by the Department of Health and Social Care. The Fit and Proper Person Test should be applied to both executives and non-executives on regulatory boards.

Consultation question 7: Do you agree or disagree that regulators should be able to establish their own committees rather than this being set out in legislation? Please give a reason for your answer.

We agree that regulators should be able to establish their own committees rather than this being set out in legislation although a distinction should be drawn between administrative or other internal committees of the regulator such as decisions reached by Case Examiners, and committees of the regulator exercising a wholly independent and quasi-judicial role such as the Fitness to Practise Committee or its equivalent. Human Resources considerations and fairness require that all committees, their roles, powers and functions be clearly set out in legislation and/or rules. If in rules, the enabling legislation should provide an HR compliant framework.

Consultation question 12: Do you agree or disagree that the Privy Council's default powers should apply to the GDC and GPhC? Please give a reason for your answer.

The role of the Privy Council was considered in some detail by the Law Commission, the Scottish Law Commission and the Northern Ireland Law Commission in their report *Regulation of Health Care Professionals, Regulation of Social Care Professionals in England:* paragraphs 2.48 to 2.56.

The Law Commissioners recognised that the Government has played and continues to play an active role in overseeing the regulators. In the majority of cases, this is achieved through its role as adviser to the Privy Council. In formal legislative terms, the Privy Council is required to approve new rules and regulations made by the regulators and has default powers to intervene in cases of regulatory failure. But, in practice, the Privy Council performs no real

independent function and lacks the resources to undertake an active role in this regard. It therefore defers to the Department of Health as the relevant Government department with responsibility for professional regulation. In effect, the Department – not the Privy Council – is the main player in developing, scrutinising and seeking the approval of rules and regulations, and would be required to implement the default powers in the event they were ever deployed.

For the above reasons, and those stated in answer to Consultation question 3 above, we agree that the Privy Council's default powers, available in practice to the Department of Health, should apply to the GDC and the GPhC.

PART 3: REGISTRATION

Consultation question 30: Do you agree that all regulators should have the same offences in relation to protection of title and registration within their governing legislation?

Consultation question 31: Do you agree or disagree that the protection of title offences should be intent offences or do you think some offences should be non-intent offences (these are offences where an intent to commit the offence does not have to be proven or demonstrated)? Please give a reason for your answer.

The Consultation document is conflating two issues; namely, restricted professional activities and the use of protected titles. In the case of a restricted professional activity, we see no problem in there being strict liability for breach of the offence. The Law Commissioners recommended in clause 210 of and Schedule 5 to their draft Bill that certain activities should give rise to strict liability. For example, Schedule 5 states:

> "1 (1) It is an offence for a person to –
> (a) practise dentistry,
> (b) hold himself or herself out, directly or by implication, as practising or being prepared to practise dentistry,
> unless that person is a registered dentist or registered dental care professional."

> "15 (1) It is an offence for a person who is not a registered pharmacist to practise as a pharmacist."

In both instances, these would be strict liability offences.

A different situation arises where it is alleged that the defendant has used a protected title or made a false representation as to his or her registration or license to practise, such as, for example, use of the words “optometrist” “osteopath” or “registered nurse”. The Law Commissioners recommended in clause 211 and Schedule 6 of the draft Bill that such offences should require proof of an intent to deceive.

Some of us considered that wrongly using a protected title or false claims to be entitled to use a protected title should give rise to strict liability. The public policy in question is that reliance should be capable of being placed on the title. That applies whether a person intends to misuse it or not. Accordingly, that supports the imposition of strict liability perhaps subject to a due diligence defence with the legal burden being placed on the accused. Others agreed with the approach of the Law Commissioners that proof of an intent to deceive was required in the case of the use of a protected title or the false representation as to the defendant’s registration or license to practise.

Consultation question 33: Do you agree or disagree with our proposal that regulators should be able to set out their registration processes in rules and guidance? Please give a reason for your answer.

In our view, guidance has a place but a distinctly secondary place. The essential criteria and prescribed relevant considerations should be set out in the rules, which should take precedence over the guidance and, in the event of a perceived conflict, trump the guidance. Moreover, for the reasons stated in answer to Consultation question 3 above, we consider that rules promulgated by the regulator should go through a period of consultation and have oversight by the Department of Health and, like most regulators’ rules, be made by Order in Council.

Consultation question 34: Should all registrars be given a discretion to turn down an applicant for registration or should applicants be only turned down because they have failed to meet the new criteria for registration? Please give a reason for your answer.

Whatever registration process and criteria are adopted for registration, and whether the framework for registration is consistent across all regulators, we are concerned to avoid any possible arbitrariness or discrimination that may arise in the registration process. The assessment of whether the criteria are met (or at least some of them) will necessarily involve a discretion or an assessment. However, the criteria for the exercise of any discretion or assessment should be clearly articulated in order to avoid arbitrariness. The

criteria should be published in appropriate rules and guidance and its impact assessed in respect of BAME candidates or those with a disability. An applicant who is refused registration should always be entitled to appeal the registrar's decision before a Registration Appeal Tribunal or the equivalent which should look at the matter as a true appeal and not a review.

Consultation question 36: Do you agree or disagree that in specific circumstances regulators should be able to suspend registrants from their registers rather than remove them? Please give a reason for your answer.

Section 30(5) of the Medical Act 1983 provides that the Registrar may, by letter addressed to the registered person at his address on the register, inquire whether he has changed his address and, if no answer is received to the inquiry within six months from the posting of the letter, may erase from the register the entry relating to that person. Section 32(2) provides that regulations may authorise the Registrar to erase from the medical register the name of a practitioner who, after such notices and warnings as may be prescribed by the regulations, fails to pay his registration fees. Section 32(3) provides that upon payment his name shall be restored to the register.

Against this background, it is not clear why regulators should need to be given a new and additional power allowing them to "suspend" registrants for late payment, or failure to maintain a contact address or the other circumstances identified in paragraph 206 of the consultation document such as failure to provide information or meet a requirement relating to revalidation.

This seems a purely administrative new power for the convenience of the regulator whereby on sending a first or later reminder to the registrant his registration is automatically then marked "Suspended" in the register. Whilst recognising that registrants have a professional obligation to ensure that their registration is properly maintained, automatic suspension could have serious repercussions for the dilatory or wayward registrant far beyond their misdemeanour. The present rules adequately provide a period of time for compliance and to mark the practitioner's registration in the meantime as "Suspended" is not called for. Should there be real concerns about the registrant's refusal to provide up to date information to enable the Registrar to maintain the register an application should be made for an interim suspension order. The administrative removal criteria as distinct from suspension from the register should be confined to basic hard-edged and clearly stated criteria and not those that involve a discretion.

Consultation question 37: Do you agree or disagree that the regulators should be able to set out their removal and readmittance processes to the register for administrative reasons in rules, rather than having these set out in primary legislation? Please give a reason for your answer.

As stated in answer to consultation question 36 above, administrative removal should be confined to basic hard-edged and clearly stated criteria and not those that involve a discretion. Consistent with "greater freedom to set their own operating procedures", we see no reason why regulators should not be given such powers in their rules rather than in primary legislation. However, this is subject to the caveat we have previously identified that regulators' rules should be subject to proper oversight in the public interest and in order to maintain public confidence in the profession.

Consultation question 38: Do you think any additional appealable decisions should be included within legislation? Please give a reason for your answer.

We consider that legislation and rules should provide that all decisions taken by the regulator including the decisions of case examiners should be appealable decisions with a right of appeal to a Fitness to Practise panel.

Consultation question 39: Do you agree or disagree that regulators should set out their registration appeals procedures in rules or should these be set out in their governing legislation? Please give a reason for your answer.

Whilst we agree that regulators should set out their registration appeal procedures in rules rather than in their governing legislation, we have concerns about what is said in paragraphs 216 and 217 of the Consultation document about restricting registration appeals.

The basic principle should be that any registration decision should be capable of being reconsidered or appealed. There may be many reasons giving rise to the events outlined in paragraph 216, such as the registrant's failure to pay fees, and their reasons for not doing so may be without merit or foundation. But the practitioner should be given the opportunity to put his or her case however groundless or without merit an appeal may appear on paper.

It is not clear what is meant in paragraph 217 to an appeal being heard first by an "internal appeal panel". We assume this to mean that any appeal would be

heard by an independent Registration Appeal Tribunal or equivalent and that the panel would hear the appeal on its merits rather than as a review of an in-house case examiner's decision or internal panel of the regulator.

Consultation question 42: Do you agree or disagree that the prescriptive detail on international registration requirements should be removed from legislation? Please give a reason for your answer.

We agree that the requirements for registration of internationally qualified healthcare professionals should be contained in rules rather than primary legislation subject to two caveats, namely, (1) there is oversight of the rules in the way we have indicated and (2) the rules must be fair and not discriminate against BAME candidates or others who have an appropriate qualification and are safe to practise in the United Kingdom.

PART 4: FITNESS TO PRACTISE

Whilst paragraph 38 of the Consultation document says that one of the key changes the reforms will deliver will be to modernise the regulators' fitness to practise processes, which will enable safe and quick conclusion of many cases without the need for expensive and lengthy panel hearings, it is important to put this in context when set against the number of complaints received by regulators.

The Annual Reports 2018 and 2019 (being the most recent available) of the General Medical Council, for example, give details of the numbers of doctors holding a licence, the number of complaints or concerns received, the outcome of cases disposed of by case examiners and the number heard by the Medical Practitioners Tribunal Service.

The table below shows that the number of cases heard by the MPTS is low in comparison with the number of complaints or concerns received by the GMC in each year. The overwhelming majority of concerns are either closed or concluded by case examiners, leaving a relatively small number of cases to be resolved at a hearing before a Fitness to Practise panel. Inevitably, these cases will frequently be the most serious and are often contested, involving greater cost and at times lengthy panel hearings.

	Year ended 31.12.2018	Year ended 31.12.2019
Number of licensed doctors in UK	250, 210	260,313
Number of concerns reviewed at triage	8,573	8,654
Outcome of concerns	6,629 closed. • 1,544 opened as meeting threshold for investigation. • 394 referred to employer or responsible officer.	? closed. • 1,532 opened as meeting threshold for investigation. • 602 considered under provisional enquiry (404 later closed).
Outcome of cases decided by case examiners	1,208 cases decided by case examiners as follows: • Concluded with no further action 700; • Concluded with advice 66; • Warnings issued 69; • Undertakings agreed 93; • Referred to MPTS 280.	1,279 cases decided by case examiners as follows: • Concluded with no further action 719; • Concluded with advice 52; • Warnings issued 85; • Undertakings agreed 76; • Referred to MPTS 347.
Outcome of MPTS Fitness to Practise tribunal hearings	Total of 247 outcomes as follows: • Erasure 65; • Suspension 101; • Conditions 25; • Undertakings 0; • No impairment-warning 17;	Total of 257 outcomes as follows: • Erasure 55; • Suspension 120; • Conditions 14; • Undertakings 0; • No impairment-warning 17;

	• Impaired – no further action 2; • No impairment – warning 10; • Voluntary erasure 3.	• Impairment – no further action 4; • No impairment, no action 44; • Voluntary erasure 3.

Consultation question 43: Do you agree or disagree with our proposal that regulators should be given powers to operate a three-step fitness to practise process, covering:

- **1: initial assessment**
- **2: case examiner stage**
- **3: fitness to practise panel stage?**

Please give a reason for your answer.

In principle we see nothing wrong with these three stages. However, how they each operate and the processes suggested are not accepted in their entirety.

Initial assessment

As the table above shows, the majority of concerns or complaints fall at the first stage of initial assessment. This is not necessarily a bad thing. The threshold bar for referral of cases should be made high with only cases that are reasonably likely to result in regulatory intervention being referred onward having met the threshold for investigation. Cases that do not meet the threshold criteria should rightly be closed at this stage.

Paragraph 246 of the Consultation document refers to ongoing cases where there is an immediate public protection risk. We agree that such cases will require prompt action but the regulator should not be able to merely impose an interim order. Regulators have well established processes whereby an interim order on justifiable grounds can be sought speedily from an Interim Orders Tribunal or similar within days of the regulator first receiving notification of the concern. The making of an interim order needs to undergo the appropriate process, which in our experience is sufficiently timely to deal with urgent cases.

Fitness to Practise panel stage

We support harmonisation and consistency in regulatory procedures; and the same suite of regulatory sanctions amongst all regulators. We deal below with

the question of powers and the measures available to case examiners and Fitness to Practise panels.

Case examiner stage

This is plainly one of the most controversial topics in the Consultation document. Before we address paragraphs 248 to 251, it may be useful to remind oneself that, in her 5th Shipman Inquiry Report, Dame Janet Smith pointed out that case examiners were contracted to the GMC and were trained, directed and appraised by the GMC, and may not be sufficiently independent, particularly with no lay involvement in decision-making (since remedied).

Dame Janet Smith said:

"25.99. It seems to me that there are a number of potential advantages attaching to the appointment of case examiners to undertake the functions formerly carried out by screeners. First, the case examiners will be working in dedicated time. Screeners had to fit their GMC duties into the interstices of days already occupied with a busy medical practice or a demanding job. Also, because the work will be done at the GMC's premises, there should be much closer communication between case examiners and staff and between case examiners. Screeners worked from home and communication was less easy. Case examiners will be employed by the GMC and can be required to carry out their duties in a particular way. They could, for example, be given instructions that all cases of a certain category must be referred to a FTP panel. This was not possible with screeners; they were members of the GMC and could not be required to conform to instructions. I described in Chapter 19 the way in which some medical screeners sabotaged the GMC's efforts to encourage consistency of treatment at the screening stage by creating categories of misconduct which would be 'SPM by definition' and which should automatically have been referred by screeners to the PPC. It seems that the screeners persuaded members of staff to change the standard documents so as to circumvent the system that had been agreed. It seems highly unlikely that employed case examiners would be able to do that and, if they did, they would be at risk of disciplinary action. Another advantage is that case examiners will have only one set of functions. Screeners had often had experience of sitting on the PPC or the PCC in the past and it seems that they were sometimes unwilling or unable to confine themselves to their screening role.

25.100. The only potential disadvantage of the use of case examiners appears to be that there is a danger that they might be insufficiently independent; they might be too closely directed by GMC members or committees and might not be permitted to use their professional judgement. Also, they might have too little 'say' in how a case is investigated. I hope that

these problems will not occur, as the appointment of case examiners provides potential for real improvement over the old procedures. It is essential that standards and criteria should be set and guidance given but, within those parameters, case examiners should be able to exercise their professional judgement."

We agree that case examiners have a role to play in the three-stage fitness to practise process, in particular in closing cases by undertakings or agreed warnings at an early stage. Nonetheless, the working group has concerns about the enhanced role and powers of case examiners as proposed in the Consultation document.

Our concerns include that:

- Case examiners are employees of the regulator and their identity is not disclosed or made known to the registered practitioner.
- The expertise and qualification of the case examiners are unknown.
- It is unclear what training case examiners receive. They must be capable of adequate quasi-judicial decision-making. They require adequate training and experience in order to do that.
- There is a case for case examiners to be appointed by open and public competition and to be independent appointees, much in the same way as panel members go through an open, independent and transparent appointments process based on merit.

We are also concerned at the lack of oversight of the decisions of case examiners. Whilst the Registrar is given the power to review case examiners' decisions, and any other person, including the PSA, is given the right to request such a review, no person is given the duty of oversight. This seems to us to be a weakness. The Registrar, who is the sole arbiter of when the power of review can be exercised, is unlikely to be held to account properly for regulatory decision making by case examiners, because he or she is a member of the unitary board.

Moreover, the PSA is concerned primarily with the protection of the public and is unlikely to regard it as part of its own functions to check that a registrant has not unwisely agreed to an inappropriate outcome. Nor is the Registrar, as a creature of the regulator, focused on the interests of the registrant. Put simply, the decisions of case examiners are not, nor seemingly envisaged to be, subject to independent scrutiny within the regulator or external scrutiny by the PSA.

There is a case to audit case examiners' decisions and to publish these audits.

We turn to paragraphs 249 to 251 of the Consultation document.

We consider it of concern that, as envisaged in paragraphs 249 and 250, case examiners may be in a position to determine, without any form of public scrutiny or oversight, that a registrant's fitness to practise is impaired and have the full suite of measures available to them with which to conclude a case by an accepted outcome. It seems to us that as a pre-condition to closing any case in this way there would need to be robust measures in place both for the protection of the registrant and in the public interest and the maintenance of public confidence in the regulated profession.

1. There would need to be an open and unequivocal admission by the registered practitioner of all the facts, an admission of current impairment on an agreed basis, such as lack of competence or misconduct, and an agreement as to sanction.

2. It would be important to ensure that the registrant is sufficiently well informed to make the important decision-making involved in agreeing an outcome.

3. This may be less of a problem where the registrant is represented by a solicitor or a defence body such as the Medical Defence Union or Medical Protection Society or a union such as the Royal College of Nursing.

4. One needs to make sure that the unrepresented or ill-informed registrant does not go along with an unjust outcome, with nobody standing by to safeguard their interests.

5. Many registrants are unrepresented and often from an ethnic minority. In such cases there may be a case for the regulator to at least offer to pay for the registrant's legal representation and advice in the same way that banks regularly insist that a third party guarantor seeks independent legal advice before charging their security with the bank agreeing to fund the reasonable cost of such legal advice.

6. The registrant is given a right of appeal although we question how effective that would be when absent duress the registrant was aware of what he did and accepted the agreed outcome.

In the light of these concerns we consider there is a case for ensuring that any accepted outcome, especially one involving a period of suspension or removal from the register, be approved by a Fitness to Practise panel before taking effect. We do not mind whether such approval is in the first instance on paper

although we are inclined towards an open if short public hearing in the same way that accepted outcomes agreed by the Solicitors Regulation Authority and practitioners are listed for a hearing before a panel of the Solicitors Disciplinary Tribunal.

We consider that such a procedure is particularly appropriate in circumstances where case examiner decisions are not covered by PSA appeal rights. A practitioner could seemingly agree disposal and a review under the rule 12 process of the GMC (Fitness to Practise) Rules, or in the case of the NMC accept a "Remediation Statement" and the file would be closed. We think that it is in the public interest that agreed outcomes involving suspension or removal from the register should be heard orally in public to maintain public confidence in the profession. Simply posting the agreed outcome on the regulator's website is not sufficient.

Finally, we disagree with the proposal in paragraph 251 of the Consultation document that case examiners should be able to impose a decision where a registrant has not responded to the case examiner's offer of an accepted outcome. If the registrant does not consent to an accepted outcome then an agreed outcome cannot be achieved. We do not understand how an "accepted outcome" can be foisted on a party without their agreement. Nor do we consider it appropriate that case examiners should have the power to impose conditions, suspend or remove a registrant from the register if the facts and impairment are not agreed.

Consultation question 44: Do you agree or disagree that:

- **All regulators should be provided with two grounds for action – lack of competence, and misconduct?**
- **Lack of competence and misconduct are the most appropriate terminology for these grounds for action?**
- **Any separate grounds for action relating to health and English language should be removed from the legislation, and concerns of this kind investigated under the ground of lack of competence?**
- **This proposal provides sufficient scope for regulators to investigate concerns about registrants and ensure public protection?**

Please give a reason for your answers.

We deal with these issues separately.

Lack of competence

The proposed "lack of competence" ground appears to combine the different concepts/terminology that are currently used across the regulators. For example, the term "deficient professional performance" is presently used by the GMC, "lack of competence" by the NMC and HCPC, "professional incompetence" by the GCC and GOsC, "deficient professional performance (which includes competence)" by the GPhC – and so on.

In *Calhaem v. General Medical Council* [2007] EWHC 2606 (Admin), [39], Jackson J said that "deficient professional performance" within the meaning of section 35C(2)(b) of the Medical Act 1983 is conceptually different from negligence and from misconduct. It connotes a standard of professional performance which is unacceptably low and which (save in exceptional circumstances) has been demonstrated by reference to a fair sample of the doctor's work; and that a single instance of negligent treatment, unless very serious indeed, would be unlikely to constitute "deficient professional performance". In *R (Remedy UK Ltd) v. GMC* [2010] EWHC 1245 (Admin), at [8], Elias LJ said that poor judgment may in an appropriate case, and particularly if exercised over a period of time, constitute seriously deficient performance.

There is very little on the meaning of "lack of competence" and the term has never been satisfactorily explained in case law. In *Remedy,* Elias LJ, at [8], said that deficient performance or incompetence may in principle arise from the inadequate performance of any function which is part of a medical calling. Which charge is appropriate depends on the gravity of the alleged incompetence. Incompetence falling short of gross negligence but still seriously deficient will fall within the term deficient professional performance rather than misconduct.

It seems to us that "lack of competence", if such a term is to be introduced, should be limited to a failure to provide care to the required standard. It could arise from a single incident or by reference to a sample of the registrant's work but which is not so grave as to be classified as misconduct. The term "deficient professional performance" is more apt to cover the situation, for example, where colleagues have concerns about a practitioner's overall capabilities or performance, or someone has failed to keep themselves up to date in their area of practice or there has been a failure to comply with revalidation.

In many respects, the distinction between the terms "misconduct", "deficient professional performance" and "lack of competence" was foreshadowed by Dame Janet Smith in her 5th Shipman Report. Dame Janet referred to lack of competence as "deficient clinical practice".

> "25.70. It will be seen that, in drafting the tests that I have proposed for the investigation and adjudication stages, I have adopted the five categories of allegation by means of which, under section 35C of the 1983 Act, an impairment of fitness to practise may be

demonstrated. However, in my view, there is a *lacuna* in these five categories. There is a category of allegation which does not fall easily within the range of 'deficient professional performance' or of 'misconduct'. Misconduct, as I explained in Chapter 17, generally connotes behaviour which has been undertaken deliberately or recklessly. In order to give the GMC jurisdiction to deal with cases of serious negligence which put patients at risk, the bounds of SPM were extended to embrace negligent acts or omissions, usually arising in a clinical context, provided that they were sufficiently serious. However, to describe some of these cases as 'misconduct' requires some 'stretching' of the use of the language. A typical example might be that of a doctor who gave a gross overdose of a dangerous drug. He or she might have done so because s/he was very careless about the size of ampoule s/he picked up or because s/he had not bothered to find out the correct dosage. Another example might be operating on the wrong arm, leg or kidney. Such cases of serious negligence might equally well – or even more appropriately – be described as cases of 'deficient clinical practice'. With the advent of the performance procedures came the concept of SDP. This was usually characterised by a pattern of unacceptable clinical practice, although it could relate to organisational or behavioural problems. Such a pattern might result from ignorance, from a failure to keep up to date, from laziness, from poor health or from a concatenation of social or professional difficulties. So, there were then two concepts, SPM and SDP, neither of which comfortably accommodated a case of serious negligence such as that I described above. Such a case could not sensibly be termed SPM; nor, if it was a 'one-off' incident, could it possibly amount to SDP. Under the old procedures, there was a real danger that such cases would fall through the net and would be closed at a preliminary stage.

25.71. Unfortunately, section 35C has perpetuated this problem. There is still no place for the isolated or nearly isolated serious error, committed not deliberately or recklessly, but negligently. Nor is there a place for a case of two or three 'lower level' incidents which do not demonstrate the 'pattern' necessary to constitute deficient performance but which may nonetheless put patients at risk. It seems to me to be obvious that such cases ought to enter the FTP procedures because they could be cases of impairment of fitness to practise. I suggest that, if the legislation is to be amended, a further category should be added to the means by which impairment may be proved, namely 'deficient clinical practice', which could relate to one or more than one incident. The aim would be to ensure that the 'routes' to impairment of fitness to practise embrace all the circumstances which might put patients at risk."

The Law Commissioners in their report, *Regulation of Health Care Professionals, Regulation of Social Care Professionals in England,* considered it necessary in the light of cases such *as Calhaem* and *Remedy* to expand deficient professional performance to incorporate a single incident. Hence clause 120 of the draft Bill proposed retaining the term "deficient professional performance" which was defined as including "an instance of negligence".

Paragraph 261 of the Consultation document says that "lack of competence" means the registrant is either unable to or has failed to provide care to a sufficient standard. It is not clear whether this means deficient professional performance based on a fair sample of the registrant's work, or a single incident of lack of care to a sufficient standard, or both. A clear statutory definition of the "new" term "lack of competence" would assist to ensure consistency. It would be unsatisfactory if regulators were to define the term differently.

The boundaries of lack of competence and misconduct

Paragraph 261 goes on to propose that "lack of competence" would include a lack of the necessary knowledge of English, or a health condition which affects a registrant's ability to practise safely.

We consider that it is not appropriate to include health and language skills within the term "lack of competence". Describing someone who is unwell as not 'competent' gives a misleading impression to the public and will undoubtedly cause additional stress to the individual concerned. It would be wrong to allege "lack of competence" when the charge really means health. Also, an inability to use/understand the English language to such an extent that it renders the person not competent to practise should be dealt with separately. It is not clear how such an individual would be able to obtain registration in the first place. The suggestion that the proposal is more sensitive and supportive is not accepted; it appears to be the opposite.

Impairment to practise through ill health is very much a separate and largely private process. The Law Commissioners considered this issue at paragraph 7.19 of their report when they said:

> "We also accept that there are important procedural reasons for keeping the health grounds separate. For instance, the presumption of a public hearing is reversed in cases concerning the physical or mental health of the registrant, and most regulators do not remove practitioners from the register in cases of adverse physical or mental health. On balance, therefore, we have decided reluctantly to retain the health ground. However, in coming to this conclusion we wish to stress that it would be unacceptable for the regulators or their panels to use this ground to justify any general requirement that a practitioner

must be in good health mentally or physically. Nor should it be used to support a finding of impairment based on assumptions about the impact or disability or ill health generally, rather than defensible findings about the practitioner's condition and its consequences."

Put simply, we do not think that concerns raised by deficiencies in health or language skills are well expressed under the umbrella term competence. Any definition would need to address each proposed area – i.e., health, performance/competence and language skills - if they are all to be encompassed within this ground. Health does not sit comfortably within the current "lack of competence" terminology. If they are to be included, "lack of capability" is a better term and might better encompass all the proposed areas, although our preferred option is for health and lack of knowledge of English to remain as stand-alone issues of impairment.

As proposed at paragraph 262 of the Consultation document, we agree that regulators should be able to investigate, as they currently do, concerns in relation to registrants' English language skills and health concerns. Supportive measures should be put in place to assist registrants to pass an English language test or assisting the person back to good health.

Misconduct

We turn to "misconduct" and the suggestion at paragraph 261 that "misconduct" should be an all embracing term that would include, but not limited to, a conviction or caution, and a determination by another regulatory body. Although not stated we assume the new term would also seek to embrace other categories currently in the legislation of some regulators, such as, a fraudulent entry in the register, a conviction before a Court Martial or a barring order under safeguarding legislation; see, e.g., section 27(2) of the Dentists Act 1984, article 22 of the Nursing and Midwifery Order 2001, and article 51 of the Pharmacy Order 2010.

We think this is a bad idea for two reasons. First, the big picture here is whether the concept of "misconduct" as articulated by the courts in a series of cases at the highest level, which have established that "misconduct" must be "serious" and no lower than the previous term "serious professional misconduct" (see, for example, *Roylance v. GMC, Doughty v. GDC and Meadow v. GMC)*, should be replaced by the use of "disgraceful misconduct" as proposed by the Law Commissioners.

At paragraph 7.16 of their report, the Law Commissioners said that the separation of deficient professional performance – or "lack of competence" as proposed in the Consultation document – and misconduct has the added advantage that most cases would be in future be dealt with as matters of deficient performance (or lack of competence). This would emphasise that public safety should be the main justification for regulatory intervention.

We would suggest that the term proposed in clause 120 of the draft Bill of "disgraceful misconduct (whether in the person's practice of that profession or

otherwise)" coupled with "lack of capability" would meet many of the concerns of the courts and Dame Janet Smith in her 5th Shipman Report. The term "misconduct" has become too nebulous and wide ranging over time, and its use should be restricted, as Dame Janet said, to "behaviour which has been undertaken deliberately or recklessly" (para 25.70).

Secondly, under the suggestion in paragraph 261, it would seem that non-automatic convictions would need to be proved as "misconduct", rather than the present straightforward way of establishing that the registrant's fitness to practise is impaired by reason of a conviction. In future it would mean that evidence will have to be called and the facts need to be reproved, cf *GMC v. Spackman* [1943] AC 627. The tribunal would need to make an assessment of the severity and circumstances of each offence (except for those designated as automatic) which we feel cannot sensibly be right. Paragraph 261 appears to overlook the manner of proof of the conviction.

There is a need to go back to the basic starting point – what is the regulator's jurisdiction to act? The simple answer is a concern that the practitioner is not fit to practise his or her regulated profession. To establish this a Fitness to Practise panel needs to have a clear statement of facts and clearly defined grounds on which it may properly make a finding of impairment rather than a series of concepts which make up either "lack of competence" or "misconduct". The charges have to be specific, and even if the grounds for action were to be implemented in the way proposed at paragraph 261 of the Consultation document, with just two grounds for action, we have little doubt that the courts will swiftly require that greater clarity be essential both for the regulator and the practitioner and in the public interest. The proposals only make sense, on a proportionality assessment, if one effectively incorporates the existing case law under subheadings sitting below the new proposed headings.

Consultation question 45: Do you agree or disagree that:

- **all measures (warnings, conditions, suspension orders and removal orders) should be made available to both Case Examiners and Fitness to Practise panels; and**
- **automatic removal orders should be made available to a regulator following conviction for a listed offence?**

Please give a reason for your answers.

This is not agreed.

Firstly, we have a number of concerns in relation to the proposed powers available to case examiners:

a) The measures are in line with those presently in place for Fitness to Practise panels and the question is whether and if so, in what circumstances, should such measures be available to case examiners?

b) Accepted outcomes on the lines envisaged in the Consultation document are fraught with difficulties. As we have said previously, there are questions as who the case examiners are; their independence and whether practitioners and the public would accept that decisions are taken in the public interest and not geared to cost savings. It is suggested at questions 56-57 that one can appeal an accepted outcome. That begs the question on what basis?

c) Case examiners should not have the power of removal unless the practitioner has applied for voluntary erasure.

d) The purpose of an accepted outcome is to decrease the delay in decision-making and reduce stress to the practitioner and cost to the regulator. It can also reduce stress to witnesses who know earlier than otherwise that they will not be required to give evidence. However, in order for it to be effective the process must be a final decision agreed by all parties. Hence, it should be limited to the following circumstances:

> i) The facts are not or cannot be disputed and the case examiners agree on impairment and outcome.
>
> ii) The GMC, having obtained legal advice, agrees with the decision.
>
> iii) The practitioner, having had had the opportunity to obtain legal advice, also agrees with the decision. We have previously indicated that in the same way that banks regularly fund the cost of legal advice before taking third party security a similar scheme should be developed before an accepted outcome is agreed by a practitioner who is unrepresented.
>
> iv) The decision is approved at a Fitness to Practise hearing with reasons given. The public through the press has an important interest in seeing in an open and transparent way that proper standards are maintained to ensure public confidence in the regulated profession. This cannot be satisfactorily achieved by the case examiner's decision simply being made available on the regulator's website. The SRA has a similar system of an open hearing once a case has been referred to the SDT.

If all of the above occurs then the process should proceed and the practitioner should not be able to appeal the decision, save on very limited bases, such as, duress. The GMC should have no right of appeal and as suggested in the consultation document, nor should the

PSA. If the process is subject to reviews by others then this will be a failed process. If a practitioner does not obtain legal advice (whether accepted or not), the process will involve multiple appeals.

e) In the absence of a process as set out above then the case examiners should not be able to make decisions on impairment etc just on the papers.

Secondly, the measures available in relation to registrants whose fitness to practise is found to be impaired.

a) We agree that a Warning or advice is a useful power to retain in relation to registrants whose fitness to practise is not found to be impaired. This ensures that where there is a finding of misconduct and the registrant's fitness to practise is not currently impaired (although it was undoubtedly impaired at the time of the incident or events in question) the case can be concluded and the registrant's conduct marked by a public warning that such behaviour is unacceptable and a warning is needed to uphold and maintain public confidence in the regulatory process. Presently, Fitness to Practise panels at the GMC/MPTS, the GPhC and the Opticians Council have the ability to impose a warning (or advice in the case of the GPhC) but it is not available to panels at the NMC. We consider that all regulators should be able to impose a warning or advice in relation to registrants whose fitness to practise is not currently impaired.

b) We also consider that a warning or equivalent should be available where fitness to practise is found to be currently impaired. The NMC's Conduct and Competence Committee has the power in such circumstances to issue a "caution" under article 29 of the Nursing and Midwifery Order 2001, and the GDC's Professional Conduct Committee may issue a "reprimand" under s27B of the Dentists Act 1984 in the case of a registered dentist or s36P in the case of a registered dental care professional. Similarly, the Osteopaths Act 1993, s22(4) and the Chiropractors Act 1994, s22(4) provide that the committee may "admonish" the registrant. The Disciplinary Committee Rules of the Chartered Institute of Management Accountants provide that where the panel find the respondent guilty of misconduct, it may impose, amongst its powers, an admonishment, reprimand or a severe reprimand.

c) In the experience of the working group, there are some cases where a finding of current impairment has been made by the panel and conditions are considered not to be appropriate and suspension or erasure would be disproportionate. In such circumstances the tribunal is often left with little alternative but to impose a short period of suspension when a warning or similar may be a more appropriate sanction.

d) The Law Commissioners considered that a warning should be available in relation to registrants whose fitness to practise is found to be impaired. In their report the Law Commissioners said:

"9.104. We remain of the view that giving each of the regulators' fitness to practise panels a comprehensive and uniform range of powers to deal with cases would help to promote legal clarity, and further safeguard patients and the public. Consultation has confirmed that the sanctions available following a finding of impairment should be removal from the register, suspensions, conditions, warnings or taking no further action. Where there was no finding of impairment, panels would be able to take no action, issue advice or warnings.

9.113. Thus the first question for panels should be whether to take action where a registrant's fitness to practise is found to be impaired, though taking no action is only likely to be appropriate in exceptional circumstances. Next, panels should have the power to consider warnings where it would be inappropriate to take no action at all following a finding of impairment."

Thirdly, the maximum period for conditions.

a) Paragraph 271 of the Consultation document proposes that the maximum period for which conditions could be applied would be 12 months, although this could be extended by review. Presently, many regulators have an initial maximum period of 3 years for conditions of practice orders.

b) Although in our experience a conditions of practice order for 3 years following a finding of impairment is unusual but not unheard of, there are cases where 18 months, or even 2 years, have been made. It is unclear why the potential maximum length of conditions is proposed to be reduced from 3 years to 1 year. We are unaware of any evidence for the proposed change. There is always the power to both sides to bring the matter back for an early review.

Fourthly, automatic removal orders.

a) Automatic removal orders might be better approached on the basis of the sentence imposed rather than a list of offences. Some of the list may have considerable variation in the factual basis for conviction, e.g. blackmail which can vary from the relatively minor to the very serious. It may be that in some circumstances the

imposition of an automatic removal is considered by everyone to be disproportionate. An alternative suggestion may be that automatic removal applies to any practitioner who has been sentenced to any offence where immediate imprisonment of 12 months or more has been imposed.

b) On the other hand, the recommendation of Tom Kark QC in his report for senior managers in the NHS under the Fit and Proper Person test was that any sentence of imprisonment should attract a finding of misconduct. If a registrant has done something so bad that they receive a sentence of immediate imprisonment then that ought to be an automatic removal provided that no removal is of course permanent. There must be room for rehabilitation. Specific listed offences ought also to be automatic cases.

c) The Law Commissioners said:

"8.28. We are persuaded that the draft Bill should introduce a new provision for automatic removal for certain serious criminal convictions. From the regulators' perspective, being able to act quickly against registrants convicted of serious offences will have benefits in terms of public confidence and costs. We also agree that some criminal convictions are so serious they are incompatible with continued registration. We think that automatic removal should apply in cases of murder, trafficking people for exploitation, blackmail (where a custodial sentence is imposed), rape and sexual assault (where a custodial sentence is imposed), and certain sexual offences against children. The Government should have powers to amend or add to this list. However, it is our view that automatic removal would only be compliant with article 6 of the European Convention of Human Rights if appropriate safeguards are provided. These are the ability to make representations to the regulator and a limited right to appeal to the higher courts on the factual basis of an error in law or finding of fact: *R (Royal College of Nursing) v. Secretary of State for the Home Department* [2010] EWHC 2761 (Admin), [2011] 2FLR 1399 at [92]."

d) Any automatic right of appeal should in the first instance be to a Fitness to Practise tribunal rather than direct to the High Court. It is conceivable that the registrant may wish to give evidence against an automatic removal order for which a Fitness to Practise tribunal is a more appropriate forum. The decision of the tribunal would be an "appealable decision" in respect of which the High Court would be better placed to hear an appeal.

Consultation question 46: Do you agree or disagree with the proposed powers for reviewing measures? Please give a reason for your answer.

The proposed powers for reviewing final measures seem reasonable. Presently a review of a final measure such as conditions or a period of suspension may be conducted by a legally qualified chair at the MPTS on the papers where matters are agreed and the registrant is represented. Whilst this could conveniently be conducted by case examiners we have reservations that neither of the case examiners may be legally qualified and the review follows a hearing with a legally qualified chair or where a legal adviser/legal assessor was present. The registrant should be permitted to insist that the review be conducted by a legally qualified chair.

This feeds into our earlier expressed concerns that case examiners should not be able to suspend or remove a registrant from the register without a hearing before a tribunal, and that they should not be able to impose an outcome when the registrant has not responded to the case examiner's offer of an accepted outcome. Whilst we agree that publishing decisions (and measures) by case examiners and panels supports transparency of decisions made by regulators, this is not the issue. The regulator is exercising powers to further the over-arching statutory objective of the regulator for the protection of the public; see for example section 1(1A) and 1(1B) of the Medical Act 1983. The cardinal principle in the rules of all regulators is that hearings are to be held in public. Thus, rule 41(1) of the GMC (Fitness to Practise) Rules, for example, provides that subject to well established exceptions, such as matters relating to health or that the particular circumstances of the case outweigh the public interest in holding a hearing in public, all hearings shall be held in public. In proposing that case examiners may be permitted to close a case in private without a hearing the Consultation document appears to have lost sight of this vital factor.

Consultation question 47: Do you agree or disagree with our proposal on notification provisions, including the duty to keep the person(s) who raised the concern informed at key points during the fitness to practise process? Please give a reason for your answer.

We are concerned at the proposals in paragraphs 286 to 289 of the Consultation document in relation to notifications to registrants and person(s) who raise a concern.

There are dangers in notifying the person(s) who has raised the concern and those who have a direct interest in the case, who are likely to be witnesses, of

the details of decisions. If, for example, case examiners make a decision that is provided to the individuals mentioned then their reasoning could influence the evidence given should a Fitness to Practise hearing become necessary.

We see no objection to regulators informing the person(s) who raised the concern at key points throughout the fitness to practise process, including whenever a substantive decision has been made, unless the person(s) who raised the concern does not wish to receive these updates. The regulator may also notify other relevant parties, such as employers or others with a direct interest in the concern/case, where they consider it to be appropriate and in line with data protection law.

Any notification needs to be limited to substantive decisions including any interim order imposed upon the registrant. The person(s) who raised the concern or interested parties should not be informed of material or the reasoning for a decision which might affect their own evidence or matters personal to the registrant such as health.

Consultation question 48: Do you agree or disagree with our proposal that regulators should have discretion to decide whether to investigate, and if so, how best to investigate a fitness to practise concern? Please give a reason for your answer.

We agree although there should in addition be a system for the complainant to ask for a review of a decision to refuse to investigate.

Consultation question 49: Do you agree or disagree that the current restrictions on regulators being able to consider concerns more than five years after they came to light should be removed? Please give a reason for your answer.

Not agreed. We consider that the “five year rule” should remain. There should be either exceptional circumstances or cogent reasons in the public interest for the five year rule to be circumvented.

The Law Commissioners in their Report concluded that the 5-year rule should be retained and stated:

> “8.26. There was strong support amongst consultees for establishing a time limit of five years for the receipt of allegations. To some degree, we remain concerned that setting any time limit for cases would be arbitrary, and think it better that decisions whether or not to proceed are taken on the basis of the quality of the evidence. However, consultation suggested that a time limit works well in practice and, in

particular, helps to limit the number of stale complaints which have little prospect of resulting in a finding of impairment. On balance, we accept that the draft Bill should provide that complaints relating to events that occurred more than five years ago should not be eligible for onward referral. In line with most of the existing legal provisions, this time limit should run from the most recent events giving rise to the allegation, as opposed to the date of knowledge of events.

8.27. It is also vital for the draft Bill to provide exceptions to this rule. Some consultees suggested that regulators should have a general discretion to determine the exceptions. Others felt that the draft Bill should prescribe the types of cases which are exempt. This approach may have the advantage of clarity, but there is a danger that it would be too restrictive and prevent the regulators from investigating cases where there is a clear public interest in doing so. Notwithstanding this concern, we think that greater certainty is needed on this matter, and there are some cases that could be specified in the draft Bill as being exempt, namely, criminal convictions leading to a custodial sentence, determinations by other regulatory bodies, or inclusion on a barred list. These cases are relatively discrete, will be accompanied by accepted findings of fact, and raise obvious public protection issues. Alongside these exceptions, we think that the legislation should allow a degree of flexibility for the regulators when considering cases older than five years (while also recognising that the ability to progress such cases will be the exception rather than the rule). We have therefore formulated a public interest test to deal with such cases. The definition of the public interest consists of all three objectives of the regulators contained in clause 3 of the draft Bill (see Part 3)."

For example, Rule 4 (5) of the General Medical Council (Fitness to Practise) Rules 2004 provides:

> "No allegation shall proceed further if, at the time it is first made or first comes to the attention of the General Council, more than five years have elapsed since the most recent events giving rise to the allegation, unless the Registrar considers that it is in the public interest for it to proceed."

In summary, the 5 year rule is subject to a public interest/serious exception in any event. We see no reason for doing away with the rule. Moreover, Fitness to Practise proceedings are forward looking at the point of consideration by the regulator and other decision-makers. We are not convinced that the case for a totally open-ended historical approach has been made out. In any event, if it is proposed to do away with the five year rule then the rules would require

safeguards about prejudice to the registrant where records are no longer available or witnesses can no longer be expected to give reliable evidence and so forth. Otherwise, it is likely to lead to applications to dismiss charges on the ground of an abuse of process, or applications for judicial review of decisions to proceed in circumstances where the registrant is likely to be prejudiced or handicapped in putting forward their case.

Consultation question 50: Do you think that regulators should be provided with a separate power to address non-compliance, or should non-compliance be managed using existing powers such as "adverse inferences"? Please give a reason for your answer.

We agree that all regulators should have suitable power to deal with the non-compliant registrant. It is the duty of every healthcare practitioner who is regulated to comply with a request by their regulator to assist in the circumstances described unless the request is unduly onerous.

Section 35A(1A) of the Medical Act 1983 provides that the registrar may by notice in writing require a practitioner, within such period as is specified in the notice, to supply such information or produce such documents as the registrar considers necessary for the purpose of assisting the General Council or any of their committees or the registrar in carrying out functions in respect of the practitioner's fitness to practise. Rule 17ZA of the GMC (Fitness to Practise) Rules 2004 deals with the procedure at a non-compliance hearing where the practitioner has failed to submit to, or comply with, an assessment of health or performance or knowledge of English or failed to provide information required under section 35A(1A) of the Act.

We agree that similar provisions should be available to all healthcare regulators. We note that paragraph 295 of the Consultation document states:

> *This power could be used where a regulator considers that such a failure to comply creates a risk to public protection, due to its inability to fully investigate the concerns about a registrant's fitness to practise. In cases of non-compliance, regulators would have the power to conduct a Fitness to Practise panel hearing and impose a measure on a registrant, up to and including erasure from the register.*

We agree this is a sensible approach and that similar provisions should be available to all healthcare regulators.

However, we have reservations about the ability of the regulator or panel to draw an adverse inference against a registrant in the case of non-compliance mentioned at paragraph 297 of the Consultation document. This is seeking to import into the professional regulatory process concepts used in the criminal courts. There is a substantial difference between criminal proceedings and

disciplinary proceedings, which are civil proceedings for the purposes of the Human Rights Act 1999 and the European Convention on Human Rights. The matter is adequately covered at paragraph 295 and in the case of non-compliance, regulators would have the power to conduct a Fitness to Practise panel hearing and impose a measure on a registrant, up to and including erasure from the register.

Consultation question 51: Do you agree or disagree with our proposed approach for onward referral of a case at the end of the initial assessment stage? Please give a reason for your answer.

As the question stands, agreed.

Consultation question 52: Do you agree or disagree with our proposal that regulators should be given a new power to automatically remove a registrant from the Register, if they have been convicted of a listed offence, in line with the powers set out in the Social Workers Regulations? Please give a reason for your answer.

Yes but subject to our earlier comments in answer to Consultation Question 45.

Consultation question 53: Do you agree or disagree with our proposals that case examiners should:

- **have the full suite of measures available to them, including removal from the register?**
- **make final decisions on impairment if they have sufficient written evidence and the registrant has had the opportunity to make representations?**
- **be able to conclude such a case through an accepted outcome, where the registrant must accept both the finding of impairment and the proposed measure?**
- **be able to impose a decision if a registrant does not respond to an accepted outcomes proposal within 28 days?**

Please give a reason for your answers.

We refer to out earlier response to Consultation question 43 under the sub-hearing *Case examiner stage.* As is apparent the working group is deeply concerned at the proposed enhanced powers to be available to case examiners for the reasons previously stated.

Moreover, as we have said in answer to Consultation question 46, whilst publishing decisions (and measures) by case examiners supports

transparency of decisions made by regulators, this is not the issue. The regulator is exercising powers to further the over-arching statutory objective of the regulator which is for the protection of the public, and the cardinal principle in the rules of all regulators is that hearings are to be held in public. Rule 41(1) of the GMC (Fitness to Practise) Rules, for example, provides that subject to well established exceptions, such as matters relating to health or that the particular circumstances of the case outweigh the public interest in holding a hearing in public, all hearings shall be held in public.

In proposing that case examiners may be permitted to close a case in private without a hearing the Consultation document appears to have lost sight of this vital factor.

Consultation question 53 addresses the role of the case examiners at the final decision-making process and whether to impose conditions on the registrant's registration, suspend the registrant and erase or remove the registrant from the register. These are powerful tools to be given to an employee of the regulator, who may not be legally qualified, and made beyond closed doors. One only has to stand back for a moment to ask oneself why is it so important that these powers should now been given to the regulator? The answer is all too obvious: cost. Paragraph 38 of the Consultation document admits as much and says that one of the key changes the reforms will deliver will be to bring a *quick conclusion of many cases without the need for expensive and lengthy panel hearings".* However, as we pointed out earlier, only a small proportion of concerns received by the GMC go before a Fitness to Practise tribunal and by their very nature such cases are likely to be ones where there the facts, impairment and sanction are disputed and the doctor exercises his undoubted right to test the evidence or make submissions before an independent panel chaired by a legally qualified chair or assisted by a legal assessor.

To re-iterate, whilst there may be an argument for case examiners to have some increase in their powers, as we have identified, we have concerns about the overall extended powers of case examiners to impose or agree final outcomes up to removal:

(i) Current case examiners are employees of the regulators and so the independence of "external" (independently appointed) FTP panels is lost;

(ii) There is a risk of internal pressures upon Case Examiners to dispose of as many cases as possible and avoid the time and costs of full hearings;

(iii) In some professions (e.g., NMC and HCPC in particular) there is a high incidence of un-represented registrants. Understanding the process and

its implications is likely to be difficult for them. Coupled with (ii) above, registrants may be under pressure to agree to consensual outcomes, potentially without proper advice. This will not "protect the interests of registrants". (There should at least be a requirement for some form of independent advice for them).

(iv) Although paragraph 312 states that accepted outcomes are not to be a negotiation, in reality is there not an inevitable risk that there will be "plea-bargaining" between experienced representatives aiming to avoid referral for a full hearing and case examiners under pressure to conclude cases? This will not promote public protection.

(v) Moreover, registrants may feel under pressure to agree lesser facts to minimise the scale of their wrongdoing and accept a finding of impairment and a lower sanction in order to conclude matters speedily, and avoid the glare and stress of a tribunal hearing in public. Similarly, case examiners may wish to show how successful they have been in resolving by an accepted outcome an otherwise difficult case and avoiding the cost of a lengthy hearing. In both instances, the public may not be best served and such an outcome has the potential to undermine the public's confidence in the regulatory process and the health care professions. We question too what the reaction of the public would be to learn that in a really serious misconduct case, for example, where the allegations involved a series of botched operations by a practitioner or the death of patients, the matter was concluded by an "accepted outcome" negotiated on the papers by anonymous case examiners employed by the regulator and the registrant with no airing of the matters in public whatsoever.

(vi) All the above are compounded by the removal of external independent scrutiny of Case Examiner decisions by the PSA as per para 357.

The overall effect of the package of measures in this area seems to move a potentially significant number of cases to being decided out of the public arena (raising issues about transparency and accountability).

A final point under Question 53 is imposing a decision on a non-responding registrant in 28 days. Were the registrant to then seek to set aside matters they would be starting on the backfoot by having to challenge a decision that had already been made, rather than exercising a right to have the matter determined at a hearing. If this proposal were to be introduced, we consider that 28 days is simply not a realistic or fair timeframe. The imposition of an "accepted" outcome in the absence of a response within 28 days from the practitioner is not appropriate and likely to be disproportionate when

considered against the measure being taken against the registrant's registration. The matter should go to a Fitness to Practise hearing.

Consultation question 54: Do you agree or disagree with our proposed powers for Interim Measures, set out above? Please give a reason for your answer.

An interim order is, in the first instance, normally an emergency measure to protect the public or the registrant, and can usually be obtained at short notice. Whilst a Fitness to Practise panel can and often does make an interim order where, for example, a substantive case is adjourned, the overwhelming majority of interim orders are made by an Interim Orders Tribunal or Committee. For example, Part 7 of the GMC (Fitness to Practise) Rules 2004 deals with initial consideration, notice, procedure at an interim orders hearing and review of interim order on the papers.

We are finding it difficult to understand why case examiners should be given the power to make, or whether they are properly experienced to make, the necessary risk assessment for an interim order which is a matter of judgment *par excellence* for an interim orders tribunal or panel. We also have difficulty in understanding the concept of requiring the registrant to have to agree to an interim measure proposed by a case examiner. The criteria for the making of an interim order would need to be made clear to and understood by a practitioner before they were able to consent to an interim order. We doubt whether this could be easily grasped by many unrepresented registrants.

We can see scope for a review on paper to be carried out by case examiners where there is complete agreement by a registrant who is represented, such as an interim conditions order or an interim suspension order being renewed for a further period pending the substantive hearing of allegations before a Fitness to Practise tribunal. Where confirmation is presently received in writing from the practitioner interim order reviews at the GMC are often carried out on the papers by a chair of the Interim Orders Tribunal. However, it is always open to the chair for the review to be determined by a panel. We are, therefore, concerned that this may be lost were all interim order reviews to become "rubber stamped" by an official or employee employed by the regulator. In the absence of confirmation from the practitioner the review must go before an Interim Orders Tribunal.

Consultation question 55: Do you agree or disagree that regulators should be able to determine in rules the details of how the Fitness to Practise panel stage operates? Please give a reason for your answer.

Yes. As long as the Rules are lawful, fair and proportionate, and as previously stated, made by Order in Council.

The structure that operates in relation to regulators governed by bylaws such as the accountancy regulators is that they are free to create their own rules but that the content of the rules is limited by the bylaws which, in the event of a conflict, trump the rules.

Paragraph 343 of the Consultation document states that once a case has been referred to a Fitness to Practise panel by a case examiner, the case cannot be concluded through an accepted outcome process. We do not see why not. The General Pharmaceutical Council has a rule that enables a hearing to be cancelled and disposal of allegations without a hearing after referral by the Investigating Committee. Rule 38 of the General Pharmaceutical Council (Fitness to Practise and Disqualification etc) Rules 2010 provides that where a principal hearing has yet to take place and that, on the basis of evidence available or other information in the possession of the Council, the hearing should not be held, the case presenter must inform the Investigating Committee who may give a direction that the referral to the Fitness to Practise Committee is rescinded.

Consultation question 56: Do you agree or disagree that a registrant should have a right of appeal against a decision by a case examiner, Fitness to Practise panel or Interim Measures panel? Please give a reason for your answer.

Consultation question 57: Should this be a right of appeal to the High Court in England and Wales, the Court of Session in Scotland, or the High Court in Northern Ireland? Please give a reason for your answer.

Yes to both question 56 and 57. The right of appeal should remain to the High Court (or Court of Session in Scotland or the High Court in Northern Ireland), from any decision of a Fitness to Practise panel.

An appeal from a decision of a case examiner should be as of right to a Fitness to Practise panel for the reasons previously stated rather than direct to the court.

A registrant should also be given a right of appeal to the High Court where a finding of misconduct or impairment has been made by a Fitness to Practise panel but no action is taken by the panel, rather than the registrant having to issue judicial review proceedings.

Consultation question 58: Do you agree or disagree that regulators should be able to set out in Rules their own restoration to the register processes in relation to fitness to practise cases? Please give a reason for your answer.

Consultation question 59: Do you agree or disagree that a registrant should have a further onward right of appeal against a decision not to permit restoration to the register? Please give a reason for your answer.

Consultation question 60: Should this be a right of appeal to the High Court in England and Wales, the Court of Session in Scotland, or the High Court in Northern Ireland? Please give a reason for your answer.

Question 58. Agreed as long as Rules are lawful, fair and proportionate.

Question 59. Yes. The route for an appeal from a decision of the registrar or case examiners not to permit restoration to the register should be to a Fitness to Practise panel similar to a registration appeal panel. It is not understood what is meant in paragraph 353 that an initial appeal should be considered "internally" with a further right of appeal to the court. If by "internally" it is meant that the appeal would be heard by a Fitness to Practise panel then we agree. For the reasons stated previously, we do not consider that the route for appeal from the decision of the registrar or case examiners or other "internal" body should lie direct to the court. Nor we do consider that the court would wish this to be so.

Question 60. Yes. All decisions of the Fitness to Practise panel should be appealable decisions as of right to the court.

Consultation question 61: Do you agree or disagree that the proposed Registrar Review power provides sufficient oversight of decisions made by case examiners (including accepted outcome decisions) to protect the public? Please provide any reasons for your answer.

Consultation question 62: Under our proposals, the PSA will not have a right to refer decisions made by case examiners (including accepted outcome decisions) to court, but they will have the right to request a registrar review. Do you agree or disagree with this proposed mechanism? Please provide any reasons for your answer.

Consultation question 63: Do you have any further comments on our proposed model for fitness to practise?

Question 61. We disagree, for the reasons stated previously in response to Part 1: Governance and operating framework, that the proposed Registrar Review provides sufficient oversight of decisions made by case examiners to protect the public.

A review by a Registrar is only appropriate for closure of a case at the initial assessment. At stage two, the case examiner stage, a complainant will be as badly affected if the case examiners close a case or fail to take sufficient action as they would if a Fitness to Practise panel did the same. If the case examiners powers are being extended, should the appeal process not apply to all decisions which have a similar effect?

Paragraph 354 of the Consultation document states: "*Greater autonomy must be accompanied by greater accountability. This includes effective governance underpinned by openness and transparency in how the regulatory bodies discharge their regulatory functions."* We ask, therefore, rhetorically: why limit the appeal from case examiners' decisions to registrar appeals only? We consider that all decisions of case examiners should be appealable to a Fitness to Practise panel.

We are concerned to read in paragraph 357 of the Consultation document that it is not proposed to extend the PSA's Section 29 powers to cover case examiner decisions. We are bound to say we find this surprising. In the event that case examiners are to have *"the full suite of measures available with which they can conclude a case"* it is of crucial importance that there is <u>independent oversight</u> of their decisions. This cannot be achieved by registrar review powers for the reasons stated previously. Effective oversight can only be achieved in one of two ways: either all decisions of case examiners to close a case should be considered by a Fitness to Practise panel or the PSA should have the right to refer the decision to the court.

We also consider there is a conflict of interests between the administrative and investigatory role of the Registrar under the legislation and rules and his or her accountability to the unitary board of the regulator on the one hand and the Registrar's role as Chief Executive Officer of the council and responsible for its overall running and its staff including case examiners on the other hand.

As to paragraph 359, there should be a broad power to review if the Registrar considers the decision does not protect the public or is unfair to the registrant whatever may have been the reasons for the decision of the case examiners or the information available to them at the time of the decision.

Paragraph 360 is a circular argument. The Registrar should have the ability to review any decision in the light of representations made to him or her for a review. Plainly a frivolous request would be rejected but otherwise a decision to review would be open to judicial review on well-established public law grounds.

11 June 2021