Law Commission

Scottish Law Commission

Northern Ireland Law Commission

Joint Consultation Paper LCCP 202 / SLCDP 153 / NILC 12 (2012)

REGULATION OF HEALTH CARE PROFESSIONALS

REGULATION OF SOCIAL CARE PROFESSIONALS IN ENGLAND

A Joint Consultation Paper

THE LAW COMMISSIONS: HOW WE CONSULT

About the Commissions: The Law Commission and the Scottish Law Commission were set up by section 1 of the Law Commissions Act 1965. The Northern Ireland Law Commission was set up by section 50 of the Justice (Northern Ireland) Act 2002. Each Commission has the purpose of promoting reform of the law.

- The Law Commissioners are: The Rt Hon Lord Justice Munby (*Chairman)*, Professor Elizabeth Cooke, Mr David Hertzell, Professor David Ormerod and Frances Patterson QC. The Chief Executive is Elaine Lorimer.
- The Scottish Law Commissioners are: The Honourable Lord Drummond Young *(Chairman)*, Laura J Dunlop QC, Patrick Layden QC TD, Professor Hector L MacQueen and Dr Andrew J M Steven. The Chief Executive is Malcolm McMillan.
- The Northern Ireland Law Commissioners are: The Honourable Mr Justice McCloskey *(Chairman)*, Professor Sean Doran, Mr Neil Faris, Mr Robert Hunniford and Dr Venkat Iyer. The Chief Executive is Ms Judena Goldring.

Topic: This consultation covers the regulation of health care professionals and the regulation of social care professionals in England.

Geographical scope: England and Wales, Northern Ireland and Scotland.

An impact assessment is available on our website.

Duration of the consultation: 1 March to **31 May 2012**.

How to respond
Send your responses either –

By email to: public@lawcommission.gsi.gov.uk or

By post to: Tim Spencer-Lane, Law Commission,
Steel House, 11 Tothill Street, London SW1H 9LJ
Tel: 020 3334 0267 / Fax: 020 3334 0201

If you send your comments by post, it would be helpful if, where possible, you also sent them to us electronically (in any commonly used format).

After the consultation: We plan to publish a final report with a draft Bill in 2014. It will be for Parliament to decide whether to change the law.

Freedom of information: We will treat all responses as public documents. We may attribute comments and publish a list of respondents' names. If you wish to submit a confidential response, it is important to read our Freedom of Information Statement on the next page.

Availability: You can download this consultation paper and the other documents free of charge from our websites at:

- http://www.lawcom.gov.uk (See A–Z of projects > Regulation of Healthcare Professionals);
- http://www.nilawcommission.gov.uk (See Publications); and
- http://www.scotlawcom.gov.uk (See News column).

CODE OF PRACTICE ON CONSULTATION

The Law Commission is a signatory to the Government's Code of Practice described below.

THE SEVEN CONSULTATION CRITERIA

Criterion 1: When to consult
Formal consultation should take place at a stage when there is scope to influence the policy outcome.

Criterion 2: Duration of consultation exercise
Consultations should normally last for at least 12 weeks with consideration given to longer timescales where feasible and sensible.

Criterion 3: Clarity and scope of impact
Consultation documents should be clear about the consultation process, what is being proposed, the scope to influence and the expected costs and benefits of the proposals.

Criterion 4: Accessibility of consultation exercises
Consultation exercises should be designed to be accessible to, and clearly targeted at, those people the exercise is intended to reach.

Criterion 5: The burden of consultation
Keeping the burden of consultation to a minimum is essential if consultations are to be effective and if consultees' buy-in to the process is to be obtained.

Criterion 6: Responsiveness of consultation exercises
Consultation responses should be analysed carefully and clear feedback should be provided to participants following the consultation.

Criterion 7: Capacity to consult
Officials running consultations should seek guidance in how to run an effective consultation exercise and share what they have learned from the experience.

CONSULTATION CO-ORDINATOR

The Consultation Co-ordinator for this project is Phil Hodgson. You are invited to send comments to the Consultation Co-ordinator about the extent to which the criteria have been observed and any ways of improving the consultation process.

Contact: Phil Hodgson, Law Commission, Steel House, 11 Tothill Street, London SW1H 9LJ
Email: phil.hodgson@lawcommission.gsi.gov.uk

Full details of the Government's Code of Practice on Consultation are available on the BIS website at http://www.bis.gov.uk/policies/better-regulation/consultation-guidance.

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REGULATION OF HEALTH CARE PROFESSIONALS

REGULATION OF SOCIAL CARE PROFESSIONALS IN ENGLAND

CONTENTS

Foreword by the Chairs of the Law Commissions **x**

Foreword by the Lead Commissioners **xi**

Table of abbreviations **xii**

PART 1: INTRODUCTION **1**

Background to the project 2

Historical context 3

Where are we now? 5

Structure of the consultation paper 9

Responding to this consultation paper 9

PART 2: THE STRUCTURE OF REFORM AND ACCOUNTABILITY **11**

Our general approach to law reform 11

Rules and regulations 16

Public consultation 22

Parliamentary accountability 25

Publication requirements 29

Section 60 orders 31

The number of regulators and regulated professions 34

The default powers of the Privy Council 36

Devolved responsibilities 38

Implementation issues 40

PART 3: MAIN DUTY AND GENERAL FUNCTIONS OF THE REGULATORS 42

The main duty 42

General and principal functions 48

PART 4: GOVERNANCE 52

Strategic role of the General Council 52

Status of the Councils 55

Constitution of the Councils 56

Council committees 63

Powers of delegation 66

PART 5: REGISTERS 68

The purpose of a register 68

Responsibility for maintaining the register 70

Types of registers 72

Types of registration 77

Requirements for registration 78

Processing of registration applications 83

Registration appeals 85

Publication and upkeep of the registers 86

Restoration to the register 89

Content of the registers 91

Protected titles and functions 95

PART 6: EDUCATION, CONDUCT AND PRACTICE **99**
Overlapping responsibilities 99
Education 102
Guidance 111
Ongoing standards of practice 117

PART 7: FITNESS TO PRACTISE: IMPAIRMENT **121**
The fact finding stage 121
The fitness to practise findings 126
Options for reform 127
Provisional view 132

PART 8: FITNESS TO PRACTISE: INVESTIGATION **134**
Allegations 134
Initial consideration 139
Investigation 142
Threshold test 148
Disposal of cases 149
Mediation 153
Reviews 155

PART 9: FITNESS TO PRACTISE: ADJUDICATION **158**
Article 6 compliance 158
The separation of investigation and adjudication 160
Case management 164
Composition of Panels 165
Conduct of hearings 169
Interim Orders 176
Final sanctions and other disposals 180

Review hearings 187

Should regulators be able to reconsider their decisions? 188

Appeals 189

PART 10: THE COUNCIL FOR HEALTHCARE REGULATORY EXCELLENCE 191

Role of the CHRE 191

Governance of the CHRE 193

Functions, powers and duties of the CHRE 196

Complaints about regulatory bodies 198

References to the higher courts 199

PART 11: BUSINESS REGULATION 203

Regulation in a commercial environment 203

Premises regulation 204

Register of bodies corporate 207

Consumer complaints 210

Extending business regulation 211

PART 12: OVERLAP ISSUES 213

Interfaces with other systems 213

Joint working 215

Duties to cooperate 218

PART 13: CROSS BORDER ISSUES 223

Registrants entering from within the EEA 223

Registrants entering from beyond the EEA 226

Regulating outside the UK 227

APPENDIX A: PROVISIONAL PROPOSALS AND CONSULTATION QUESTIONS 233

APPENDIX B: MAIN DUTIES OF THE REGULATORS 249

APPENDIX C: STATUTORY COMMITTEES 251

APPENDIX D: PROTECTED TITLES 253

APPENDIX E: PROTECTED FUNCTIONS 257

FOREWORD BY THE CHAIRS OF THE LAW COMMISSIONS

We are delighted to present the first tripartite joint consultation paper, published under the names of each of the three Law Commissions in the UK.

Both the Law Commission, for England and Wales, and the Scottish Law Commission were established by the Law Commissions Act 1965. Since the first joint project in 1968 (on exemption clauses in contracts), we have frequently undertaken joint projects. In each such project each stage has been approved by both sets of Commissioners. In Northern Ireland, the burden of making law reform proposals was shouldered by the Law Reform Advisory Committee. In 2007, the Northern Ireland Law Commission was established, following the recommendations of the Criminal Justice Review Group. The Commission was established under the Justice (Northern Ireland) Act 2002 (as amended by the Northern Ireland Act 1998 (Devolution of Police and Justice Functions) Order 2010). This project has been the first opportunity for the three Commissions to work together. We hope that there will be many more.

The subject matter of this project covers matters dealt with both at a UK level and by the devolved institutions. In one respect it deals with the UK government's responsibility for English social workers, an element which has to be treated formally as a distinct project. This project, therefore, shows the advantages that can accrue to undertaking joint projects covering all three UK jurisdictions. While all three Commissions will continue to concentrate on their core tasks of reforming the law of their own jurisdiction, the tripartite joint project provides an additional method for pursuing our common goals of promoting modern, fair, accessible and effective law.

THE RT HON LORD JUSTICE MUNBY
Chairman of the Law Commission

THE HON LORD DRUMMOND YOUNG
Chairman of the Scottish Law Commission

THE HON MR JUSTICE McCLOSKEY
Chairman of the Northern Ireland Law Commission

FOREWORD BY THE LEAD COMMISSIONERS

The current system of health and social care professional regulation across the UK aims to ensure high standards of care and support by setting high standards of education, conduct and practice and by taking action to remove unsuitable workers in rare cases when things go wrong. In order to function effectively, it is vital that professional regulation can adapt to provide flexible and responsive systems that protect public safety and promote professional development. But the present legal framework for professional regulation is complex and expensive, and requires continuous Government intervention to keep it up to date. There are currently seven Acts of Parliament and three Orders which govern the regulators, as well as a vast range of different rules and regulations.

This consultation paper sets out our provisional proposals for how the system for regulating health workers (and social workers in England) should be reformed to maintain high professional standards and to maintain the confidence of the public. The aim is to modernise and simplify the current complex arrangements for professional regulation and remove the inconsistencies in the over-arching legal provisions, meaning that all professionals are subject to the same framework. This would make the legal structure easier to understand for the public and health and social care professions. Our proposals also aim to enable the regulators to be able to respond more quickly to developments in the provision of health and social care, and changes in the social, political and economic environment.

FRANCES PATTERSON QC
Public Law Commissioner for England and Wales

PATRICK LAYDEN QC TD
Scottish Law Commissioner

THE HON MR JUSTICE McCLOSKEY
Chairman of the Northern Ireland Law Commission

TABLE OF ABBREVIATIONS

CHRE	Council for Healthcare Regulatory Excellence
ECHR	European Convention on Human Rights
EEA	European Economic Area
GCC	General Chiropractic Council
GDC	General Dental Council
GMC	General Medical Council
GOC	General Optical Council
GOsC	General Osteopathic Council
GPhC	General Pharmaceutical Council
GSCC	General Social Care Council
HPC	Health Professions Council
NMC	Nursing and Midwifery Council
PSNI	Pharmaceutical Society of Northern Ireland

PART 1
INTRODUCTION

1.1 Thirty-one different health professions consisting of approximately 1.4 million UK professionals are currently regulated in law by nine regulatory bodies.[1] These bodies are:

(1) General Chiropractic Council;

(2) General Dental Council;

(3) General Medical Council;

(4) General Optical Council;

(5) General Osteopathic Council;

(6) General Pharmaceutical Council;

(7) Health Professions Council;

(8) Nursing and Midwifery Council; and

(9) Pharmaceutical Society of Northern Ireland.[2]

1.2 In addition, social workers and social work students are regulated separately in all four parts of the UK by four care councils. In England this role is currently undertaken by the General Social Care Council.[3] The health and social care regulators maintain professional registers, set standards for education and practice, and ensure fitness to practise.

1.3 However, the regulators operate within a wide variety of legal frameworks which have been agreed and amended by Parliament in different ways and at different times over the past 150 years. A complex legislative landscape has evolved on a piecemeal basis resulting in a wide range of idiosyncrasies and inconsistency in the powers, duties and responsibilities of each of the regulators. There are currently seven separate Acts of Parliament and three Orders made under section 60 of the Health Act 1999 which govern 10 regulatory bodies. These have all been amended extensively by 16 Orders made under the Health Act 1999 and a range of Acts of Parliament over the last 10 years.

1.4 The current system is also expensive and requires continuous Government input for its maintenance. The regulators have powers to make rules and regulations concerning their operating procedures but the requirement of Privy Council

[1] Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers (2011) Cm 8008, para 4.1.

[2] The 31 health care professions regulated by these bodies are listed in table 2 (see Part 2).

[3] The Health and Social Care Bill 2011 proposes to close the General Social Care Council and transfer its functions to the Health Professions Council. In the other parts of the UK, social workers will continue to be regulated by the Care Council for Wales, Scottish Social Services Council and Northern Ireland Social Care Council.

approval imposes burdens on the Department of Health, as the Department with policy responsibility. In practice the Privy Council defers to the Department's policy officials and legal group when it is required to act. Constraints on Government resources mean that only the most pressing matters are taken forward, thereby restricting the regulators' ability to instigate reforms and modernise their legal frameworks.

1.5 For these reasons, the Department of Health suggested a project to review the legal framework for health and social care professional regulation. The purpose of the proposals made in this consultation paper is to address these problems by establishing a simple, consistent, transparent and modern legal framework.

BACKGROUND TO THE PROJECT

1.6 The project originated in the form of a reference from the Right Honourable Andrew Lansley CBE MP, Secretary of State for Health, in accordance with the protocol agreed between the Lord Chancellor and the Law Commission and under the provisions of section 3(1)(e) of the Law Commissions Act 1965. The specific remit of the project is to review the UK law relating to the regulation of health care professionals and, in England only, the regulation of social workers.

1.7 Due to the UK-wide nature of the review, it was agreed that the project should be a joint one between the Law Commission of England and Wales, the Scottish Law Commission and the Northern Ireland Law Commission. Indeed, this is the first ever tripartite project undertaken by the three UK Commissions. It was agreed that the England and Wales Law Commissioner, Frances Patterson QC, would be the lead Commissioner for the project as a whole and the staff team at the England and Wales Commission would work to all three Commissions. In addition, the Scottish and Northern Ireland Law Commissions each identified Commissioners responsible for the project. The lead Commissioners are Patrick Layden QC TD in Scotland and the Honourable Mr Justice McCloskey, the chair of the Northern Ireland Law Commission. The three Commissions have worked closely on the development of this paper and the final document was approved at formal meetings of the Commissions of England and Wales, Scotland and Northern Ireland in early 2012.

1.8 Ongoing meetings have taken place since the start of the project with the Department of Health, as the sponsoring department for this project, to ensure that the Law Commissions are aware of developing Government policy. Meetings have also taken place with Government officials from the Welsh Government, Scottish Government and Northern Ireland Executive. We are grateful for the input and expertise that officials and Government lawyers were able to provide.

1.9 The project has also benefited greatly from a range of pre-consultation meetings with a number of stakeholders and other experts in the field of health and social care professional regulation. These have included regular meetings with all the regulators, at both staff and General Council level, and the Council for Healthcare Regulatory Excellence. Pre-consultation meetings have also taken place with a range of patient and consumer groups, professional groups, trade unions, other regulators, academics, legal experts and law firms. On 20 October 2011, the Law Commission of England and Wales hosted a discussion forum, to which the major stakeholders were invited, to outline the scope of the project and discuss key issues. Over 100 people attended throughout the day. Meetings have also

taken place with the Right Honourable Stephen Dorrell MP as chair of the House of Commons Health Select Committee, Dame Janet Smith DBE as the chair of the Shipman Inquiry, and senior advisers to the Privy Council.

HISTORICAL CONTEXT

1.10 For the best part of 150 years since the establishment of the General Medical Council in 1858, health care professional regulation was based on a self-regulatory model. Although definitions vary, self-regulation can be described as a process whereby an organised group or body regulates the behaviour of its members without interference from the state.[4]

1.11 The emergence of self-regulation is often characterised as being the product of a bargain struck between the medical profession and the state, with the state devolving responsibility to the profession to assure the quality of its members and services. Historically, this was based on the assumption that medical expertise was beyond the ability of unqualified people to understand or evaluate.[5]

1.12 The potential benefits of pure self-regulation were said to include the development of practicable standards, which were policed effectively because standard-setting and enforcement was the responsibility of the relevant practitioners. Furthermore, peer pressure was seen to have created an environment of high standards of behaviour which was more effective and responsive than traditional legal methods of regulation.[6] As late as the 1970s the Merrison Committee examining the role of the General Medical Council concluded that the regulatory body must also be a professional body.[7]

1.13 However, the last 15 years have seen a seismic shift away from self-regulation. Three sources of pressure can be identified which undermined the legitimacy of self-regulation and enabled this shift. First, successive Government policies of market liberalisation and de-regulation transformed and challenged the health professions in England. Examples include the introduction of payment by results, expansion of the independent sector and establishment of NHS foundation trusts.[8] At the same time, Governments across the UK have developed a range of regulatory tools in relation to certain aspects of decision making, for example through systems of clinical governance (such as the National Institute for Health and Clinical Excellence) and service regulation (such as the Care Quality Commission, Healthcare Improvement Scotland, the Regulation and Quality Improvement Authority in Northern Ireland and the Health Inspectorate Wales,).[9]

[4] N Gunningham and P Grabosky, *Smart Regulation: Designing Environmental Policy* (1998) pp 50 to 51.

[5] See, for example, J Warring and others, "Modernising Medical Regulation: Where Are We Now?" (2010) 24 *Journal of Health Organisation and Management* 6, 540.

[6] N Gunningham and P Grabosky, *Smart Regulation: Designing Environmental Policy* (1998) p 52.

[7] A Merrison, *Committee of Inquiry into the Regulation of the Medical Profession* (1975).

[8] See, for example, Civitas, *The Impact of the NHS Market* (2010) and Kings Fund, *Economic Regulation in Health Care: What Can We Learn from Other Regulators?* (2011).

[9] See, for example, C Ham and K Alberti, "The Medical Profession, the Public and Government" (2002) *British Medical Journal* 324, 838.

1.14 Second, recent times have witnessed shifting social and political attitudes that have reflected a decline in trust in expert and governing elites to safeguard public interests. Traditional social deference is being challenged by a "more demanding, less deferential, more vociferous" public who are more willing to challenge professional judgements.[10] Moreover, professional control of information has been challenged by the development of the internet and greater access to information about illness and treatment, including information about the quality and effectiveness of such interventions. UK policy makers have encouraged people to take more responsibility for their own health (known as "responsibilisation"). This can be seen, for example, in the proliferation of statistics and league tables related to public service performance.[11]

1.15 Finally, there have been a series of regulatory failures in medicine. Three cases above all others were instrumental in altering the regulatory landscape, and each resulted in wide-ranging inquiries into medical professional regulation and recommendations for reform. These inquiries were the:

(1) *Bristol Royal Infirmary Inquiry*, which followed revelations that surgeons had continued to operate on children with heart defects when they knew their death rates were unacceptably high and a doctor manager had been alerted to the high mortality but failed to stop the operations;[12]

(2) *Alder Hey Inquiry* into the removal, retention and disposal of human organs and tissues from children without the consent of their parents following post-mortem examinations (see also the *McLean Report* in Scotland);[13] and

(3) *Shipman Inquiry*, which arose following the conviction of Dr Harold Shipman, a general practitioner, for the murder of 15 of his middle-aged and older female patients by lethal injections of diamorphine. Subsequent revelations showed that he had in fact killed 215 of his patients.[14]

1.16 In addition, the same period saw a series of official investigations into why certain doctors had been allowed to continue to practise even though concerns had been raised about their conduct which caused death and lasting injuries to patients;

[10] C Ham and K Alberti, "The Medical Profession, the Public and Government" (2002) *British Medical Journal* 324, 838.

[11] M Dent, "Patient Choice and Medicine in Health Care: Responsibilisation, Governance and Proto-professionalism" (2006) 8 *Public Management Review* 3, 449 and S Harrison, "New Labour, Modernisation and the Medical Labour Process" (2002) 31 *Journal of Social Policy* 3, 465.

[12] Learning from Bristol: the Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984 -1995 – Final Report (2001) Cm 5207.

[13] The Royal Liverpool Children's Inquiry Report (2000-01) No 0012-II and Independent Review Group on the Retention of Organs at Post-Mortem, *Report on Stage 3* (the "McLean Report") (2003).

[14] The Shipman Inquiry Fifth Report: Safeguarding Patients, Lessons from the Past – Proposals for the Future (2004) Cm 6394.

most notably the cases of Rodney Ledward, Clifford Ayling, Richard Neale and William Kerr and Michael Haslam.[15]

1.17 The final reports of the Bristol, Alder Hey and Shipman inquiries all criticised self-regulation as self-serving and lacking transparency and accountability, and cast serious doubts on the capacity of the profession to regulate itself satisfactorily. This opened the door for the state to undertake a more prominent regulatory role.

1.18 The Government's response to this crisis was to restore some level of state control and establish other formal modes of regulation. This included the establishment and development of the Council for Healthcare Regulatory Excellence (see Part 10), clinical governance (see Part 6) and systems regulation (see Part 6). Furthermore, the Government has initiated several reforms to the regulators' legal frameworks aimed at restoring public confidence in professional regulation and, in particular, dealing with a perceived lack of independence of the regulators from the regulated. These reforms have included the removal of elections to the governing Councils by the profession and the introduction of a recruitment process, and the increase in lay membership of Councils and removal of professional majorities (see Part 4). Other notable reforms have included prohibitions on Council members and members of the Investigation Committee from sitting on Fitness to Practise Panels (see Part 8), the widening scope of fitness to practise procedures beyond serious misconduct (see Part 7) and the development of revalidation (see Part 6).

WHERE ARE WE NOW?

1.19 The above reforms have been described as signalling a movement away from self-regulation towards "state-directed bureaucratic regulation".[16] The regulators are seen increasingly as independent regulatory agencies that are subject to various forms and degrees of oversight by the state. Nevertheless, it is important to recognise that the professions continue to play a significant role in the regulatory system. For example, professional members continue to serve on Councils (making up half of the membership) and sit on Fitness to Practise Panels and Investigation Committees. They are also a key element of the proposed systems of revalidation.

Current trends

1.20 It is highly unlikely that the policy landscape for regulating health and social care professionals is now settled. Policy will continue to develop throughout and beyond the lifetime of this project. In some areas the direction of policy is set but in others it has yet to be determined. The following provides a brief overview of some of the main and potential policy trends.

(1) *Drive for greater efficiencies*. The policy of the coalition Government is to encourage economic growth and greater personal responsibility through the reduction of regulatory burdens. In part, this is driven by the need to

[15] J Ritchie QC, *An Inquiry into Quality and Practice Within the NHS Arising From the Actions of Rodney Ledward* (2000), Report of the Clifford Ayling Inquiry (2004) Cm 6298, Report of the Richard Neale Inquiry (2004) Cm 6315, and Kerr/Haslam Inquiry (2005) Cm 6640.

[16] J Warring and others, "Modernising Medical regulation: Where Are We Now?" (2010) 24 *Journal of Health Organisation and Management* 6, 540, 551.

constrain the costs of the current system for registrants and Government, particularly in the light of the current economic climate. In the context of professional regulation this will involve giving greater independence to the regulators balanced by more effective accountability.[17]

(2) *Right-touch regulation*. Current regulatory approaches in health and social care are influenced heavily by the Hampton principles that regulation should be transparent, accountable, proportionate, consistent and targeted.[18] This can be seen in the promulgation of "right touch regulation" by the Council for Healthcare Regulatory Excellence, which recognises that different contexts expose patients to different risk levels and the use of minimum regulatory force to achieve the desired results.[19]

(3) *Early intervention*. Medical advances and other developments in professional knowledge have brought greater emphasis on education and keeping professionals up to date with new clinical interventions. The proper role of regulation is seen increasingly as ensuring proper standards of practice and reducing the need for disciplinary intervention. This can be seen in developments such as revalidation and employment liaison officers (see Part 6). In contrast, a disciplinary model emphasises intervention once harm has occurred.

(4) *Remedial measures*. The increasing complexity of clinical practice may mean a less punitive and more tolerant approach to regulation. Where appropriate, the regulators are developing ways of ensuring a greater emphasis on "remediation", rehabilitation and support for professionals who struggle to cope.[20] In part, this can be seen in the moves towards consensual disposals and the introduction of a two-stage approach to impaired fitness to practise (see Part 7).

(5) *Multi-disciplinary working*. Changes in technology, training and practice are making the boundaries between professions more blurred. For example, nurses' prescribing powers have expanded in recent years and care assistants perform tasks limited previously to registered nurses. The crossover and blurring of roles may mean that regulatory systems based purely on job title are increasingly difficult to manage.

(6) *Cross-regulator working*. Health regulation has become a multi agency activity. In addition to the professional regulators, there are systems regulators such as the Care Quality Commission, vetting and barring schemes to protect children and vulnerable adults, employment

[17] Better Regulation Executive, *Reducing Regulation Made Simple: Less Regulation, Better Regulation and Regulation as a last Resort* (2010) and Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers (2011) Cm 8008, pp 3 to 4.

[18] P Hampton, *Reducing Administrative Burdens: Effective Inspection and Enforcement* (2005) p 7.

[19] Council for Healthcare Regulatory Excellence, *Right-Touch Regulation* (2010).

[20] See, for example, Academy of Medical Royal Colleges, *Remediation and Revalidation: report and recommendations from the Remediation Work Group of the Academy of Medical Royal Colleges* (2009).

disciplinary processes, complaints procedures, the ombudsmen and criminal and civil justice agencies. There is considerable overlap between these systems, and in the future joint working is likely to increase. The trend towards multi-disciplinary teams may also mean more joint working between the professional regulators.

Devolution

1.21 The general position is that the legislation governing the health care professional regulators is of UK extent. The exceptions are the Pharmacy Order 2010 which extends to Great Britain, and the Pharmacy (Northern Ireland) Order 1976 which extends to Northern Ireland.[21]

1.22 Under the Scotland Act 1998 regulation of existing health professions is reserved to the Westminster Parliament but regulation of health professions regulated since devolution is devolved to the Scottish Parliament. This has meant that the General Dental Council, General Pharmaceutical Council and Health Professions Council are now accountable to the Scottish Parliament as well as the UK Parliament in relation to certain professional groups, namely operating department practitioners, practitioner psychologists, dental nurses, dental technicians, clinical dental technicians, orthodontic therapists and pharmacy technicians. The Scottish Parliament would also have legislative competence in relation to new groups brought into professional regulation.

1.23 The Scotland Bill 2010 proposes that the Scotland Act 1998 be amended so that all regulation of health professions is reserved to Westminster.[22] This is a controversial policy. The Scottish Government opposes the change, and the Scottish Parliament Committee at the Scottish Parliament has recommended that legislative consent is not given to the provision.[23]

1.24 In Wales, the regulation of health professionals is not devolved.[24] In Northern Ireland, health professional regulation is not an excepted or reserved matter, and the Northern Ireland Assembly therefore can legislate in this area.[25] However, although legislative competence is devolved, the principal modern instrument for legislating for professional regulation – section 60 orders – is *not* available to the Northern Ireland Assembly.[26] The UK Government has on a number of occasions in recent years used section 60 orders to legislate on a UK wide basis.

1.25 Legally, therefore, professional regulation is a UK responsibility, with important but limited current exceptions: operating department practitioners, practitioner psychologists, dental nurses, dental technicians, clinical dental technicians, orthodontic therapists and pharmacy technicians, in relation to Scotland, and pharmacy in relation to Northern Ireland.

[21] Great Britain refers to England, Scotland and Wales but does not include the Channel Island and Isle of Man which are included as part of the British Islands.

[22] Scotland Bill 2010, cl 13.

[23] Scottish Parliament Scotland Bill Committee 1st Report, 2011 (Session 4), vol 1, SP Paper 49, recommendation 20. At the time of writing, the Parliament has yet to debate the report.

[24] Government of Wales Act 2006, sch 7, pt 1, para 9.

[25] Northern Ireland Act 1998, s 4(1).

1.26 The regulation of social care professionals falls within the legislative competence of each country. England, Scotland, Wales and Northern Ireland have now introduced separate arrangements for the regulation of social workers and/or other social care staff.[27] As noted previously, the remit of our review extends only to the regulation of social workers in England. Therefore, any potential changes to regulatory functions or their implementation discussed in this paper, so far as the social work profession is concerned, will only extend to the regulation of social workers practising in England.

1.27 Health care and health services are devolved in each settlement, subject to certain exceptions. Accordingly, the Scottish Parliament, National Assembly for Wales and Northern Ireland Assembly have legislative competence, and the Governments/Executives in each country have executive powers and responsibilities. The NHS is therefore now administered differently in each of the four countries of the UK, and each has its own systems regulators. This is of major significance to the UK regulators. Professional regulation is affected by the context in which health services are delivered. Further, education and training are broadly devolved, which impacts importantly on the statutory role of the regulators to ensure proper standards of education. Current areas of significant differences in policy in both these areas include clinical governance, prescription drug charges, charging for personal and nursing care for older people, and tuition fees for students.[28]

1.28 The scope of our project does not extend to a review of the devolution settlements in the UK. However, the responsibilities of each of the three devolved administrations – legislatures and executive arms – give them a strong legitimate interest in health care professional regulation. The regulatory system has its roots in a time before devolution. One of the challenges of the project is to ensure that the legitimate interests of the devolved administrations are properly recognised and expressed in the development of regulation. Our provisional approach to doing so is set out at the various relevant parts of the consultation paper.

Legal references

1.29 Although the case law for professional regulation is spread out over three jurisdictions, in substantive terms the law is the same. In this consultation paper we have therefore drawn indiscriminately from the case law in England and Wales, Scotland and Northern Ireland.

[26] Health Act 1999, s 60.

[27] Care Standards Act 2000, s 54; Regulation of Care (Scotland) Act 2001; and Health and Personal Social Services Act (Northern Ireland) 2001.

[28] See, H Cheyne and others, "United but Divided? The Need to Consider the Practical Consequences of Devolved UK Government on Midwifery Education and Practice" (2011) 27 *Midwifery* 770.

STRUCTURE OF THE CONSULTATION PAPER

1.30 This paper is divided into 13 Parts:

(1) Part 2 considers a number of preliminary matters which concern how the new legal framework should be structured and how the regulators should be made accountable for the exercise of their powers;

(2) Part 3 is concerned with the main duty of the regulators to protect the public and their general functions;

(3) Part 4 discusses the governance arrangement for the regulators and how their internal arrangements (such as the constitution of the General Council and internal committees) are provided for in law;

(4) Part 5 considers the statutory function of the regulators to establish and maintain a register of individual professionals;

(5) Part 6 is concerned with how the regulators ensure proper standards of professional education, conduct and practice;

(6) Parts 7, 8 and 9 discuss the fitness to practise process, and how it should be provided for in our proposed framework:

(a) Part 7 considers how impaired fitness to practise is determined;

(b) Part 8 looks at the investigation of allegations; and

(c) Part 9 discusses the adjudication of fitness to practise cases;

(7) Part 10 looks at the role performed by the Council for Healthcare Regulatory Excellence;

(8) Part 11 considers the powers of the regulators to regulate businesses;

(9) Part 12 is concerned with the functions of the regulators that overlap with other organisations and areas of law; and

(10) Part 13 looks at the management of cross border issues.

1.31 In addition to these substantive Parts, we have set out all of the provisional proposals made in this consultation paper in Appendix A.

RESPONDING TO THIS CONSULTATION PAPER

1.32 In this paper we make a number of provisional proposals for law reform. In doing this, we emphasise that these represent our initial view about how the law should be reformed and we will be reviewing these proposals on the basis of the responses to this consultation paper.

1.33 Furthermore, the views we express about the regulation of this sector should not be read across into any other sector, professional or not. For instance, our views would not necessarily be the same in the context of the regulation of the legal professions.

1.34 We will be undertaking a wide consultation process in order to gather as many different views and as much information as possible. We welcome responses from all interested parties. Details of how to respond can be found on the inside front page of this consultation paper.

1.35 An analysis of consultation responses will be published on our websites. The next stage will be to produce and submit a report in 2014 to the Lord Chancellor and to the Scottish and Northern Ireland Ministers. Taking into account the responses we receive to this consultation paper, the report will contain our final recommendations and the reasons for them. A draft bill, giving effect to our final recommendations, will also be included.

PART 2
THE STRUCTURE OF REFORM AND ACCOUNTABILITY

2.1 This Part considers a number of preliminary matters which concern how the new legal framework should be structured and how the health and social care professional regulators should be made accountable for the exercise of their powers. The specific matters considered are:

(1) our general approach to law reform;

(2) rules and regulations;

(3) public consultation;

(4) Parliamentary accountability;

(5) publication requirements;

(6) Section 60 orders;

(7) the number of regulators and regulated professions;

(8) the default powers of the Privy Council;

(9) devolved responsibilities; and

(10) implementation issues.

OUR GENERAL APPROACH TO LAW REFORM

The legislative structure

2.2 As noted in Part 1, the legislative framework for health and social care professional regulation in the UK has developed in a piecemeal fashion over the past 150 years.[1] Each regulator has its own separate legal framework which has been introduced and reformed by Parliament throughout this period. For example, the General Medical Council was established by the Medical Act 1858, which has been updated on several occasions. The Council is currently governed by the Medical Act 1983 which itself has been amended heavily.[2] The legislative origins of the Nursing and Midwifery Council and General Dental Council date back to the early twentieth century and have been the subject of periodic reform.[3] The Health Professions Council is one of the newest regulators, having been established by the Health Professions Order 2001 which has also been amended

[1] For an account of the regulatory structure from a Scottish perspective see *Stair Memorial Encyclopaedia Reissue Medical Law,* paras 12 to 88.

[2] For example, by the Professional Performance Act 1995 and European Qualifications (Health and Social Care Professions) Regulations 2007, SI 2007 No 3101.

[3] For example, by the Midwifes Registration Act 1902 and Dentists Act 1921.

on several occasions.[4]

2.3 There are currently ten separate pieces of legislation that govern the regulators. Seven regulators are governed by an Act of Parliament and three by an Order in Council made under section 60 of the Health Act 1999. The relevant legislation is listed in table 1 below.

	Governing legislation
GCC	Chiropractors Act 1994
GDC	Dentists Act 1984
GMC	Medical Act 1983
GOC	Opticians Act 1989
GOsC	Osteopaths Act 1993
GPhC	Pharmacy Order 2010
GSCC	Care Standards Act 2000
HPC	Health Professions Order 2001
NMC	Nursing and Midwifery Order 2001
PSNI	Pharmacy (Northern Ireland) Order 1976

Table 1: Governing legislation

2.4 In addition to this legislation, the Council for Healthcare Regulatory Excellence is governed by the NHS Reform and Health Care Professions Act 2002. This legal framework will be reformed as a result of the Health and Social Care Bill 2011. The Council is an independent overarching body with the general task of overseeing the work of the nine health care regulators. The role of the Council and the proposed reforms are discussed in detail in Part 10.

2.5 Because the legislative framework has been allowed to develop in a piecemeal fashion, there are various idiosyncrasies and inconsistencies in the powers, duties and responsibilities of each regulator. For example, although the regulators fulfil broadly similar functions – maintaining a register, setting standards of education and training, and investigating and adjudicating fitness to practise cases – their ability to make rules and regulations which flesh out the detail of these functions varies. For example, some regulators have no powers to screen out certain categories of complaint and therefore must deal with all allegations through formal fitness to practise procedures, while other regulators have considerable discretion to dispose of cases without the need for formal procedures (see Part 8). There are also differences in the powers to gather and

[4] For example, Health Care and Associated Professions (Miscellaneous Amendments and Practitioner Psychologists) Order 2009, SI 2009 No 1182.

share information, definitions of a vulnerable witness, powers to call witnesses, and sanctions that can be imposed by a Fitness to Practise Panel (see Part 9).

Professional groups

2.6 The legal framework extends to a diverse range of professional groups; the regulators are responsible for regulating 31 different health professions consisting of approximately 1.4 million professionals across the UK, and 105,000 social workers and social work students in England.[5] The 32 registered health and social care professions and the relevant regulator are listed in table 2 below.

	Registered professions
GCC	Chiropractors
GDC	Dentists, clinical dental technicians, dental hygienists, dental nurses, dental technicians, dental therapists and orthodontic therapists
GMC	Doctors
GOC	Optometrists and dispensing opticians
GOsC	Osteopaths
GPhC	Pharmacists and pharmacy technicians in Great Britain
GSCC	Social workers in England
HPC	Arts therapists, biomedical scientists, chiropodists/podiatrists, clinical scientists, dieticians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists/orthotists, radiographers and speech and language therapists
NMC	Nurses and midwives
PSNI	Pharmacists in Northern Ireland

Table 2: Registered professions

2.7 The differences between the professions do not relate only to the types of work undertaken. Each of the professional groups has its own culture, background, expertise and structure. For example, some professions have a long history of self-regulation, while others are relatively young professions with little experience of being regulated at all. A significant number of the professional groups are employed largely in the public sector (such as doctors, nurses and social

[5] Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers (2011) Cm 8008, para 4.1 and General Social Care Council, *Annual Report and Accounts: 2010-11*, (2011) p 14.

workers), some are largely self-employed and work in the private sector (such as chiropractors and osteopaths), and other professional groups work in private commercial firms (such as high street opticians and pharmacists).

2.8 These differences impact on how each regulator approaches its core functions. For some professions (such as doctors) the costs of regulatory failure are potentially considerable and consequently the approach of the regulator may be less flexible than for a profession whose core tasks represent a lower negative impact in the case of regulatory failure. Furthermore, differences in the marketplace mean that some regulators undertake premises regulation, as well as regulating individual practitioners (see Part 11).

2.9 There are also significant differences between the regulators in terms of their size and resources. The size of the regulators varies from the Pharmaceutical Society of Northern Ireland which has just over 2,000 individual registrants, to the Nursing and Midwifery Council which is the largest regulator with 665,599 registrants.[6] Several regulators are responsible for one group of professionals, whereas the Health Professions Council regulates 15 professions (soon to increase to 17 when they take over the regulation of herbal medicine practitioners and in England, social workers). Some of the larger regulators may hear several hundred fitness to practise cases a year, while smaller regulators may hold less than ten hearings. As is clear from table 3 below, there is also variation in the fees charged, expenditure and total number of registrants.

.	**Fee**	**Expenditure (£M)**	**Registrants**
GCC	£1000	£2.9	2,918
GDC	£575	£26.8	95,583
GMC	£420	£87.3	248,287
GOC	£270	£5.1	24,628
GOsC	£750	£2.8	4,440
GPhC	£262	£8.3	68,590
GSCC	£30	£48.7[7]	104,469
HPC	£76	£16.2	215,476
NMC	£76	£44.7	668,084
PSNI	£345	£0.86	2,060

Table 3: Registration fees, expenditure and registrants of the regulators[8]

[6] Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers (2011) Cm 8008, p 27.

[7] Includes the Education Support Grant.

Provisional view

2.10 Two main criticisms can be directed at the legislative framework described above: first, it establishes inconsistency in the *ability* of the regulators to undertake their statutory functions, and second it *delivers* inconsistency across the regulators in how those functions are implemented.

2.11 We think that the first criticism has considerable force. The effective regulation of health and social care workers depends on the ability of the regulators to adapt to changing circumstances and effectively fulfil their statutory obligations to protect the public. In order to do so, we believe that the regulators should be given the same powers and ability to undertake their statutory functions, and all arbitrary restrictions should be removed. We see no reason why, for example, some regulators should be given powers to screen complaints but not others.

2.12 In order to achieve this type of consistency, it would be possible to retain the existing 10 separate pieces of legislation (see table 1), one for each regulator, while harmonising the various rule and regulation-making powers. However, this option would re-establish an unnecessarily complex framework and demand a considerable amount of Parliamentary time and resources to implement. There would also be the potential for future divergence since amendments could be made to individual pieces of legislation rather than across the board. Alternatively, the legal framework could retain separate bodies but harmonise the different legislation in a single Act. This is our preferred option since it would reduce the number of complex pieces of legislation and deliver potentially some economies of scale.

2.13 The second criticism of the legislative framework is that it *delivers* inconsistency across the regulators in how they implement their functions. We think that this criticism has less force. Each regulator faces a broad range of different circumstances and unique political, social and economic demands. These differences mean that the experience of one regulator is not easily extrapolated to another, and each regulator will need to tailor their approach to regulation in the light of its own individual circumstances. It would be wrong in our view for the statute to impose a one size fits all approach to regulation.

2.14 Nevertheless, there are several areas where consistency is essential. The precise areas are identified throughout this paper, but in general terms they are areas where we think consistency will help to achieve one or more of the following aims:

(1) to establish and maintain certain core statutory functions for the regulators, namely, maintaining a register, setting standards for education, conduct and practice, and the investigation and adjudication of fitness to practice cases;

[8] Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers (2011) Cm 8008, p 27.

(2) to guarantee minimum procedural requirements (such as those relating to the procedures for hearings undertaken by Fitness to Practise Panels); and

(3) to establish certain core requirements in the public interest (for example, a single overarching duty for professional regulation and setting the size and composition of Councils).

2.15 We therefore propose that the new legal framework should impose consistency where necessary in order to achieve one or more of these aims, but otherwise the regulators should be given greater autonomy in the exercise of their statutory responsibilities and to adopt their own approach to regulation in the light of their circumstances and resources.

2.16 However, drawing a clear distinction between issues where consistency is necessary, on the one hand, and where discretion is important on the other is not always easy. For example, the establishment of a statutory process for the investigation of complaints could be seen to benefit the complainant and the alleged wrongdoer, but there are also strong arguments for giving the regulators discretion to adopt a proportionate approach to managing risk on such matters. In a specific context, these are difficult judgments to make and we might not have got them right. We are interested in your views on whether we have drawn the correct line in this paper.

2.17 Moreover, our general approach to law reform identified above is subject to the regulators being subject to an appropriate level of accountability. The ways in which the regulators would be held to account are discussed in the rest of this Part.

Provisional Proposal 2-1: All the existing governing legislation should be repealed and a single Act of Parliament introduced which would provide the legal framework for all the professional regulators.

Provisional Proposal 2-2: The new legal framework should impose consistency across the regulators where it is necessary in order to establish the same core functions, guarantee certain minimum procedural requirements and establish certain core requirements in the public interest. But otherwise the regulators should be given greater autonomy in the exercise of their statutory responsibilities and to adopt their own approach to regulation in the light of their circumstances and resources.

RULES AND REGULATIONS

2.18 In order to undertake their statutory functions, the regulators are given powers to make rules and regulations which in most cases must be approved by Order of the Privy Council.[9] These Orders are statutory instruments which do not need the direct approval of the Queen (as opposed to Orders in Council which do require such approval). The only exceptions are the General Social Care Council who

[9] The Privy Council is a formal body that advises the Monarch in the UK on the exercise of the Royal Prerogative, and is made up mostly of senior politicians who are or have been members of the House of Commons or the House of Lords.

have powers to create their own rules and the Pharmaceutical Society of Northern Ireland who can make regulations approved by the Northern Ireland Department of Health, Social Services and Public Safety.

2.19 In the governing legislation, the distinction between rules and regulations is not straightforward. In general terms, rules are used for procedural and operational matters (such as internal governance and fitness to practise hearings), whereas regulations are intended to cover broader territory (such as registrant fees, continuing professional development and revalidation). To a degree it is merely a matter of terminology. Some regulators (such as the General Pharmaceutical Council) have powers to make rules only, even for matters which are covered by regulations for other Councils.

2.20 Not all rules and regulations require Privy Council approval in order to take effect. Whether such approval is needed will be stated in the legislation. For example, the General Medical Council can make regulations about erasure on the basis of failure to pay fees which do not need Privy Council approval.[10] The General Dental Council does not need Privy Council approval for certain rules relating to the education and registration of dental care professionals.[11] Where rules or regulations do not require Privy Council approval before they can take effect, then the procedural requirements end after the Council has made them.

2.21 However, the great majority of rules and regulations do require Privy Council approval. The process is as follows:

(1) the regulator proposes new rules or regulations (and in most cases is required to hold a public consultation) and produces a draft instrument with input and advice from the Department of Health;

(2) the regulator votes to make the instrument and seals it;

(3) the relevant Minister indicates that he or she is content for the draft to be put to the Privy Council;

(4) the sealed instrument is put to the Privy Council for approval by two Privy Counsellors;

(5) submissions are sent to the Secretary of State for Health in his or her capacity as a Privy Councillor, the Lord President of the Privy Council, and where appropriate the Scottish Ministers;

(6) Privy Council approval, if given, takes the form of an Order of Council;

(7) the instrument is laid in Parliament (and where appropriate the Scottish Parliament), if there is a laying requirement, together with the Explanatory Memorandum and any impact assessment document; and

[10] Medical Act 1983, s 32(2).

[11] Dentists Act 1984, s 50C.

(8) the instrument is scrutinised by the Joint Committee on Statutory Instruments and if it has been laid before Parliament, by the Merits of Statutory Instruments Committee.[12]

2.22 Not all rules and regulations which are approved by the Privy Council and take the form of statutory instruments must be laid before Parliament.[13] Nonetheless, even these rules and regulations still require all the formalities of a statutory instrument. These are printing (which must be done on a specific format and specially prepared), registration as a statutory instrument (which is undertaken by the Privy Council), and scrutiny by the Joint Committee on Statutory Instruments. This scrutiny process means that it must conform fully to standard drafting rules for statutory instruments and may be reported by the Joint Committee if they contain errors. The Department of Health must field officials and lawyers to respond to any requests made by the Joint Committee.

2.23 In addition, Orders approving the rules of the Health Professions Council and the General Pharmaceutical Council, or rules and regulations of the General Dental Council will need to be laid in Scotland if they relate to the regulation of those professions for whom regulation is devolved to Scotland (see Part 1).

Government policy

2.24 It is recognised widely that the process described above is unduly complex and resource intensive, and prevents the regulators from updating their powers and functions. The Government has stated that:

> The Councils are autonomous bodies who are free to make new rules and rule changes when they identify a need, but the requirement of Privy Council approval necessarily imposes burdens on the Department of Health as the Department with policy responsibility and as Privy Council advisers. Furthermore, the priority which the Department can give the proposal will depend on available resources and this will affect substantially the timetable for making new regulations.
>
> The constraints on Government resources mean that only the most pressing issues are acted upon and the process for making these changes takes about two years. Consequently, regulators are frequently unable to make important changes that would allow them to improve their performance, work less bureaucratically, reduce costs to registrants and respond more fairly and effectively to both public and professional concerns. The current legislative framework

[12] Department of Health and DH Legal Services, *Protocol for New Rules and Regulations, and Amendments, which require Privy Council Approval in the Form of a Statutory Instrument (Draft)* (2011).

[13] See, for example, Chiropractors Act 1994, ss 35 and 36, Medical Act 1983, ss 31(4A) and (4B), 31(10) and 51, and Osteopaths Act 1993, ss 35 and 36.

over-regulates the regulators themselves by constraining their freedom to adapt and modernise.[14]

2.25 Consequently, the Government has announced its intention that there will be "an increase in autonomy of the regulatory bodies in the exercise of their statutory responsibilities" which will allow the regulators freedom to develop their own rules and procedures, balanced by a "commensurate strengthening of their public and parliamentary accountability for their performance". [15]

Standing orders

2.26 The regulators have powers to make standing orders with respect to various matters, including the composition and procedures of the non-statutory committees, which do not require approval by any external body and are not statutory instruments (and so do not have statutory force).[16] Standing orders cannot conflict with any rule or provision in either primary or secondary legislation, and exist to enable the regulator to function efficiently.

Provisional view

2.27 A number of difficulties can be identified with the current system for issuing rules and regulations, not least of which are its complexity, the burdens it places on Government resources and the limitations it places on the regulators' ability to modernise and innovate. It is not unusual for statute law to give independent bodies formal subordinate law making powers, without the need for Parliamentary approval.[17] Indeed, there are precedents for giving professional regulators such autonomy, for instance the General Social Care Council and Solicitors Regulation Authority.[18]

2.28 However, any increase in the regulators' rule-making autonomy does give rise to a number of important concerns. Some regulators report significant benefits arising from the current procedure, mainly in the form of the expert advice and assistance provided by the Department of Health in developing and drafting rules and regulations. By removing this process, errors in rules may be more likely, and there may be resource implications if the regulators need to increase their legal costs which may need to be passed on to registrants in the form of increased fees.

2.29 Increasing the regulators' autonomy may lead to a democratic deficit in their accountability. Most Orders of the Privy Council are laid before Parliament and

[14] Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social care Workers (2011) Cm 8008, para 3.5.

[15] As above, para 3.8.

[16] For example, Chiropractors Act 1994, s 1(4) and sch 1, Part 1, para 1B(3).

[17] Examples include byelaws made by local authorities and railway operators, regulations made by utilities regulators and rules governing the financial market made by the Financial Services Authority.

[18] However, the General Social Care Council's rules must be approved by the Secretary of State (Care Standards Act 2000, s 71(4)) and alterations to the Solicitor Regulation Authority's regulatory arrangements require the approval of the Legal Services Board (Legal Services Act 2007, sch 4, para 19).

subject to scrutiny by the Joint Committee on Statutory Instruments and the Merits of Statutory Instruments Committee. The Government also plays an active role in scrutinising new rules or regulations. Arguably, the process of Government approval provides a useful break in the system to allow for example the Government to test whether the proposals are fully in the public interest and to allow professional and patient groups to make representations. All of these checks and balances would disappear if the regulators were given greater autonomy to issue their own rules. The regulators could not be given powers to lay rules as statutory instruments in Parliament without going through either the Department or Privy Council.[19]

2.30 Finally, there may be confusion about the formal legal status of rules issued by the regulators which are not approved by Parliament. In law, this matter is relatively straightforward. Rules made by a body authorised by statute have the full force of law. This applies irrespective of whether or not the relevant rules have been laid in Parliament or the person entrusted with issuing the rules is not an emanation of the state.[20] In effect, registrants would still be required to comply with any requirements set by the regulators, for example, in relation to cooperating with a fitness to practise investigation. Nonetheless, it remains possible that the status of the rules is insufficient to guarantee the required certainty for the effective operation of the regulators.

2.31 We welcome further evidence on all of these points. Our provisional view is that many of these concerns are legitimate, and that certain aspects of the current system for approving rules provide important safeguards. Nevertheless, on balance we think these concerns are outweighed by the advantages of giving the regulators more flexibility to adapt and modernise. We therefore propose that the regulators should therefore be given broad powers to make or amend rules without Privy Council or Government oversight. This would not, of course, mean that the regulators would be completely free to act without any external constraints. Any rules issued would be required to be compatible with, for example, European Union law or public law requirements including those imposed by the European Convention on Human Rights. Registrants and members of the public could also challenge the regulators through judicial review. The regulators would also continue to be held to account through several mechanisms which are discussed in the rest of this Part, such as public consultation and Parliament.

2.32 But what would be lost is any form of direct prior oversight of the regulators' rules. One possibility might be for the Council for Healthcare Regulatory Excellence to be given an active role in scrutinising new rules. At one extreme this could be an enhanced role whereby the Council would approve formally all new rules. Alternatively, their role could be limited to auditing the quality of rules, developing principles and standards to assist the regulators in making new rules and reporting on all of these matters to Parliament.

2.33 But any form of direct control by the Council for Healthcare Regulatory Excellence would carry risks. First, it could lead to a degree of imposed

[19] Statutory Instruments Act 1946, s 4.

[20] *Swain v Law Society* [1983] 1 AC 598 and *Mohamed v Alaga* [1998] 2 All ER 720.

harmonisation which could stifle innovation. Second, it might hamper the regulators' ability to respond quickly to the need for change and simply replicate the existing role of the Department for Health. Third, the Council would require additional expertise and resources than it currently possesses. The costs would need to be passed on to Government and in the future, the regulators and therefore the registrants themselves.[21] However, it may be the case that some of these risks, to the extent that they are real risks, would not be insurmountable. We welcome further views on this option.

2.34 A further alternative would be to establish a more targeted version of the existing system of Parliamentary oversight. In effect, a small number of decisions could be subject to approval by the Secretary of State and contained in a statutory instrument. This could be limited to certain areas where there is a significant public interest in the decisions of the regulators, such as for example their constitution orders and fitness to practise rules. This has the advantage that the relevant rules would be made by the regulator, and not by Government, but are nonetheless subject to Parliamentary scrutiny.

2.35 We also propose to abolish the separate power of the regulators to issue standing orders. This would not prevent Councils adopting normal standing orders to regulate the way that they conduct their business, as any organisation might do. But statutory authority is not necessary for such a step. On the other hand, if the statutory power to make standing orders is in fact being used to implement measures which should really be in the form of rules, the wider powers we are provisionally proposing should make that unnecessary.

2.36 Finally, we do not think it is necessary to perpetuate any distinction – if indeed there is one – between rules and regulations in the new statute. In effect the statute would provide that all the statutory powers of the regulators can be implemented by rules, instead of by a mixture of rules and regulations.

Provisional Proposal 2-3: The regulators should be given broad powers to make or amend rules concerning the exercise of their functions and governance without any direct oversight, including Privy Council approval and Government scrutiny (subject to certain safeguards).

Question 2-4: Would the perceived status of legal rules be less clear or certain without Parliamentary approval? Should the CHRE be given an active role in scrutinising new rules, or should a limited number of the rules be subject to Secretary of State approval and contained in a statutory instrument?

Provisional Proposal 2-5: The power of the regulators to issue standing orders should be abolished.

Provisional Proposal 2-6: The regulators should have the ability to implement their statutory powers by making rules, instead of a mixture of rules and regulations.

[21] The Health and Social Care Bill 2011 proposes that the Council will in future be financed through a levy on the regulatory bodies.

PUBLIC CONSULTATION

2.37 Consultation can be an important procedure through which the regulators are held to account by the public for the exercise of their statutory functions. When performing specific tasks – such as the issuing of guidance, codes of conduct, regulations, rules, competencies and standards – the regulators are normally required to consult extensively.

2.38 Some of the consultation requirements include duties to consult specific groups. For example, the General Chiropractic Council is required to consult representatives of practising chiropractors before issuing or varying a code of practice and the General Optical Council when making rules in relation to its Companies Committee must consult organisations that "represent the interests of substantial numbers of business registrants".[22] In places, the legislation also requires the regulators to consult internally with one of its statutory committees; for example, the General Osteopathic Council must consult its Education Committee on matters relating to education, training, examinations or tests.[23]

2.39 Some of the consultation requirements are more general. For example, the General Social Care Council is required "to consult any persons it considers appropriate to consult" before issuing or varying a code of practice.[24] Some of these general duties to consult include an illustrative list of consultees. For example, the General Pharmaceutical Council is required before undertaking most of its functions to consult such persons it considers appropriate, including:

(1) registrants;

(2) employers of registrants;

(3) professional bodies or organisations appearing to the Council to represent registrants;

(4) users of the services of registrants;

(5) persons or bodies commissioning or funding the services provided by registrants or at registered pharmacies;

(6) persons carrying on a retail pharmacy business at a registered pharmacy; and

(7) persons or bodies providing, assessing, regulating or funding education and training.[25]

2.40 Similar illustrative lists are contained in the governing legislation of the Health Professions Council and Nursing and Midwifery Council, although the

[22] Chiropractors Act 1994, s 19(3) and Opticians Act 1989, s 3(3).

[23] Osteopaths Act 1993, ss 11(3) and 14(6).

[24] Care Standards Act 2000, s 62.

[25] Pharmacy Order 2010, SI 2010 No 231, arts 5, 36 and 66.

requirement is not to consult any appropriate person but any appropriate representative of any these groups.[26]

2.41 Duties to consult do impose certain legal standards, including the following:

(1) consultation must take place at a time when proposals are still at a formative stage, so the decision maker must have an open mind;

(2) the authority must give sufficient reasons for a proposal so as to enable intelligent consideration and response;

(3) adequate time must be given for consideration of the proposals by consultees; and

(4) consultation responses must be conscientiously taken into account when the ultimate decision is taken. [27]

2.42 In addition, the duties imposed on the regulators to consult are subject to the requirements of the Equality Act 2010 including having due regard to the need to eliminate discrimination and to advance equality of opportunity in relation to, for example, age, disability, gender and race.[28] This should mean that the regulators engage in a meaningful way with a diverse range of individuals and communities and that, for example, consultation documents are provided in a range of accessible formats and events are publicised widely.

Provisional view

2.43 It is essential for the regulators to consult widely before issuing or setting for example guidance, codes of conduct, fees, rules, competencies and standards. This ensures that the regulatory bodies command the confidence of the public, registrants and other key groups who are involved with, or affected by, professional practice. Duties to consult can also ensure that the regulators remain subject to some degree of public scrutiny and accountability. Indeed, under our proposed system with the removal of the Privy Council and Government roles, the importance of consultation as a means of holding the regulators to account is heightened.

2.44 For all the importance of public law standards for consultation, it is important to recognise that duties to consult are limited and do not impose any requirement to accept or act in accordance with the views, including those of the majority, expressed at consultation.

2.45 In our view, the current legal framework which imposes different consultation requirements on individual actions or decisions is unnecessarily complex. We propose that the statute itself should set out a core central duty to consult which is imposed on each regulator before it issues or varies:

[26] Health Professions Order 2001, SI 2002 No 254, art 3(14) and Nursing and Midwifery Order 2001, SI 2002 No 253, art 3(14).

[27] *R v North and East Devon Health Authority ex p Coughlan* [2001] QB 213, 258.

[28] Equality Act 2010, s 149.

(1) that which is binding (such as fitness to practise rules and fees);

(2) that which sets a benchmark or standard without being binding as such (for example a Code of Conduct); and;

(3) a competency (such as a standards of proficiency).

2.46 We welcome views on whether this is the correct approach and in particular whether it is realistic for there to be consultation on every variation of a rule, guidance, competencies or standards.

2.47 Although we can see advantages in having a simple statement in the statute to the effect that a regulator must consult any person(s) it considers appropriate to consult, we think that the inclusion of an illustrative list is a useful way of assisting legal clarity and encouraging the regulators to consult widely. We therefore propose that the statute should require the regulators to consult such persons as it considers appropriate, including:

(1) members of the public,

(2) patients and other users of the services of registrants;

(3) registrants (including business registrants);

(4) employers of registrants;

(5) the other health and social care professional regulators covered by the statute, the Council for Healthcare Regulatory Excellence, the health and social care inspectorates, the independent safeguarding authorities and any other regulatory bodies;

(6) the Department of Health, Northern Ireland Executive, Scottish Government and Welsh Government;

(7) professional bodies or organisations appearing to the Council to represent registrants;

(8) persons or bodies commissioning or funding the services provided by registrants or at a registered premises/business.

2.48 It is important to emphasise that the proposed list of consultees is non-exhaustive and the regulators would be expected to consult other groups as appropriate.

2.49 The above list represents a consolidation and streamlining of the existing provisions, but with some additions. In our view, it is particularly important to include an express requirement to include members of the public, patients and service users in consultation. Public engagement may be particularly challenging since interest in the system of regulation often arises only when something is perceived to have gone wrong. It is therefore important for the statute to ensure that regulators continue to encourage whenever appropriate full public engagement. We welcome further views on this proposed list and in particular on whether any categories could be added or removed.

2.50 We do not think it is necessary for the statute to specify matters such as the format, timeframe and requirement to follow up with a formal response. These and other matters are already covered by other legal provisions, such as the Equality Act 2010 and the standards identified in *Coughlan* set out above.

2.51 As well as duties to consult the public, the statute would also place duties on the regulators to inform the public about its work. This is discussed in Part 4.

Provisional Proposal 2-7: The statute should require the regulators to consult whenever issuing or varying anything which is binding, anything which sets a benchmark or standard, and a competency. The regulators should be required to consult such persons it considers appropriate, including:

(1) members of the public, patients and service users;

(2) registrants (including business registrants);

(3) employers of registrants;

(4) the other health and social care professional regulators, the Council for Healthcare Regulatory Excellence, the health and social care inspectorates, the independent safeguarding authorities and any other regulatory bodies;

(5) the Department of Health, Northern Ireland Executive, Scottish Government and Welsh Government;

(5) professional bodies that represent registrants;

(6) persons or bodies commissioning or funding the services provided by registrants or at a registered premises/business.

PARLIAMENTARY ACCOUNTABILITY

2.52 As described in Part 1, the regulators have historically been seen as accountable to registrants through the system of self-regulation. However, in law it has always been the case that as statutory bodies, the regulators are accountable to the UK Parliament (and in some cases also to the devolved assemblies).

2.53 The Privy Council is theoretically the main accountability mechanism. For example, the regulators are required to seek the approval of the Privy Council in order to make or amend rules (see above) and are required to submit certain reports to the Privy Council (see below). The role of the Privy Council has been seen by Government as ensuring that there is some distance between the Government and the regulators, thus giving a measure of independence from Government. It is also claimed that the Privy Council ensures wider cross-Government participation and "is an important part of 'joined-up Government'".[29]

[29] See, http:www//privycouncil.independent.gov.uk/work-of-the-privy-council-office/professional-bodies/ (last visited 15 February 2012).

2.54 The role of the Privy Council in holding the regulators to account is a historical feature of the legislative framework which is by common consent a formality.[30] The secretariat defers to the relevant Government department when it is required to act. In the case of health care professional regulation, it is left to the Department of Health and their legal group to undertake the vast majority of the matters formally allocated to the Privy Council. In effect, the Department is the active player in developing, scrutinising and securing the approval of draft rules and regulations and the requirement on the regulators to submit reports to the Privy Council is regarded as nothing more than "a post box to the Department of Health".[31]

2.55 However, the role of the executive in holding the regulators to account can be viewed as problematic. A key principle of health and social care professional regulation is that the regulators should be autonomous bodies, independent of the Government, and constitutionally insulated from day-to-day political pressures.[32] The need for independence is particularly important because in many situations professionals act as agents of the state (for example, assessing access to work and for detention under the Mental Health Act 1983) and it may be important for public confidence that they are seen to do so in a way that is independent and just. The current system, which is heavily reliant on input from the Department of Health and its legal advisers, is at odds with the need to ensure such independence.

2.56 In recent times, there have been attempts to bolster the Parliamentary accountability of the regulators. First, the Council for Healthcare Regulatory Excellence, itself a statutory body and accountable to Parliament, has been given responsibility for reviewing the operation of the regulators. The Council undertakes a programme of detailed scrutiny of each of the regulators, the results of which are published annually in a performance review. The performance review is laid in Parliament and the devolved assemblies (see Part 10).

2.57 In 2008, the Government asked Niall Dickson, then Chief Executive of the Kings' Fund, to chair a working group on enhancing public confidence in the regulators. The report recommended that Parliament should consider establishing a joint committee of both Houses to enhance Parliamentary accountability. The recommendation envisaged this Committee's work tying in with the Council for Healthcare Regulatory Excellence's performance review function, such that the Committee could question the regulators and hold them to account on the basis (in part) of the Council's findings.[33]

[30] See, for example, House of Commons Health Committee, Revalidation of Doctors: Fourth Report of Session 2010–11, HC 557, para 4.

[31] Department of Health, *Implementing the White Paper Trust, Assurance and Safety: Enhancing Confidence in Healthcare Professional Regulators: Final Report* (2008) para 3.4.

[32] See, for example, Trust, Assurance and Safety – the Regulation of the Health Professions in the 21 Century (2007) Cm 7013, paras 1.5 to 1.7.

[33] Department of Health, *Implementing the White Paper Trust, Assurance and Safety: Enhancing Confidence in Healthcare Professional Regulators: Final Report* (2008).

Provisional view

2.58 Given the considerable responsibilities that the regulators have for assuring patient and public safety, it is essential that an effective and transparent mechanism for Parliamentary scrutiny is established. The role of the Privy Council can be described as at best symbolic. It lacks both the resources and the mechanisms to hold the regulators to account in any meaningful way, and in practice this role is undertaken by the executive. In our view, the Privy Council does not ensure any distance between the regulators and the Government, it merely masks this relationship. If one of the reasons for retaining the role of the Privy Council is to provide the appearance of wider cross-Government participation, there are more effective and transparent ways for achieving this. We therefore provisionally propose that the formal role of the Privy Council in relation to the health and social care professional regulators should be removed entirely. This is not just in relation to the approval of rules but also its other roles (such as its default powers, see below).

2.59 However, it is important to emphasise that the views we express about the role of the Privy Council in this context should not be read across into other sectors. This includes the role of the Privy Council in relation to the regulation of universities.

2.60 It has been suggested that removing the Privy Council entirely would result in the Office for National Statistics reclassifying the regulators as non-departmental public bodies rather than private sector bodies. This would bring them within the Government's accounting framework and impose other requirements which would reduce the operational flexibility of the regulators. We doubt that a mere formality like the role of the Privy Council could have such a significant effect. As a matter of substance, it is clear that the Councils are not and should not be regarded as non-departmental public bodies.

2.61 It is a matter for Parliament to determine how it should organise itself to perform its constitutional functions, and we would not consider it appropriate to make final recommendations to Parliament on such questions. Nevertheless, the proposal for a Joint Committee of both Houses of Parliament is clearly attractive. In our view it would ensure that the performance of the regulators would be subject to a high degree of Parliamentary scrutiny. The Committee would have the time and resources to build up a high level of expertise, and would have the capacity to hold evidence sessions every year with each regulator; and it would be able to hold the Council for Healthcare Regulatory Excellence itself to account.

2.62 However, the establishment of such a Committee would be a major departure for both Houses. In particular, there are currently only a limited number of Joint Committees, established for very specific purposes. We think that Parliament would only be likely to sanction such a significant step in the context of a wider reform of Parliament's role in relation to arms length regulators generally. Resource constraints on Parliament itself also militate against the introduction of a Joint Committee.

2.63 In the last year, the House of Commons Health Select Committee has announced that "in the absence of a mechanism which makes [accountability to the Privy Council] effective, we intend to exercise this function ourselves, on behalf of

Parliament".[34] It is likely that the Health Committee had the proposal for a Joint Committee in mind when it made this commitment. In pursuance of this objective, the Committee has undertaken an inquiry into the revalidation of doctors and has held annual accountability hearings with the General Medical Council and the Nursing and Midwifery Council.[35]

2.64 In the nature of things, inquiries by the Health Committee will be more limited than a Joint Committee dedicated solely to this role. The Health Committee's remit is far wider than professional regulation and includes most aspects of health and social care provision, and therefore it would only be able to investigate some of the regulators at relatively infrequent periods. Members will necessarily be interested in a wide range of health and social care matters, and so could not be expected to acquire the level of expertise of a dedicated Joint Committee.

2.65 Nevertheless, if it were to become an accepted and regular part of the work of the Heath Committee, annual accountability hearings would constitute a major and very welcome extension in the Parliamentary accountability of the regulators. The effectiveness of such hearings would be enhanced if they were co-ordinated with the reporting round of the Council for Healthcare Regulatory Excellence. That would enable the Committee to take evidence from both the oversight body and those overseen on the basis of the performance reviews. While no doubt the Committee would usually expect to regularly call only the General Medical Council and the Nursing and Midwifery Council, it would be advantageous if, each year, it considered calling one or more of the other regulators, perhaps on the basis of questions raised in that regulator's performance review.

2.66 We also consider that, given the devolved legislatures' legitimate interest in this area (see Part 1), a similar form of accountability should be instituted by the Scottish Parliament, National Assembly for Wales and Northern Ireland Assembly.

Provisional Proposal 2-8: The formal role of the Privy Council in relation to health and social care professional regulation should be removed entirely.

Provisional Proposal 2-9: The House of Commons Health Committee should consider holding annual accountability hearings with the regulators which should be coordinated with the Council for Healthcare Regulatory Excellence's performance reviews. The Scottish Parliament, National Assembly for Wales and Northern Ireland Assembly should also consider instituting similar forms of accountability.

[34] House of Commons Health Committee, Revalidation of Doctors: Fourth Report of Session 2010-2011, HC 557, para 7.

[35] House of Commons Health Committee, Revalidation of Doctors: Fourth Report of Session 2010-11, HC 557; House of Commons Health Committee, Annual Accountability Hearing with the Nursing and Midwifery Council: Seventh Report of Session 2010-12, HC 1428; and House of Commons Health Committee, Annual Accountability Hearing with the General Medical Council: Eighth Report of Session 2010-12, HC 1429.

The role of Government

2.67 As noted above, the Government currently plays an active role in overseeing the operation of the regulators. This role is often seen to be in conflict with the principle that the regulators must be free to exercise their statutory functions dispassionately and without undue political pressure from Government.

2.68 Our view is that it is, indeed, right for the regulators to be protected from Government interference. But at the same time, Government does have a legitimate interest in the proper regulation of health and social care professionals, and a legitimate role to play. Government is responsible for the overall design of the regulatory system; and certain decisions can, we think, only properly be taken by Government. These include decisions on matters that require a political policy decision to be made, including matters where there is a sufficient public interest and matters that give rise to questions about the allocation of public resources. Examples include decisions to establish new regulators and extend regulation to new professional groups (see below), extending protected titles and functions (see Part 5) and introducing new sanctions (see Part 9). For such decisions, we believe that the Secretary of State should continue to have the main responsibility.

Provisional Proposal 2-10: The Secretary of State should be given formal powers to make decisions on matters that require a political policy decision to be made, including matters where there is a sufficient public interest and matters that give rise to questions about the allocation of public resources.

PUBLICATION REQUIREMENTS

2.69 Requiring the regulators to publish certain information can be an important way of encouraging greater transparency and ensuring that the regulators can be held to account. Many of the regulators are subject to general duties to publish public information. For example, there is a statutory duty imposed on the General Medical Council to publish or provide in such manner as they see fit information about the Council and the exercise of its functions.[36] A similar duty is placed on the General Pharmaceutical Council.[37] Both the Health Professions Council and Nursing and Midwifery Council have a statutory obligation to inform and educate registrants, and inform the public, about its work.[38]

2.70 Since 2008, most of the regulators are required to produce general reports, statistical reports and strategic plans.[39] The exceptions are the General Social Care Council and the Pharmaceutical Society of Northern Ireland. The regulators are required to publish by such a date that the Privy Council shall specify:

[36] Medical Act 1983, sch 1, para 9B(1).

[37] Pharmacy Order 2010, SI 2010 No 231, sch 1 para 6(1).

[38] Health Professions Order 2001, SI 2002 No 254, art 3(13) and Nursing and Midwifery Order 2001, SI 2002 No 253, art 3(13).

[39] See Health Care and Associated Professions (Miscellaneous Amendments) Order 2008, SI 2008 No 1774.

(1) a report on the exercise of its functions including the arrangements that have been put in place to ensure they adhere to good practice in relation to equality and diversity;

(2) a statistical report on the efficiency and effectiveness of its arrangements to protect the public from registrants whose fitness to practise is impaired, and the regulator's observations on the report; and

(3) a strategic plan in respect of such number of years as the regulator shall determine.[40]

2.71 These must be submitted to the Privy Council who must lay copies before each House of Parliament. In addition, the reports of the General Dental Council, General Pharmaceutical Council and Health Professions Council must be laid in the Scottish Parliament.[41] The Council for Healthcare Regulatory Excellence is required to lay its annual report before Parliament, the Scottish Parliament, the National Assembly for Wales and the Northern Ireland Assembly.[42]

2.72 Most of the regulators have similar requirements in relation to the keeping of their accounts. In particular, they are generally required to:

(1) keep proper accounts and prepare annual accounts in respect of each financial year, in such form as the Privy Council may determine;

(2) ensure that their accounts are audited by a statutory auditor under Part 42 of the Companies Act 2006; and

(3) publish the accounts after the end of each financial year and the report by the auditors.

2.73 The laying requirements in relation to the regulators' accounts are exactly the same as those specified above for general reports, statistical reports and strategic plans.[43] Before their accounts are laid before Parliament, the General Dental Council, General Social Care Council, Health Professions Council and Nursing and Midwifery Council are required to send a copy of the annual accounts and the auditors report to the Privy Council, the Comptroller and Auditor General and where appropriate the Auditor General for Scotland.

Provisional view

2.74 In our view the existing reporting requirements are an important aspect of ensuring that the regulators act in a transparent manner and can be held to account. We provisionally propose to maintain and in some areas expand the existing reporting requirements. First, the statute would place a duty on each

[40] See, for example, Opticians Act 1989, s 32A.

[41] Dentists Act 1984, s 2B, Pharmacy Order 2010, SI 2010 No 231, sch 1 para 8(2) and Health Professions Order 2001, SI 2002 No 254, art 44(2).

[42] NHS Reform and Health Professions Act 2002, sch 7, para 16(2).

[43] Dentists Act 1984, s 2C, Pharmacy Order 2010, SI 2010 No 231, sch 1 para 7(4), Health Professions Order 2001, SI 2002 No 254, art 46 and NHS Reform and Health Professions Act 2002, sch 7, para 15.

regulator to provide information to the public and registrants about its work. The Council for Healthcare Regulatory Excellence and the Equality and Human Rights Commission would both continue to play a role in this area by monitoring the implementation of this duty and ensuring that the regulators comply with their duties under the Equality Act 2010 to provide information that is accessible for disabled people and other people who may need special arrangements.

2.75 Second, we think that the reporting requirements in relation to annual reports, statistical reports, strategic plans and accounts should be expanded to include in all cases the Scottish Parliament, the National Assembly for Wales and the Northern Ireland Assembly. This is on the basis that health and social services provision and education are devolved matters and it is therefore important that the legitimate interests of the devolved assemblies are appropriately reflected in the legal structure, and they are assisted in being made fully aware of the work of the regulators.

2.76 Furthermore, we believe that the regulators themselves should be responsible for laying the reports in the various legislatures. This in part reflects our proposal above to remove the role of the Privy Council. But we also think that this proposal underlines the importance of the regulators' direct accountability to Parliament and the devolved assemblies. This task can be undertaken by the regulators as statutory bodies without going through the Department of Health or Privy Council. In addition, the Council for Healthcare Regulatory Excellence's reports and accounts will continue to be required to be laid before Parliament, the Scottish Parliament, the National Assembly for Wales and the Northern Ireland Assembly.

2.77 As noted above, some of the regulators are required to send a copy of their accounts to the Comptroller and Auditor General and/or to the Auditor General for Scotland who must examine, certify and report on the annual accounts. In our view this generates a lot of bureaucracy and it is not clear that it enhances accountability in any meaningful way. We therefore propose that the requirement to send accounts to the Comptroller and Auditor General or to the Auditor General for Scotland should be removed.

Provisional Proposal 2-11: The statute should place a duty on each regulator to provide information to the public and registrants about its work.

Provisional Proposal 2-12: Each regulator and the CHRE should be required to lay copies of their annual reports, statistical reports, strategic plans and accounts before Parliament and also in all cases the Scottish Parliament, the National Assembly for Wales and the Northern Ireland Assembly.

Provisional Proposal 2-13: The statute should not require the regulators to send a copy of their accounts to the Comptroller and Auditor General or to the Auditor General for Scotland.

SECTION 60 ORDERS

2.78 Until the Health Act 1999 was implemented, the creation and amendment of the regulators' governing statutes and orders was through primary legislation. The governing statutes and orders can now be amended by Her Majesty by Order in Council under powers contained in section 60 of the Health Act 1999. As noted

earlier in this Part, Orders *in* Council differ from Orders *of* Council since they must be approved by the Queen.

2.79 A section 60 order may make provision, in relation to any of the regulated professions, for a number of matters including the following:

(1) the establishment and continuance of a regulatory body;

(2) the keeping of a register of members admitted to practise;

(3) the education and training before and after admission to practise;

(4) the privileges of members admitted to practise;

(5) standards of conduct and performance;

(6) discipline and fitness to practise;

(7) investigation and enforcement by or on behalf of the regulatory body;

(8) appeals; and

(9) the default powers exercisable by a person other than the regulator.[44]

2.80 However, the section 60 order procedure cannot be used to abolish any existing regulatory body within the remit of the Council for Healthcare Regulatory Excellence, and may not impose any requirement that would have the effect of excluding a majority of the members from the register. The procedure cannot also be used to remove any function of any existing regulatory body.[45]

2.81 Over the last 10 years 18 such orders have been made. These include the section 60 orders which established the General Pharmaceutical Council and the Health Professions Council, and those which have extended statutory regulation to new professional groups.[46] Many of the proposals for section 60 orders are initiated by the regulators themselves and are aimed at modernising and improving their legal framework, for example by abolishing certain statutory committees, establishing powers of delegation, amending the requirements for registration and enabling detailed fitness to practise rules to be made.[47]

2.82 The formal process for a section 60 order is as follows:

(1) the Secretary of State must publish a draft and invite representations from representatives of any profession to be regulated and service users, and any other persons appropriate to consult about the draft;

[44] Health Act 1999, sch 3, para 1.

[45] As above, para 7.

[46] For example, Health Professions (Hearing Aid Dispensers) Order 2010, SI 2010 No 233.

[47] For example, Medical Act 1983 (Amendment) Order 2002, SI 2002 No 3135.

(2) if any provision of the draft amends or repeals any enactment that applies in Scotland, the Secretary of State must also consult the Scottish Ministers;

(3) after the end of the period of three months beginning with the publication of the draft, the Secretary of State may lay the draft (including any revisions as he or she sees fit) together with a report about the consultation before Parliament;

(4) if any provision of the draft falls within the legislative competence of the Scottish Parliament then step (1) above must also be performed by the Scottish Ministers;

(5) the draft must be approved by an affirmative resolution of each House of Parliament. Any Order in Council is subject to annulment through a resolution of either House of Parliament; and

(6) if any provision lies within the legislative competence of the Scottish Parliament, it must additionally have been laid before, and approved by, a resolution of the Scottish Parliament prior to any recommendation to Her Majesty being made.[48]

2.83 A section 60 order takes about two years between Ministerial commitment and full implementation.[49]

Provisional view

2.84 The need for section 60 orders has arisen due to the current inadequate legal framework which gives most of the regulators limited and inflexible legal powers. The main advantage of section 60 orders is that they can be initiated at any time without waiting for an Act of Parliament, and so they are more flexible.

2.85 Under our proposed legal framework the need for a section 60 order making power is reduced. The aim of our reforms is to provide the regulators with a broad range of powers to introduce rules, which would give the regulators greater freedom to reform their legal framework in the light of their circumstances and resources. In effect, a more flexible legal framework should replace the need for section 60 orders.

2.86 However, section 60 orders are also the mechanism through which the Secretary of State can introduce reforms which require a political policy decision and the allocation of resources. Examples of such reforms include establishing a new regulatory body and extending statutory regulation to new professional groups. These types of reforms are in our view properly matters for Government, rather than individual regulators. Therefore, the section 60 power could usefully be retained in our scheme for these limited purposes.

[48] Health Act 1999, sch 3, para 9.

[49] Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers (2011) Cm 8008, para 3.5.

2.87 But the retention of section 60 orders means that the Privy Council would retain a role in the new legal structure, albeit a minor role in advising Her Majesty before such orders are made. As set out above, we propose to establish a legal scheme where Government responsibility is transparent, and the role of the Privy Council is removed. It is also not necessary for the new statute to include a section 60 order power. It could be left to the Secretary of State to amend the primary legislation by introducing a new Act of Parliament in order to, for example, add to the number of regulators. The disadvantage would be the increased time and expense for the introduction of such reforms.

2.88 An alternative option would be to give the Secretary of State powers to issue regulations on certain matters, such as the establishment, abolition or merger of regulatory bodies and the exercise of default powers. These decisions could be made subject to certain criteria being satisfied – for example, that any reforms are necessary in order to protect the public – as well as Parliamentary approval. On balance, we prefer this option since it would establish greater transparency and introduce new bespoke safeguards for individual decisions. Precise examples of this regulation-making powers are discussed in the rest of this Part.

2.89 We therefore provisionally propose that the section 60 order making power should be repealed. Instead regulators will be given broad powers to update their legal framework. In areas where political decisions need to be made and Government resources allocated, we propose that the Act should allocate responsibility clearly to the Government by introducing a series of regulation-making powers.

Provisional Proposal 2-14: The order making power in section 60 of the Health Act 1999 should be repealed and instead the Government should be given regulation-making powers on certain issues.

THE NUMBER OF REGULATORS AND REGULATED PROFESSIONS

2.90 There are currently 10 health and social care professional regulators. That number has remained static since the establishment of the Health Professions Council in 2001. The number of regulators will be reduced to nine when the General Social Care Council's functions are transferred to the Health Professions Council. It is possible that the number of regulators will change again in the future either as a result of the mergers of existing regulators, the establishment of new regulatory bodies, or even bringing groups out of regulation.

2.91 As set out in table 2 above, there are currently 32 registered health and social care professions in the UK. This number will increase to 33 with the introduction of registration for practitioners of herbal medicine, which includes medical herbalists, traditional Chinese medicine practitioners and other practitioners who use unlicensed herbs in their practice. These practitioners will fall within the remit of the Health Professions Council.[50] It is possible that the number of regulated professions could reduce in the future as a result of the merger of existing professions or bringing groups out of regulation, or increase if new professional groups are brought within the regulatory framework.

[50] As above, para 4.113.

Government policy

2.92 Government policy on future mergers of regulators recognises "the disruption and professional concern that centrally imposed consolidation can cause" but nonetheless:

> should any regulators wish to propose mergers with other regulatory bodies to reduce costs as part of this work, the Government will view these proposals sympathetically.[51]

2.93 As an alternative to mergers, the Council for Healthcare Regulatory Excellence has been commissioned to undertake a sector wide review of the cost-efficiency and effectiveness of each regulator. But if cost reductions are not forthcoming over the next three years, "then the Government will revisit the issue of consolidating the sector into a more cost-effective configuration".[52]

2.94 The Government has stated that it does not support the extension of statutory regulation to all health and social care workers in the UK. Instead, a system of voluntary registration is to be introduced for professionals and occupational groups which are currently not subject to statutory professional regulation. The Council for Healthcare Regulatory Excellence will act as the national accrediting body, and will set standards against which the governance, procedures, registration criteria and performance of voluntary registers will be judged.[53] Voluntary registers are discussed in Part 5.

Provisional view

2.95 We make no provisional proposals in relation to the number of regulatory bodies or regulated professions. This is a matter for the Government to decide in the light of political policy and resource considerations. However, it is important for the new statute to be future proofed and allow for the development of policy in these areas. It may be the case that in the future a number of the existing regulators decide to merge and/or Government may decide that new regulatory bodies are needed or to extend regulation to other occupational groups.

2.96 Section 60 orders are the main mechanism through which such reforms are achieved currently, although as noted above they do not allow for the abolition of any of the existing regulators.

2.97 We provisionally propose that a regulation-making power should be included in the statute which would allow the Secretary of State to abolish or merge any existing regulator, or to establish a new regulatory body. In addition, the Secretary of State would be given the power to add new professional groups to, or remove professional groups from, the statute.

2.98 However, before using these powers the Government would be required to undertake a full public consultation. Furthermore, the Secretary of State must be satisfied that the use of these powers does not undermine in any way the health,

[51] As above, paras 2.6 to 2.7.

[52] As above, para 2.7.

[53] As above, paras 4.1 to 4.14.

safety and well-being of the public. This must be evidenced in a report by the Secretary of State. Finally, the report and the draft regulations must be laid before Parliament. The statutory instrument would be subject to the affirmative resolution procedure, requiring approval by both Houses of Parliament. It would also be subject to scrutiny by the House of Lords Merits of Statutory Instruments Committee. Thus, Parliament would retain oversight of any proposals to extend regulation and protection of title to unregulated occupational groups, or to deregulate currently regulated groups of staff.

2.99 We recognise concerns that this proposal may be perceived as weakening the existing position in relation to the abolition of a regulator. This currently falls outside the section 60 order system, and can only take place through the introduction of primary legislation. We welcome views on whether this decision should similarly be outside the proposed regulation-making power.

2.100 Currently the Health Professions Council has a statutory power to make recommendations to the Secretary of State and Scottish Minsters concerning any profession which it believes should be regulated pursuant to section 60 of the Health Act 1999.[54] We do not believe that this power is necessary given that there is nothing in law to prohibit any regulator making such a recommendation. We think that it might be more appropriate for the Council for Healthcare Regulatory Excellence to be given an express power to recommend a profession for statutory regulation, or the removal of a profession from statutory regulation. Although the Government would not be required to comply with any such recommendation, it would be required to set out in a report its reasons for not doing so.

Provisional Proposal 2-15: The Government should be given a regulation-making power to abolish or merge any existing regulator, or to establish a new regulatory body. This power would also enable the Government to add new professional groups to, or remove professional groups from, statutory regulation.

Question 2-16: Should the CHRE be given a power to recommend a profession for statutory regulation, or the removal of a profession from statutory regulation? If the Government decided not to comply, it would be required to issue a report setting out its reasons.

THE DEFAULT POWERS OF THE PRIVY COUNCIL

2.101 Most of the governing legislation includes an express provision whereby if a regulator has failed to perform any of its functions, the Privy Council can issue a direction, and if the regulator fails to comply with the direction the Privy Council may give effect to the direction.[55] The only legislation which does not include such a provision is the Dentists Act 1983, The Pharmacy Order 2010 and the Pharmacy (Northern Ireland) Order 1976. In relation to the General Social Care Council, the default powers are exercisable by the Secretary of State.[56] In

[54] Health Professions Order 2001, SI 2002 No 254, art 3(17)(a).

[55] See, for example, Chiropractors Act 1994, s 34 and Medical Act 1983, s 50.

[56] Care Standards Act 2000, s 113.

addition, an order made under section 60 of the Health Act 1999 enables the governing legislation to be amended by Order in Council to make provision for default powers exercisable by a person other than the regulatory body.[57] To this date, no such directions or section 60 orders have been made.

2.102 At the Health Professions Council and the Nursing and Midwifery Council, the Privy Council is given powers to initiate a public inquiry on any matter connected with the exercise by the Councils of their functions.[58]

Provisional view

2.103 It is important for the new legal framework to retain a power of last resort to intervene if a regulator is failing to meet its statutory duties. This helps to ensure for example the protection of the public in the case of an emergency and in other situations. Furthermore, the need for such powers may be particularly important in our proposed legal framework which will give the regulators more powers.

2.104 Powers exercised in the name of the Privy Council are in fact exercised by the Government. We think that the new statute should be transparent and make that the default powers directly exercisable by the Government.

2.105 We provisionally propose that the Government should be given powers to issue a direction in circumstances where a regulator has failed to perform any of its functions, and if the regulator fails to comply with the direction, to allow the Government to give effect to the direction. Although directions do not need to be laid in Parliament, the Health Committee would still be able to investigate the use of directions as part of its oversight role in relation to health and social care professional regulation.

2.106 We also think that the statute should provide that in the most serious of cases the Secretary of State should be given powers to exercise certain functions of a regulator or appoint a nominee to do so. This would be similar to the Secretary of State's powers under section 15(6) of the Local Government Act 1999 and would be a power of last resort for the Government to intervene directly and take over a regulator which is failing to carry out its statutory functions.

2.107 We do not propose that the Government should have express powers in the statute to initiate a public inquiry. In our view, this is not necessary since the Government can initiate a public inquiry anyway on any matter connected with the exercise by the regulators of their functions.[59]

Provisional Proposal 2-17: The Government should be given powers to issue a direction in circumstances where a regulator has failed to perform any of its functions, and if the regulator fails to comply with the direction, the Government may itself give effect to the direction (see also provisional proposal 13-2).

[57] Health Act 1999, sch 3, para 1(j).

[58] Health Professions Order 2001, SI 2002 No 254, art 47 and Nursing and Midwifery Order 2001, SI 2002 No 253, art 53.

[59] See, for example, Inquiries Act 2005.

Provisional Proposal 2-18: The Government should be given powers to take over a regulator which is failing to carry out its functions.

Provisional Proposal 2-19: The Government should not have express powers in the statute to initiate a public inquiry. This would continue to be provided for under other existing Government powers.

DEVOLVED RESPONSIBILITIES

Scotland

2.108 As we explained in Part 1, whether the Scottish Parliament should retain its current legislative competence in relation to professional regulation is a matter of controversy; and where responsibility *should* lie is not part of our project. If the current proposals in the Scotland Bill 2010 are not enacted, therefore, it is important to carry forward the current powers of the Scottish Parliament into our proposed new system.

2.109 Our proposals would not affect the Scotland Act 1998, and accordingly the Scottish Parliament would continue to have legislative competence in relation to operating department practitioners, practitioner psychologists, dental nurses, dental technicians, clinical dental technicians, orthodontic therapists, and pharmacy technicians. Importantly, the Scottish Parliament would also have legislative competence in relation to new groups brought into professional regulation.

2.110 We do, however, propose the repeal of section 60 of the Health Act 1999, the principal modern tool for legislation on healthcare professional regulation. Where a section 60 order is to be made in respect of a profession for which the Scottish Parliament has legislative competence, it must be consulted on by Scottish Ministers and laid before the Scottish Parliament as well as the UK Parliament.

2.111 We propose above the replacement of section 60 with a broadly comparable power. It is therefore necessary to preserve the existing powers of the Scottish Parliament under section 60 in the context of this proposed replacement. On the assumption that the Scotland Bill 2010 does not become law, therefore, we provisionally propose that the replacement power should contain provisions equivalent to those in section 60.

The Pharmaceutical Society of Northern Ireland

2.112 The Pharmaceutical Society of Northern Ireland is responsible for the regulation of the pharmacy profession in Northern Ireland. It was created in 1925 by the Pharmacy and Poisons Act (Northern Ireland) 1925 and derives most of its present legal powers from the Pharmacy (Northern Ireland) Order 1976. The Society maintains a register of approximately 2000 pharmacists and 500 pharmacy premises in Northern Ireland.[60]

2.113 The Society is different from the other professional regulators in several ways. First, the functions of the Society include both regulation and professional

[60] Pharmaceutical Society of Northern Ireland, *Annual Report and Accounts 2010/11* (2011).

representation.[61] Second, the Society's Council members are elected instead of being appointed.[62] Third, the Society's Registrar is appointed by the Department of Health, Social Services and Public Safety, whereas the other regulators' Registrars are appointed by their Councils.[63] Fourth, the Society currently has no provision for the investigation of fitness to practise cases. As described in Part 8, this is normally undertaken by the Department of Health, Social Services and Public Safety. Finally, the Society is only able to use the single sanction of removal from the register in fitness to practise cases.[64]

2.114 The Northern Ireland Assembly has recently legislated to reform many aspects of the Society's legal framework. For example, the Council of the Society will be appointed by the Department of Health, Social Services and Public Safety, consisting of seven lay members and seven registrants. The Council will delegate all professional leadership duties to a new Professional Forum Board, which is a members-led body consisting of eight elected members and three members nominated by professional bodies. The Society will be required to set standards for the practice of pharmacy and continuing professional development. A new Scrutiny Committee will be established to investigate allegations of impaired fitness to practise. Furthermore, the Statutory Committee, which deals with fitness to practise cases, will be reconstituted and given new powers.[65]

Provisional view

2.115 The Pharmaceutical Society of Northern Ireland is in a very different historical position to that of the other regulators. Its position as a regulator in a single jurisdiction means that the general approach to professional regulation may have to be adapted in its case.

2.116 Many of the proposed reforms in this consultation paper would amount to a significant reconfiguration of the role of the Society, even taking into account the recent reforms. The most striking example would be the removal of its professional representative functions.

2.117 We do not propose that any such reforms should be imposed on the Society. Given the context, this is properly a matter for the Northern Ireland Executive and the Society to decide. Nonetheless we do believe that the proposals made in this consultation paper would be of benefit to the Society and we would wish to leave open the option of their entering into the new legal framework.

2.118 One option for reform would be to retain the Pharmacy (Northern Ireland) Order 1976 as a separate standalone piece of legislation alongside the new legal framework. Alternatively it could be retained in the new statute as a separate Part. We would prefer the latter. One of the advantages of the proposed scheme is that it allows all UK health care professional regulation law to be located in one place.

[61] Pharmacy (Northern Ireland) Order 1976, SI 1976 No 1213, art 3.

[62] As above, sch 2 para 12.

[63] As above, art 9(1).

[64] As above, art 20(1).

2.119 But we also consider it important to enable the Society to incorporate itself into the mainstream legal framework of the new statute. We therefore propose that the Government's regulation-making power in relation to the number of regulators (see provisional proposal 2-15 above) should include a specific provision to incorporate the Society in the main legal framework of the new statute. The use of such a power would first need to be approved by the Northern Ireland Assembly.

2.120 A hybrid approach, in addition to creating a separate Part and providing for the regulation-making power, would be to apply specific reforms to the Society. Thus it could, for instance, retain its distinct structure, but have available the general range of sanctions we propose in Part 9. We therefore invite views on which, if any, of our specific reforms should be applied piecemeal to the Society.

Provisional Proposal 2-20: If the Scotland Bill 2010 does not become law, any use of the proposed regulation-making power set out in provisional proposal 2-14 in respect of a profession for which the Scottish Parliament has legislative competence, must be consulted on by Scottish Ministers and laid before the Scottish Parliament as well as the UK Parliament.

Question 2-21: Should the Pharmacy (Northern Ireland) Order 1976 be reconstituted and retained as a separate part of the new statute?

Question 2-22: Should the proposed regulation-making power set out in provisional proposal 2-15 include a general provision to incorporate the Pharmaceutical Society of Northern Ireland into the main legal framework of the new statute (following approval by the Northern Ireland Assembly)?

Question 2-23: Which, if any, of the specific proposals which follow in this consultation paper should be applied to the Pharmaceutical Society of Northern Ireland?

IMPLEMENTATION ISSUES

2.121 The introduction of the new statute will inevitably lead to a number of challenges. One of the main difficulties will relate to how the implementation of the new law will deal with cases that have been opened under the previous system. For example, in Australia the Health Practitioner Regulation and National Law Act 2009 which introduced a unified scheme for health professional regulation, provided that cases that had been received but were not "being dealt with" under the previous legal regime would be considered under the new Act, while any cases already being dealt with would fall under the old law.[66]

2.122 This led to some confusion in relation to when a complaint was being dealt with by a regulator. For example, some regulators interpreted this as excluding cases which had gone through initial screening but where no formal proceedings had been undertaken. Ultimately, a large number of complaints fell under the previous

[65] Pharmacy (1976 Order) (Amendment) Order (Northern Ireland) 2012.

[66] Health Practitioner Regulation and National Law Act 2009, ss 228 and 229.

legislation which caused some problems, for example with different criteria being applied to fitness to practise decisions and some forms of sanctions not being available under the old regime. Other transitional issues included dealing with the renewal of suspensions which were in place during the changeover and the re-registration of practitioners who had conditions placed on their practice under the old regime.

2.123 The General Pharmaceutical Council faced a similar situation when it inherited the legacy cases from the Royal Pharmaceutical Society of Great Britain. However, the difficulties were alleviated to some extent by the provisions of the Pharmacy Order 2010 which enabled the General Pharmaceutical Council to deal with such cases in a manner it considers "just".[67] As of September 2011, the Council was on target to dispose of 589 legacy cases within 15 months, instead of the initial projection of four years.[68]

2.124 A further potential difficulty relates to the repeal/revocation (or amendment) of existing legislation in Acts, Orders in Council or other statutory instruments as a consequential part of setting up the new rules for each profession. There are likely to be resource implications if the regulators are expected or required to start with new rules and it may be necessary to consider a transitory or transitional device pending completion of the change to the new system. Alternatively, it might be possible for the regulators to leave some of the existing laws in place. These issues will need to be explored further with Parliamentary Counsel, but at this stage we welcome views on the practical difficulties that are likely to arise.[69]

Question 2-24: How should the new legal framework deal with cases left over from the previous legal regimes? What practical difficulties are likely to arise from the repeal of existing legislation and rules?

[67] Pharmacy Order 2010, SI 2010 No 231, sch 5, para 12(2)(b).

[68] General Pharmaceutical Council, *Just Disposal of Legacy Cases Guidance* (2010).

[69] See *Davies t/a All Stars Nursery v Scottish Commission for the Regulation of Care* [2012] CSIH *7* for an example of the difficulties caused by transitional provisions.

PART 3
MAIN DUTY AND GENERAL FUNCTIONS OF THE REGULATORS

3.1 One of the distinguishing features of the legal framework for health and social care professional regulation is that each of the various statutes and orders attempts to set a clear overall purpose for the regulator in question. This is despite significant variation in the content of the legislation (see Part 2). The legislation does this by setting a main duty for the regulator in question and general functions. This Part considers the main duties and general functions of the regulators, and how they should be provided for in our proposed statute.

THE MAIN DUTY

3.2 In most cases, the governing legislation specifies a main duty or objective for the regulator when exercising its functions. Although the precise form of wording varies, this duty will normally require the regulator to "protect, promote and maintain the health and safety of the public" and/or those needing the services of registrants.[1] This is referred to as the public protection duty.

3.3 However, the public protection duty is not stated expressly in all the legislation. Most notably the Chiropractors Act 1994 and Osteopaths Act 1993 do not set out such a duty and instead provide that the main duty of the regulator in question is to "regulate and develop the profession".[2] Furthermore, the statutory objectives for the Pharmaceutical Society of Northern Ireland include advancing chemistry and pharmacy and promoting the interests of its members, reflecting the wider remit of the Society compared to the other regulators.[3]

3.4 Appendix B lists the main duty for each regulator and the Council for Regulatory Healthcare Excellence. The only regulator that does not have a main duty or objective is the General Dental Council. Instead the Dentists Act 1984 describes a number of matters that the Council must take into account when exercising its functions.[4] These types of legal provisions are discussed in more detail below.

3.5 In 2008, the Department of Health proposed to introduce a single main duty for all the UK health care regulators. The following form of words was put forward for consultation:

> The main objective of the General Council in exercising such of its functions as affect the health, safety or well-being of members of the public is to protect, promote and maintain the health, safety and well-being of members of the public, and in particular of those members of the public who use or need the services of fully registered or

1 For example, Medical Act 1983, s 1A and Opticians Act 1989, s 2A.

2 Chiropractors Act 1994, s 1(2) and Osteopaths Act 1993, s 1.

3 Pharmacy (Northern Ireland) Order 1976, SI 1976 No 1213, art 3(3).

4 Dentists Act 1984, s 1(1A) and (2).

provisionally registered persons, by ensuring standards which the Council considers are necessary for the safe and effective practice of the registrants' profession.[5]

3.6 However, this proposal was not taken forward in the resulting legislative reforms. The reason given was that respondents supported the principle of giving greater emphasis to the need and importance of public protection, rather than the wording of the provision itself.[6] However, the wording was reflected subsequently in the main duty of the General Pharmaceutical Council introduced in 2010.[7]

3.7 Public protection is a broad objective and can be used to justify various regulatory interventions. The public who need protecting can include the individual complainant, service users, potential service users or the public in general, and the form of intervention may vary depending on which public is identified. For example, if the regulator is seeking primarily to protect the individual complainant then sanctions against the professional may be more likely, whereas if the aim is to protect future service users then the question of rehabilitation may be more relevant. Of course this distinction is not absolute; sanctions protect future service users too, and rehabilitation will benefit the individual complainant if they receive the same care from the professional in the future. Nevertheless, public protection should not be viewed as a "unitary rationale for intervention".[8] The approach of the regulator will depend on the particular circumstances of the individual case. The challenges presented by the public protection duty are evident particularly when considering its relationship to the principle of maintaining confidence in the profession.

Maintaining confidence in the profession

3.8 The governing legislation makes no express reference to maintaining confidence in the profession as being a duty of the regulator. However, the courts and in practice the regulators have long recognised that the need to maintain confidence has an important role to play in regulating health and social care professionals.

3.9 This is evident in the 1975 report of the Merrison Committee, set up to examine the role of the General Medical Council. The Merrison Committee stated that the Council should be able to take action in the interests of the public, and that the public interest had "two closely woven strands", namely the need to protect individual patients and the need to protect the reputation of the profession.[9] This position is also apparent in the judgment given by the Court of Appeal in *Bolton v Law Society*, and adopted in *Gupta v General Medical Council*, where the profession's reputation was described as "the profession's most valuable

5 Department of Health, *Health Care and Associated Professions (Miscellaneous Amendments) Order 2008: A Paper for Consultation* (2007) para 3.5.

6 Department of Health, *Health Care and Associated Professions (Miscellaneous Amendments and Practitioner Psychologists) Order 2009: Consultation Report* (2009) pp 18 to 20, 21 and 23.

7 Pharmacy Order 2010, SI 2010 No 231, art 6(1).

8 For further discussion of the point see F Zacharias, "The Purpose of Lawyer Discipline" (2003) 45 *William and Mary Law Review* 2.

9 Report of the Inquiry into the Regulation of the Medical Profession (1975) Cmnd 6018.

asset".[10] The courts have also recognised that the need to preserve confidence in the profession is particularly significant when considering sanctions against a practitioner whose fitness to practise is impaired, and in some cases this consideration can amount to the "paramount interest" of the regulator.[11]

3.10 The meaning of ensuring confidence in the profession is normally explained in utilitarian terms. Accordingly, Mr Justice Irwin has stated that there are several public benefits to be gained from trust in the medical profession:

> It is not just a matter of whether the doctor is risky in practice, or whether indeed a doctor can be trusted to understand what he has done wrong and can be trusted not to repeat it; public trust in doctors is essential to the whole enterprise of medicine. A destruction of that trust would be corrosive to the general attitude to the profession and therefore to the effectiveness overall of treatment. In a questioning and doubting world where trust is at a premium, if public trust in doctors falls generally then people will be likely to suffer as a direct consequence and may not seek help or seek help quickly enough. They may doubt the advice or prescriptions given to them by doctors and fail to follow it, or fail to follow the advice of prescriptions rigorously. The regulatory arm of the profession, it seems to me, does have a special knowledge of this and of its implications; and this consideration must underpin the various dicta in which the courts emphasise the degree of respect to be paid to Fitness to Practise Panels on questions of honesty and the implications of dishonesty.[12]

3.11 The implication is that although the preservation of trust in the profession is not a stated statutory objective, it can be regarded as subsumed within the public protection duty if it is accepted that confidence in the profession is essential to good quality care and that loss of trust will have negative implications for the health and safety of the public. In effect, maintaining confidence in the profession is part and parcel of the main statutory duty of public protection.

3.12 The difficulty with this explanation is that it fails to demarcate any limits to the regulatory aim of preserving confidence in the profession. Any matter which potentially undermines public confidence in the profession becomes necessarily a matter of public protection. But not all matters that undermine public confidence will be relevant to public protection, for example matters which involve private conduct or belief and do not raise any concerns about patient safety or clinical competence.

[10] *Bolton v Law Society* [1994] 1 WLR 512, 518 and *Gupta v General Medical Council* [2002] 1 WLR 1681, 1702. Also, see *Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council* [2011] EWHC 927 (Admin), [2011] ACD 72 at [74].

[11] *Wentzel v General Medical Council* [2004] EWHC 381 (Admin), (2005) 82 BMLR 127 at [25].

[12] *Makki v General Medical Council* [2009] EWHC 3180 (Admin), [2009] All ER (D) 106 (Dec) at [43] by Irwin J.

3.13 An alternative explanation is that public protection and maintaining confidence in the profession are overlapping concepts in part, but essentially separate. But if this is true, then it becomes necessary to explain the relationship between them. The Merrison Committee's report implies that public protection and preserving public confidence are two separate but closely woven strands which should be equally weighted. However, this fails to explain why public protection is identified as the main statutory objective.

3.14 A further interpretation is that public protection is the primary duty of the regulators, and maintaining confidence in the profession should be viewed as consequential and therefore relevant insofar that it can assist the regulator in public protection. However, this does not accord with case law which confirms that regulatory intervention can be justified primarily on the basis of preserving confidence in the profession rather than public protection.[13]

Provisional view

3.15 The governing legislation taken as a whole does not establish clearly the primary objective of health and social care professional regulation. Although most of the legislation provides that the main duty of the regulator is public protection, the precise form of wording often varies. Furthermore, public protection is not mentioned at all as the main duty of several regulators. Establishing a single primary duty for all the regulators would encourage a consistent approach to decision-making, and provide registrants and the public with a clear statement of the purpose of professional regulation. A clearly defined objective has been identified by the Better Regulation Taskforce as being vital to the proper targeting of regulatory regimes and a necessary aspect of proper accountability.[14]

3.16 There are cogent arguments for establishing public protection clearly as the primary duty for all the regulators. As noted above, public protection has been long established as the overarching purpose of professional regulation and is already stated in most of the governing legislation. However, we are concerned that a main duty based entirely on public protection may inadvertently distort understanding of the role of professional regulation. In our view, the proper role of regulation should be understood in more positive terms as ensuring proper standards of practice and reducing the need to protect the public from professionals whose fitness to practise is impaired. In contrast, a public protection duty emphasises a disciplinary model for regulation based on fitness to practise proceedings and provides that the proper role of the regulators is to protect the public from miscreant practitioners.

3.17 We therefore provisionally propose that the duty should provide that the regulators must protect the public by ensuring proper standards for safe and effective practice. The reference to *ensuring proper standards* does not refer to the specific statutory tasks of issuing codes of conduct or standards of proficiency. It is a far broader concept that encompasses the need to raise the standards of the profession overall and reduce the instances in which regulator intervention is needed to protect the public from registrants whose fitness to

[13] For example, see *Yeong v General Medical Council* [2009] EWHC 927 1923 (Admin), [2010] 1 WLR 548 and *Ige v Nursing and Midwifery Council* [2011] EWHC 3721 (Admin).

[14] Better Regulation Taskforce, *Principles of Good Regulation* (2003).

practise is impaired. Thus, in making this proposal we are not seeking to narrow the core duty of public protection. The focus remains on public protection but there is an additional acknowledgement that this is achieved through the broad range of activities undertaken by the regulators, not just fitness to practise proceedings. Thus, all the statutory functions of the regulators – registration, setting standards for education, conduct and practice, and taking action where the standards are not met – would flow from this duty.

3.18 We also think that this duty should apply to the Council for Healthcare Regulatory Excellence. Although the Council is not tasked directly with ensuring proper standards of practice in the professions, it does scrutinise and assist the regulators in performing this role.

Maintaining confidence in the profession

3.19 In our view, a major deficiency of the existing legislative framework is the failure to clarify, or even to mention, the relationship between public protection and confidence in the profession.

3.20 We welcome views on the extent to which maintaining confidence in the profession is a legitimate aim of professional regulation. The dangers of preserving public confidence becoming a regulatory aim in itself may include a perception that the self-interest of the profession is being allowed to creep in. Furthermore, the concept of preserving public confidence in the profession can be seen as unhelpfully vague; it is difficult to gauge levels of public confidence and to what extent they need protecting. Commentators have argued that notions of professional reputation are left over from a bygone age when the nature of the public's trust was very different. In modern times it is possible to "trust members of a profession with matters of personal health care and yet not trust their judgment or probity in other areas".[15]

3.21 However, protection of the public is through the maintenance of proper professional standards, which in turn result in high levels of confidence in the profession. The two concepts, namely, the protection of the public and maintenance of confidence in the profession are thus interlinked and cannot be looked at entirely separately. Although there have been criticisms of the concept of maintaining confidence in the profession, it is not something that can be divorced from the duty that we provisionally propose.

3.22 There are two approaches that the statute could take in order to clarify the relationship between public protection and confidence in the profession, which we would like to test at consultation. The first would be to establish clearly that public protection is the overarching duty of the regulators and confidence in the profession is relevant insofar as it relates to this duty. In effect, the regulators would not be able to intervene in cases where the registrant's conduct does not endanger the health, safety or well-being of the public or raise issues concerning the quality of care provided. Such cases may lead to action in other legal systems, such as criminal justice prosecution or civil actions, but the primary role

[15] P De Prez, "Self-Regulation and Paragons of Virtue: The Case of 'Fitness to Practise'" (2002) 10 *Medical Law Review* 28, 52. See also P Case, "The Good, the Bad and the Dishonest Doctor: The General Medical Council and the 'Redemption Model of Fitness to Practise'" (2011) 31 *Legal Studies* 4, 591.

of the regulators would be public protection.

3.23 Alternatively, the duty could confirm that regulatory intervention can and should be justified on the basis of maintaining confidence in the profession. Thus, the overarching duty of the regulators would be to protect, promote and maintain the health, safety and well-being of the public *and* maintain confidence in the profession, by ensuring proper standards for safe and effective practice.

Other issues

3.24 Some of the current main duties include reference to the particular need to protect those who need or may need the services of registrants. In our view, the main duty should be the wider duty to the public. It is unnecessary and potentially confusing to specify that particular attention should be given to certain groups. Furthermore, regulatory intervention can extend beyond service users of the regulated profession. For example, regulators may need to provide general information for the public (see Part 4), deal with allegations made against professionals registered with another regulator (see Part 7) and prosecute non-registrant service providers who undertake activities which are restricted in law to registrants (see Part 11).

3.25 Some of the legislation states that the public protection duty applies only to those functions that affect the health, safety and well-being of the public.[16] In our view, this statement is at best confusing since all of the regulators' functions affect the health, safety and well-being of the public. Our proposed duty would not therefore include such a statement.

3.26 The precise meaning of a *main duty* is not defined in legislation. But it is likely that a court would consider the correct interpretation as being that all the actions and decisions of the regulator must be construed in the light of this duty.[17] The difficulty is that the use of the term *main duty* implies that there might be other duties or objectives that the regulator must take into account. It may be unclear whether other duties of the Council should be balanced against the main duty, or whether the main duty should always prevail over a conflicting duty. We propose that the statute should refer to the *paramount duty* of the regulators. This would mean that it "rules upon and determines the course to be followed" and reflects the well established position in other areas of law such as the Children Act 1989.[18] However, we recognise that this would introduce a demanding standard and welcome views on any unintended difficulties.

3.27 There are several other objectives or duties specified in the legislation, such as a duty to develop the profession. At first blush, the aim of developing the profession conflicts potentially with the duty of public protection. However, it has been suggested to us that developing the profession can be a helpful means of ensuring high standards of professionalism within a nascent and less cohesive profession. The potential conflict of interest is more evident in the objectives of the Pharmaceutical Society of Northern Ireland, which include promoting the

[16] For example, Opticians Act 1989, s 2A.

[17] See, for example, *Yeong v General Medical Council* [2009] EWHC 1923 (Admin), [2010] 1 WLR 548 at [20].

[18] *J v C* [1970] AC 668, 710 to 711.

interests of its members. Under our proposed duty, the regulators would be able to undertake tasks aimed at, for example, developing the profession only where this is in accordance with the paramount duty.

Question 3-1: Should the statute specify the paramount duty of the regulators and the Council for Healthcare Regulatory Excellence is to: (1) protect, promote and maintain the health, safety and well-being of the public by ensuring proper standards for safe and effective practice; or (2) protect, promote and maintain the health, safety and well-being of the public and maintain confidence in the profession, by ensuring proper standards for safe and effective practice?

GENERAL AND PRINCIPAL FUNCTIONS

3.28 All of the regulators are given broadly the same statutory functions of registration, setting standards for education, conduct and practice, and ensuring fitness to practise. The governing legislation gives the regulators specific powers and duties to undertake each of these functions.

3.29 In addition, the legislation often contains a declaratory statement of the regulator's general or principal function(s). This is normally stated at the beginning of the legislation following (and sometimes before) the main duty. In most cases the general function of the regulator relates specifically to their role in relation to education and professional conduct. For example:

(1) the General Medical Council has the general function of promoting high standards of medical education and co-ordinating all stages of medical education;[19] and

(2) the General Optical Council's general function is to promote high standards of professional education, conduct and performance among registrants.[20]

3.30 At the General Chiropractic Council and General Osteopathic Council, the general duty is placed on the Education Committee in question rather than the General Council.[21] The General Dental Council is not placed under a general duty but rather is required to have a "general concern" to promote high standards of education and professional conduct, performance and practice.[22]

3.31 Some of the governing legislation identifies several general or principal functions for the regulator in question. For example, the Pharmacy Order 2010 lists the following seven principal functions for the General Pharmaceutical Council:

(1) to establish and maintain a register;

(2) to set and promote standards for safe and effective practice;

[19] Medical Act 1983, s 5(1).

[20] Opticians Act 1989, s 1(2).

[21] Chiropractors Act 1994, s 11.

[22] Dentists Act 1984, s 1(2).

(3) to set requirements by reference to which registrants must demonstrate that their fitness to practise is not impaired;

(4) to promote the safe and effective practice of pharmacy;

(5) to set standards and requirements in respect of the education, training, acquisition of experience and continuing professional development that are necessary to achieve in order to be entered in the register and to maintain competence; and

(6) to ensure the continued fitness to practise of registrants.[23]

3.32 Some regulators are required, when exercising their principal functions, to:

(1) have proper regard for the interests of service users and any differing interests of different categories of registrants; and

(2) co-operate, in so far as is appropriate and reasonably practicable, with public bodies or other persons concerned with employment, education, regulation and service provision.[24]

3.33 In addition to its general functions, the General Optical Council is given a power "to do anything which in their opinion is calculated to facilitate the proper discharge of their functions".[25] Although in practice this general power is restricted by the more specific provisions of the Opticians Act 1989, which for example specify statutory committees that must be established and set out precisely what rules must be prescribed.

Provisional view

3.34 The meaning and utility of general functions varies across the legislation. In some cases, general functions are merely descriptive statements of powers which are provided for elsewhere in the legislation, such as establishing and maintaining a register. We think it is unnecessary for statute law to include such statements

3.35 In other cases, general functions are used to describe an aim or objective for a specific function; for example, promoting high standards of professional training. These provisions appear to be useful legal provisions which empower the regulators to do almost anything they consider likely to achieve this objective (except if it is expressly prohibited or restricted in law). The specific powers and duties detailed elsewhere in the legislation are merely particular manifestations of this general duty. These types of general duties are performing therefore a proper legal role. However, it is unclear why one particular function of the regulator (normally in relation to education and training) is identified as *the* general or principle function above all the others.

[23] Pharmacy Order 2010, SI 2010 No 231, art 4(3).

[24] See, Pharmacy Order 2010, SI 2010 No 231, art 6(2), Health Professions Order 2001, SI 2002 No 254, art 3(5) and Nursing and Midwifery Order 2001, SI 2002 No 254, art 3(5).

[25] Opticians Act 1989, sch 1 para 11.

3.36 In our view, the need for general or principal functions disappears in our proposed scheme. The regulators would be required when undertaking all their functions to protect, promote and maintain the health, safety and well-being of the public (and maintain confidence in the profession) by ensuring proper standards of practice. In effect, the general function of ensuring proper standards has been wrapped up in the paramount duty.

3.37 Furthermore, if one of the major advantages of a general duty is the flexibility that it gives to the regulators, in our view a similar degree of flexibility could be achieved by giving the regulators broad powers to undertake their functions. This does not require any general declaratory statement setting out a general or principal function. Instead, the statute would give the regulators broad powers to undertake their specific functions, subject only to the paramount duty. In our view, this would be a clearer and more straightforward way of structuring the legal framework. We therefore provisionally propose that the statute should not include a general statement expressing the general or principal function(s) of the regulators. The only exception is in relation to the Council for Regulatory Healthcare Excellence which is discussed in Part 10.

3.38 In some cases the regulators are required to co-operate with certain individuals and bodies when undertaking their functions. In our view this is an important legal provision and needs to be separated from the notion of general or principal functions. Duties to co-operate are discussed in detail in Part 12.

3.39 Some regulators are also required to have proper regard to certain matters when undertaking their general functions, such as the differing interests of different groups of registrants. This appears to be an attempt to establish guiding principles for decision-making by the regulators, which has been a successful innovation used in other jurisdictions.[26] The difficulty is that the matters listed are selective and do not provide a comprehensive guide for decision-making. For example, there is no mention of the need to consider the interests of the wider public or ensure that the functions are carried out efficiently and expeditiously. We are attracted by the idea of establishing general principles for decision-making and welcome further views on what these principles might consist of.

3.40 We also welcome views on whether the statute should include a general power for the regulators to do anything which facilitates the proper discharge of their functions. Our provisional view is that such a power is not necessary given that the new legal framework will give the regulators broad powers to undertake their functions. But it may be that the inclusion of a general duty will help to resolve uncertainty where the necessary legal powers already exist but are not clear, and encourage the regulators to engage in new approaches and activities.

[26] For example, the Children Act 1989 and Mental Capacity Act 2005.

Provisional Proposal 3-2: The statute should not include a statement setting out the general or principal function(s) of the regulators.

Question 3-3: Should the statute include guiding principles which would apply to all decisions made by the regulators, and if so what should they be?

Question 3-4: Should the statute include a general power for the regulators to do anything which facilitates the proper discharge of their functions?

PART 4
GOVERNANCE

4.1 All of the regulators are governed by General Councils that set policy and strategy and oversee operational matters. In addition, a considerable body of administrative staff undertake the day-to-day work of the regulators. At the head is the Chief Executive, who at most of the regulators is also the Registrar.[1]

4.2 This Part of the consultation paper considers the governance arrangements for the regulators and how this should be provided for in the new statute. Specifically, this Part considers:

(1) the strategic role of the General Council;

(2) status of the Councils;

(3) the constitution of the Councils;

(4) Council committees; and

(5) powers of delegation.

STRATEGIC ROLE OF THE GENERAL COUNCIL

4.3 Historically, the identity and role of the General Council was developed during the era of professional self-regulation (see Part 1). Councils were often large bodies, sometimes consisting of over 100 members.[2] Seats on the Council were established to reflect the composition and interests of the profession. This was achieved initially through systems of nominations; for example, most members of the original General Medical Council were nominated by the medical Royal Colleges and the universities. Subsequently, this was achieved through the election of members by registrants introduced as a result of the Medical Act 1978. A further historical feature is that Council members would often be involved in operational matters such as adjudicating fitness to practise cases and acting as health screeners. Thus, Councils were associated with self-regulation and perceived as unwieldy, lacking independence and not sufficiently focused on holding the executive to account.

4.4 The White Paper *Trust*, *Assurance and Safety* led to a programme of reforms aimed at ensuring that each regulator "has a smaller, more board-like Council whose members are appointed rather than elected in order to fulfil more effectively their strategic role".[3] Consequently, Council members are now appointed through an independent process; there are equal numbers of professional and lay members and the size of the Councils has reduced

[1] The only exception is the Pharmaceutical Society of Northern Ireland where different personnel undertake these roles.

[2] For example, in 2003 there were 104 members of the General Medical Council.

[3] Department of Health, *Implementing the White Paper Trust, Assurance and Safety: Enhancing Confidence in Healthcare Professional Regulators: Final Report* (2008) para 2.2.

considerably to 24 members or fewer.

4.5 However, the debate over the strategic role of the General Council goes beyond relatively straightforward matters such as its size and composition, with many arguing that Councils should become more board-like in their operation. For example, the *Enhancing Confidence* report commissioned by the Department of Health concluded that Councils should set the direction of the organisation in line with its mission and purpose, and ensure systems are in place to hold the executive to account, while Council members should "bring their knowledge, skill and experience to bear to ensure that all statutory duties are delivered in a cost-effective and appropriate manner".[4]

4.6 This approach is influenced heavily by the work of John Carver, whereby the role of the Council should be demarcated clearly as deciding the "ends" of the organisation rather than the "means" by which these ends may be achieved.[5] Under this approach, the Council defines the organisation's policies, holds the executive to account for organisational performance and ensures that public protection is central to all decisions, and Council members are not able to sit on its internal operational committees. Some of the regulators have already adopted this approach through informal means such as issuing policy statements on the proper role of the Council and the role of officials.[6]

4.7 Arguably, the major disadvantage with this approach is that it merely tinkers with a system ill-designed for modern regulation. As noted previously, the role of the Council was defined largely during the era of self-regulation. General Councils are essentially voluntary bodies of people whose other job is elsewhere and who in the past ensured professional control of the regulator.

4.8 Legally, this system is based on the notion that the Councils and its staff are one and the same, and the majority of statutory functions are therefore given directly to the General Council. In order to make this work in practice, most Councils have developed systems of internal delegation to enable the executive to carry out the day-to-day running of the organisation. This process can be seen as procedurally cumbersome and ill-suited to, for example, unforeseen circumstances which require an urgent response. Moreover, it fails to recognise the significant role played by the executive who in practice are responsible for operational matters and implementing policy and strategy.

Executive board model

4.9 An alternative approach would be to establish a legal structure which is focused on the role of the executive, allows it to operate effectively and efficiently, and builds in a system to hold it to account. Accordingly, the regulators would be governed by a statutory executive board. The legal duties and powers of the

[4] As above, paras 2.2 and 7.1.

[5] See J Carver, *Boards that Make a Difference: A New Design for Leadership in Non-profit and Public Organizations* (2006).

[6] For example, General Dental Council, *Matters Reserved to the Council and Matters Delegated to the Chief Executive* (2011).

regulators would be placed directly on the board rather than a General Council (or alternatively placed directly on the chief executive who then delegates them to other board members).

4.10 The executive would consist of the chief executive and other senior managers, such as the directors of standards, fitness to practise, education, policy and communications, registration and resources. The executive board would be responsible for all aspects of professional regulation; it would set policy and strategy in accordance with its functions and aims set out in the governing statute, and be responsible for operational matters.

4.11 Within this approach the role of the Council would become focused clearly on holding the executive board to account. This would be similar to the role currently performed by statutory boards of governors whose duty is to scrutinise and review the way in which the executive board discharges its functions. The powers of the Council could include the appointment of the chief executive and the non-executive directors, making recommendations on how the operation of the regulator could be improved and reporting annually to Parliament.

Provisional view

4.12 Most of the calls for the Councils to become more board-like focus on their size and appointment. We consider these issues later in this Part and make proposals for reform. However, the statute could go further in modernising the regulatory system. We set out three main options in this respect.

4.13 First, the statute could reform the existing structure to encourage the Council to become more board-like in its purpose and role. Statutory powers and duties would continue to be placed on the General Council and delegated to staff. There would be a clear statement in the statute to the effect that the role of the Council is to govern the regulator by establishing broad policies and objectives, ensure the availability of adequate financial resources, and scrutinise and review the way in which the regulator in question discharges its functions, and does not extend to operational matters. Essentially, this option would retain the existing legal structure but is an internally driven move towards a more board-like Council.

4.14 Second, the statute could reform the existing structure by establishing a statutory executive board consisting of the chief executive and senior directors. The legal duties and powers of the regulator would be placed directly on the board (or on the Chief Executive), which would be responsible for all aspects of professional regulation including setting policy and strategy, financial matters and all operational matters. The executive board would be accountable to the Council who would be required to scrutinise and review the way in which the executive board discharges its statutory functions and report to Parliament. This option is an externally driven move towards a board-like structure which would reconfigure the legal position of the executive and the role of the Council.

4.15 Finally, the statute could establish a unitary board structure which would move away from a two-tier approach based on a Council and officials. Instead, General Councils would consist of both officials and appointed Council members each of whom have equal status and accountability. In effect, there would be three categories of Council membership: registrant, lay and officials. Statutory powers and duties would continue to be placed on the General Council. This option aims

to maximise efficiency and faster decision-making, and closer co-operation between the supervisory and managerial roles of the regulator.

4.16 Under all three options, we envisage that the requirements in the statute relating to registrant and lay members would apply. This is discussed in more detail below.

4.17 We welcome views on all of these options. They are not intended necessarily to be mutually exclusive options. It would be possible to create a structure in which the regulators could retain a General Council and the statute would encourage it to become more board-like, while also allowing individual regulators to move away from this model and establish an executive board or a unitary board if they wished to do so.

4.18 Moreover, the discussion in the rest of this consultation paper does not depend on one particular governance model being introduced. The proposals apply to all three models. When the paper refers to powers or duties being placed on the Councils/regulators for example, this would apply whichever approach is adopted. In the case of the executive board model this would infer that the powers and duties would be placed on the board, while for the two other models this would refer to the General Council. Where individual issues arise between the three models, these are highlighted in the text.

4.19 The role of the Registrar in relation to the General Council is discussed separately in Part 5.

Question 4-1: Should the statute: (1) reform the existing structure to encourage Councils to become more board-like; *and/or* (2) reform the existing structure by establishing a statutory executive board consisting of the chief executive and senior directors; *and/or* (3) establish a unitary board structure which would move away from a two-tier approach based on a Council and officials?

STATUS OF THE COUNCILS

4.20 All of the regulators are bodies corporate established by statute. As creatures of statute, their powers and duties are conferred and limited by that statute. A body corporate has perpetual succession and a legal personality distinct from that of its members.

4.21 A statutory body corporate can be held accountable in both public law and private law. This is because it is able to exercise public law functions and perform private law acts. Thus, it can be amenable to public law challenges such as judicial review claims and claims under the Human Rights Act 1998; and in private law, it can be liable for failures to perform contracts and for its tortious actions, and also vicariously liable for the tortious actions of its employees.

4.22 The General Medical Council and Nursing and Midwifery Council are also charities registered with the Charity Commission. This brings certain tax advantages and means the body is subject to the regulatory framework of the Charity Commission. The regulatory framework includes administration requirements on charities (such as annual returns and financial reporting) and the provision of information and advice by the Commission. The Commission has

powers to investigate and intervene if it has serious cause for concern that a charity's beneficiaries, assets or reputation are at risk. Council members become trustees and cannot be remunerated for their work, and must also avoid personal interests that would conflict with acting in the best interests of the charity. The General Dental Council Charitable Trust was wound up in 2008.

Provisional view

4.23 In our view the existing status of the regulators as bodies corporate should be continued in the new legal framework. Furthermore, the regulators would continue to be able to apply to become registered with the Charity Commission if they wish to do so. Indeed, it is likely that registration with the Charity Commission can enhance the regulators' governance arrangements and accountability.

Provisional Proposal 4-2: The statute should establish each Council as a body corporate. The regulators should continue to be able to apply to become registered with the Charity Commission if they wish to do so.

CONSTITUTION OF THE COUNCILS

4.24 The governing legislation provides that each Council shall be constituted as provided by order of the Privy Council. These orders normally specify matters such as the size and composition, terms of office and the removal of members of the General Council and are known as *constitution orders*.[7] The following provides an overview of the various requirements.

Size and composition

4.25 The constitution orders specify the size of each General Council by prescribing numbers of registrant and lay members. As set out in table 4 below, the size of the Councils varies between 12 and 24 members. There has been a movement in recent years towards smaller more board-like Councils. For example, the *Enhancing Confidence* report which was commissioned by the previous Government recommended that Councils should consist of between nine and 15 members.[8]

4.26 More recently the Council for Healthcare Regulatory Excellence was commissioned by the Department of Health to look at whether there is a case for moving to smaller Councils for regulatory bodies. In an interim report, they concluded that a smaller size of Council helps them to focus their efforts on core governance issues and ensures that they are more strategic, and a Council of around eight to 12 members is likely to be most conducive to effectiveness.[9] Consequently, the Government has announced its intention (subject to consultation) to legislate to reduce the size of the General Dental Council and General Medical Council to eight members, and in the future to reduce the size of

[7] For example, General Medical Council (Constitution) Order 2008, SI 2008 No 2554.

[8] Department of Health, *Implementing the White Paper Trust, Assurance and Safety: Enhancing Confidence in Healthcare Professional Regulators: Final Report* (2008) para 5.4.

[9] Council for Healthcare Regulatory Excellence, *Board Size and Effectiveness: Advice to the Department of Health Regarding Health Professional Regulators* (2011).

the Health Professions Council.[10] The Government has also announced that it will consult on a change to the Nursing and Midwifery Council's Constitution Order to reduce the size of the Council.[11]

4.27 In the past the regulators were seen sometimes to be partial to the interests of professionals because they formed a majority on their General Councils. The White Paper *Trust, Assurance and Safety* proposed to address this by ensuring that registrants do not form a majority.[12] The constitution orders for all the regulators now prescribe equal numbers of lay and professional members. The exception is the Pharmacy Order 2010 where it is left open as to the balance of lay and professional members, although the power has been exercised so that there are equal numbers.[13]

4.28 In addition, the Health and Social Care Act 2008 enables orders to be made under section 60 of the Health Act 1999 to impose a requirement that a majority of Council members must be lay members.[14] However, this power has never been used. Instead, most of the governing legislation continues to establish a prohibition on the use of constitution orders to establishing a lay majority.[15]

4.29 The orders for the regulators also set a quorum for Council meetings. Table 4 below summarises the size, composition and quorum requirements for each General Council.

	Registrant members	**Lay Members**	**Quorum**
GCC	7	7	8
GDC	12	12	13
GMC	12	12	14
GOC	6	6	7
GOsC	7	7	8
GPhC	7	7	8
HPC	10	10	11
NMC	7	7	8

Table 4: Size, composition and quorum requirements for each General Council

[10] Department of Health, *Proposed Government Response to CHRE's Report 'Board Size and Effectiveness'* (2011) (letter).

[11] Written Ministerial Statement, *Hansard* (HC), 26 January 2012, vol 539, col 25WS.

[12] Trust, Assurance and Safety – The Regulation of Health Professionals in the 21 Century (2007) Cm 7013, para 1.9.

[13] Pharmacy Order 2010, SI 2010 No 231, sch 1 para 2.

[14] Health and Social Care Act 2008, sch 8, para 5(3).

[15] See, for example, Nursing and Midwifery Order 2001, SI 2002 No 253, sch 1 para 1B(2).

4.30 A regulator not included in table 4 above is the General Social Care Council where different composition rules apply. The General Council consists of a chairman and not more than 24 members. A majority of the Council must be lay members and the quorum for meetings is one third of members.[16] The position of the Pharmaceutical Society of Northern Ireland is discussed below.

4.31 At most Councils, a registrant member is defined in statute law as any person entered into the register of that particular regulatory body. Lay members are defined as members who are not and have never been registered and do not hold qualifications which would entitle them to be registered. However, some of the regulators have adopted alternative definitions. The General Pharmaceutical Council's definition of a lay member is any person who is not and has never been entered in the register of any regulatory body.[17] The General Social Care Council has adopted a narrower definition of lay members as people who are not, and have not within 12 months of their appointment, been social workers or involved in the training, education, appointment, employment, supply, supervision, monitoring or representation of social workers.[18]

Appointment of Council members

4.32 In the past, the majority of Council seats were elected by registrants thus giving rise to a perception that the interests of the public were being given less weight than those of the profession.[19] In order to address this perception the Health and Social Care Act 2008 gave the Privy Council powers to appoint Council members (with the exception of the General Social Care Council and Pharmaceutical Society of Northern Ireland).

4.33 In addition to appointing Council members, the Privy Council was also given powers to appoint chairs. The only exceptions are the General Dental Council and General Medical Council where the chairs are elected from within the General Council. The Government has announced recently its intention to move both to a system of appointed chairs (subject to consultation).[20]

4.34 At present, the Privy Council's appointments functions are delegated to the Appointments Commission by means of directions made under the Health Act 2006. Before the Privy Council gives such a direction, it must consult the relevant Council.[21] The Health and Social Care Bill 2011 proposes to abolish the Appointments Commission and amend the NHS Reform and Health Professions Act 2002 to empower the Privy Council to make arrangements with others (including the regulator in question, the Council for Healthcare Regulatory

[16] General Social Care Council (Appointments and Procedure) Regulations 2001, SI 2001 No 1744, art 2 and sch, para 4 and General Pharmaceutical Council (Constitution) Order 2010, SI 2010 No 300, art 2.

[17] Pharmacy Order 2010, SI 2010 No 231, sch 1 para 1(1)(b).

[18] General Social Care Council (Appointments and Procedure) Regulations 2001, SI 2001 No 1744, art 2.

[19] Trust, Assurance and Safety – The Regulation of Health Professionals in the 21 Century (2007) Cm 7013, para 1.16.

[20] Department of Health, *Proposed Government Response to CHRE's Report 'Board Size and Effectiveness'* (2011) (letter).

[21] See, for example, Nursing and Midwifery Order 2001, SI 2002 No 253, sch 1 para 1A(4).

Excellence or a third party such as a recruitment agency) to assist it in making appointments to the regulatory bodies.[22] The intention is that in the short term the Privy Council will delegate the process of administering appointments to the regulators, with formal responsibility for actually making appointments remaining with the Privy Council.

4.35 The Council for Healthcare Regulatory Excellence has been given responsibility for providing the regulatory bodies with guidance on good practice in appointment processes, "stressing the need for an independent mechanism", and working with the regulators to agree common standards. The Council will also be expected to provide "appropriate assurance that good practice in the appointments process has been followed" before the Privy Council makes the appointment. Longer-term options for appointments to Councils are being considered by the Government through deliberations with the devolved administrations, the Privy Council, the regulators, the Council for Healthcare Regulatory Excellence and others.[23]

4.36 The governing legislation also provides for appointment of Council members by country. For example, the Privy Council must ensure that at least one of the members of the General Pharmaceutical Council lives or works wholly or mainly in each of England, Scotland and Wales.[24] In most cases the constitution orders specify that the duration of membership shall be determined by the Privy Council upon appointment and that the maximum duration of membership is an aggregate of eight years during any period of 20 years.

Disqualification and removal from office

4.37 In most cases the governing legislation requires a constitution order to include the grounds on which persons are disqualified from appointment and the circumstances in which members cease to hold office or may be removed or suspended from office. The majority of orders provide that a person can be disqualified from appointment as a member for reasons such as being convicted of a crime involving dishonesty and deception and the conviction is not spent, being removed from the office of charity trustee, being adjudged bankrupt and where there has been a finding of impaired fitness to practise.

4.38 As a result of the Health and Social Care Act 2008, the function of suspension and removal of Council members has been taken away from the Councils and given to the Privy Council (which may delegate this role to the Appointments Commission). The triggers for Privy Council action are detailed in the constitution orders and include reasons that often correspond to the grounds on which persons are disqualified from appointment as members and other reasons such as unsatisfactory attendance and adverse health. There are, however, provisions which allow the Councils to suspend a member provisionally, pending the taking of a decision by the Privy Council.

[22] Health and Social Care Bill 2011, cl 211.

[23] Department of Health, *Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers: Analytical Strategy for the Command Paper* (2011) paras 28 to 31.

[24] Pharmacy Order 2010, SI 2010 No 231, sch 1, para 1(3).

Education and training

4.39 Most constitution orders give the Councils powers to make provision in standing orders for matters relating to the education and training of Council members, including the ability to allow that education and training to be the responsibility of another body.

Pharmaceutical Society of Northern Ireland

4.40 Currently, the Pharmaceutical Society of Northern Ireland is unique in continuing to allow Council members to be elected. Out of its 23 members, 18 are elected as the representatives of pharmaceutical chemists, one is elected as the representative of the registered druggists, two are nominated by Queen's University Belfast, one is nominated as a representative of the medical profession and one is nominated to represent the wholesale drug trade.[25]

4.41 However, the Northern Ireland Assembly has recently legislated to reform many aspects of the Society's legal framework, including its governance arrangements. In the future, the Council of the Society will be appointed by the Department of Health, Social Services and Public Safety and will consist of seven lay members and seven registrants. The Council will delegate all professional leadership duties to a new Professional Forum Board, which is a members-led body consisting of eight elected members and three members nominated by professional bodies.[26]

Provisional view

4.42 As noted in Part 2, our proposed scheme involves removing the formal role of the Privy Council. In accordance with this scheme, Councils would no longer be constituted by order of the Privy Council. Instead, we provisionally propose that the statute would require that each Council must be constituted by rules issued by the regulators. This would be subject to the requirement of public consultation set out in Part 2.

4.43 On some matters where the effective operation of the General Council relies on rules being issued we propose that a duty should be placed on each regulator to issue such rules. These matters are the appointment of Council members and chairs, terms of office, duration of membership, grounds for disqualification, quorum for meetings, circumstances in which members (including chairs) cease to hold office, are removed or are suspended, education and training of Council members, and attendance requirements of Council members. Although the regulators would be required to make rules on these matters, the content of the rules would be left to the regulators to determine in the light of their own individual circumstances and resources. On most other matters, the regulators would have powers but would not be required to make rules. Moreover, the regulators could set requirements for national/regional based appointments to the Council, if they wish to do so.

4.44 As noted above, this proposal would mean that the regulators would be required to make rules governing the appointment of Council members and Chairs. Currently, the formal responsibility for doing this rests with the Privy Council but

[25] Pharmacy (Northern Ireland) Order 1976 SI 1976 No 1213 (NI 22), sch 2 para 12.

[26] Pharmacy (1976 Order) (Amendment) Order (Northern Ireland) 2012.

in practice is delegated to the Appointments Commission, and in the future the administration of appointments will be delegated to the regulators. In our view, the involvement of the Appointments Commission has been a positive step which has ensured the appointment of high calibre members appointed against competencies in a fair and transparent manner, and it is important that these factors are not lost. We have considered whether Council appointments should be subject to external approval, such as approval by the Council for Healthcare Regulatory Excellence, Health Committee or Government. But on balance, we think that the regulators should be given overall responsibility for appointments. The Council for Regulatory Healthcare Excellence would continue to have responsibility for providing the regulatory bodies with guidance on good practice in appointment processes and setting agreed standards. Appointees would still be expected to commit to the Nolan principles of public life, which would provide some safeguards.[27] Any individual appointments could also be investigated by the Health Committee.

4.45 We welcome views on whether any additional form of oversight is needed, and in particular whether the Government should have powers to remove members in grave or extreme circumstances. This may be a useful way in which to ensure effective leadership and to prevent organisational failure occurring. An example of how this could operate is Monitor's proposed power to remove, suspend or disqualify board members from Foundation Trusts and appoint interim or full members.[28]

4.46 As set out in Part 12, the regulators would have powers to enter into partnership arrangements with others to recruit and appoint Council members, such as a recruitment agency. Alternatively, they could enter into arrangements with other regulators to establish an external body to carry out this role, similar to the role performed by the Appointments Commission.

4.47 The proportion of lay members and registrant members on Councils and arguably the size of Councils are matters which affects public confidence in, and therefore the effectiveness of, the regulatory system. We therefore do not think that these matters should be left entirely to the regulators. Instead, we wish to test three options at consultation.

4.48 First, the statute could specify a ceiling for the size of the Councils of for example 12 members. In addition the statute could specify that a majority of members cannot be registrants. It would then be left to the regulators to make rules on the size and composition of their Councils within these general parameters. This approach has the advantages of legal clarity while also affording the regulators some degree of discretion.

4.49 Second, the Government could be required to specify in regulations the size of Councils and the proportion of lay and registrant members on Councils. This would be a broad power whereby the Government could for example set the same size for each Council or place a ceiling or range for the size of Councils. Furthermore, the Government could require that a majority of Council members

[27] Committee on Standards in Public Life, *The First Seven Reports: A Review on Progress* (2001).

[28] Health and Social Care Bill 2011, cl 114(4).

must be lay or that there should be equal lay/registrant membership. This approach has the advantage of flexibility since it gives the Government power to alter the size and balance of Council membership to reflect political policy changes.

4.50 Finally, the regulators could be given general powers to set the size and composition of their Councils but the Government would retain default powers to intervene if this is necessary in the public interest. This would afford the regulators a significant degree of autonomy while also enabling the Government to intervene as a last resort if, for example a regulator decided to establish a disproportionately large Council or a majority of registrant members.

4.51 The governing legislation currently adopts different definitions of lay members. We think that on this matter there should be some degree of consistency between the regulators. Therefore, we propose that the statute would establish the following definitions:

(1) a lay member is any person who is not and has not been entered in the register of that particular regulatory body; and

(2) a registrant member is any person who is entered in the register of that particular regulatory body.

4.52 As noted above, these definitions are already used by most of the regulators. However, some regulators have adopted more stringent definitions of a lay member. It would be possible under our scheme for individual regulators through rules to set additional requirements above and beyond the legal definition of a lay member. For example, regulators could provide that lay members must never have been entered in the register of any health or social care professional regulator or have not in the last 12 months been involved in the training, education and employment of the relevant profession. But it would not be possible for the regulators to go below the proposed statutory definition.

4.53 It has been suggested to us that the current definitions of a lay member are too narrow and reduce the pool of potential Council members. In particular, it has been put forward that a person should be entitled to sit as a lay member providing they have not been registered within a certain period of time (for example 10 years). The risk of course is professional domination by the back door, but this may be a relatively low risk. We welcome comments on this suggestion. On balance we think that our proposed definition would ensure that a lay member is fully independent of the registered professions and is in keeping which the expectations that most members of the public would have of a lay member.

4.54 Finally, it has been pointed out to us that a significant number of Council members also serve concurrently as members of other Councils. Some see this as impacting negatively on the image of the regulators by suggesting an old-boys network, while others argue that experience of Council membership is an important attribute of a member. We welcome views on whether or not cross Council membership impacts negatively on the image of the regulators, and whether this should be prohibited or retained in our scheme.

Provisional Proposal 4-3: The statute should require that each Council must be constituted by rules issued by the regulators.

Provisional Proposal 4-4: Each regulator should be required to issue rules on the appointment of Council members and chairs, terms of office, duration of membership, grounds for disqualification, quorum for meetings, circumstances in which members (including chairs) cease to hold office, are removed or are suspended, education and training of Council members, and attendance requirements of Council members.

Question 4-5: Is an additional form of oversight required over the appointment of the General Council members? For example, should the Government have powers to remove members in certain circumstances?

Question 4-6: Should: (1) the statute specify a ceiling for the size of the Councils of and the proportion of lay/registrant members; *or* (2) the Government be required to specify in regulations the size of Councils and the proportion of lay/registrant members; *or* (3) the regulators be given general powers to set the size and composition of their Councils and the Government be given default powers to intervene if this is necessary in the public interest?

Provisional Proposal 4-7: The statute should define a lay member of the Council as any person who is not and has not been entered in the register of that particular regulatory body, and a registrant member as any person who is entered in the register of that particular regulatory body.

Question 4-8: Should Council members be prohibited from concurrent membership of another Council?

COUNCIL COMMITTEES

4.55 Each regulator is required to have a number of committees, sometimes referred to in the legislation as the "statutory committees". These committees are assigned operational functions by or under the legislation, such as undertaking investigations, setting standards and requirements for education and training and adjudicating fitness to practise cases. In most cases, members of a panel are drawn from the committee to consider individual cases. Some statutory committees also meet collectively as a body to advise the Council on matters relating to its functions.

4.56 In addition the regulators have established various non-statutory committees to whom it delegates work. At some but not all regulators the power to establish such committees is provided for expressly in the governing legislation.[29] The non-statutory committees normally advise the Council on issues other than operational matters within the remit of the statutory committees. The other regulators have freedom to establish a range of informal committees. In addition to the formal and informal committee structure, some regulators have set up working groups, reference groups and boards to assist with aspects of their work.

[29] For example, see Health Professions Order 2001, SI 2002 No 254, art 3(b).

4.57 The General Medical Council has in recent years moved away from a formal system of statutory committees. The Medical Act 1983 now requires the Council to establish one or more panels rather than formal committees (with the single exception of the Investigation Committee). The governance structure of the Council consists of three corporate governance committees (audit and risk, remuneration and resources); three boards themed around the main phases of a doctor's career (undergraduate, postgraduate and continued practice); and various committees, including one for each of the main statutory functions (educational and training, registration, standards and ethics, and fitness to practise) and other matters such as equality and diversity and research. None of these bodies are required to be established by the governing legislation, and the Council can therefore reorganise its governance structure according to developing needs.

4.58 Appendix C lists the statutory committees and panels that are required to be established and maintained by the regulators.

Committee membership

4.59 At most of the regulators, appointments and other matters relating to the constitution of the statutory committees are provided for by rules made by the Council. In most cases, appointments to the committees are made by the Council. However, at the General Medical Council appointments are made by the registrar and at the General Dental Council and General Pharmaceutical Council appointments are made by the Appointments Committee.

4.60 Most of the regulators have established prohibitions on Council members from sitting on some or all of the statutory committees. For example, the General Dental Council and Nursing and Midwifery Council provide that Council members cannot serve concurrently as a member of any committee.[30] At the General Pharmaceutical Council this prohibition includes current and former Council members.[31]

4.61 There are also various rules which prevent members of a statutory committee from being a member of one or more other committees. For example, the General Chiropractic Council, General Osteopathic Council and General Pharmaceutical Council have a general prohibition on multi-committee membership.[32] At other regulators the prohibition applies to members of a specific committee. For example, at the General Dental Council and Nursing and Midwifery Council a member of the Investigation Committee cannot serve concurrently as a member of any other committee.[33] At the Nursing and Midwifery Council no member of the Midwifery Committee can be a member of a Practice

[30] General Dental Council (Constitution of Committees) Rules Order of Council 2009, SI 1813, r 4 and Nursing and Midwifery Council (Midwifery and Practice Committees) (Constitution) Rules 2008, SI 2008 No 3148, r 6(3).

[31] General Pharmaceutical Council (Statutory Committees and their Advisers) Rules 2010, SI 2010 No 1616, r 7.

[32] Chiropractors Act 1994, s 24(1) and Osteopaths Act 1993, s 24(1).

[33] General Dental Council (Constitution of Committees) Rules Order of Council 2009, SI 1813, r 4 and Nursing and Midwifery Council (Midwifery and Practice Committees) (Constitution) Rules 2008, SI 2008 No 3148, r 6(2).

Committee.[34]

4.62 Some regulators have case specific prohibitions which are aimed at ensuring independence in the way that cases are considered. For example, at the General Chiropractic Council and General Osteopathic Council a member of the Professional Conduct Committee or Health Committee cannot deal with a case if they were also a member of a committee which referred the allegation.[35] At the General Pharmaceutical Council, a member of a Fitness to Practise Committee which has made an Interim Order cannot sit on subsequent proceedings in that case (unless they relate solely to the Interim Order).[36]

4.63 The General Pharmaceutical Council rules also include detailed provisions on who can be committee members. These include prohibitions on employees of the Council and certain people who have been the subject of disciplinary proceedings from membership of any statutory committees.[37] The rules provide for the establishment of required competencies and standards and training for members of statutory committees (including requirements to attend and prepare for meetings).[38]

Size of committees

4.64 Some of the Councils set limits for the size of committee membership. These limits can relate both to the overall number of committee members and to individual committees or panels. For example, the Health Professions Council's rules provide that the overall size of each Practice Committee must be no more than 350 members from which individual committees are composed (quorum of three).[39]

Provisional view

4.65 The statutory committee system is a long established feature of the regulatory framework. The main advantage of this system being that it provides for a clear delineation of roles within the regulator and therefore promotes transparency. One option for law reform might be the consolidation of the existing requirements into a single list of statutory committees for all the regulators. However, such consolidation would be difficult to achieve. There is little consistency in the statutory committees that are currently required to be established across the regulators. Indeed, there is no one statutory committee that is common to all regulators, although it is the case that the Investigation Committee and Fitness to Practise Committee are common to most.

[34] Nursing and Midwifery Council (Midwifery and Practice Committees) (Constitution) Rules 2008, SI 2008 No 3148, r 4(2).

[35] Chiropractors Act 1994, s 24(2) and Osteopaths Act 1993, s 24(2).

[36] Pharmacy Order 2010, SI 2010 No 231, sch 1 para 5(4)(c).

[37] General Pharmaceutical Council (Statutory Committees and their Advisers) Rules 2010, SI 2010 No 1616, r 8.

[38] As above, r 10.

[39] Health Professions Council (Practice Committees and Miscellaneous Amendments) Rules 2009, SI 2009 No 1355, r 3(1) and (6).

4.66 Moreover, it is not evident that a system of committees will always represent the most efficient or effective way of organising a regulator's governance structure. Among other matters, committees may bind the organisation into a particular way of managing business which is less flexible in adapting to changing needs. In relation to some functions, systems of panels, reference groups or boards for example may be more appropriate. We also think that the new legal framework should enable regulators to minimise bureaucracy.

4.67 This is not to argue that regulators should be prohibited from establishing a system of committees but merely that committees should be one of a range of options for each regulator. In our provisional view, each Council should be able to determine its own governance structure in accordance with its own needs and circumstances and should not have a structure imposed in statute law. We therefore provisionally propose that the regulators should be given broad rule-making powers to determine their own governance arrangements, including the ability to establish committees.

4.68 The only exception to this approach is in relation to Fitness to Practise Panels. This is discussed in Part 9.

4.69 The regulators would be able to set rules for committees or any other internal bodies they establish, including their size and membership. We do not propose to establish any restrictions on cross committee/panel membership, but the regulators could if they wished to do so establish such rules. Again, the only exception is in relation to Fitness to Practise Panels which is discussed in Part 9.

Provisional Proposal 4-9: The regulators should be given broad rule-making powers to determine their own governance arrangements, including the ability to establish committees if they wish to do so.

Provisional Proposal 4-10: The regulators should be able to make rules for committees or any other internal groups it establishes, including their size and membership.

POWERS OF DELEGATION

4.70 The scheme of delegation enables functions ascribed to the Council and the Registrar under the governing legislation and associated rules to be undertaken by committees and staff. Most of the Councils are given formal powers in their legislation to delegate its functions to any of its committees (sometimes including the non-statutory committees), although there is normally a prohibition on delegating any power to make rules or regulations.

4.71 Some of the legislation also allows the Councils to delegate their functions to the Registrar and/or any officer of the Council. In the case of the latter, this allows the Council to by-pass the Registrar and delegate functions directly to staff members, such as individual directors. Where the legislation confers functions directly on the Registrar, they are normally given powers to delegate these functions to any other members of staff.

4.72 These formal powers of delegation are normally required to be approved by the Council. The detail of any delegations which are normally contained in standing orders. Some of the regulators also publish a schedule or statement of delegation codifying the functions and powers that have been delegated to committees and staff.

Provisional view

4.73 Delegation is an important aspect of ensuring that the regulators can function effectively. We provisionally propose that each Council should be given powers to delegate, either generally or specifically, any of its functions to any Council officers or any internal body (such as a committee, panel, board or reference group). Any such delegations must be recorded clearly in a publicly available document.

4.74 We envisage that, in a similar way to a local authority, each Council will devise a scheme of delegation which will then be available for public inspection. The scheme of delegation should be comprehensive and include the delegation of functions between members of staff and, where appropriate, internal bodies. There would continue to be a prohibition on delegating any power to make rules which would at all times remain with the Council.

4.75 The separate issue of regulators entering into partnership arrangements with external bodies to carry out its functions is discussed in Part 12.

Provisional Proposal 4-11: Each Council should be given powers to delegate any of its functions to any Council member, officer or internal body. Any delegations must be recorded in publicly available scheme of delegation. There should continue to be a prohibition on delegating any power to make rules.

PART 5
REGISTERS

5.1 A key statutory function of the regulators is to establish and maintain a register. Registration refers to the compilation of a list of individuals (and sometimes businesses) who have satisfied a regulator that they are qualified and fit to practise. Registration may be voluntary or mandatory. This Part considers the registration of individual professionals. Business registration is discussed separately in Part 11.

5.2 This Part considers the following matters:

(1) the purpose of a register;

(2) responsibility for maintaining a register;

(3) types of registers;

(4) types of registration;

(5) requirements for registration;

(6) processing of registration applications;

(7) registration appeals;

(8) publication and upkeep of the registers;

(9) restoration to the register;

(10) content of the registers; and

(11) protected titles and functions.

THE PURPOSE OF A REGISTER

5.3 At its most basic level, the establishment and maintenance of a professional register serves to provide information. Registration enables members of the public and employers to identify professionals who are qualified and any current sanctions that have been imposed as a result of fitness to practise proceedings. A key aim of registration is therefore to reduce the risk posed by unqualified and/or incompetent practitioners to the public. However, the professional registers are not merely an administrative record of personal and professional details, educational achievements and fitness to practise determinations. They also aim to promote high standards of practice by requiring registrants to continue to develop their knowledge and skills while they are registered.

5.4 However, the extent to which entry on a register will guarantee the quality of service provision is not straightforward. Registration may indicate that the professional has signed up to a code of conduct or certain standards of practice issued by the regulator, but entry on the register is not necessarily linked to an appraisal of an individual professional's performance. The introduction of revalidation may go some way to address this by making continued registration

conditional on a professional providing assurance to the regulator on a regular basis that he or she is up to date and fit to practise.

5.5 The public may see the purpose of registration as giving a stamp of approval to an individual as a professional. This may be particularly significant where the profession is largely self-employed, registration is voluntary, a significant number of practitioners are unregulated or the professional works from home or some other non-official environment. For members of the public seeking professional support, registers can play a useful role in providing additional information to inform their choice. However, the information on registers alone would not be sufficient to help them choose one professional over another as it does not indicate who would offer the best service. Notwithstanding the limits of registers in this respect, most regulators maintain lists of specialist practitioners or include in each individual entry educational qualifications above the standard required for qualification. These lists and entries may help guide public choice and inter-professional referrals, although they may be less relevant where registrants are employed predominantly in the public sector.

5.6 Research indicates that the public are reassured by the existence of registers, although expectations of registers vary; some people only want basic information about a health professional and any current fitness to practise determinations, while others expect to see information relating to the quality and performance of the professional.[1] However, there is also generally low awareness of the health and social care professional registers, and of the regulatory bodies themselves.

5.7 However, a function of a register (although not a deliberate aim) is to define a profession for the purpose of regulation and thereby enhance the status of that profession. Registration achieves this in some cases by protecting the use of a professional title.[2] Thus only registrants are entitled to use certain titles, and it is a criminal offence for a person to use a protected title if they are not registered with the relevant regulator. In some cases the legislation also specifies certain protected functions, whereby only registered professionals can undertake certain activities. Protected titles and functions are discussed later in this Part.

5.8 Indeed, registration is sometimes seen as an essential trait of a profession which refers to an occupation with "autonomy, status and a degree of occupational closure".[3] This is linked to what is often seen as the economic purpose of registration. The establishment of a register is a way in which a professional group can defend itself against other occupational groups who may want to claim a share of its market, as well as against "would-be members who do not conform to the occupational ideal or would make occupational resource less scarce and thereby less costly".[4] Indeed, the purpose of specialist registers can be seen as conferring certain advantages, for example by providing that only registrants who are included in the specialist register can take up certain high status and comparatively well remunerated appointments (such as a hospital consultant).

[1] Council for Healthcare Regulatory Excellence, *Health Professional Regulators' Registers: Maximising their Contribution to Public Protection and Patient Safety* (2010).

[2] The protected titles used in the governing legislation are listed in Appendix D.

[3] K Van Heugten, "Registration and Social Work education: A Golden Opportunity or a Trojan Horse?" (2011) 11 *Journal of Social Work* 174, 180.

5.9 However, the significance of registration in securing a profession's status is contested. Other factors may be more significant including individual experience, public opinion, media coverage and the status of the population served by the profession. It may be that registration has the opposite effect of sending a message that the occupation is not to be trusted, especially when introduced by Government on a platform of preventing harm to the public.[5]

Provisional view

5.10 The above discussion indicates that while the main purpose of registration is to provide important information for the public (such as indicating those professionals who are appropriately qualified, fit to practise and have met continuing professional development requirements), an important by-product of registers are the privileges they bestow on professionals. Seen in this light, any increase or decrease in the number of professional registers would have socio-economic consequences. Therefore, in our view the overarching issue of which professions are to be registered must remain with the Government (see provisional proposal 2-15).

5.11 Nevertheless, the registration of professional groups is a key function of the regulators. We provisionally propose that the statute should set out a core duty on all the regulators to establish and maintain a professional register. However, in accordance with provisional proposal 2-2, much of the detail on how this duty should be implemented will be left to the regulators themselves to determine by issuing rules.

5.12 In Part 12 we discuss the possibility of formal partnership arrangements between the regulator and other organisations in relation to the exercise of their statutory functions, including registration.

Provisional Proposal 5-1: The statute should set out a core duty on all the regulators to establish and maintain a professional register.

RESPONSIBILITY FOR MAINTAINING THE REGISTER

5.13 The governing legislation requires each Council to appoint a Registrar to establish and maintain the register. The sole exception is the Pharmaceutical Society of Northern Ireland where the Registrar is appointed by the Department of Health, Social Services and Public Safety.[6] The governing legislation also enables the regulators to determine matters such as terms of office, remuneration and any other functions.[7] Some Councils are given statutory powers to appoint a Deputy Registrar and Assistant Registrars.[8] The roles of Chief Executive and Registrar are combined at all the Councils except the Pharmaceutical Society of Northern Ireland where different personnel undertake these roles.

4 As above.

5 Orme, J and Rennie, G, "The Role of Registration in Ensuring Ethical Practice" (2006) 49 *International Social Work* 333.

6 Pharmacy (Northern Ireland) Order 1976, SI 1976 No 1213, art 9(1).

7 See, for example, Chiropractors Act 1994, s 2.

8 See, for example, Dentists Act 1983, s 14(4).

5.14 As noted in Part 4, some of the governing legislation places responsibility directly on the Registrar, rather than the General Council, for certain functions relating to registration. For example, the Registrar of the General Medical Council is required to keep the register correct, erase the names of certain registrants (for example, those who have died) and make any other necessary alterations to "registered particulars" such as addresses and qualifications.[9] In some cases the governing legislation gives the Registrar significant powers which impact directly on the registrant's livelihood, such as decisions to remove from the register those with unsatisfactory continued professional development or to restore to the register those who have been removed as a result of a fraudulently procured or incorrect entry.[10] In practice, the powers vested in the Registrar will be delegated to others in the organisation, although there may be some important decisions – including those which impact directly on the registrant's livelihood – where the Registrar may wish to take personal and direct responsibility. However, the ability of the Registrar to be directly involved in decisions will vary between the regulators according to the number of registrants and/or cases.

5.15 Not all of the legislation places responsibility directly on the Registrar for the establishment and maintenance of the register. One such exception is the Opticians Act 1989 which in several places gives direct responsibility for maintaining the register to the General Council and establishes a Registration Committee to advise the Council on matters relating to registration.[11] However, in practice the General Council delegates its powers to the Registrar.

Provisional view

5.16 To some extent the existing structure – whereby each Council is required to appoint a Registrar who is given direct statutory responsibility for certain tasks relating to registration – is a historic feature of the legal framework. It appears to assume that the Council and the organisation are one and the same, rather than a board-like structure where the Council sets over-arching strategy which is implemented by the executive (see Part 4).

5.17 The main advantage of a legal structure which requires each Council to appoint a Registrar is that it creates clear accountability for maintaining and establishing a register. However, there are alternative and more efficient ways in which the regulators could discharge this function, while also retaining clear lines of accountability. These might include delegating this function internally to other officials or a committee, or to an external organisation with the experience and technical expertise in the administration and maintenance of registers (see Part 4). Moreover, it is not obvious why the regulators are required to appoint an office holder directly charged with maintaining the register but are not required to appoint an office holder for its other functions, such as setting standards and maintaining a fitness to practise system. We provisionally propose that each regulator should have the ability to appoint a Registrar if they wish to do so. This would give the regulators flexibility to determine their own arrangements for establishing and maintaining the register.

[9] Medical Act 1983, s 30(4).

[10] See, for example, Pharmacy Order 2010, SI 2010 No 231, arts 28(3), 29(3) and 43(8).

[11] Opticians Act 1989, ss 5 and 7.

5.18 In effect, statutory powers would no longer be vested directly on the Registrar but would instead be given to the General Council who could delegate these powers to the Registrar or any other person or body, if it wished to do so. In our view this would create a clear governance structure. This proposal would apply whichever governance model is adopted. In Part 4 we put forward three governance models: a board-like Council, an executive board and a unitary board. Under all of these structures, the regulators could decide whether or not to appoint a Registrar or whether this function should be delegated to another person or body.

Provisional Proposal 5-2: The regulators should have the ability but not a duty to appoint a Registrar.

TYPES OF REGISTERS

5.19 Across the regulators there are several different types of registers and lists of registered professionals. Some regulators must establish a single register for a given profession, for example the General Chiropractic Council. Others must establish a single register which is divided into different parts. For example, the Health Professions Council is required to establish a register of the 15 relevant professions, which must be divided into different parts based on designated titles as specified by order of the Privy Council.[12] Similarly, the General Pharmaceutical Council's register must be divided into five parts.[13]

5.20 Some regulators are required to establish separate registers of specialist practitioners. For example, the Registrar of the General Medical Council must establish three registers: the main register, a General Practitioner register and a register of specialist medical practitioners (those doctors eligible to work as substantive, fixed-term or honorary consultants in the NHS).[14] The latter was created for the purpose of defining those to whom the term *medical specialist* was applicable under the predecessor to Directive 2005/36/EC. The General Optical Council must establish two registers: a register of optometrists and a register of dispensing opticians.[15] The General Dental Council has statutory powers (but not a duty) to establish specialist lists, and has exercised these powers to establish 13 such lists.[16]

5.21 Both the General Optical Council and the General Social Care Council are required to maintain registers of students.[17] The General Social Care Council currently registers student social workers on a voluntary basis. However, by requiring that students must be registered prior to commencing practice

[12] Health Professions Order 2001, SI 2002 No 254, arts 5 and 6.

[13] Pharmacy Order 2010, SI 2010 No 231, art 19(2). The five parts are pharmacists, pharmacy technicians, premises, visiting pharmacists and pharmacy technicians who are visiting practitioners.

[14] Medical Act 1983, s 30(A1).

[15] Opticians Act 1989, s 7.

[16] The specialist lists are: Orthodontics; Oral Surgery; Endodontics; Periodontics; Prosthodontics; Restorative Dentistry; Dental Public Health; Paediatric Dentistry; Oral Medicine; Oral and Maxillofacial Pathology; Oral Microbiology; Dental and Maxillofacial Radiology; and Special Care Dentistry.

[17] Opticians Act 1989, s 8A and Care Standards Act 2000, s 56(1) and General Social Care Council (Registration) (Description of Social Care Workers) Order 2004, SI 2004 No 562.

placements and linking registration to the funding that is available for practice placements, the Council has managed to ensure that student registration is at very high levels – around 95%.[18] The Health Professions Council is considering the most effective ways of ensuring student fitness to practise and whether the student register will be maintained when the General Social Care Council is abolished and its functions transferred to the Health Professions Council.[19]

5.22 The General Medical Council has in the past maintained a register of medical students which was discontinued for economic reasons, but has considered its reintroduction at various times in recent years.[20] The Nursing and Midwifery Council plans to introduce a student index. This is a database which is maintained by the Council and will contain the data of every student who is enrolled on an approved programme. The main purpose is to track information, so that an education provider can check whether a student has been removed from another programme of study due to concerns about their conduct. The Council would not make fitness to practise decisions about students, which will continue to be the responsibility of the education institutions.[21]

5.23 A voluntary register is a register of persons who are not required by law to be on that register in order to use a title and practise. But over time, registration might become a requirement of employers and commissioners. None of the regulators has express powers to set up voluntary registration schemes. However, the Health and Social Care Bill 2011 proposes to give each regulator such powers in relation to groups whose work supports or relates to the work of the profession which they regulate.[22] This would include student registers. In order to introduce any form of voluntary register, the regulator must first publish an assessment of the impact of doing so and hold a public consultation. The regulators will also be given powers to establish and maintain a voluntary register jointly with another regulatory body. The Council for Healthcare Regulatory Excellence will have powers to set standards for and to accredit any voluntary registers which are introduced.[23] It is intended that these reforms will be implemented in 2012.

5.24 Some of the regulators have established what amount to informal lists of practitioners within the general register. These can be accessed through the search facilities in the regulators' online registers. In some cases it is possible through an online search to establish full lists of registered practitioners according to gender, additional qualifications, specialisms, region and/or country. Of course these lists are based on largely factual data which is common to all registrants and available on the public register, as opposed to specialist lists based on additional qualifications which are verified and accredited by the regulators.

[18] General Social Care Council, *Health and Social Care Bill – Second Reading Briefing* (2011) para 18.

[19] Health Professions Council, *Consultation on Student Fitness to Practise and Registration* (2011).

[20] See, for example, General Medical Council, *Medical Student Registration – the GMC's Position* (2011).

[21] See, http://www.nmc-uk.org/Get-involved/Consultations/Student-indexing/#whatisastudentindex (last visited 15 February 2012).

[22] The Health Professions Council is not subject to the restriction of only setting up a voluntary register for a group linked to those which they regulate.

[23] Health and Social Care Bill 2011, cls 225 and 227.

5.25 Finally, a small number of the regulators have powers to establish non-practising registers. These may include for example academics, those taking a career break or retired professionals. The General Medical Council achieves this by issuing a licence to practise as well as registration. In order to practise medicine, doctors are not required merely to register but to hold a licence. This allows some registrants such as retired doctors to remain in good standing with the General Medical Council while not holding a licence to practise medicine. The General Pharmaceutical Council has recently abolished its non-practising register on the basis that they should only register those who are appropriately qualified, fit to practise and have met continuing professional development requirements.

Provisional view

Specialist lists

5.26 It would be possible to give the regulators broad powers to divide their registers into different parts and establish specialist lists. Arguably, the regulators are best placed to know which specialisms may be useful for potential users of the register and whether particular specialisms are sufficiently differently from the ordinary to make it necessary or desirable to create a specialist register.

5.27 On the other hand, there are concerns that specialist lists could be used to advance careers in the profession rather than as a mechanism to enhance public protection, and that there are other ways in which for example specialisms can be advertised such as by the relevant professional bodies and employers.[24] On this basis it might be more appropriate for such decisions to be a matter for Government.

5.28 It is also important to consider that the existence of specialist lists and different parts of the registers is referred to in other legislation. For example, the Performers List Process requires an NHS authority or board to satisfy itself that a General Practitioner is a suitable person to be delivering NHS services by requiring them to provide a range of information including a declaration that they are on the General Medical Council's specialist register.[25] Therefore, if regulators were given powers to alter or remove specialist lists this could have consequential implications for other legislation which would need to be amended. This may reinforce the view that such decisions should be a matter for Government.

5.29 On balance we think that the regulators should not be given powers to establish specialist lists. Instead, we propose that the statute itself should specify which types of registers should be established by the regulators, including any different parts and specialist lists. Our assumption is that the existing types of registers would be maintained in the new statute. The Government would then have powers to make regulations to create or remove specialist lists or alter the existing parts of registers.

[24] Council for Healthcare Regulatory Excellence, Advance *Practice: Report to the Four UK Health Departments* (2009).

[25] NHS (Performers List) Regulations 2004, SI 2004 No 585.

Provisional Proposal 5-3: The statute should specify which registers must be established by the regulators, including any different parts and specialist lists. The Government would be given a regulation-making power to add, remove or alter the parts of the register and specialist lists.

Student registers

5.30 Only one regulator currently maintains a compulsory student register. It would be possible for the new statute to give all regulators powers to introduce such a register if they wished to do so. However, any extension of compulsory student registration would impose burdens on others, including students and education institutions. We therefore think that the introduction of student registers should be a matter for Government to decide, in the same way that the regulation of new professional groups would be (see Part 2). In effect, the Government would be given a regulation-making power to introduce compulsory student registers in relation to any of the regulated professions. This would also include systems of student indexing or other ways of monitoring students.

5.31 However, we also think that our consultation provides a valuable opportunity to consider the efficacy of student registration. Proponents of student registers argue that the current systems established by higher education institutions to exclude unsuitable students are ineffective and inconsistent. In effect, the introduction of student registration would bring improved quality and consistency to fitness to practise decisions since the regulators would take over responsibility for most of them. Furthermore, in some professions, students have direct and unsupervised contact with service users, some of whom may be vulnerable or in vulnerable situations. In such cases there may be strong public protection arguments for student registration.

5.32 Opponents of student registration argue that it is unlikely that the regulators would be able to address concerns about students in as timely a manner as educational institutions are able to. This is particularly important for students on a time-limited course. Significant resources would be required to manage student fitness to practise cases, which might be more effectively spent on supporting higher educational institutions. It would therefore be manifestly disproportionate to register significant numbers of students in order to deal with a handful of serious fitness to practise cases which would be better dealt with locally in the first place. The Council for Healthcare Regulatory Excellence's report on student registration did not support the widespread introduction of student registration, but instead argued that there was a need to embed the principles and practices of professionalism in pre-registration training.[26]

Provisional Proposal 5-4: The Government should be given a regulation-making power to introduce compulsory student registration in relation to any of the regulated professions.

Question 5-5: Should student registration be retained in the new legal framework, and/or how can the legal framework help to ensure that the principles and practices of professionalism are embedded in pre-registration training?

[26] Council for Healthcare Regulatory Excellence*, Advice on Student Registration* (2008).

Voluntary registers

5.33 Our provisional view is that voluntary registers do not necessarily need to be a matter which is left to Government. This is on the basis that professionals will not be required to join, and the registers will be paid for on a self-funding basis. Thus voluntary registers do not extend the definition of a profession nor would they have an economic impact on the Government.

5.34 It would be possible for our new system to retain the reforms which are proposed in the Health and Social Care Bill 2011. In effect, all the regulators would have express powers to establish and maintain voluntary registers and the Council for Healthcare Regulatory Excellence would have powers to set standards for and accredit any voluntary registers which are introduced.

5.35 However, a number of concerns have been raised in relation to the establishment of voluntary registers. For example, the Council for Healthcare Regulatory Excellence has in the past stated that:

> In our view the introduction of an assured voluntary registration scheme needs to be clearly distinguished from statutory regulation in order to avoid confusing the public and undermining the validity of either model. For this reason, we recommend that statutory regulators should not also hold voluntary registers as it is likely that the public may assume that the standards and controls are the same.[27]

5.36 Others have argued that there is little point in a voluntary register at all since professionals who pose a risk to the public can "drop below the radar".[28] We welcome further views on the establishment of voluntary registers

5.37 If voluntary registers were embedded in our new scheme, the Council for Healthcare Regulatory Excellence could be given an express power to recommend a group to become voluntarily registered or that a particular group cease to be voluntarily registered (see also question 2-16). Although the regulators would not be required to comply with any such recommendation, they would be required to set out in a report their reasons for not doing so. We welcome further views on this.

Question 5-6: Should the regulators be given powers to introduce voluntary registers?

Question 5-7: If the regulators are given powers to introduce voluntary registers, should the CHRE be given a formal power to recommend to the regulator in question that a group should become or cease to be voluntarily registered? If the regulator decided not to comply, it would be required to issue a report setting out its reasons.

[27] Council for Healthcare Regulatory Excellence, *Proposals for CHRE's New Roles and Responsibilities* (2010), para 2.2.

[28] See, for example, C Santry, "Bill Represents a Missed Opportunity to Regulate HCAs" *Nursing Times* (1/2/11).

Non-practising registers

5.38 As noted above, a small number of the regulators have established non-practising registers. It would be possible for the regulators to continue to have powers to include such people in their registers (for example through annotation or by issuing a separate licence to practise) or to be given powers to establish a separate non-practising register. We do not necessarily think the establishment of non-practising registers is a matter which should necessarily be left to Government. This is on the basis such registers do not extend the definition of, or confer additional advantages on, a profession (although arguably they do bestow a privilege on the person).

5.39 However, there are legitimate concerns about use of non-practising registers. Arguably, they undermine one of the key aims of registration which is to indicate those professionals who are appropriately qualified, fit to practise and have met continuing professional development requirements. The use of non-practising registers is also associated historically with self-regulation where the regulators were seen as protecting the interests of registrants. The ability of retired professionals to remain in good standing with the regulator appears to serve primarily the interests of the profession rather than the public. On the other hand, given that members of a profession spend many years achieving that status and over their careers may move in and out of active practice, some form of passive membership may be useful and administratively sensible. We welcome views on whether non-practising registers should be retained or abolished.

Question 5-8: Should non-practising registers be retained or abolished?

TYPES OF REGISTRATION

5.40 The governing legislation normally outlines a number of different types of registration. The following are common across all the regulators:

(1) full registration;

(2) conditional registration, where the registrant can practise subject to certain conditions such as restrictions on the type of work undertaken or a requirement that the registrant must undergo retraining; and

(3) temporary registration, which applies normally for practitioners who are established elsewhere in the European Economic Area states or Switzerland, and are coming to the UK to provide services for a short period of time, but it can also apply to non-qualified UK practitioners in cases of emergency (see below).

5.41 In addition some of the regulators can register applicants on a provisional basis. This is where newly qualified professionals must demonstrate that they satisfy certain standards before becoming fully registered. At the General Medical Council, for example, provisionally registered doctors with a licence to practise can practise only in certain approved posts and must gain the award of Certificate of Experience before becoming fully registered.

5.42 Some of the governing legislation provides that if the Secretary of State advises that an emergency has occurred, the Registrar can make certain temporary changes to the registrar. For example, the Registrar of the General Medical

Council may register a person (or group of persons) who appears to be fit, proper and suitably experienced to be registered.[29] The Registrar of the Nursing and Midwifery Council can make temporary annotations in the register indicating that certain registrants are entitled to prescribe drugs, medicines and appliances notwithstanding that the registrant is not so qualified.[30]

Provisional view

5.43 Currently, all the regulators register professionals on a full, conditional or temporary basis. Only some, such as the General Medical Council, can register professionals on a provisional basis. We propose that the statute should require all of the regulators to register on a full, conditional or temporary basis. In addition, the regulators would be given powers to introduce provisional registration if they wish to do so. It would be left to the regulators to decide if they wanted to introduce such a system and if so, what form it would take, such as restrictions on practice and educational requirements.

5.44 We also propose that the statute should provide that if the Secretary of State advises that an emergency has occurred, a regulator can make certain temporary changes to the register.

Provisional Proposal 5-9: The regulators will be required to register applicants on a full, conditional or temporary basis. In addition, the regulators will be given powers to introduce provisional registration if they wish to do so.

Provisional Proposal 5-10: The statute will provide that if the Secretary of State advises that an emergency has occurred, a regulator can make certain temporary changes to the register.

REQUIREMENTS FOR REGISTRATION

5.45 Against each type of registration, different requirements for registration will apply. For example, often the governing legislation specifies how applications should be made and the information required, or gives the regulator a power to specify these matters in rules or regulations. The following provides an overview of the various requirements for registration.

Qualifications

5.46 The legislation normally establishes that an applicant must hold an *approved qualification* which is then defined further in rules or regulations. The legislation also provides that the regulator may recognise qualifications obtained outside the UK and register applicants who do not hold a recognised qualification but satisfy the Registrar that they have reached the required standard of proficiency. The registration requirements for European Economic Area nationals are likely to differ from UK and non-European Economic Area applicants. For example, non-European Economic Area applicants are often required to produce evidence that they have sufficient knowledge of spoken and written English to enable them to

[29] Medical Act 1983, s 18A.

[30] Nursing and Midwifery Order 2001, SI 2002 No 253, art 6A.

practise safely and competently.[31] The education requirements for non-UK qualified practitioners are discussed in Part 13.

Good health

5.47 Some of the governing legislation includes a general statement to the effect that in order to be registered an applicant must demonstrate that they are in good health, both physically and mentally.[32] However, some of the legislation takes a different approach by linking any health issues to the person's fitness to practise. In effect, the applicant must be registered if their fitness to practise is not impaired by reason of adverse physical or mental health.[33]

5.48 Some of the regulators require applicants for initial registration to provide a formal health reference from a doctor, while others require merely a self-declaration confirming good health. Other regulators only require a formal medical report at the initial registration stage and not when registration is being renewed.

Good character

5.49 Some of the governing legislation contains a general statement to the effect that in order to be registered the applicant must be of good character.[34] However, not all of the legislation contains such a statement but requires applicants to disclose details of past behaviour and conduct which may impact on their fitness to practise. For example, the Health Professions Council requires applicants to provide details of previous convictions and cautions, details of any disciplinary action and a self-declaration of good character.[35] The regulators may also initiate advance record checks on such matters.

Other requirements

5.50 In addition to the above requirements, some of the legislation specifies that in order to be registered the prescribed fee must be paid. Most of the regulators are given powers to make rules or regulations with respect to the charging of fees for registration. The General Optical Council and General Pharmaceutical Council also require the applicant to show that they have adequate insurance or indemnity arrangements.[36] This is not required by all the regulators, including the Health Professions Council and General Social Care Council.

5.51 However, Directive 2011/24/EU on patients rights in cross border health care, which is due to be transposed into domestic law by October 2013, requires members states to ensure that systems of professional insurance or their equivalent are in place for all health care provided in their territory.[37] This reflects the policy of the four UK health administrations that when harm has been caused

[31] For example, Dentists Act 1984 s 15.

[32] For example, Chiropractors Act 1994, s 3(2)(c).

[33] For example, Medical Act 1983, ss 3(1) and 35C(2)(d).

[34] For example, Osteopaths Act s 3(2)(b).

[35] Health Professions Council (Registration and Fees) Rules Order of Council 2003, SI 2003 No1572, sch 1.

[36] Opticians Act 1989, s 10A and Pharmaceutical Order 2010, SI 2010 No 231, art 32.

[37] Art 4.

through negligence on the part of a registered health care professional, the patient or client should receive any redress to which they are entitled, and the mechanism through which this will be achieved is to require all professionals to hold indemnity or insurance either in their own right or through their employers as a condition of registration.[38] This requirement will not apply to social workers. It is understood that draft legislation will be consulted on in due course and will give the regulators enabling powers to make appropriate rules and regulations.

5.52 Some regulators also require applicants to demonstrate that they have "adequate practical experience" or that the applicant intends to practise in Great Britain, the Channel Islands or the Isle of Man.[39] Some regulators have powers to impose additional educational, training requirements or work experience on certain applicants, for example if they have not practised or have not practised for a certain period of time.[40]

Conditional registration

5.53 Most of the governing legislation deals with conditional registration by giving the Fitness to Practise Panel or similar committee powers to require that registration is conditional on the person concerned complying with certain requirements. However, both the General Chiropractic Council and General Osteopathic Council have alternative systems whereby the applicant is entitled to be registered conditionally if they satisfy certain criteria which includes that the applicant has worked at least four years as a practitioner, passed a prescribed test of competence and given the required undertaking.[41]

Renewal of registration

5.54 Some of the regulators have slightly different requirements for initial registration and the renewal of registration. These often relate to the requirements for continuing professional development. In addition, as noted previously, some regulators also allow for self-declaration of good health at renewal but not initial registration. But not all regulators have a formal renewal process. For example, the General Medical Council requires only the payment of a yearly fee for a doctor's registration and licence to practise to be retained. Renewal of registration is discussed in more detail in Part 6.

Proceeding from provisional to full registration

5.55 Currently, when doctors apply to proceed from provisional to full registration, the General Medical Council can only grant registration if their fitness to practise is not impaired. If investigations are taking place, full registration may still be granted without prejudice to the outcome of those investigations. But if the

[38] Department of Health and others, Response to the Independent Review of the Requirement to have Indemnity or Insurance as a Condition of Registration as a Healthcare Professional (2010). Also see, F Scott, *Independent Review of the Requirement to have Indemnity or Insurance as a Condition of Registration as a Healthcare Professional* (2010).

[39] Opticians Act 1989, s 8(1)(b) and Pharmaceutical Order 2010, SI 2010 No 231, art 20(3).

[40] For example, Health Professions Order 2001, SI 2002 No 254, art 19(3).

[41] Chiropractors Act 1994, ss 3 and 4 and Osteopaths Act 1993 ss 3 and 4.

investigation has concluded that the doctor's fitness to practise is impaired, registration must be refused. It is argued that this causes difficulties because:

(1) in cases where a doctor's fitness to practise is found to be impaired, but the Panel has concluded that he or she is safe to practise subject to conditions on their practise, full registration cannot be granted; and

(2) the way the legislation is worded means that international medical graduates are treated differently from UK and European Economic Area graduates, since their applications cannot proceed until any outstanding investigations are resolved.

5.56 The Council is therefore proposing to remove the test of fitness to practise for provisionally registered doctors applying for full registration.

Provisional view

5.57 There are significant differences in the requirements for full and temporary registration across the regulators. These differences are often a consequence of the broad range of different circumstances faced by each regulator. One possible option for reform therefore would be for the statute to give the regulators broad powers to determine whatever registration requirements they thought were appropriate. In effect, the statute would not specify matters such as qualification or payment of fees, but leave these to be specified by the regulators in rules.

5.58 Although we are attracted to this option, we believe that in some areas the legal framework must establish some degree of consistency across the regulators. Not only would this establish greater legal clarity and certainty for those seeking registration and the public, it would also help to address some of the difficulties associated with some of the requirements for registration.

5.59 First, we provisionally propose that the statute should specify that the applicant must hold one or more approved qualifications in order to be registered. The regulators would then be required to specify in rules what those qualifications are, including those for applicants who have qualified overseas. As noted above, this is in line with the approach taken in most of the governing legislation. This power would also enable the regulators to set any additional education, training or experience requirements for the purposes of conditional registration and renewal.

5.60 Second, we think that the general requirements of good health and character which are contained in some of the legislation should be removed. In our view these provisions suggest some general state of health or character that is required for registration and obscures the primary issue for the regulators of whether these matters affect a professional's fitness to practise. Moreover, there is evidence that these provisions can impact negatively on disabled people, often leading to unwillingness to disclose a disability which in turn reduces the availability of reasonable adjustments in law and individual support.[42]

[42] Disability Rights Commission, *Maintaining Standards: Promoting Equality* (2007). See also Council for Healthcare Regulatory Excellence, *Health Conditions: A Report to the Four UK Health Departments* (2009).

5.61 We propose that the statute should require simply that in order to be registered the applicant must be fit to practise. A person's health or character would only be relevant if this impairs their fitness to practise. This proposal would not mean that the regulators would be prohibited from setting registration requirements relating to health and character, but it would mean that any such requirements must be for the purpose of ensuring that the registrant is fit to practise. However, this proposal would mean an end to the requirement of full health reports for registration. A regulator would still have powers to require such a report, but only if it has concerns about the applicant's fitness to practise.

5.62 However, we welcome views on whether the statute should provide, in addition to the educational and clinical measures of competence, for some criterion that an applicant is a "fit and proper person" to exercise the responsibilities of their profession. Under this approach, it could be left to the regulators to set in rules the different criteria that would be required in this respect.

5.63 Third, we propose that the statute should require that the applicant must be covered by adequate indemnity or insurance (except for social workers). This reflects the requirements of the relevant draft EU Directive which is due to be implemented in 2013 (see above). Finally, the regulators would be required to specify a prescribed fee for the various forms of registration. The precise details of the indemnity or insurance arrangements and the level of fees would be left to the regulators to determine.

5.64 In summary, we provisionally propose that the statute should specify that in order to be registered on a full l or temporary basis the applicant must:

(1) be appropriately qualified (including any additional requirements relating to education, training and experience);

(2) be fit to practise;

(3) have adequate indemnity or insurance arrangements (except social workers); and

(4) have paid a prescribed fee.

5.65 The regulators would have broad rule-making powers to specify the precise detail under each of these headings. Except for the requirement that the applicant is fit to practise, the regulators would also be able to vary the details of the requirements according to the type of registration. Thus, different forms of qualifications could be specified for full and temporary registration. The regulators could also establish different registration requirements where, for example, the person does not hold a recognised qualification.

5.66 We do not propose to establish any separate criteria for conditional registration. Under the new statute, conditional registration would be established at the initial application stage by the regulator specifying that the applicant must meet additional requirements or following registration as a result of a direction being issued by a Fitness to Practise Panel or any other decision-maker empowered to make such a decision (such as the Registrar).

5.67 We propose that the regulators should be given powers to establish separate criteria for the renewal of registrations if they wish to do so. This would enable the regulators to link renewal to systems of continuing professional development and/or revalidation. Both of these are discussed in Part 6. However, as noted previously, regulators would not be able to specify any general requirements of good health or character, and would be required to link any such matters to the registrant's fitness to practise.

5.68 We also propose that under our scheme it will be possible for separate registration requirements to apply to registrants who proceed from provisional to full registration. In effect, the regulators would be given rule making powers to specify separate criteria for such cases. This would allow the removal of the fitness to practise requirement for cases where a registrant moves from provisional to full registration. In our view, this would not compromise the duty to protect the public since the regulator would still have powers to remove, suspend or impose conditions on the registrant's practice.

5.69 Finally, most of the legislation states that applicants are *entitled* to be registered provided that they satisfy the relevant criteria. It has been argued that the reference to *entitled* is problematic because it suggests that registration is something that is owned by the profession rather than the regulator. Instead, the statute could provide for example that the regulator shall register the applicant provided that he or she satisfies the relevant criteria. In legal terms there is no difference between the two formulations, but we can see that symbolically the terminology used may be important. We welcome views on this point.

Provisional Proposal 5-11: The statute should specify that in order to be registered on a full or temporary basis the applicant must be appropriately qualified, be fit to practise, have adequate insurance or indemnity arrangements (except social workers), and have paid a prescribed fee. The regulators should have broad rule-making powers to specify the precise detail under each of these requirements.

Provisional Proposal 5-12: The regulators should be given powers to establish separate criteria for the renewal of registration and for registrants proceeding from provisional to full registration.

Question 5-13: Should the statute provide that in order to be registered an applicant must demonstrate that they are a "fit and proper person" to exercise the responsibilities of their profession?

Question 5-14: Should the legislation state that applicants are entitled to be registered provided that they satisfy the relevant criteria or that the regulator must register the applicant provided that they satisfy the relevant criteria? Does either formulation make any difference in practice?

PROCESSING OF REGISTRATION APPLICATIONS

5.70 Most of the legislation sets out procedural requirements for how registration applications should be processed. In addition, some regulators have developed procedures which govern how registration decisions should be made and

communicated, which have no formal legal status but are consistent with their statutory obligations concerning registration.[43]

5.71 In some cases, time limits for responding to communications are specified. For example, at the General Dental Council and the General Pharmaceutical Council, the Registrar is required to acknowledge the receipt of the application within one month, inform the applicant of any missing documents and notify most applicants of the result of the application within three months.[44]

5.72 In some cases time limits and the mode of communication are specified. For example, the Registrar of the General Medical Council must wait six months for someone not to reply to a letter before they can be removed from the register.[45] Most of the legislation requires that if the application is refused, reasons must be given in writing and the applicant should be informed of their right to appeal.[46]

5.73 Timescales in relation to processing applications from European Economic Area applicants have also been included in Directive 2005/36/EC on the recognition of professional qualifications.[47] The Directive is currently under review and the European Commission have proposed amendments to the Directive that, if adopted, would affect timescales, such as the proposed introduction of a professional card which would include putting timescales on the face of the Directive.[48]

5.74 In order to determine whether the applicant is entitled to be registered, further investigations may be necessary. The ability of the regulators to require information is discussed in more detail in Part 8.

Provisional view

5.75 Most of the governing legislation specifies similar requirements for the processing of registration applications, such as requirements to give written reasons when registration is refused and maximum time limits for responding to applicants. The utility of these statutory provisions is questionable. On the one hand, they appear to be important requirements which guarantee certain minimum procedural standards for applicants and therefore should not be left to the regulators to vary in rules. On the other hand, the time limits specified are now dated and assume communication using the postal service, rather than more modern forms such as email. Moreover, the use of such minimum procedural requirements may inhibit innovation and encourage regulators to aim for the prescribed legal requirements rather than improving their performance to the best possible standard.

[43] See, for example, General Medical Council, *Registration Decisions – Arrangements of Procedures*.

[44] Dentists Act 1983, s 21A and Pharmacy Order 2010, SI 2010 No 231, art 24.

[45] Medial Act 1983, s 30(5).

[46] See, for example, Health Professions Order 2001, SI 2002 No 254, art 9(6) and Nursing and Midwifery Order 2001, SI 2002 No 253, art 9(4).

[47] Art 7(4).

[48] European Commission, *Green Paper: Modernising the Professional Qualifications Directive* (2011).

5.76 We provisionally propose that the statute should require the regulators to communicate expeditiously with registrants and potential registrants. We see this as an area where the Council for Healthcare Regulatory Excellence might be able to assist by encouraging the regulators to improve on their performance (see Part 10). However, our final recommendations will need to take into account the requirements of EU law in relation to European Economic Area applicants.

5.77 In addition, the regulators would also be given broad powers to make rules concerning the processing of registration applications, including any other information that must be provided by the regulator following receipt of the application, time limits for the different stages and how further investigations should be carried out.

Provisional Proposal 5-15: The statute should require the regulators to communicate expeditiously with registrants and potential registrants. The regulators would be given broad rule-making powers concerning the processing of registration applications.

REGISTRATION APPEALS

5.78 The governing legislation provides that most decisions to refuse registration can be appealed. The main exceptions are decisions to refuse registration or remove a person's name from the register by reason only that the person failed to pay the registration fee, make an application or produce the required certificates.[49]

5.79 At some of the regulators, such as the General Chiropractic Council and the General Osteopathic Council, the right of appeal is to the General Council.[50] At the General Dental Council, General Medical Council and General Optical Council a specific Registration Appeals Panel or Committee has been established for this purpose and the regulators can make rules as to the procedure and rules of evidence which are to apply.[51] At the General Social Care Council there is a right of appeal to the Health, Education and Social Care Chamber within the First–tier Tribunal.[52]

5.80 At most of the regulators the right to appeal against the decision of the registration appeals body is to the county court or, in Scotland, the sheriff.[53] The Pharmacy (Northern Ireland) Order 1976 has recently been amended to make provision for appeals to the High Court against fitness to practise decisions.[54]

Provisional view

5.81 In our view, it is important for the new statute to continue to guarantee that most decisions to refuse registration can be appealed. We have considered whether

[49] For example, Medical Act 1983, sch 3A, para 2(2) and Dentists Act 1983, sch 2A, para 2(2).

[50] Chiropractors Act 1994, s 29 and Osteopaths Act, s 29.

[51] Dentists Act 1984, s 50C, Medical Act 1983, sch 3A, para 4 and sch 3B, para 3, and Opticians Act 1989, sch 1A, para 4.

[52] Care Standards Act 2000, s 68.

[53] For example, see Medical Act 1983, sch 3A, para 5.

[54] Pharmacy (1976 Order) (Amendment) Order (Northern Ireland) 2012.

the statute should impose the same appeals process across the regulators, for example by requiring each regulator to set up a Registration Appeals Committee. However, this would have resource implications for some regulators and is not in keeping with our general approach to law reform which would give the regulators greater autonomy to exercise their statutory functions (see provisional proposal 2-2). Instead, we believe that the statute should provide a broad duty within which the regulators can establish their own appeals system.

5.82 We therefore propose that the statute should require each regulator to establish an appeals process when registration applications are refused. Councils would be given discretion in deciding the precise process it wishes to introduce, subject to other considerations such as the outcome of consultation (see Part 2). This could involve the establishment of an appeals panel or committee, or passing the appeals decision to the Registrar.

5.83 The statute would provide a further right to appeal to a court. We do not consider that the county court system or the sheriff in Scotland has sufficient experience to deal with such matters. However, we welcome further views on this point. We propose that the right to appeal should be to the High Court in England and Wales, the Court of Session in Scotland, or the High Court in Northern Ireland. However, a more radical option would be to allow appeals to be considered under the tribunal structure created by the Tribunals, Courts and Enforcement Act 2007. We welcome views on this option. The unified Tribunal Service is discussed in more detail in Part 9 (see question 9-3).

Provisional Proposal 5-16: The statute should require each regulator to establish an appeals process for when registration applications are refused. The regulators would have broad powers to decide the precise process it wants to introduce.

Provisional Proposal 5-17: The statute should provide a right of appeal when registration applications are refused, to the High Court in England and Wales, the Court of Session in Scotland, and the High Court in Northern Ireland.

PUBLICATION AND UPKEEP OF THE REGISTERS

5.84 The governing legislation often includes detailed provisions which govern the publication of the registers and allow for the regulators to amend and alter their registers. Most of the regulators are placed under a duty to publish their registers periodically. For example, the General Medical Council is required to publish the register from "time to time", while the General Chiropractic Council and General Osteopathic Council must publish the register every 12 months.[55]

5.85 The governing legislation also includes general provisions concerning how registers should be published. For example, the Registrar of the General Dental Council is required to publish the register in such form, including electronic, as they consider appropriate.[56] A similar requirement is placed on the General Optical Council.[57] Most regulators are also required to make the register available

[55] Medical Act 1983, s 34, Chiropractors Act 1994, s 9(2) and Osteopaths Act 1993, s 9(2).

[56] Dentists Act 1984, s 22.

[57] Opticians Act 1989, s 11.

for inspection by members of the public at all reasonable times.[58] At the General Pharmaceutical Council, few requirements for the publication of registers are specified in the legislation, and instead the Council can specify most of this detail in rules.[59]

5.86 The legislation also contains provisions which enable the regulator to amend and alter its register.[60] These provisions allow for the making, alteration, corrections and deletions of entries. They often include the removal of an entry with the registrant's consent or if a registration has lapsed.[61] Some regulators can add further information to a register entry when the registrant acquires specialist qualifications or extra skills. At the General Pharmaceutical Council, the registrant is placed under a duty to notify the Registrar of any change to the name under which the registrant practises and any change to the registrant's home address or contact details within one month.[62]

Fraudulently procured and incorrect entries

5.87 The governing legislation sets out a wide range of mechanisms for dealing with entries in the register that have been fraudulently procured or incorrectly made. At some regulators, the Registrar has the power to erase the entry in these circumstances.[63] At others, the final decision on removing the entry rests with the General Council.[64]

5.88 At the General Dental Council, the Registrar can erase entries that have been incorrectly made, but if the Registrar believes the entry has been fraudulently procured the matter must be referred to the Professional Conduct Committee. Following a decision to erase made by the Professional Conduct Committee, the applicant can apply to the Council to have their name restored and the matter is decided by the Committee.[65]

5.89 At the Health Professions Council and Nursing and Midwifery Council all allegations of fraudulently procured or incorrectly made register entries must be referred to the Investigating Committee who can order that the Registrar remove or amend the entry.[66] At the General Optical Council the decision to remove fraudulently procured or incorrectly made register entries can be made only by the Fitness to Practise Committee.[67]

[58] See, for example, Chiropractors Act 1994 and Nursing and Midwifery Order 2001, SI 2002 No 253, art 8(1).

[59] Pharmacy Order 2010, SI 2010 No 231, art 19.

[60] For example, Dentists Act 1983, s 23.

[61] For example, Nursing and Midwifery Order 2001, SI 2002 No 253, art 7.

[62] General Pharmaceutical Council (Registration) Rules 2010, SI 2010 No 1617, r 8.

[63] For example, Medical Act 1983, s 39 and Pharmacy Order 2010, SI 2010 No 231, art 29(3).

[64] For example, Chiropractors Act 1994, s 10 and Osteopaths Act 1993, s 10.

[65] Dentists Act 1983, s 24.

[66] Health Professions Order 2001, SI 2002, arts 26(7) and Nursing and Midwifery Order 2001, SI 2002 No 253, art 26(7).

[67] Opticians Act 1989, s 13J.

5.90 In some cases, the right to appeal is to the High Court in England and Wales, the Court of Session in Scotland, or the High Court in Northern Ireland. But elsewhere the appeal is to the county court or in Scotland to a sheriff.[68]

Provisional view

5.91 Other than requiring the regulators to publish a register, we believe that the regulators should be given discretion to determine matters relating to the upkeep and publication of the register. We therefore propose that the Councils should be given broad rule-making powers on these matters.

5.92 In our view, it is important for the new statute to ensure that all the regulators have powers to deal with fraudulently procured or incorrectly made entries. We have considered whether the statute should impose a consistent process for dealing with these matters across the regulators, for example by requiring that the decision to remove such entries can be made only by a Fitness to Practise Panel or the Registrar. However, this would have resource implications for some regulators and is not in keeping with our general approach to law reform which would give the regulators greater autonomy to exercise their statutory functions (see provisional proposal 2-2). Instead, we think the statute should provide a broad duty within which the regulators can establish their own process.

5.93 We propose that each regulator should be required to establish a process for dealing with fraudulently procured or incorrectly made entries. Councils would be given discretion in deciding the precise process they wish to introduce, subject to other considerations such as the outcome of consultation (see Part 2). This could involve the establishment of a bespoke panel or committee, or giving the decision to the Registrar or a Fitness to Practise Panel.

5.94 We propose that the right of appeal should in all cases be to the High Court in England and Wales, the Court of Session in Scotland, or the High Court in Northern Ireland. However, as noted above, we also welcome views on whether such appeals should be considered under the tribunal structure created by the Tribunals, Courts and Enforcement Act 2007. This is discussed in Part 9 (see question 9-3).

Provisional Proposal 5-18: The regulators should have broad powers to establish rules concerning the upkeep and publication of the register.

Provisional Proposal 5-19: The statute should require each regulator to establish process for dealing with fraudulently procured or incorrectly made entries. The regulators would have broad powers to decide the precise process it wishes to introduce.

Provisional Proposal 5-20: The statute should provide a right to appeal against registration decisions relating to fraudulently procured or incorrectly made entries, to the High Court in England and Wales, the Court of Session in Scotland, and the High Court in Northern Ireland.

[68] Health Professions Order 2001, SI 2002 No 254, art 38(1)(b) and Nursing and Midwifery Order 2001, SI 2002 No 253, art 38(1)(b).

RESTORATION TO THE REGISTER

5.95 A person who has been removed from the register can apply to be restored. In most cases where a registrant's entry has been erased following fitness to practise proceedings, applications for restoration must be referred to a Fitness to Practise Panel or similar committee.[69]

5.96 In such cases, the legislation sets out a prescribed time limit before which applications for restoration cannot be made. The various time limits are set out in table 5 below.

	Time limit for application for restoration	**Time limit for subsequent applications**
GCC	10 months	Not specified
GDC	5 years	After 12 months
GMC	5 years	After 12 months
GOC	2 years	After 2 years
GOsC	10 months	Not specified
GPhC	12 months	Not specified
GSCC	Not specified	Not specified
HPC	5 Years	12 months
NMC	5 years	12 months
PSNI	Not specified	Not specified

Table 5:Time limits for applications for restoration and subsequent applications

5.97 Most of the regulators have detailed rules for how restoration hearings should be conducted. These include rules governing the further investigation of cases, notification of hearings, order of proceedings, the giving of reasons for decisions, publication of decisions, powers of joinder and powers to refer to other committees. In most cases, the restoration decision can be appealed to the High Court in England and Wales, in Scotland the Court of Session and the High Court in Northern Ireland.[70]

5.98 A different procedure applies to applications for restoration in cases not related to fitness to practise proceedings, such as where the person has been removed from the register because they have been working abroad, taken a career break,

[69] For example, Medical Act 1983, s 41(3) and General Medical Council (Fitness to Practise) Rules Order of Council 2004, SI 2004 No 2608, r 23(1). At the General Optical Council such hearings are undertaken by the Registration Appeals Committee, but in practical terms this is the same as a fitness to practise committee; Opticians Act 1989, s 13K.

[70] For example, Opticians Act 1989, s 23G.

not complied with continuing professional development requirements or failed to pay the registration fee. In most cases the application for restoration is decided by the Registrar, with a right of appeal to for example an appeals committee.[71] Most of the regulators require applications to be accompanied by supporting documentary evidence such as a self-declaration on health and conduct matters, evidence of continuing professional development and a letter of good standing.[72]

Provisional view

5.99 We believe that the new legal framework should provide that applications for restoration in cases where a registrant's entry has been erased following fitness to practise proceedings must be referred to a Fitness to Practise Panel or similar committee. Our approach to such hearings including the procedures to be adopted is set out in detail in Part 9. The right of appeal against restoration decisions would continue to be to the High Court in England and Wales, the Court of Session in Scotland, or the High Court in Northern Ireland. We also welcome views on whether restoration hearings and appeals could be transferred to the Unified Tribunal Service. This is discussed in more detail under question 9-3.

5.100 We also welcome views on whether the legislation should establish a consistent time period before which applications for restoration cannot be made, and if so what the appropriate time period should be. This could be seen as an important matter on which greater consistency and certainty would be beneficial for professionals and members of the public. The statute could, for example, specify that across all the regulators an application for restoration cannot be made before the end of the period of five years, and in any period of twelve months in which the application has already been made. This is the current time period used by most regulators, and would have no significant resource implications overall since it is a longer time period than that used by the other regulators. However, we recognise this would limit rights to appeal for former registrants where the deadline is much less than 5 years.

5.101 In other cases which are not related to fitness to practise proceedings, we think that the regulators should be able to develop their own processes, taking into account their own circumstances and resources. In effect, the statute would require each Council to establish in rules a process for considering applications for restoration. This could include for example a system whereby all applications are referred to the Registrar or to a committee. The regulators would also have broad powers to establish rules on matters such as supporting documentary evidence, time limits and fees.

Provisional Proposal 5-21: The statute should provide that applications for restoration in cases where a registrant's entry has been erased following fitness to practise proceedings must be referred to a Fitness to Practise Panel or similar committee.

[71] General Pharmaceutical Council (Registration) Rules 2010, SI 2010 No 1617, r 16.

[72] See, for example, General Pharmaceutical Council (Registration) Rules 2010, SI 2010 No 1617, r 16(3)(a).

Provisional Proposal 5-22: The statute should provide a right to appeal against restoration decisions by a Fitness to Practise Panel to the High Court in England and Wales, the Court of Session in Scotland, and the High Court in Northern Ireland.

Question 5-23: Should the statute set a consistent time period before which applications for restoration cannot be made (in cases where a registrant's entry has been erased following fitness to practise proceedings), or should this matter be left to the regulators to determine?

Provisional Proposal 5-24: The statute should require each regulator to establish in rules a process for considering applications for restoration in cases which are not related to fitness to practise proceedings. The regulators would be given broad discretion to determine the precise process they wish to adopt.

CONTENT OF THE REGISTERS

5.102 The governing legislation often specifies what information must be included in the registers, such as the person's name, address, date of registration and qualifications. In most cases, the regulators are also given powers to make rules and regulations further specifying the content of the registers. These powers have been exercised to establish long and detailed lists of information that must be included in the register, such as gender, title, honours and distinctions, additional qualifications, fitness to practise history and specialisms. As noted previously, these powers have also been used to indicate non-practising registrants. The rules and regulations can specify the minutiae of detail, such as requiring that the register must set out the names of registrants in alphabetical order.[73] In some cases the Registrar is also given wide powers to enter any information in the register which is material to the registrant's registration.[74]

5.103 Public registers raise questions of data protection and freedom of information. A professional may not feel that the details of their registration are salient in the public domain, whereas the public interest may indicate that full disclosure is appropriate. At most of the regulators, there are differences between what appears in the public register and what is otherwise entered into the register. Various rules and regulations specify which details can and cannot appear in the public register. For example, the rules made by the Health Professions Council provide that the home address of a practitioner shall not appear in the public register without that person's consent.[75]

5.104 The White Paper *Trust, Assurance and Safety*, setting out the previous Government's programme of reform for the regulation of health professionals, argued that for the non-medical health professions post registration qualifications should be recorded in the register only "where these are relevant to patient care, risk management and are at a level substantially beyond the requirements for basic registration". Regulators were also asked to look at what other changes

[73] General Chiropractic Council (Registration) Rules 1999, SI 1999 No 1856, r 3(2).

[74] Health Professions Council (Registration and Fees) Rules Order of Council 2003, SI 2003 No 1572, r 3(4).

[75] As above, r 3(2).

could be made to provide better information for patients, the public and employers when considering post-registration qualifications.[76]

5.105 The Health Professions Council currently annotates its register to indicate where a registrant has undertaken additional training on medicines and has obtained entitlements to supply, administer or prescribe these medicines. The Council is required to do this under the Prescriptions Only (Human Use) Order 1997.[77] The register is annotated where:

(1) A chiropodist/podiatrist, physiotherapist or radiographer has completed an approved programme enabling them to become a supplementary prescriber; and

(2) A chiropodist/podiatrist has completed an approved programme allowing them to sell or supply prescription only medicines and/or administer local anaesthetics.

5.106 The Council is consulting on whether, in addition, post registration qualifications in neuropsychology and podiatric surgery should be annotated in the register.[78]

5.107 The Council for Healthcare Regulatory Excellence has raised concerns that only some of the regulators provide access through their online registers to information about health professionals currently prevented from practising because of fitness to practise sanctions. It recommended that the regulators should provide information about all current fitness to practise sanctions on their online registers, including suspensions and those who have been struck off.[79] Some of the regulators have specific rules requiring details of sanctions to be published in the register. For example, the General Pharmaceutical Council requires all warnings, undertakings, suspensions, conditions and determinations of impaired fitness to practise to be entered in the register.[80] The General Medical Council's regulations also provide a detailed list of sanctions which must be included in the register.[81] Others deal with this issue by giving the Registrar general discretion to enter any information which is material to the case.[82]

5.108 Some but not all of the regulators are required to publish information about former registrants who have been struck off or erased from the register. For example, the General Medical Council is required to publish against each entry in

[76] Trust, Assurance and Safety – the Regulation of the Health Professions in the 21 Century (2007) Cm 7013, para 6.12.

[77] SI 1997 No 1830. Issued under the Medicines Act 1968.

[78] Health Professions Council, *Consultation on Our Proposals for Post-Registration Qualifications* (2010).

[79] Council for Healthcare Regulatory Excellence, *Health Professional Regulators Registers: Maximising the Contribution of the Regulators' Registers to Public* (2010).

[80] General Pharmaceutical Council (Registration Rules) Order of Council 2010, SI 2010 SI 1617, r 5.

[81] General Medical Council (Form and Content of the Registers) Regulations (No 2) 2010, reg 2 and 5(k).

[82] Health Professions Council (Registration and Fees) Rules Order of Council 2003, SI 2003 No 1572, r 3(4).

the register any order for erasure by Fitness to Practise Panel.[83] The General Chiropractic Council and General Dental Council have adopted the practice of maintaining in their registers the details of those who have been struck off, but are not required to do so by their governing legislation.

Provisional view

5.109 In accordance with provisional proposal 2-2, we believe that the regulators should in most cases have a significant degree of flexibility in determining the content of their registers. This would include powers to indicate a person's name, gender, title, address, date of registration, qualifications and specialisms.

5.110 We welcome further views on annotating the register to indicate additional qualifications. The advantage of indicating additional qualifications is mainly where it leads to a protected title or protected functions. It provides clarity for the public about which professionals do not have the qualifications or meet the standards for that specific title or role. But where a qualification is indicated which is not linked to a protected title or function the advantages are less clear. This could add clarity in recognising standards for certain areas of practice. However, this may result in confusion about the purpose or meaning of the annotation.

5.111 In our view there are compelling reasons why primary legislation should establish minimum requirements where issues of public protection are relevant, such as requiring all registers to include details of any existing sanctions that have been issued following a finding of impaired fitness to practise. At present, the legal framework often leaves this matter to the discretion of the Registrar. We propose that the statute should establish greater clarity and require all current fitness to practise sanctions to appear in the public register. However, we welcome views on whether there are exceptions where it is not appropriate to make certain sanctions public or whether the level of information provided should be limited, for example where the sanctions relates solely to a professional's ill health.

5.112 We also believe there are strong arguments for including on the register the details of other sanctions or forms of disposal which have been issued without a finding of impaired fitness to practise. This might include undertakings, warnings and Interim Orders. However, since in these cases the professional's fitness to practise has not been found to be impaired, we propose that the regulators should be given discretion to include details of these sanctions. In making this decision they will need to consider whether it is necessary in order to protect, promote and maintain the health, safety and well-being of the public.

5.113 It may also be important for public protection reasons to include in the registers details of former registrants who have been struck off. This would help the public to identify individuals who have been struck off the register but continue to provide similar services under a different, unregulated title. In such cases, fitness to practise sanctions may remain relevant long after the panel has issued its determination. The Council for Healthcare Regulatory Excellence has recommended that regulators should publish information about health professionals who have been struck off on their online register for at least 5 years

[83] General Medical Council (Form and Content of the Registers) Regulations No 2 2010, reg 2 and 5(k).

and provide links to information about previous fitness to practise sanctions.[84] We welcome views on this recommendation.

5.114 We also welcome views on whether the registers should also be required to include details of all previous sanctions. On balance, our view is that such details should not be included in the register, especially since the purpose of the fitness to practise process is not to punish a professional.[85] Arguably, a registrant's fitness to practise history is irrelevant unless it impacts on their current ability to do their job. Alternatively, a more flexible approach could be introduced whereby the Councils are given discretion to include details of all past sanctions based on severity of the misconduct or lack of competence and the time limits for each sanction. There may be some forms of sanctions for which it is not appropriate to maintain details, such as interim orders that have been revoked because there was no finding of impairment or sanction. Any such decisions would of course be subject to the paramount duty of the regulators to protect the public (and confidence in the profession) by ensuring proper standards for safe and effective practice (see question 3-1). However, giving such discretion is not without its difficulties. For example, it would mean that a regulator would in effect be saying that although a registrant is *fit to practise*, public protection necessitates telling the public that they were suspended 10 years ago; in effect, some are more *fit to practise* than others. This in turn may lead to more litigation.

Provisional Proposal 5-25: The regulators should have broad powers to make rules concerning the content of the registers. The only exception to this approach would be that set out in provisional proposal 5-27.

Question 5-26: Should the regulators be given broad powers to annotate their registers to indicate additional qualifications or should this power be subject to certain restrictions?

Provisional Proposal 5-27: The statute should require all current fitness to practise sanctions to appear in the public register.

Provisional Proposal 5-28: The regulators should have discretion to include details of undertakings, warnings and interim orders in the public register (subject to the main duty of the regulators to protect the public by ensuring proper standards).

Question 5-29: Should the regulators be required to publish information about professionals who have been struck off, for at least 5 years after they have been struck off?

Question 5-30: Should the regulators be required to include in their registers details of all previous sanctions?

[84] Council for Healthcare Regulatory Excellence, *Health Professional Regulators Registers: Maximising the Contribution of the Regulators' Registers to Public* (2010).

[85] See Part 9.

PROTECTED TITLES AND FUNCTIONS

5.115 All of the governing legislation creates criminal offences in relation to titles that are restricted to registrants and activities that are restricted to registrants. The Council for Healthcare Regulatory Excellence has stated that:

> Patients and the public recognise health professional titles because they indicate competence and fitness to practise. There is a risk to patient safety and public protection when unqualified people pass themselves off as registered professionals. Health professional regulators have a duty to ensure protection for patients and the public, and tackling title misuse is an important part of this.[86]

5.116 The governing legislation provides for over 70 protected titles (see Appendix D). In the majority of cases the protected titles are specified in the governing legislation. However, this is not always the case. For example, the General Dental Council can make regulations to prescribe protected titles in addition to the titles dentist, dental surgeon or dental practitioner which are specified in statute law.[87] The Privy Council is given an order making power to designate protected titles in relation to each part of the register maintained by the Health Professions Council.[88]

5.117 However, the ability of registers to protect titles can be limited. For example, practitioners may evade the requirements of registration by using a protected title with a prefix (such as student, trainee or consultant) or by carrying out the same functions as a registered professional but under some other title. Alternatively, it has been reported to us that some practitioners use titles such as *manipulative therapist* and *footcare practitioner* in or to avoid registration with the General Chiropractic Council or the General Osteopathic Council.

5.118 Some legislation also provides that certain activities or functions can only be undertaken lawfully by registrants or certain registrants. Some of these protected functions are contained in the governing legislation. For example, the Opticians Act 1989 restricts the testing of sight, fitting of contact lenses and sale and supply of optical appliances to registered medical practitioners, optometrists and dispensing opticians.[89] In many instances protected activities are established under different legislation. For example, certain activities that can only be undertaken by medical practitioners that have been registered with the General Medical Council are specified in a wide range of legislation including the Abortion Act 1967, Children Act 1989, Court Marital (Appeals) Act 1968, Finance Act 2004, Medicines Act 1968, Mental Health Act 1983, Police and Criminal Evidence Act 1984, Road Traffic Act 1968, Terrorism Act 2000 and Veterinary Surgeons Act 1966. The regulators are sometimes required to indicate in their registers

[86] Council for Healthcare Regulatory Excellence, *Protecting the Public from Unregistered Practitioners: Tackling Misuse of Protected Title* (2010) para 1.1.

[87] Dentists Act 1984, s 26.

[88] Health Professions Order 2001, SI 2002 No 254, art 6.

[89] Medical Act 1983, ss 47 and 48 and Opticians Act 1989, ss 24 to 27.

which practitioners have undertaken additional training to be able to undertake protected functions.[90]

5.119 In addition to protected functions some of the regulators also refer to the concept of scope of practice. This refers to the areas of practice that professionals have the knowledge, skills and experience to practise lawfully. This is linked to the issuing of standards of proficiency and is discussed in Part 6.

Misuse of protected titles and functions

5.120 As noted above, the legislation establishes criminal offences relating to protected titles and functions. Although the regulators are not given express statutory prosecution powers, some have adopted a policy of bringing prosecutions in some cases as part of their public protection duty. This role has developed in the main because of concerns amongst the regulators that the view of the police is that prosecutions under a regulator's own statutory provisions are a matter for that regulator. In most cases the decision whether or not to prosecute is delegated to the Registrar or the Investigation Committee.

5.121 The General Optical Council, for example, has a protocol setting out the procedure to be followed in investigating criminal offences and determining in each case whether criminal proceedings should be brought.[91] However, the Council only has powers to bring prosecutions in England and Wales, and not in Scotland (where all prosecutions proceed in the name of the Lord Advocate or the Procurator Fiscal). Other options available include a referral to their internal fitness to practise procedures, another regulator, the NHS Counter Fraud Agency, trading standards agencies, the police and the Public Prosecution Service for Northern Ireland and the Crown Office and Procurator Fiscal Service in Scotland.

5.122 In addition to offences created by the governing legislation, regulators may consider other offences that are relevant to its remit, for example someone who has gained registration by providing false information or someone has breached a court order requiring the production of a document requested by the regulator in the course of an enquiry.

5.123 Some of the regulators do not bring prosecutions and focus instead on tackling title misuse by alternative means, such as improving the awareness of employers and registrants about the importance of checking registration. This policy has been adopted largely because of the practical difficulties associated with bringing prosecutions including the perceived high threshold for pursuing prosecutions, the insufficient deterrent effect of fines, and the fact that any fine imposed is not received by the regulator and any costs order is highly unlikely to cover the costs of preparing the case.[92]

[90] For example, Prescription Only Medicines (Human Use) Order 1997, SI 1997 No 1830. Issued under the Medicines Act 1968.

[91] Council for Healthcare Regulatory Excellence, *Protecting the Public from Unregistered Practitioners: Tackling Misuse of Protected Title* (2010) para 4.17.

[92] As above, pp 5 to 10.

Provisional view

5.124 The current system of protected titles and functions is an important aspect of the existing regulatory system. Our provisional view is that to ensure sufficient legal certainty and clarity all the existing protected titles and functions that are set out in the governing legislation should be specified in the statute.

5.125 As noted above, some of the regulators and in some cases the Privy Council have powers to establish additional protected titles. We propose that these powers should be removed in the new legal framework. Instead, our view is that the Government should be given a power to issue regulations which would add to or remove any of the existing protected titles and functions. This is because such decisions will require a political policy decision to be made about which titles and functions should be protected through the introduction of criminal offences, and the allocation of public resources (such as court time and police support) to support this policy decision (see provisional proposal 2-10).

5.126 However, our review does present an opportunity to look again at the titles that are protected, or to prevent the use of particular title by specific groups. For example, concerns have been raised about the use of the term doctor in circumstances where it implies that the person is a medical practitioner.[93] Other examples might include allowing doctors and dentists to describe themselves as surgeons but not osteopaths and podiatrists. There may also be a need to look again at the existing protected functions. For example, it has been argued that the skills required to carry out refraction are within the competencies of dispensing opticians and should not be restricted to physicians and optometrists.[94]

5.127 We propose that the regulators should continue to have the ability to bring prosecutions. It would be left to the regulators to decide whether or not to do so. The regulators would be required to set out in a publicly available document their policy on bringing prosecutions, including any procedures and criteria that will apply. However, this would not apply in Scotland where all prosecutions proceed in the name of the Lord Advocate or, in the sheriff court, in the name of the Procurator Fiscal.

5.128 Finally, the Law Commission has recently completed a project to establish a principled basis for the creation of criminal offences in a regulatory context. The main recommendations made by the Commission include that, for example, criminal law should only be employed to deal with wrongdoers who deserve the stigma associated with criminal conduct (and not as the primary means of promoting regulatory objectives) and that separate offences should be removed when a general criminal offence would suffice (for example those in the fraud Act 2006).[95] The regulatory aspects of this project have been implemented in part by

[93] W Jerjes, "Use of Medical Titles By Non-Doctors Can Mislead Patients" (2011) *British Medical Journal* 343, d4241.

[94] Association of British Dispensing Opticians, *Refraction by Dispensing Opticians* (2010).

[95] Criminal Liability in a Criminal Context (2010) Law Commission Consultation Paper No 195.

the Government in its guidance to departments.[96] Our final recommendations will need to reflect the principles set out in this review.

Provisional Proposal 5-31: All the existing protected titles and functions that are contained currently in the governing legislation should be specified in the new statute.

Provisional Proposal 5-32: Government should be given a regulation-making power to add to or remove any of the protected titles and functions.

Question 5-33: How appropriate are the existing protected titles and functions?

Provisional Proposal 5-34: The regulators will have powers to bring prosecutions and will be required to set out in a publicly available document their policy on bringing prosecutions (except in Scotland).

[96] Ministry of Justice, *Criminal Offences Gateway Guidance* (2011).

PART 6
EDUCATION, CONDUCT AND PRACTICE

6.1 One of the key functions of the regulators is to ensure proper standards of practice throughout a professional's career. To achieve this, the regulators oversee the quality of pre-registration and post-registration education and training in order to equip students with the skills and knowledge they need for practice. They also issue guidance such as codes of conduct, standards of proficiency and ethical guidelines which set out the values and principles on which good practice is founded. In addition, the regulators require registrants to keep their knowledge and skills up to date throughout their working life and to maintain and improve their performance.

6.2 This Part considers how the new statute should enable the regulators to carry out these roles. It is divided into the following:

(1) overlapping responsibilities;

(2) education;

(3) guidance; and

(4) ongoing standards of practice.

OVERLAPPING RESPONSIBILITIES

6.3 The regulator is only one player in the complex fields of ensuring proper standards of professional education, conduct and practice. Furthermore, health and social care education and clinical standards are to a significant degree devolved matters, which adds a further level of complexity.

6.4 In education and training, there is considerable overlap between the functions of the regulators in setting standards and the roles undertaken by other bodies. For example, the education of health and social care professionals will fall often within the sphere of higher education and the auditing and inspections regimes that apply. These regimes in England include those maintained by the Higher Education Funding Council for England, Quality Assurance Agency, Office for Fair Access and Office of the Independent Adjudicator. These external quality assurance activities are in addition to higher education institutions' own internal quality assurance processes.

6.5 There are also a number of different bodies with varying degrees of responsibility for education and training provision, including universities and other education institutions (such as medical and dental schools), Royal Colleges and other representative bodies, local authorities, Skills Sector Councils (such as Skills for Health), Medical Education England, NHS Education for Scotland, Wales Deanery and the Northern Ireland Medical and Dental Training Agency. This degree of overlap requires significant coordination between the various bodies. For example, at the General Medical Council this is achieved through a three tier quality assurance model: the General Medical Council sets the standards, requirements and outcomes for medical education and training, the medical schools and deaneries provide the Council with evidence that the standards are

being met by the local education providers and the medical schools and local education providers ensure that students and trainees receive education and training which meet the required standards.[1]

6.6 For some of the professions, such as nurses and midwifes, funding for education comes primarily through the NHS, and the Government therefore exerts a strong influence over its content. Currently in England, Strategic Health Authorities determine where to invest the £5 billion central budget for education and training and monitor value for money of the contracts they award to education providers. The Department of Health has proposed the introduction of Local Education and Training Boards which will take on many of the responsibilities currently undertaken by the Strategic Health Authorities and the creation of a new body, Health Education England, to support the networks nationally.[2] In Wales, the National Leadership and Innovation Agency for Healthcare is responsible for annual contract reviews with education providers. In Scotland, NHS Education for Scotland has recently taken on the role of contract monitoring on behalf of the Scottish Government Health Directorates. In Northern Ireland, a similar role is performed by a number of agencies including the Northern Ireland Medical and Dental Training Agency.

6.7 There is also a good deal of overlap between the conduct and practice standards set by the regulators, and Government standards placed on health and social care services and monitored by bodies such as the Care Quality Commission in England, the Care Inspectorate in Scotland, Healthcare Inspectorate Wales and the Regulation and Quality Improvement Authority in Northern Ireland. For professionals practising in the NHS, clinical governance arrangements are also important in regulating the conduct of individual clinicians. Clinical governance is the system through which NHS organisations are held accountable for the quality of their services and for example includes National Service Frameworks, national clinical audits and in England and Wales, guidelines issued by the National Institute of Clinical Excellence.[3] Each of the devolved countries produces its own clinical guidance, setting out priorities and allocating funds from the overall budget allocation.

6.8 Professional bodies, such as the Royal Colleges, or trade unions may also publish standards for conduct for members.[4] International bodies, such as the International Confederation of Midwives and the International Federation of Social Workers, also publish competencies for professionals.[5]

6.9 An example of the overlap between the conduct and practice standards set by the regulators and other professional and legal responsibilities can be seen in the duty of candour (a requirement on professionals to be open and honest with patients when things go wrong). Both the General Medical Council and Nursing

1 General Medical Council, *GMC Education Strategy 2011-2013* (2010).

2 Department of Health, *Liberating the NHS: Developing the Healthcare Workforce* (2011).

3 Department of Health, *A First Class Service: Quality in the New NHS* (1998) p 33.

4 For example, British Association of Social Workers, *Code of Ethics in Social Work* (2002).

5 For example, International Confederation of Midwives, *Competencies* (2006) and International Federation of Social Workers and International Association of Schools of Social Work, *Ethics in Social Work – Statement of Principles* (2004).

and Midwifery Council's standards contain requirements that if a patient has suffered any harm, the registrant must act immediately to put matters right and provide a full explanation promptly.[6] In England, similar statements are contained in the *NHS Constitution*, the *Code of Conduct for NHS Managers*, guidance provided by the National Patient Safety Agency, and regulation requirements published and enforced by the Care Quality Commission. A similar duty of candour is also provided for under the Compensation Act 2006. Moreover, the Department of Health has proposed the introduction of a new duty of candour which will be introduced in the new contract arrangements for NHS commissioning.[7]

Provisional view

6.10 The regulators' role in ensuring proper standards of professional education, conduct and practice is a complex one. A multitude of agencies have varying degrees of responsibility for ensuring proper standards of professional education, conduct and practice, and therefore decisions cannot be taken in isolation. While the regulators are responsible for setting standards in these areas, their ability to monitor and deliver those standards is heavily reliant on others. This is in marked contrast to their other statutory functions. However, the available research suggests that the legitimacy of the regulators' involvement in education, conduct and practice is beyond doubt and their contribution is valued in particular "for the confidence and subject-specific insight that it can provide".[8]

6.11 Under our proposed legal framework, the regulators would continue to be required to ensure proper standards of professional education, conduct and practice. But it is also important that the framework does not add to the existing complexity in these areas, and encourages a more streamlined and coordinated approach to this regulatory task. We believe this could be achieved in two ways.

6.12 First, consistent with provisional proposal 2-2, the regulators would be given greater freedom to adopt their own approach to regulating education, conduct and practice, including a lighter-touch approach where appropriate. This would enable a regulator, for example, to reduce its regulatory activity or withdraw from a specific task, especially where the impact is marginal and other agencies are undertaking similar tasks. Any decision to reduce or withdraw involvement in an area would, of course, be subject to the main duty to protect the public (and maintain confidence in the profession) by ensuring proper standards (see Part 3). An example might include issuing guidance, which is discussed in more detail below.

[6] General Medical Council, *Good Medical Practice: Being Open and Honest with Patients if Things Go Wrong* (2009) and Nursing and Midwifery Council, *The Code: Standard of Conduct, Performance and Ethics for Nurses and Midwifes* (2008).

[7] Department of Health, *NHS Constitution for England* (2010); Department of Health, *Code of Conduct for NHS Managers* (2002); National Patient Safety Agency, *Being Open: Communicating Patient Safety Incidents with Patients, their Families and Carers* (2009); Care Quality Commission, *Guidance about Compliance: Essential Standards of Quality and Safety* (2010); Compensation Act 2006, s 2; and Department of Health, *Implementing a Duty of Candour: A New Contractual Requirement for Providers* (2011).

[8] Council for Healthcare Regulatory Excellence, *Quality Assurance of Undergraduate Education by the Healthcare Professional Regulators* (2009) para 5.7.

6.13 Second, our legal framework would encourage greater joint working between the regulators themselves for the purpose of ensuring proper standards of professional education, conduct and practice. This is discussed in more detail in Part 12. Currently, regulators typically undertake their own quality assurance and information gathering activity, but our scheme would enable them to co-ordinate such activity and reduce the burdens on the institutions being regulated, for example by entering into partnership arrangements. It is likely that joint work in education will become increasingly important with moves towards greater multi-disciplinary education and training, for example as certain health practitioners take on roles of diagnosis and prescribing. Of course, there are limits to what the law can achieve in relation to encouraging joint working, and limits to what greater joint working between the regulators can achieve in simplifying the complex field of education, conduct and practice. We welcome further views on how or whether our proposals could go further to encourage a streamlined and coordinated approach to regulation of these areas.

6.14 It is also important to recognise that there are consequences which arise for our proposed reforms from the fact that regulators rely significantly on others in these areas. A significant number of current legal provisions in this area – such as duties to provide information and give access to inspectors – are directed towards other bodies, including educational institutions and training providers. It would be possible to leave these matters to the regulators to introduce similar requirements in rules. However, we believe that such an approach could produce uncertainty in the areas of education, conduct and practice, and have therefore proposed that some of these provisions should be set out in statute law. The specific provisions are discussed in the rest of this Part.

Question 6-1: Should our proposals go further in encouraging a more streamlined and coordinated approach to regulation in the areas of education, conduct and practice? If so, how could this be achieved?

EDUCATION

6.15 Health and social care education is seen as the process through which individuals are imbued with a set of professional values and standards that they are expected to meet throughout their career. Historically it has therefore been seen as important for the regulators to be responsible for the assurance of educational standards for professionals. The following discussion considers how the regulators approach this task. The issue of student registration is discussed separately in Part 5.

The general approach to regulation

6.16 The broad structure for undertaking this function is the same across the regulators, in that the quality assurance of education is not targeted at individual students but is concerned with the approval and monitoring of courses/programmes and institutions. Typically such activity may involve surveys, inspections and interviewing students, trainers and patients. But there are clear differences in the ways in which, and the frequency with which, the regulators undertake these tasks.

6.17 The rationale for different approaches in part can be explained by the differences between the professions and the regulators themselves. For example, following

the transfer of the functions of the Postgraduate Medical Education and Training Board to the General Medical Council in 2010, the Council now oversees every stage of a doctor's pre-registration and postgraduate education and training. This is possible in part due to medicine's long history of pre-registration education and clearly structured career pathway through post-registration education and training. In contrast, some of the newer professions have smaller numbers, and less developed education and training structures, which can limit the degree of oversight maintained by the regulator.

Pre-registration education

6.18 In most cases, the governing legislation provides the regulators with the function of approving courses, programmes or qualifications for the purpose of initial registration. This includes the approval of qualifications from outside the UK (see Part 13). This is normally contained in a statutory provision which requires the regulator in question to establish the standards and requirements for qualifications leading to initial registration. The legislation achieves this in various ways.

6.19 The General Medical Council is required to hold a list of the bodies which are entitled to hold qualifying examinations for the purpose of granting a "primary UK qualification". These examinations must conform to the standard of proficiency prescribed by the Council. The Medical Act 1983 lists the qualifications needed for a primary UK qualification as including a degree of bachelor of medicine.[9]

6.20 The General Optical Council is required to establish the competencies a person must demonstrate to be granted a qualification as an optometrist or dispensing optician, and the content and standards of education and training.[10] The Council may approve establishments, qualifications and any test of a candidate's competency in, or knowledge of, English and must from time to time publish a list of establishments and qualifications approved by them, indicating the purposes for which the approval was granted.[11]

6.21 As well as establishing the standards of education, the Nursing and Midwifery Council is given powers to establish the requirements that must be satisfied for admission to, and continued participation in, such education and training including requirements of good health and good character.[12]

6.22 The governing legislation also includes several references to Directive 2005/36/EC on the recognition of professional qualifications. As set out in Part 13, the Directive provides a framework for the recognition of professional qualifications across the EU to allow professionals to practise in countries other than their own. The references to the Directive in the governing legislation include requirements that any relevant qualification and any rules made on training are in accordance with the Directive, and confirmation that the Council is a competent authority for the purposes of the Directive. The Medical Act 1983 also states that in undertaking its general functions in relation to medical education, the General

[9] Medical Act 1983, s 4.

[10] Opticians Act 1989, s 12.

[11] As above.

[12] Nursing and Midwifery Order 2001, SI 2002 No 253, art 15(1)(b).

Medical Council must satisfy the requirements of article 24 of the Directive.[13] The obligation to observe the Directive's requirements under section 12A of the Dentists Act 1984 falls directly onto universities.

6.23 In practice, most of the regulators no longer focus on detailed prescription of the specific topics and subjects which should feature in the courses/programmes and how these should be taught to students, but instead place emphasis on the learning outcomes which must be achieved by the student. However, the Dentists Act 1984 contains detailed provisions setting out, amongst other matters, who can carry out examinations for a degree or licence in dentistry and requirements for those examinations.[14] The Act also empowers the General Dental Council to make representations to the Privy Council if a dental authority attempts to impose on an exam candidate an obligation to adopt, or to refrain from adopting, the practice of any particular theory of dentistry. The Privy Council can direct the authority not to impose any such obligation and that the authority shall cease to have power to grant degrees or licences in dentistry.[15]

6.24 In some cases the regulators are given additional administrative requirements when approving courses and programmes. For example, the General Chiropractic Council and General Osteopathic Council must request the approval of the Privy Council before recognising a qualification.[16] Most of the regulators are required to publish their standards and requirements for the approval of qualifications, and make copies available for the relevant education institutions. The evidence upon which quality assurance judgments rest is wide ranging and includes national training surveys, annual returns and reports by providers, and interviews with trainers, students and patients. The General Medical Council is also introducing Employment Liaison Officers and Regional Liaison Officers to assist in this task.

6.25 All of the regulators have powers to refuse or withdraw recognition of courses, programmes, qualifications and institutions, for example where there is no longer evidence of having reached the required standard of proficiency.[17] When withdrawing their approval, many of the regulators are required to follow specific steps such as notifying the relevant body and providing reasons within a specified time scale.[18] At the General Medical Council, the outcome is essentially binary in that the medical school is either recognised or not.

6.26 Some of the regulators are also given powers to regulate aspects of the education and training environment. This includes institutional policies and procedures, resources provided for training, caseload limits for trainees, teaching time allocated to work placements, supervision requirements, and the quality of teaching rooms.

[13] Medical Act 1983, s 5 (2A).

[14] Dentists Act 1984, ss 3 to 7.

[15] As above, s 12.

[16] Chiropractors Act 1994, s 14 and Osteopaths Act 1993, s 14.

[17] For example, Chiropractors Act 1994, s 16.

[18] Nursing and Midwifery Order 2001, SI 2002 No 253, art 18.

Inspection

6.27 Most of the regulators are given powers, or required, to appoint visitors to visit approved education providers or those seeking approval. For example, the General Optical Council is placed under a duty to keep itself informed of the nature of the instruction given by any approved training establishment and for this purpose may appoint visitors.[19] How these powers or duties are implemented varies between the regulators. For example, the General Medical Council operates a policy of a five year cycle of visits for organisations and in addition targeted checks, for example where concerns are raised, and random checks. Visiting teams normally consist of a medically qualified member, a lay member, a student or trainee and a member of staff from the Council.

6.28 In most cases, institutions are required to comply with any reasonable request for information made by the regulator, and if the institution refuses then the regulator may consider refusing or withdrawing approval from the relevant course or programme.[20] Some regulators are also given express powers to appoint inspectors to attend exams.[21] Visitors are prohibited from interfering with the operation of the education institution but empowered to issue a report on any relevant matters.[22]

6.29 The General Dental Council's powers to appoint visitors are subject to any direction that may be given by the Privy Council. Furthermore, the Privy Council has a power to issue directions in relation to visits being carried out to dental schools and post graduate institutions and copies of the monitoring report must be sent to the Privy Council.[23]

Post-registration qualifications

6.30 Some of the Councils have powers to oversee post-registration qualification. This includes setting standards for the delivery of foundation and speciality training for registrants. For example, the General Medical Council is given powers to approve programmes and establish standards and requirements for the two year foundation programme that all registrants must undertake, plus the optional three year training to become a General Practitioner or longer to become a specialist consultant.[24] The legislative framework for the Council sets different approaches for undergraduate and postgraduate training. Thus, in relation to undergraduate training the Council sets outcomes and the system of quality assurance is based on recognition of institutions, but for postgraduate training the Council approves curricula and assessment systems. Furthermore, at undergraduate level the medical school is either recognised or not, but in postgraduate education, there is more flexibility in that the Council can grant conditional approval for a training programme or post.

[19] Opticians Act 1989, s 13.

[20] For example, Nursing and Midwifery Order 2001, SI 2002 No 253, art 17.

[21] For example, Dentists Act 1984, s 10.

[22] For example, Medical Act 1983, ss 6 and 7. See also, General Medical Council, *The Trainee Doctor : Foundation and Speciality, including GP Training* (2011).

[23] Dentists Act 1984, s 9.

[24] Medical Act 1983, ss 10A and 35H.

6.31 The Health Professions Council has powers to annotate its register to record post-registration qualifications or additional competencies, approve post-registration qualifications for these purposes, approve and establish standards of education and training for post-registration qualification, and produce standards of proficiency or their functional equivalent.[25] Currently it annotates its register to indicate where a registrant has undertaken additional training on medicines and has obtained entitlements to supply, administer or prescribe these medicines. The Council is required to do this under the Prescriptions Only (Human Use) Order 1997.[26] The register is annotated where:

(1) a chiropodist/podiatrist, physiotherapist or radiographer has completed an approved programme enabling them to become a supplementary prescriber; and

(2) a chiropodist/podiatrist has completed an approved programme allowing them to sell or supply prescription only medicines and/or administer local anaesthetics.[27]

6.32 Some regulators do not have powers to establish or have decided not to implement quality assurance systems for post-registration qualifications. This is often on the basis that post-registration qualifications are undertaken by individuals who are already statutorily registered and therefore work within a regulatory framework, or that the practitioner's area of practice would not alter substantially or pose a risk to the public as a result of post-registration qualifications. The White Paper *Trust, Assurance and Safety* argued that for the non-medical health professions, post-registration qualifications should be recorded in the register only in cases "where these are relevant to patient care, risk management and are at a level substantially beyond the requirements for basic registration".[28]

Statutory committees

6.33 For many regulators, statutory committees are given a key role in the regulatory function of overseeing professional education. For example, the General Optical Council's Education Committee and Standards Committee are given important roles by the Opticians Act 1989 in giving advice and assistance to the General Council on matters relating to education and training. For instance, the Council must consult its Standards Committee when establishing the competencies which a person must be able to demonstrate in order to be granted a qualification as an optometrist or a dispensing optician and the Education Committee when establishing the content and the standard of education and training required for the purpose of achieving those competencies.[29] The Health Professions Council's Education and Training Committee is required to advise the Council (whether on

[25] Health Professions Order 2001, SI 2002 No 254, arts 2(4) and 19(6).

[26] SI 1997 No 1830. Issued under the Medicines Act 1968.

[27] Health Professions (Parts of and Entries in the Register) Order of Council 2003, SI 2003 No 1571, art 6.

[28] Trust, Assurance and Safety – the Regulation of the Health Professions in the 21 Century (2007) Cm 7013, para 6.12.

[29] Opticians Act 1989, s 12(2).

the request of the Council or otherwise) on the performance of the Council's functions in relation to education and training.[30]

6.34 The General Osteopathic Council's Education Committee is given the general duty of promoting high standards of education and training in osteopathy and keeping this matter under review, including, where it considers it to be necessary, providing, or arranging for the provision of, education or training. The General Council is required to consult the Education Committee on matters relating to education, training, examinations or tests of competence. The Education Committee is also given powers to appoint visitors.[31]

Provisional view

6.35 In accordance with provisional proposal 2-2, we believe that the regulators should be given greater autonomy to determine their own approach to the approval of pre-registration and post-registration education and training. This would enable the regulators to undertake the task of regulation in such a way that reflects the circumstances each faces, including the potentially significant costs and burdens imposed by quality assurance systems. For example, the regulators could opt for a process-driven approach to regulation which relies heavily on approving the content of courses/programmes and inspection, or an outcomes-based approach. The regulators could also choose to regulate individual education programmes and/or education institutions and/or the environment in which education is delivered.

6.36 We do not believe that the regulators should be required to adopt fundamentally different approaches to pre and post-registration education. Rather, they should have discretion to adopt a consistent or a different approach depending on their circumstances and resources. We also think that the regulators should be able to adopt a range of regulatory sanctions to address quality assurance problems, such as formal warnings and conditions. Alternatively, the regulators may wish to adopt formal systems of giving advice to institutions or programme leaders, and/or introduce special measures for struggling institutions or the flagging of excellence.

6.37 This would be subject only to the duty to protect the public (and maintain confidence in the profession) by ensuring proper standards (see Part 3). Thus any decision to accredit, for example, post-registration should be based on risk to the public and patients, rather than career enhancement. This should help to prevent a proliferation of additional annotations on the register.

6.38 Our provisional view is that there is a small number of important tasks in this area that each regulator should be required to undertake. However, these requirements should be worded in broad terms to give the regulators considerable discretion on how they are implemented. For other tasks we think the regulators should be given powers but not duties to implement them.

6.39 We provisionally propose that the statute should require the regulators to make rules on:

[30] Health Professions Order 2001, SI 2001 No 254, art 14.

[31] Osteopaths Act 1993, ss 11 and 12.

(1) which qualifications are approved qualifications for the purposes of pre registration and post-registration qualifications;

(2) the approval of education institutions, courses, programmes and/or environments leading to an award of such qualifications and the withdrawal of approval;

(3) rights of appeals to an individual or a panel against the decision of the regulator to refuse or withdraw approval from an institution or course/programme;

(4) the quality assurance, monitoring and review of institutions, courses, programmes and/or environments; and

(5) the appointment of visitors and establishment of a system of inspection of all relevant education institutions.

6.40 The regulators would be given broad powers to establish further rules on how these matters are implemented.

6.41 The statute would also require the regulators to establish and maintain a published list of approved institutions and/or courses and programmes, and publish information on any decisions regarding approvals.

6.42 As discussed in Part 12, the statute would also place duties on education institutions to cooperate with the regulator in relation to its education function (including for the purposes of quality assurance and inspection). This would enable the regulators formally to require certain information and require the institutions to give reasons in writing if they decide not to comply. Such a refusal (depending on the reasons given) could lead to the regulator considering refusing or withdrawing approval from the relevant course or programme; but we do not think it is necessary to include this as a statement in the legislation.

6.43 In addition, we propose that the statute should include a specific requirement on education institutions to pass on to the regulator in question information about student fitness to practise sanctions, including warnings, conditions, undertakings, suspension from the course/programme and expulsion.[32] This reflects the conclusions of the inquiry of the Council for Healthcare Regulatory Excellence into student fitness to practise, which argued that it is in the interests of public protection to share an individual student's fitness to practise sanctions with a regulator.[33]

6.44 In addition, the regulators would be given powers but would not be required to issue rules on other matters, including but not limited to:

[32] In most cases education providers for courses leading to a professional qualification investigate and take action where there are concerns about a student's fitness to practise. See, for example, Sheffield Hallam University, *Student Fitness to Practise Regulations* (2011). Some of the regulators issue guidance for education providers.

[33] Council for Healthcare Regulatory Excellence, *Student Fitness to Practise: Should the Regulators Receive Every Outcome?* (2010).

(1) additional ways of limiting recognition of courses, programmes and institutions such as the issuing of formal warnings or conditions for approval;

(2) the use of special measure for struggling institutions;

(3) establishing schemes to recognise excellence in professional education;

(4) the payment of visitors; and

(5) charging fees for performing any aspect of their education function.

6.45 As noted above, much of the regulatory activity in relation to education involves inspecting institutions and approving courses and programmes. This can be seen as a proxy for the real concern which is ensuring that the student or professional is fit to practise. An alternative approach would be to focus more on the individuals emerging from training and for the regulators to take steps to assure themselves that the newly qualified professionals possess the qualities that are necessary to practise. This could involve for example a national assessment of students or auditing data which highlights individual progression. We welcome views on whether the powers of the regulators should extend to such matters.

6.46 In most cases, the law does not give the regulators a role in selecting those entering pre-registration or post qualification specialist training. It has been argued that such a role would usurp and duplicate unnecessarily that of education institutions.[34] However, in relation to post graduate specialist training where selection is increasingly based on assessment techniques, there may be a role for regulatory oversight.[35] Our provisional view is that the regulators should not be given powers over the selection of those entering education, due to the dangers of unnecessary duplication of function, but we would welcome further views on whether this would be a useful power.

6.47 As noted earlier in this Part, education may increasingly cross occupational boundaries, especially with certain health practitioners taking on areas in diagnosis and prescribing. The *Royal Infirmary Inquiry* (see Part 1) stated that the benefits of educating students such as doctors and nurses together should be explored "with vigour" and urged that there should be a first year which is "common to all" despite the acknowledged differences in educational qualifications.[36] Our proposals set out above would allow the regulators to undertake joint education courses/programmes and in Part 12 we discuss the ways in which the statute would allow the regulators to work jointly on such matters. However, we would welcome any views on whether our proposals could go further in providing a framework for the approval of multi-disciplinary education and training.

[34] General Medical Council, *Final Report of the Educational and Training Regulation Policy Review: Recommendations and Options for the Future Regulation of Education and Training* (2010), para 57.

[35] As above, para 93.

[36] Learning from Bristol: the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 -1995 (2001) Cm 5207, p 329.

6.48 Finally, there are a number of features of the current legislative framework that are in our view unnecessary and should be removed. We propose that the marginal role of the Privy Council in education, such as issuing directions concerning visits, should be repealed. Our approach to the role of the Privy Council is set out in Part 2. In addition, we propose that statutory education committees should no longer be a feature of the legislative framework. In accordance with provisional proposal 4-9, there would be no statutory committees in our proposed scheme, although the regulators would have powers to establish systems of committees if they wished to do so. Also, we do not propose to include in the statute express references to the requirements of EU law. It is unnecessary and inappropriate for the statute to simply repeat other provisions stated elsewhere in law.

Provisional Proposal 6-2: The statute should require the regulators to make rules on:

(1) which qualifications are approved qualifications for the purposes of pre-registration and post-registration qualifications;

(2) the approval of education institutions, courses, programmes and/or environments leading to an award of approved qualifications and the withdrawal of approval;

(3) rights of appeals to an individual or a panel against the decision of the regulator to refuse or withdraw approval from an institution, course or programme;

(4) the quality assurance, monitoring and review of institutions, courses, programmes and/or environments; and

(5) the appointment of visitors and establishment of a system of inspection of all relevant education institutions.

Provisional Proposal 6-3: The statute should require the regulators to establish and maintain a published list of approved institutions and/or courses and programmes, and publish information on any decisions regarding approvals.

Provisional Proposal 6-4: The statute should require education institutions to pass on to the regulator in question information about student fitness to practise sanctions.

Question 6-5: Should the powers of the regulators extend to matters such as a national assessment of students?

Question 6-6: Should the regulators be given powers over the selection of those entering education?

Question 6-7: Could our proposals go further in providing a framework for the approval of multi-disciplinary education and training, and if so how?

GUIDANCE

6.49 There are various types of guidance issued by the regulators which can be divided into the following categories: codes of conduct, standards of proficiency, and ethical guidelines and other guidance. However, in practice there is no bright line distinction and much overlap between the categories.

6.50 The following discussion considers guidance issued for individual registrants. Some of the regulators are also given powers to set standards for businesses. These are discussed separately in Part 11.

Codes of conduct

6.51 A code of conduct which incorporates a declaration of professional values has been described as "a distinguishing feature and its observance a condition of membership of most professional bodies".[37] The purpose of such a code is to provide a summary of how registrants are expected to behave and informs not only the professionals themselves but also patients and the general public. Most of the regulators are required or empowered by their governing legislation to prepare and publish a code of conduct.[38] However, the nomenclature used for each document varies across the regulators and includes Code of Conduct, Standards of Practice, Code of Practice and Standards of Conduct, Ethics and Performance. The governing legislation often states that this document should be published and reviewed from time to time.

6.52 The content and length of these documents varies considerably. Some are only short pamphlets which contain a brief list of broad principles. These principles can include generic values which reflect more general commitments for instance honesty, integrity, confidentiality and trustworthiness, as well as values that relate directly to professional practice such as beneficence, respect for autonomy and the centrality of the service user. Some codes also include technical information about matters such as indemnity insurance. Other codes are more expansive and amount to detailed guidance on how a professional should perform their core tasks. These types of guidance tend to combine both standards of practice and standards of proficiency (see below). Some of the codes also cover complex ethical/legal matters such as disclosures without consent, obtaining informed consent and living wills.

6.53 It has been pointed out that, in the past, codes have been concerned with issues of professional self-interest and etiquette such as restrictions on advertising and refraining from making disparaging remarks about colleagues. In recent times they have become concerned with emphasising a patient-led approach that places weight on patient autonomy and prioritises the patient's interests. This has led to increased emphasis on consent, confidentiality and responding to complaints.[39] One of the most detailed codes is the General Medical Council's

[37] D Badcott, "Professional Values: Introduction to a Theme" (2011) 14 *Medical Health Care and Philosophy* 185, 185.

[38] For an example of a requirement, see Chiropractors Act 1994, s 19(1) and Dentists Act 1984 s 36M. For an example of a general power see Health Professions Order 2001, SI 2001 No 254, art 21.

[39] J Stone "Evaluating the Ethical and Legal Content of Professional Codes of Ethics" in J Allsop and M Saks (eds), *Regulating the Health Professions* (2003).

Good Medical Practice which covers matters such as the duties of a doctor, good clinical care, maintaining good professional practice, teaching and training, appraising and assessments, relationships with patients, probity and health.[40] Some of the regulators, such as the General Dental Council and General Pharmaceutical Council, adopt the approach of a short high-level code of conduct which is supported by more detailed guidance booklets that explain how the code should be implemented.

6.54 It has been argued that codes of conduct are generalised statements of common values and therefore unenforceable in law.[41] Nonetheless, the Codes are in fact enforced through administrative decisions made by the regulator, the decisions of Fitness to Practise Panels and the courts.[42]

6.55 Some of the codes themselves contain statements which indicate their legal status. In the majority of cases this statement will be to the effect that all registrants must act in accordance with the code or guidance and a failure to comply will put registration at risk.[43] The main exception is *Good Medical Practice* which contains a more detailed statement to the effect that:

(1) the document is guidance and not a statutory code and doctors must use their judgement to apply the principles to the various situations faced;

(2) where the guidance uses the term "you must" this indicates an overriding duty or principle, but where the term "you should" is used this indicates an explanation of how doctors should meet the overriding duty or where the main duty will not apply to all situations; and

(3) "serious or persistent" failure to follow the guidance will put registration at risk.[44]

Standards of proficiency

6.56 All of the regulators are required to determine from time to time the standards of proficiency for safe and competent practice.[45] Standards of proficiency are described as being based on the principle that every practitioner must follow "the current, sound practice of a reasonable practitioner".[46] They are applicable to prospective registrants applying for the first time and existing registrants.

6.57 The standards that are published are generally speaking minimum standards that are necessary for safe and effective practice, rather than best practice or aspirational standards. The areas covered typically include assessment skills,

[40] General Medical Council, *Good Medical Practice* (2006).

[41] J Stone "Evaluating the Ethical and Legal Content of Professional Codes of Ethics" in J Allsop and M Saks (eds), *Regulating the Health Professions* (2003) p 63.

[42] For example, *General Medical Council v Meadow* [2006] EWCA Civ 1390, [2007] 2 WLR 286 at [113].

[43] For example, Nursing and Midwifery Council, *The Code: Standards of Conduct, performance and Ethics for Nurses and Midwives* (2008), p 2.

[44] General Medical Council, *Good Medical Practice* (2006) p 5.

[45] For example, Dentists Act 1984, s 36D and Medical Act 1983, s 5.

[46] General Chiropractic Council, *Code of Conduct and Standard of Proficiency* (2010) p 38.

obtaining case histories, understanding the legislation relevant to the field of practice, establishing and maintaining personal and professional boundaries, planning care and support interventions and the evaluation of such interventions, and joint working. The content of standards of proficiency is more likely than codes of practice to vary in substantive terms between the different regulated professions. Indeed, the Health Professions Council publishes a single code of conduct which applies to all fifteen regulated professions, and also publishes separate standards of proficiency for each.

6.58 Most of the regulators are required from time to time to publish and review their statement of standards of proficiency. The General Osteopathic Council is also required, if at any time it varies the standard, to publish a statement of the differences between that statement and the statement prior to the revision.[47] Most of the regulators publish standards of proficiency which are separate documents to the code of conduct. The main exceptions include the General Medical Council which combines elements of a code of conduct and standards for proficiency in *Good Medical Practice* and the General Chiropractic Council which publishes a separate code of conduct and standards for proficiency in a single document.[48]

6.59 In addition to standards of proficiency, the Nursing and Midwifery Council must make rules which regulate the practice of midwifery for local supervising authorities, which are the bodies responsible for ensuring that statutory supervision of midwives is undertaken according to the Nursing and Midwifery Council's rules.[49] There is some overlap between these rules and matters contained typically in standards of proficiency, such as sphere of practice and record keeping, but they also include detailed practice requirements such as the procedure for giving notice of intention to practise in an area, the administration of medicines, and suspension from practice by local supervising authorities.[50]

6.60 The Opticians Act 1989 adopts an unusual approach in providing for a number of specific practice standards in the statute itself, in addition to empowering the General Optical Council to make rules specifying standards of proficiency. For example, the Secretary of State is given powers to require in regulations that when a professional tests the sight of another person, they must perform certain examinations for detecting injury, disease or abnormality, and provide a written statement confirming this has been carried out and whether or not a referral will be made to a registered medical practitioner. The Secretary of State exercised these powers in 1989.[51] In addition, the Opticians Act 1989 requires practitioners who have tested the sight of another person to provide a prescription or a statement to the effect that optical appliances are not necessary. The 1989 Act also sets out prohibitions on practitioners when selling or supplying contact lens

[47] Osteopaths Act 1989, s 13(3).

[48] General Medical Council, *Good Medical Practice* (2006) and General Chiropractic Council, *Code of Practice and Standard of Proficiency* (2009).

[49] The bodies are Strategic Health Authorities (England), Public Health Agency (Northern Ireland), Regional Boards (Scotland) and Health Inspectorate Wales. See, Nursing and Midwifery Order 2001, SI 2002 No 253, arts 42 and 43.

[50] Nursing and Midwifery Council, *Midwifes Rules and Standards* (2004).

[51] Opticians Act 1989, 26(1); Sight Testing (Examination and Prescription) Regulations 1989, SI 1989 No 1176 and Sight Testing (Examination and Prescription) (No 2) Regulations 1989, SI 1989 No 1230.

and other optical appliances, such as not providing lenses to people unless they have a valid specification and requiring sales of certain appliances to be effected by or under the supervision of a registrant.[52]

Ethical guidelines and other guidance

6.61 The importance of ethics, values and attitudes alongside clinical competence is recognised by some regulators through the provision of separate guidance. For example, the General Medical Council publishes supplementary ethical guidance on matters such as end of life care, treating children and young people, consent and personal beliefs and medical practice. This guidance is intended to expand on the principles in *Good Medical Practice*. The Council has established a standards and ethics committee which amongst other matters oversees the development and publication of such guidance. However, not all of the regulators issue ethical guidance, and as noted above some of the regulators combine their ethical guidance with their codes of conduct and/or standards of proficiency.

6.62 There is a range of other forms of guidance published by the regulators. Much of this guidance is intended to support or expand on the core code of conduct. For example the Nursing and Midwifery Council issues guidance on matters such as whistle blowing, record keeping and the care of older people and their carers.

6.63 Most of the regulators issue detailed internal guidance for members of staff or committee members. For example, most regulators issue indicative sanctions guidance to promote consistency and transparency in decision-making by Fitness to Practise Panels or Committees. Mr Justice Collins stated that each Panel "must have regard to [indicative sanctions guidance] although obviously each case will depend on its own facts and guidance is what it says and must not be regarded as laying down a rigid tariff".[53]

6.64 Depending on the profession, there are other professional bodies and stakeholders that share the task of developing, disseminating and ensuring good practice alongside the regulators.

Provisional view

6.65 Three main concerns arise in this area. The first relates to the sheer volume of professional guidance. The professional code of conduct may not necessarily be central to a practitioner's practice as it must compete with other guidance, including guidance issued by professional bodies and Government.[54] In effect, the guidance issued by the regulators will only be one of several overlapping sources of practice, ethical and legal guidance.[55] There is a danger of overload and unnecessary duplication. We welcome further views particularly from professionals on this point. Of course, the regulators are not the sole or even the

[52] Opticians Act 1989, s 27.

[53] *Council for the Regulation of Healthcare Professionals v General Medical Council* [2004] EWHC 1850 (Admin), [2004] All ER (D) 563 (Jul) at [24].

[54] However, the regulators' obligatory professional guidance would override guidance from professional bodies which would not be mandatory.

[55] For an example, see the discussion of the duty of candour provided earlier in this Part.

main cause of this problem, but it does point towards the need to streamline overall the amount of guidance issued to practitioners.

6.66 Second, the legal status of the guidance issued by the regulators is uncertain. Some of the codes of conduct do contain an explicit statement, but many codes and other forms of guidance do not. But in our view even the existing statements – normally to the effect that registrants must act in accordance with the code and a failure to comply will put registration at risk – fail to provide a clear description of their legal status. This is not to say that guidance has the same status as the law of the land which is enforceable in a court, a rule of the profession enforceable in a professional tribunal or a rule of conduct which is binding. Instead, guidance can be of two forms: a matter to which the professional must follow unless there is good reason not to and something which must be given due weight but is not binding in formal terms. We think that the regulators should be required to specify which form of guidance in this sense they are issuing.

6.67 A further concern relates to the quality and efficacy of some of the guidance issued by the regulators. The content of some codes of conduct can at best be described as vague and rhetorical, and would appear to be of little practical value for professionals. It might be argued that if professionals need to be reminded, for example, to “act kindly”, “be honest”, not to “abuse, neglect or harm service users” and not to enter into sexual relations with patients, then they ought not be practising. However, the inclusion of such statements in an official code may make them easier to enforce by Fitness to Practise Panels. We welcome further views on the utility of the standards of practice issued by the regulators.

6.68 We propose that the statute should require the regulators to produce guidance for professional conduct and practice. In our view, this should be a duty and not a power because the issuing of such guidance is an essential part of the regulatory role, and it would not be acceptable for a regulator to decide not to issue any form of guidance in relation to the standards it is responsible for enforcing.

6.69 However, the regulators should be given discretion to decide how they will implement this duty. This would enable each regulator to tailor its guidance to suit the needs of the professions it regulates. In effect, the statute would not specify which documents must be produced, thus allowing them to issue codes of conduct, standards of proficiency, ethical guidelines and/or other guidance. For example, a regulator could decide to issue all of these as separate documents or in a single document. Alternatively, they could decide to issue, for example, standards for proficiency but not a code of conduct.

6.70 This would enable the regulators to streamline the overall amount of guidance that is produced. In part, this decision might be influenced by the availability of similar guidance which has been issued by others. For example, a regulator could decide not to issue guidance on a certain matter because it is satisfied that adequate guidance is already being produced by a professional body.

6.71 It is also important to note that under our proposed reforms the regulators would be given express powers to issue joint standards for practice with each other and/or with other bodies, such as the Royal Colleges, if they wish to do so. This would also allow some reduction in the overall amount of guidance. Joint working (including joint guidance) is discussed separately in Part 12.

6.72 We also believe that the new legal framework should ensure greater clarity over the legal status of the regulators' guidance. We propose that the statute should provide for two separate types of guidance:

(1) *tier one guidance* which has a higher legal status and must be complied with by registrants with unless there are good reasons for not doing so; and

(2) *tier two guidance* which is weaker in status than tier one guidance but it still must be taken into account by registrants and given due weight.

6.73 When issuing guidance, the regulators would be required to state whether the document is tier one guidance or tier two guidance. This statement would appear in the document itself. This approach to the issuing of guidance is used in other areas of health and social care law, and will therefore be familiar to most professionals.[56] In deciding whether a particular document should be tier one guidance or tier two guidance, the regulators will need to consider the nature of the guidance contained therein. Thus, tier two guidance can include generalised statements of good practice, while tier one guidance will need to be clear and precise. Our intention is to ensure that at least in level one guidance, the language used is instructive and not overly vague and rhetorical.

6.74 Under this proposal, it would be possible for the regulators to publish guidance which is a mixture of tier one and tier two guidance. But it would be important for such guidance to distinguish between those statements that have a higher legal status and those that do not (for example, by setting out in bold the relevant level one guidance in the text and by clearly distinguishing between statements in the guidance which use "you should" and "you must").

6.75 Finally, we welcome further views on how the legal framework should deal with the regulators' responsibilities in relation to professional ethics. Currently some of the governing legislation gives the regulator in question a power to advise members of the profession on ethics, and separates this clearly from standards of conduct and performance.[57] However, some of the other legislation either does not mention ethics at all, or treats ethical guidelines as a subset of codes of conduct or standards of proficiency. There may be a case for establishing a clear separation between the regulators' ethical guidelines and standards of conduct and performance. Arguably, the latter amounts to technical guidance for professional practice and will in the majority of cases vary in content between the different professions, while ethical guidance (such as not having sexual relations with a patient) is more likely to be applicable to all the professions. On the other side, the distinction between standards and ethics may not be as sharp as this analysis suggests and it may not be possible for the law to treat them differently.

Question 6-8: Is too much guidance being issued by the regulators and how useful is the guidance in practice?

Provisional Proposal 6-9: The statute should require the regulators to issue guidance for professional conduct and practice.

[56] Mental Health Act 1983, s 118 and Mental Capacity Act 2005, s 42.

[57] For example, Medical Act 1983, s 35.

Provisional Proposal 6-10: The statute should provide for two separate types of guidance: *tier one guidance* which must be complied with unless there are good reasons for not doing so, and *tier two guidance* which must be taken into account and given due weight. The regulators would be required to state in the document whether it is tier one guidance or tier two guidance.

Question 6-11: How should the legal framework deal with the regulators' responsibilities in relation to professional ethics?

ONGOING STANDARDS OF PRACTICE

6.76 Until recently, as long as registered professionals continued to pay their fees and was not the subject of fitness to practise proceedings, the regulator assumed continued fitness to practise. However, as a consequence of the high profile events outlined in Part 1, the regulators have placed more emphasis on ensuring ongoing standards of conduct and practice. Moreover, scientific and clinical advances in knowledge, changing roles in health and social care and rising expectations have reinforced this development. The main mechanisms used by the regulators are continuing professional development and revalidation.

Continuing professional development

6.77 Most of the regulators are given powers to make rules providing for continuing education and training of registrants. Some of the regulators are under a duty to issue such rules. For example, the General Dental Council must make rules to require registered dentists and other dental care professionals to undertake such professional training and development as may be specified in the rules.[58] Similarly, the General Pharmaceutical Council must set the standards for the safe and effective practice of pharmacy which is necessary in order for registration to be renewed and set the standards of continuing professional development.[59] At most of the regulators, the completion of continuing professional development is linked to the process of renewal of registration.

6.78 There are several models of continuing professional development. In most cases the regulators are required to publish standards for continued professional development and consult before issuing them. A failure to satisfy such requirements can lead to a professional being removed from the register. A practitioner can be required to undertake a certain number of hours of continued professional development and it is left to the discretion of practitioners to decide their own needs. Alternatively, the regulator may suggest hours and options for training and monitor compliance. Some regulators have adopted a combination of both approaches. The Nursing and Midwifery Council requires that in order to maintain their registration, professionals must declare that they have completed 35 hours of continuing professional development in the previous three years (as well as 450 hours of registered practice). The Council recommends that registrants keep a portfolio of their continued professional development activity and states that these will be audited.[60] However, in practice the portfolios are

[58] Dentists Act 1984, ss 34A and 36Z(1).

[59] Pharmacy Order 2010, SI 2010 No 231, art 43.

[60] Nursing and Midwifery Council, *Meeting the PREP Standards* (2010).

looked at in detail only when concerns have been raised about the registrant.[61] The General Osteopathic Council's scheme requires registrants to complete 30 hours of continuing professional development each year, at least 15 hours of which must be learning with others.[62]

6.79 In some professions, there is a Royal College or Chartered Society which accredits continuing professional development courses or can provide advice about the quality of continuing professional development courses.

Revalidation

6.80 Revalidation describes a process through which registered professionals can demonstrate to the regulator that they are up-to-date and fit to practise. As set out in Part 1, the history of revalidation is linked to the Bristol, Alder Hey and Shipman cases, amongst others, which cast doubt on the capacity of the medical profession to regulate itself satisfactorily. The General Medical Council first proposed a formal process of revalidation in 2000, which has been the subject of several revisions.[63] The current revalidation proposals originated in the 2007 White Paper *Trust, Assurance and Safety*, although they only recently moved into the implementation phase.

6.81 The General Medical Council's proposed system of revalidation is based on the issuing and renewal of a licence to practise. Since 2005, every doctor needs a licence in order to practise medicine in the UK. Licences do not have an expiry date but will have to be revalidated by the Council. The system for revalidation of that licence will be as follows:

(1) licensed doctors will be required to link to a Responsible Officer[64] and maintain a portfolio of supporting information drawn from their practice which demonstrates how they are continuing to meet the principles and values set out in *Good Medical Practice*;

(2) licensed doctors will participate in a process of annual appraisal based on their portfolio, and the Responsible Officer will make a recommendation to the General Medical Council about a doctor's fitness to practise, normally every five years (based on the outcome of a licensed doctor's annual appraisals and information drawn from the clinical governance system of the organisation in which they work); and

(3) the General Medical Council's decision to revalidate a licensed doctor will be informed by the Responsible Officer's recommendations.[65]

[61] House of Commons Health Committee, Annual Accountability Hearing with the Nursing and Midwifery Council: Seventh Report of Session 2010-12, HC 1428, para 27.

[62] General Osteopathic Council, *Continuing Professional Development Guidelines for Osteopaths* (2006).

[63] See, L Fenton and B Salter, "Competition and Compromise in Negotiating the New Governance of Medical Performance: the Clinical Governance and Revalidation Policies in the UK" (2009) 4 *Health Economics, Policy and Law* 283.

[64] A Responsible Officer is a senior licensed medical practitioner and must be appointed by designated bodies such as Primary Care Trusts in England and Health Boards in Scotland.

[65] General Medical Council, *Revalidation: The Way Ahead* (2010).

6.82 The Government will make an assessment of whether the system is ready to support revalidation in the summer of 2012. Subject to this decision, it is expected that revalidation will be launched in late 2012.[66]

6.83 In 2007, the then Government stated its support for the principle that revalidation should also be introduced for the non-medical health care professions, however "its intensity and frequency needs to be proportionate to the risks inherent in the work in which practitioner is involved".[67] However, the Coalition Government has expressed an "open mind on this issue" and has asked the regulators for the non-medical health care professionals:

> to continue to develop their evidence base that will inform their proposals for revalidation over the next year. For those professions where there is evidence to suggest significant added value in terms of increased safety or quality of care for users of health care services from additional central regulatory effort on revalidation, the Government will agree with the relevant regulators, the devolved administrations, employers and the relevant professions the next steps for implementation.[68]

6.84 The General Dental Council conducted a public consultation in late 2010 on a system for revalidation.[69] It was proposed that revalidation for dentists will take place every five years at which there will be a three step process. The Council has since announced that following the publication of *Enabling Excellence* it will undertake further research on how revalidation might be implemented.[70]

6.85 The General Osteopathic Council launched a pilot scheme in September 2011 for stage one of a four stage revalidation scheme. The first stage is based on self-assessment by osteopaths of their practice. The Nursing and Midwifery Council has also confirmed that it will introduce a system of revalidation by 2014 which will replace the current requirements for maintaining registration. Detailed proposals have not yet been published. The General Chiropractic Council published a consultation document on revalidation in 2010 but has subsequently decided not to introduce a system of revalidation.

Provisional view

6.86 Ensuring ongoing standards of conduct and practice is an essential aspect of the regulatory regime. It helps to ensure that professionals keep their knowledge and skills up to date throughout their working lives and maintain and improve their performance. We provisionally propose that the statute should require the regulators to ensure ongoing standards of conduct and practice through continuing professional development. In effect, it will no longer be acceptable for

66 General Medical Council and others, *Revalidation: A Statement of Intent* (2010) p 3.

67 Trust, Assurance and Safety – the Regulation of the Health Professions in the 21 Century (2007) Cm 7013, para 2.29.

68 Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers (2011) Cm 8008, para 5.3.

69 General Dental Council, *Revalidation for Dentists: Our Proposals* (2010).

70 General Dental Council, *Revalidation: Post Consultation Statement on Revalidation for Dentists* (2011) p 2.

professionals to remain registered merely on the basis that they have paid their fees and have not been subject to fitness to practise proceedings.

6.87 It would also be left to the regulators to decide how to implement this duty. For example, they could place requirements on registrants to undertake and evidence their completion of continuing professional development and introduce powers to remove from the register those who did not meet any such requirements. However, in making this proposal we recognise that requirements for continuing professional development can have a financial impact for organisations such as the NHS. It will therefore be important for the regulators to undertake an impact assessment and consult widely before introducing new requirements (see provisional proposal 2-7)

6.88 Revalidation is likely to become an increasingly important system through which at least some of the regulators will ensure ongoing standards of conduct and practice. However, some systems of revalidation could be expensive and costly for organisations like the NHS to comply with. Arguably, the introduction of revalidation could be seen as matter that should rest with Government to implement via its proposed regulation-making power (see provisional proposal 2-10). However, on balance we propose that the regulators should be able to introduce various systems of revalidation based on a full risk assessment and public consultation. This would include powers to make rules on:

(1) licences to practise for registrants and the circumstances in which they can be granted, varied, withdrawn and any conditions placed on them;

(2) the requirements for the revalidation of the licence or registration (including the frequency of revalidation and information requirements);

(3) any fees charged by the regulators for the purposes of revalidation;

(4) rights to appeal against any revalidation decision;

(5) the restoration of a licence or registration after withdrawal; and

(6) a system of Responsible Officers or any other similar system.

6.89 We welcome further view on this approach and in particular on whether any additional oversight is needed on the introduction of revalidation.

6.90 As noted previously in this Part, most of the regulators have explicit powers to quality assure education and training. Under our proposals, these powers will include any individuals or organisations that deliver revalidation at a local level.

Provisional Proposal 6-12: The statute will require the regulators to ensure ongoing standards of conduct and practice through continuing professional development (including the ability to make rules on revalidation).

PART 7
FITNESS TO PRACTISE: IMPAIRMENT

7.1 Parts 7, 8 and 9 of the consultation paper consider the fitness to practise process, and how it should be provided for in the new statute. Fitness to practise attracts a significant amount of public and media attention and is undoubtedly the most high profile aspect of the regulators' work. The costs of running a fitness to practise procedure also take up a substantial proportion of the regulators' resources.[1] This Part considers how impaired fitness to practise is determined. The following Parts consider the procedures that apply once an allegation of impairment has been made, namely investigation and adjudication.

7.2 Before 2004, all the regulators approached the task of determining a practitioner's fitness to practise by focusing on whether the facts alleged have been proved to the requisite standard. In order to do this, most regulators ran three separate legal processes to which cases were allocated at an early stage: health, conduct and performance. This produced difficulties of demarcation and procedural complexity. In 2004, amendments to the Medical Act 1983 introduced a new unified procedure at the General Medical Council under the jurisdiction of the Fitness to Practise Panel. This procedure inserted an additional stage whereby if the facts alleged are proved to the requisite standard the Panel must then decide whether or not the practitioner's fitness to practise is impaired. In effect, fitness to practise determinations consist of three distinct stages: the fact finding stage, the fitness to practise finding and sanctions. It follows that not every case of misconduct or deficient performance will mean automatically that the practitioner's fitness to practise is impaired.[2] This approach has since been adopted by all the regulators.

7.3 This Part of the consultation paper considers the first two stages of fitness to practise determinations: the fact finding stage and the fitness to practise finding. The sanctions stage is considered in Part 9.

THE FACT FINDING STAGE

7.4 At the first stage, the task for the Panel is to consider whether the facts alleged are proven and, if so, whether those facts amount to the statutory ground specified in the allegation. The statutory grounds are legal categories of conduct or explanations of conduct which form the basis of a finding of impaired fitness to practise. The principal statutory grounds fall under the following headings: misconduct; deficient performance; convictions and determinations; and health.

7.5 The statutory grounds often vary between the regulators. There is also considerable overlap between the different grounds, such that a single case may demonstrate one or more of the different categories.

[1] For example, in 2000 the General Medical Council spent just under £15 million on fitness to practise and in 2010 this increased to just under £44 million out of a total expenditure of £87 million. See, General Medical Council, *Reform of the Fitness to Practise Procedures at the GMC: Changes to the Way We Deal with Cases at the End of an Investigation: A Paper for Consultation* (2011) p 17.

[2] *Cohen v General Medical Council* [2008] EWHC 581 (Admin), [2008] LS Law Medical 246 at [63].

Misconduct

7.6 Most of the governing legislation refers expressly to misconduct as one of the ways in which fitness to practise may be impaired. Although the Chiropractors Act 1994 and the Osteopaths Act 1993 use the phrase "conduct which falls short of the standard required", in practice this covers the same ground as misconduct.[3]

7.7 According to case law, misconduct is of two principal kinds:

(1) sufficiently serious misconduct in the exercise of professional practice; and

(2) conduct of a morally culpable or otherwise disgraceful kind which may or may not be related to the exercise of professional skills, but which brings disgrace upon the practitioner and thereby prejudices the reputation of the profession.[4]

7.8 In most cases, misconduct is interpreted as meaning only serious incidents such as a criminal conviction, dishonest or fraudulent behaviour and sexual contact with a patient. A single negligent act or omission is less likely to cross the threshold of misconduct than multiple acts or omissions but depending upon the circumstances, "a single negligent act or omission, if particularly grave" could be characterised as misconduct.[5]

7.9 Several cases relating to doctors have grappled with the question of which acts or omissions fall within a registrant's professional practice for the purpose of the first limb of misconduct identified above. Activities which have been held as being sufficiently related to the practice of medicine include where a doctor acts in an administrative capacity as chief executive of a hospital or gives expert evidence in a trial.[6] However, in *R (Remedy UK Ltd) v General Medical Council* the involvement of two doctors in developing a medical training appointments system was not sufficiently linked to their professional practice to bring it within the first limb of misconduct outlined above.[7]

Deficient performance

7.10 Most of the governing legislation now refers to deficient professional performance or lack of competence as one of the ways in which fitness to practise may be impaired.[8] Deficient performance as a form of impaired fitness to practise was introduced in the 1990s to deal with cases where a professional's behaviour or

[3] Chiropractors Act 1994, s 20(1)(a) and Osteopaths Act 1993 s 20(1)(a).

[4] *R (Remedy UK Ltd) v General Medical Council* [2010] EWHC 1245 (Admin), [2010] Med LR 330 at [37].

[5] *Calhaem v General Medical Council* [2007] EWHC 2606 Admin, [2008] LS Law Medical 96 at [39].

[6] *Roylance v General Medical Council* [2000] 1 AC 311 and *General Medical Council v Meadow* [2006] EWCA Civ 1390, [2007] QB 462.

[7] *R (Remedy UK Ltd) v General Medical Council* [2010] EWHC 1245 (Admin), [2010] Med LR 330 at [51].

[8] The exception is the General Social Care Council whose governing legislation, the Care Standards Act 2000, does not refer to any form of professional performance or incompetence.

actions suggested a pattern of seriously deficient performance that could not be dealt with effectively under the existing conduct and health procedures. However, commentators have argued that these reforms were unnecessary since the existing categories were sufficiently flexible to deal with such cases.[9] Notwithstanding these arguments, the courts have confirmed that deficient performance is conceptually separate from misconduct and refers to a standard of professional performance which is "unacceptably low" and which is often founded on an "underlying pattern of conduct".[10] Crucially it carries no requirement of harm or of proof that patients were endangered.

7.11 The regulators often assess professional performance through a variety of tests including tests of competence (such as tests of knowledge and practical tests relevant to the practitioner's field of specialism and tests of communication skills) and peer review (such as a site tour, assessment of records, case based discussion with the appellant and third party interviews). The results of the tests are then assessed against the relevant guidance or code of conduct issued by the regulator.

7.12 Case law has confirmed that deficient performance is concerned with the professional's actual past performance, and not their current professional competence.[11] However, the process should not be restricted entirely to a "backward-looking exercise".[12] As is the case with misconduct, deficient professional performance can relate to matters outside the clinical context as long as they are "sufficiently linked" to the registrant's professional practice.[13]

Convictions and determinations

7.13 Nearly all of the governing legislation refers expressly to a conviction for a criminal offence in the "British Islands" as one of the ways in which fitness to practise can be impaired, and most also include a reference to a police caution. The legislation refers normally to a conviction outside of the British Islands which if committed in England and Wales would constitute a criminal offence. The Pharmacy Order 2010 also refers to convictions which if committed in Scotland would constitute a criminal offence .[14]

7.14 Some of the legislation also refers to certain other court determinations other than a complete acquittal. For example:

[9] The Shipman Inquiry Fifth Report: Safeguarding Patients, Lessons from the Past - Proposals for the Future (2004) Cm 6394, para 24.5 and P De Prez, "Self-Regulation and Paragons of Virtue: The Case of 'Fitness to Practise'" (2002) 10 *Medical Law Review* 28, 37.

[10] *R (Vali) v General Optical Council* [2011] EWHC 310 (Admin), [2011] All ER (D) 280 (Mar) at [27] to [29].

[11] *Krippendorf v General Medical Council* [2001] 1 WLR 1054.

[12] *Sadler v General Medical Council* [2003] 1 WLR 2259, 2266.

[13] *R (Remedy UK Ltd) v General Medical Council* [2010] EWHC 1245 (Admin), [2010] Med LR 330 at [50].

[14] See, Pharmacy Order 2010, SI 2010 No 231, art 51(f).

(1) an order under section 246(2) or (3) of the Criminal Procedure (Scotland) Act 1995 discharging the person absolutely (admonition and absolute discharge);

(2) having accepted a conditional offer under section 302 of the Criminal Procedure (Scotland) Act 1995 (fixed penalty: conditional offer by procurator fiscal);

(3) agreement to pay a penalty under section 115A of the Social Security Administration Act 1992 (penalty as alternative to prosecution); and

(4) agreement to be bound over to keep the peace by a magistrates' court in England or Wales.[15]

7.15 The courts have confirmed that proof of a conviction shall constitute conclusive evidence that the practitioner is guilty of the offence and it is not possible to challenge a criminal conviction in disciplinary procedures save in exceptional circumstances.[16] This position has been written into some of the fitness to practise rules.[17]

7.16 Most regulators have the power to establish impaired fitness of practise by reason of the determination of any body responsible for the regulation of a health or social care profession to the effect that the person's fitness to practise is impaired. Some of the legislation also makes specific reference to the inclusion of the person in a barred list within the meaning of the Safeguarding Vulnerable Groups Act 2006, the Safeguarding Vulnerable Groups (Northern Ireland) Order 2006 or the Protection of Vulnerable Groups (Scotland) Act 2007.[18]

7.17 The General Medical Council's rules provide that a certificate from the other body that made the determination "shall be conclusive evidence of the facts found proved in relation to the determination" and the only evidence that can be adduced in rebuttal of a determination is evidence "for the purposes of proving that he is not the person referred to in the certificate".[19] Not all regulators adopt this approach however. The Nursing and Midwifery Council rules provide that such certificates are only "admissible as prima facie evidence of the facts referred to in the evidence".[20] Other regulators do not make any specific provision in their rules for the admissibility of certificates of determinations by other bodies.

[15] See, for example, Dentists Act 1984, s 27(2); Opticians Act 1989, s 13D(2) and Pharmaceutical Order 2010, SI 2010 No 231, art 51(1).

[16] *General Medical Council v Spackman* [1943] AC 627. See also *Shepherd v Law Society* [1996] EWCA Civ 977. In Scotland the corresponding references are Law Reform (Miscellaneous Provisions) (Scotland) Act 1968, s 10; Criminal Procedure (Scotland) Act 1995, s 124(2); and *Hoekstra v HM Advocate* [2000] SCCR 1121, 1121.

[17] For example, General Medical Council (Fitness to Practise) Rules Order of Council 2004, SI 2004 No 2608, rr 34(3) to (5) and Nursing and Midwifery (Fitness to Practise) Rules Order of Council 2004, SI 2004 No 1761, r 31(3).

[18] For example, Health Professions Order 2001, SI 2002 No 254, art 22(1)(vi).

[19] General Medical Council (Fitness to Practise) Rules Order of Council 2004, SI 2004 No 2608, rr 34(4) and 31(5).

[20] Nursing and Midwifery (Fitness to Practise) Rules Order of Council 2004, SI 2004 No 1761, r 31(4).

Health

7.18 All of the governing legislation provides that a registrant's fitness to practise may be impaired by reason of adverse physical or mental health. This category of impaired fitness to practise was introduced following increasing concerns in the 1960s and early 1970s about the inability of the existing regulatory system to deal adequately with professionals who as a result of ill-health presented a risk to patients but had not committed a criminal offence or been guilty of serious misconduct. The most quoted example was professionals misusing drugs and alcohol.[21] At some regulators health cases are dealt with separately through a process which is overseen by a Health Committee, but others have subsumed their Health Committees into the Fitness to Practise Committee or Panels.

7.19 Both the General Medical Council and the Nursing and Midwifery Council have introduced rules which provide that when determining whether a practitioner's fitness to practise is impaired by reason of adverse physical or mental health, the following may be taken into account:

(1) the practitioner's current physical or mental condition;

(2) any continuing or episodic condition suffered by the practitioner; and

(3) a condition suffered by the practitioner which, although currently in remission, may be expected to cause a recurrence of impairment of the practitioner's fitness to practise.[22]

7.20 The General Pharmaceutical Council's fitness to practise rules state that in relation to evidence about the registrant's physical or mental health which might cast doubt on their fitness to practise, the committee must have particular regard to "actual or potential self harm" and "harm to patients or the public".[23]

Other matters

7.21 Most of the governing legislation includes a specific provision that a person's fitness to practise may be regarded as impaired as a result of matters arising outside of the jurisdiction of the regulator or when the person was not registered.[24] Indeed, even where this is not stated expressly the position is likely to be the same.[25]

7.22 The General Optical Council's fitness to practise procedures also extends to business registrants. This is discussed separately in Part 11.

[21] The Shipman Inquiry Fifth Report: Safeguarding Patients, Lessons from the Past – Proposals for the Future (2004) Cm 6394, paras 22.1 to 22.3.

[22] General Medical Council (Fitness to Practise) Rules Order of Council 2004, SI 2004 No 2608, r 17(6) and Nursing and Midwifery (Fitness to Practise) Rules Order of Council 2004, SI 2004 No 1761, r 31(5).

[23] General Pharmaceutical Council (Fitness to Practise and Disqualification etc Rules) Order of Council 2010, SI 2010 No 1615, r 5(3).

[24] The General Chiropractic Council, General Osteopathic Council and General Social Care Council do not.

[25] *R v Prosthestists and Orthodontists Board ex p Lewis* [2001] EWCA Civ 837, [2001] ACD 72 at [33].

THE FITNESS TO PRACTISE FINDINGS

7.23 At the second stage, the Panel must decide whether, on the basis of the facts found proven, the practitioner's fitness to practise is impaired. Legislation does not define impairment of fitness to practise. In the absence of a definition, the courts have stated that the Fitness to Practise Panel must take into account certain "critically important public policy issues", namely the need to protect individual patients and the collective need to maintain confidence in the profession as well as declaring and upholding proper standards of conduct and behaviour.[26]

7.24 The governing legislation requires the Panel to consider whether fitness to practise *is* impaired; that is, at the time of the hearing rather than at the dates of the incidents giving rise to the allegations. Accordingly, Sir Anthony Clarke MR in *General Medical Council v Meadow* emphasised that:

> The purpose of the [Panel] is not to punish the practitioner for past misdoings but to protect the public against the acts and omissions of those who are not fit to practise. The [Panel] thus looks forward not back. However, in order to form a view as to the fitness of a person to practise today, it is evident that it will have to take account of the way in which the person concerned has acted or failed to act in the past.[27]

7.25 In undertaking this exercise, the Panel must take into account all relevant factors such as the extent to which the practitioner has gained insight into their shortcomings, whether the issues raised are easily remediable, whether action has been taken by the practitioner to remedy their failings and the likelihood of such actions or omissions being repeated.[28] Thus, relatively minor incidents of misconduct can result in a finding of impaired fitness to practise when for example, accompanied by uncooperative behaviour by the registrant.[29] The weight of the relevant factors to be considered will vary from case to case depending on the facts.[30] In reaching its decision, the Panel is entitled to take into account material other than the allegations which they have considered.[31] But it cannot take into account further incidents not subject of the charge and not adduced in evidence.[32]

7.26 The jurisprudence indicates that a finding of impairment will follow more naturally from some forms of conduct. In *Yeong v General Medical Council* the High Court accepted the argument that in cases where a registrant has entered into sexual relations with a patient the efforts made by a practitioner to address that

[26] *Cohen v General Medical Council* [2008] EWHC 581 (Admin), [2008] LS Law Medical 246 at [62].

[27] *General Medical Council v Meadow* [2006] EWCA Civ 1390, [2007] QB 462 at [32].

[28] *Cohen v General Medical Council* [2008] EWHC 581 (Admin), [2008] LS Law Medical 246 at [65].

[29] P Case, "The Good, the Bad and the Dishonest Doctor: The General Medical Council and the 'Redemption Model of Fitness to Practise'" (2011) 31 *Legal Studies* 4, 591.

[30] *Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council* [2011] EWHC 927 (Admin), [2011] ACD 72 at [94].

[31] *Nicolas-Pillai v General Medical Council* [2009] EWHC 1048 (Admin) at [16].

[32] *Sharp v Nursing and Midwifery Council* [2011] EWHC 1520 (Admin).

behaviour may be "of far less significance" than in cases where the misconduct consists of clinical errors or incompetence.[33] In *Zygmunt v General Medical Council* Mr Justice Mitting opined that "in perhaps the great majority of cases the issue will not be live", meaning that a finding of impairment *will* follow from the finding of misconduct or deficient professional performance.[34]

7.27 The judgment given in *Yeong* also illustrates that even in the absence of an assessment that the registrant poses a risk to patients, a finding of impaired fitness can be made based on the need to maintain confidence in the profession.[35] Similar reasoning may also be evident in cases of impaired fitness to practise by reason of a criminal conviction or caution where research indicates that most offences have no direct relationship to practitioner's clinical work and rarely is risk to the patients identified as a reason for the determination.[36]

OPTIONS FOR REFORM

7.28 There are several ways in which the statute could approach determinations of impaired fitness to practise. These are discussed in turn below.

Option 1: rule making powers on impairment

7.29 It would be possible for our legal framework to maximise flexibility by giving each regulator powers to establish in rules its own approach to determining impaired fitness to practise, including the statutory grounds. This would enable the regulators to retain the existing differences in terminology and definitions of the statutory grounds, for example in relation to criminal convictions. The statute could provide some minimum procedural requirements, such as requiring each regulator to adopt a two-stage approach. But on all other matters, the regulators would have freedom to adopt its own approach.

7.30 However, we have provisionally discounted this option on the basis that it lacks sufficient clarity and certainty. How the regulators determine impaired fitness to practise is a crucial aspect of professional regulation and therefore should be specified clearly on the face of the statute. As recognised in the Fifth Report of the Shipman Inquiry, such matters should be enshrined in legislation so that the public should know that the regulator is "applying the law of the land and not just a formula of its own making".[37] Moreover, we believe that in principle all the regulators must be able to consider the same allegations against professionals, and that public protection could be undermined if some regulators' ability to consider some allegations is limited.

[33] *Yeong v General Medical Council* [2009] EWHC 1923 (Admin), [2010] 1 WLR 548 at [51].

[34] *Zygmunt v General Medical Council* [2008] EWHC 2643 (Admin) at [27].

[35] *Yeong v General Medical Council* [2009] EWHC 1923 (Admin), [2010] 1 WLR 548 at [58]. See also *Ige v Nursing and Midwifery Council* [2011] EWHC 3721 (Admin).

[36] P Case, "The Good, the Bad and the Dishonest Doctor: The General Medical Council and the 'Redemption Model of Fitness to Practise'" (2011) 31 *Legal Studies* 4, 591.

[37] The Shipman Inquiry Fifth Report: Safeguarding Patients, Lessons from the Past – Proposals for the Future (2004) Cm. 6394, para 25.69.

Option 2: consolidation of the existing framework

7.31 Our reforms could establish a single framework for determining impaired fitness to practise based on the existing two-stage approach. The statute would first set out a list of statutory grounds of impaired fitness to practise which would apply to all the regulators. This list would consist of the following grounds:

(1) misconduct;

(2) deficient professional performance;

(3) a criminal conviction or caution (and certain court determinations other than a complete acquittal);[38]

(4) a determination by another health or social care regulator (including by the relevant safeguarding body) to the effect that a person's fitness to practise is impaired; or

(5) physical or mental health problems.

7.32 The list would include allegations based on a matter alleged to have occurred outside the UK or at a time when the person was not registered. We welcome further views on this list, including whether it is sufficiently comprehensive.

7.33 The above list has been constructed by consolidating the existing statutory grounds across the regulators and simplifying the language. One of the difficulties in constructing such a list is that some of the statutory grounds, mainly in relation to convictions, vary across the regulators. For example, not all of governing legislation includes absolute discharge and conditional offers under the Criminal Procedure (Scotland) Act 1995 or penalties as alternative to prosecution under the Social Security Administration Act 1992. It would be possible to build some degree of flexibility by allowing the regulators to make rules specifying different types of convictions or other disposals. However, we believe that all of the matters listed above should be taken into account by the regulators when considering allegations. Our provisional view is that the same list should apply to all the regulators and that the regulators should not have powers to vary the grounds. However, we welcome further views on this point.

7.34 We also welcome views on whether the list of non-conviction disposals should be expanded to cover for example fixed penalty notices in contexts other than social security fraud such as for theft and public disorder offences.

7.35 Furthermore, we also welcome views on how adequate the powers of the regulators are to require disclosures from the Independent Safeguarding Authority and Disclosure Scotland. Currently, the legislation requires disclosure by the relevant safeguarding authority about whether a registrant is barred or not, and if so the information relied upon to bar the individual. It has been suggested

to us that these powers may not be effective and that the regulators should have the ability to access information in cases where a decision to bar an individual had not been taken (such as if an individual is under consideration for inclusion in the relevant barring list). Moreover we are interested in any difficulties or practical issues that arise as a result of the interface between professional regulation and the different safeguarding schemes in England, Wales and Northern Ireland and Scotland.

7.36 Following the list of statutory grounds, the statute would then provide that if the allegation is proved to the requisite standard, the Panel must decide whether or not the practitioner's fitness to practise is impaired.

7.37 The establishment of a two-stage approach in the statute would have the advantage of maintaining a system with which the regulators are familiar and of preserving legal concepts that have been the subject of a long history of case law which are now largely settled. However, the major disadvantage of this option is that it fails to address some of the existing difficulties that are apparent in determining impaired fitness to practise. These are discussed in more detail under option 4 below.

Option 3: the Shipman Inquiry proposal

7.38 Under option 2 above, impaired fitness to practise would remain undefined. This has the advantage of flexibility, being capable of embracing a multiplicity of problems, but also has the disadvantages that flow from a lack of clarity and definition, which include ongoing disagreements regarding both the meaning of impaired fitness to practise and the nature and quality of the evidence that can be relied upon.[39]

7.39 The Fifth Report of the Shipman Inquiry argued that there are two stages at which a clear definition of impaired fitness to practise is required. The first is at the investigation stage and the second at the adjudication stage. The report recommended the following two-stage test at the investigation stage which related the impairment of fitness to practise to the underlying reasons why the practitioner's fitness to practise might be impaired:

(1) is there one or more allegation of misconduct, deficient professional performance, or adverse health, and/or one or more allegation of conviction, caution or determination which if proved or admitted might show that the practitioner:

[38] This would consist of a conviction or caution in the "British Islands"; an order under section 246(2) or (3) of the Criminal Procedure (Scotland) Act 1995 discharging the person absolutely (admonition and absolute discharge); a conditional offer under section 302 of the Criminal Procedure (Scotland) Act 1995 (fixed penalty: conditional offer by procurator fiscal); agreement to pay a penalty under section 115A of the Social Security Administration Act 1992 (penalty as alternative to prosecution); and agreement to be bound over to keep the peace by a magistrates' court in England or Wales.

[39] See, The Shipman Inquiry Fifth Report: Safeguarding Patients, Lessons from the Past – Proposals for the Future (2004) Cm. 6394, para 25.42 and Martin Forde QC, "Impairment of Fitness to Practise: has the Pendulum Swung?" (2009) 15 *Clinical Risk* 2, 64 to 68.

(a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or

(b) has in the past brought and/or is liable in the future to bring the profession into disrepute; and/or

(c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the profession; and/or

(d) has in the past acted dishonestly and/or is liable to act dishonestly in the future; and

(2) If so, is the available evidence such that there is a realistic prospect of proving the allegation.[40]

7.40 It was argued that the above test would introduce objective standards into the investigation process and avoid the investigators having to "second guess" the decision of the Fitness to Practise Panel.[41]

7.41 At the adjudication stage the test would be:

> Do the findings of fact in respect of the professional's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that their fitness to practise is impaired in the sense that he or she:
>
> (a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or
>
> (b) has in the past brought and/or is liable in the future to bring the profession into disrepute; and/or
>
> (c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the profession; and/or
>
> (d) has in the past acted dishonestly and/or is liable to act dishonestly in the future.[42]

7.42 It is therefore only at the adjudication stage that the Panel must consider whether or not fitness to practise is impaired to such an extent justifying action. The report suggests that the test should be based on what the "reasonable and well-informed member of the public" would conclude.[43]

7.43 The advantages of this approach were described in the following terms by Mrs Justice Cox:

[40] The Shipman Inquiry Fifth Report: Safeguarding Patients, Lessons from the Past – Proposals for the Future (2004) Cm 6394 para 25.63.

[41] As above, para 25.65.

[42] As above, para 25.67.

[43] As above, para 25.68.

> It identifies the various types of activity which will arise for consideration in any case where fitness to practise is in issue; it requires an examination of both the past and the future; and it distils and reflects, for ease of application, the principles of interpretation which appear in the authorities. It is, as it seems to me, entirely consistent with the judicial guidance to which I have already referred, but is concisely expressed in a way which is readily accessible and readily applicable by all Panels called upon to determine this question.[44]

7.44 However, the potential disadvantages of this approach are discussed in more detail under option 4 below.

Option 4: risk to the public/confidence in the profession approach

7.45 There are several existing difficulties that are apparent in determining impaired fitness to practise. First, the current system is difficult to understand for complainants and the public due in part to the use of imprecise and confusing concepts. For instance, what amounts to deficient professional performance and how it differs conceptually from misconduct can sometimes appear obscure. Furthermore, as the Shipman inquiry pointed out, in most cases of misconduct and convictions "impairment of fitness to practise is not a helpful concept"; where a registrant has been found guilty of the theft of a pair of shoes from a shop or falsifying medical records, they might be considered a disgrace to the profession or untrustworthy but it is difficult to say that their fitness to practise was impaired.[45] It has also been argued that complainants find it difficult to understand why a Panel can find that a professional has committed professional misconduct and caused considerable suffering but no sanction is handed down.[46]

7.46 Second, it is not clear why is it necessary to prove facts by reference to a list of pre-determined and largely pejorative legal categories of impaired fitness to practise. The use of statutory grounds appears to limit unnecessarily the scope of the evidence that can be produced. For example, conduct which does not fall within the legal definition of misconduct or deficient performance cannot be taken into account or can only be taken into account insofar as it is relevant to these categories. It is at least arguable that in such cases the focus should be on proving the facts by reference to the need to protect the public rather than engaging in protracted and unnecessary legal argument about whether the admission of evidence is relevant to a number of predefined categories.

7.47 The use of statutory grounds for impaired fitness to practise is associated with the statutory committee system. Dividing allegations into categories was historically a means through which fitness to practise cases could be siphoned off to the relevant statutory committee, such as the health or conduct committee. However, the use of categories for allocating cases is less relevant today given

[44] *Council for Healthcare Regulatory Excellence v Nursing and Midwifery Council* [2011] EWHC 927 (Admin), [2011] ACD 72 at [76].

[45] The Shipman Inquiry Fifth Report: Safeguarding Patients, Lessons from the Past – Proposals for the Future (2004) Cm 6394, para 25.45.

that many of the regulators have developed a single Fitness to Practise Committee or Panel. Moreover the use of categories for allocating cases has always been problematic given that in practice allegations overlap so that a single case may demonstrate one or more of the different categories.

7.48 In order to address these difficulties, an alternative option for reform would be to remove the statutory grounds for impairment altogether and introduce a simplified test of impaired fitness to practise based on whether the registrant poses a risk to the health, safety or well-being of the public (and whether confidence in the profession has been or will be undermined). The precise form of words will depend on the eventual approach that is taken to the main duty of the regulators (see Part 3)

7.49 We envisage that this option would operate as a two-stage test:

(1) the regulator would need to consider whether the facts alleged are proved and if so, whether they indicate that the Registrant is a risk to the health, safety or well-being of the public (and whether confidence in the profession has been or will be undermined). A wide range of evidence could be gathered as evidence and would not be restricted to any predetermined categories; and

(2) the regulator would need to consider on the basis of those facts, whether the registrant's fitness to practise is impaired.

7.50 Arguably, this option for reform would be clearer and more straightforward than the current system, and would emphasise the paramount duty of professional regulation (see Part 3). In effect, any evidence of risk to the public (and that confidence in the profession has been or will be undermined) could be submitted to support an allegation and it would not be necessary to prove that the evidence amounted to pre-existing categories such as misconduct or deficient professional performance.

7.51 On the other hand there may be concerns that by removing the statutory grounds, the threshold for an allegation will be reduced. In effect, allegations would not necessarily have to meet the criteria of, for example, misconduct or deficient performance but would merely have to indicate a potential risk to the health, safety or well-being of the public (and that confidence in the profession has been or will be undermined). This may mean an increase in the number of cases which are referred to formal fitness to practise proceedings.

PROVISIONAL VIEW

7.52 There are three options for reform that we wish to test at consultation. The first is option 2 (consolidation of the existing framework) which would establish a single framework for determining impaired fitness to practise based on the current two-stage approach. The second is option 3 (the Shipman Inquiry proposal) which is based on a two-stage test at the investigation stage, and a further test at the

[46] G Micklewright and B Lapthorne, "Impairment of Fitness to Practise: Is the Concept Undermining Public Confidence in Professional Regulation?" (2011) *Association of Regulatory and Disciplinary Lawyers Quarterly Bulletin* (March), 1.

adjudication stage. The third is option 4 (risk to the public/confidence in the profession approach) which would remove the current statutory grounds that form the basis of an impairment and introduce a new test of impaired fitness to practise based on whether the registrant poses a risk to the health, safety or well-being of the public (and confidence in the profession has been or will be undermined).

7.53 We welcome views on all these options for reform, as well as any other potential options for law reform.

Question 7-1: Should the statute: (1) retain the existing two-stage approach for determining impaired fitness to practise; *or* (2) implement the recommendations of the Shipman report; *or* (3) remove the current statutory grounds which form the basis of an impairment and introduce a new test of impaired fitness to practise based on whether the registrant poses a risk to the public (and that confidence in the profession has been or will be undermined)?

Question 7-2: If a list of statutory grounds of impaired fitness to practise is retained, should it refer to a broader range of non-conviction disposals?

Question 7-3: How adequate are the powers of the regulators to require disclosures from the Independent Safeguarding Authority and Disclosure Scotland? What practical difficulties, if any, arise as a result of differences between the protection of vulnerable groups schemes in England, Wales, Northern Ireland and Scotland?

PART 8
FITNESS TO PRACTISE: INVESTIGATION

8.1 The governing legislation establishes detailed processes that the regulators must follow when considering fitness to practise cases. The process begins with the investigation of allegations of impaired fitness to practise. This Part considers the investigation stage and covers the following issues:

(1) allegations;

(2) initial consideration;

(3) investigation;

(4) threshold test;

(5) disposal of cases;

(6) mediation; and

(7) reviews.

8.2 Although the adjudication stage is covered separately in Part 9, there is considerable overlap between that stage and the investigation stage. Some of the matters discussed in this Part, including consensual disposals and mediation, are also relevant at the adjudication stage.

ALLEGATIONS

8.3 The fitness to practise process begins with the making of an "allegation".[1] In most cases the legislation states that any such allegation must be made to the regulator in question against a registered practitioner that their fitness to practise is impaired by reason of one or more of the statutory grounds.[2] In most cases, the statutory grounds are misconduct, deficient performance, criminal conviction or determination by another regulatory body, and adverse physical or mental health (see Part 7).

8.4 In addition, the Health Professions Council and Nursing and Midwifery Council define allegations as including any allegation made against the registrant to the effect that an entry in the register relating to them has been fraudulently procured or incorrectly made.[3] Other regulators deal with this issue separately to their fitness to practise procedures by giving the Registrar powers to erase such an entry from the register and a right to appeal to a Registration Appeals Panel.

[1] All of the relevant legislation uses the term "allegation", except for the rules governing the General Social Care Council which refer to a "complaint": General Social Care Council (Conduct) Rules 2008, r 12(4).

[2] For example, Nursing and Midwifery Order 2001, SI 2002 No 253, art 22(1).

[3] Health Professions Order 2001, SI 2002 No 254, art 22(1)(b).and Nursing and Midwifery Order 2001, SI 2002 No 253, art 22(1)(b).

These procedures are discussed in more detail in Part 5.

8.5 A feature of the governing legislation is the requirement that allegations have to be made *to* the regulator in question. This presupposes a complainant, and that the regulator's role is essentially a passive and reactive one. As a result, some of the legislation includes a supplementary provision which allows information which comes to the regulator's attention to be treated as an allegation. This provision may be utilised when, for example, the regulator identifies cases from reports in the media or anonymous information that is passed to the regulator. While the ability of regulators to undertake a pro-active policing role is necessarily limited, sometimes high profile cases have been initiated through information that has come to the regulator's attention rather than a formal allegation. For example, the Nursing and Midwifery Council used its powers under article 22(6) of the Nursing and Midwifery Order to open over 200 investigations in 2011 following media reports, including an investigation and suspension of two nurses who were working at the Winterbourne View care home in Bristol following allegations of the abuse of disabled people in an investigation by the BBC's Panorama programme.[4]

8.6 Not all of the regulators have a supplementary provision to consider information which comes to its attention. Some have therefore developed the policy of initiating an investigation by way of a Registrar's complaint. This is where the Registrar adopts the formal role of complainant by initiating an allegation based on information that has come to their attention. A Registrar's complaint is not provided for expressly in legislation but is implied since there are no limitations on who can refer a potential allegation to the regulators. Registrars' complaints form a small but regular part of the Councils' fitness to practise caseload. For example, in 2009 to 2010 out of the 21 cases considered by the Investigation Committee of the General Osteopathic Council, two were raised by the Registrar.[5]

8.7 The General Social Care Council is given express powers to assume the role of the complainant when anonymous information is received. However, the relevant guidance states that, in order to protect registrants from malicious complaints, the Council will only take action on the basis of anonymous information in "exceptional circumstances".[6]

8.8 The format of an allegation is not specified in legislation. However, each regulator has developed policies specifying a preferred format. The requirement that the allegation must be in writing is common across all regulators. Most also require complainants to use a prescribed form, which is made available online. Arguably, such requirements disenfranchise certain individuals who are uncomfortable with writing or using a keyboard, do not have access to the internet or whose first

[4] A Jaeger, "Facing the Music" (2011) 3 *NMC Review* 4, 8 and Nursing and Midwifery Council, *NMC to Investigate the Conduct of More Nurses Employed by Castlebeck: Press Release 28/7/2011* (2011).

[5] General Osteopathic Council, *Annual Report and Accounts 2009-10* (2010) p 15.

[6] General Social Care Council (Conduct) Rules 2008, r 12(4) and General Social Care Council, *Guidance on Complaints* (2008) p 3.

language is not English.[7] However, almost all the regulators provide a helpline where staff can assist in completing the form or making any other special arrangements. Most specify that allegations can be sent through a variety of routes, including post, fax and email. The General Optical Council is unique in specifying that the form must be posted.

8.9 Practice also varies on the amount of information a complainant has to supply. Most regulators require the name and contact details of the subject of the allegation, while the Nursing and Midwifery Council asks for the name of the practitioner if possible or the shift they were working, or a physical description.[8] Others require the written agreement of the complainant to contact the practitioner and reveal the complainant's identity.[9] This practice is intended to ensure that the complainant is aware that their identity may need to be disclosed to the practitioner in question.[10]

8.10 Some regulators set a time limit for bringing an allegation against a registrant. For example, at the General Medical Council, an allegation cannot proceed if more than five years have elapsed since the most recent events giving rise to the allegation. The exception is if "it is in the public interest, in the exceptional circumstances of the case, for it to proceed".[11]

Provisional view

8.11 An allegation is a legal concept designed to be the gateway for the fitness to practise process. In effect, any complaint or information which falls within the definition of an allegation will trigger an investigation. We are concerned that this approach may be overly rigid and formulaic. First, it suggests that most allegations are best dealt with through formal fitness to practise procedures. However, formal proceedings are not always necessary and this approach fails to recognise the need to adopt a proportionate approach to managing risk. For example, the system often requires a complaint about a single incident of treatment to be managed in the same way as disclosure of a registrant's conviction for murder or other criminal offences. Second, this approach fails to give the regulators sufficient flexibility to deal with matters which fall short of the formal definition of an allegation but which, for example, still concern standards of professional conduct or performance that represent a risk to the public. Finally, some matters which fall within the remit of an allegation may be better dealt with

7 See, for example, Public Services Ombudsmen (2010) Law Commission Consultation Paper No 196, paras 4.86 to 4.91.

8 See http://www.nmc-uk.org/Documents/FtP_Information/NMC_referral_form.doc (last visited 15 February 2012).

9 See, for example, http://www.gdc-uk.org/Newsandpublications/Publications/Publications/HowtoReportEnglishfinal[1].pdf (last visited 15 February 2012).

10 The right of the practitioner to be made aware of, and comment on, an allegation is guaranteed under Article 6 of the European Convention on Human Rights, see *Ruiz-Mateos v Spain* (1993) 16 EHRR 505 at [63].

11 General Medical Council (Fitness to Practise) Rules Order of Council 2004, SI 2004 No 2608, r 4(5).

by alternative agencies or processes.

8.12 An alternative approach would be to remove the concept of an allegation entirely. The regulators would instead be given broad powers and discretion to deal with all the information and complaints they receive or that come to their attention, and deal with this in such manner as the regulator considers just. This is the approach specified in the Pharmacy Order 2010 in relation to its legacy cases.[12] Depending on the individual case, the regulators could for example decide to refer the matter to another agency, mediate, initiate a full investigation or refer the matter directly to a Fitness to Practise Panel. However, we believe that it would need to be made clear that cases where it appears there are reasonable prospects of proving impairment must be referred for fitness to practise proceedings. Otherwise, there is a real risk that such cases will not be referred. It would not be necessary to specify requirements in statute law concerning the format of an allegation or time-limits for making an allegation. Each case would be dealt with on the basis of the quality of evidence available. We welcome further views on this approach.

8.13 If the concept of an allegation is retained in our statute, then its definition will depend on how the statute approaches the concept of impaired fitness to practise. In Part 7 we have put forward for discussion three options for reform. Under options 2 (consolidation of the existing framework) and 3 (the Shipman Inquiry proposal), an allegation would continue to be defined as being made to the regulator in question against a registered practitioner that their fitness to practise is impaired by reason of misconduct, deficient performance, convictions and determinations, or health.

8.14 Under option 4 (risk to the public/confidence in the profession approach), the statutory grounds which form the basis of an impairment would be removed. An allegation would be defined as being made to the regulator in question against a registered practitioner that their fitness to practise is impaired on the basis that they are a risk to the health, safety and well-being of the public (and that confidence in the profession has been or will be undermined).

8.15 We do not propose that the definition of an allegation should refer expressly to cases where an entry in the register has been fraudulently procured or incorrectly made. In our view these cases should be dealt with separately through the broad powers given to the regulators to establish and maintain registers (see Part 5). But where such a case raises concerns about a registrant's fitness to practise, it could be referred for fitness to practise proceedings.

8.16 It is also our provisional view that the statute should enable all the regulators to allow information *which comes to their attention* to be treated potentially as an allegation. This appears to be a useful and often important provision which encourages regulators to adopt a proactive role towards allegations. Furthermore, even those regulators that do not have this express power have recognised the importance of adopting a similar approach and have found ways

[12] Legacy cases are those cases which were active prior the legislation coming into force. See, Pharmacy Order 2010, SI 2010 No 231, sch 5, para 12(2)(b).

of working around their legislative framework in order to do so. However, we welcome further views on this proposal particularly on any potential resources implications.

8.17 We do not consider that the legislation should impose any formal requirements for how allegations should be made. It is important that the legal framework does not adopt a restrictive approach to the making of allegations and instead ensures that a wide range of information can be considered by the regulators. It is also important that the regulators are able to react to technological developments and the changing communication preferences of the public. However, we remain concerned that some of the regulators' websites suggest that only allegations in writing can be accepted. It is clear that complaints must eventually become recorded, but this does not mean that the process must commence in writing. We therefore propose that the statute should contain a clear statement to the effect that there is no set format for allegations. The regulators would still be free to develop policies and procedures to assist complainants, but they would need to be clear that these are not a legal requirement. We believe that it is important that the Council for Healthcare Regulatory Excellence should continue to play a role in this area by monitoring, amongst other matters, the accessibility of the allegation procedures of the regulators for disabled people and other people who may need special arrangements. The role of the Council for Healthcare Regulatory Excellence in our proposed legal framework is discussed in Part 10.

8.18 Some but not all of the regulators specify that any allegation must be made within a set period of time (except in exceptional circumstances). Our reforms could give the regulators flexibility to set such a time limit if they wish to do so. However, we think that on this matter the statute should establish some degree of consistency. It is difficult to justify why for example most allegations against a doctor may not be able to proceed if more than five years have elapsed, but similar allegations against another professional could proceed. One possibility would be for the statute to introduce for example a five-year time limit for allegations across the regulators. However, this may be unnecessarily restrictive; it is at least arguable that regulators should be able to consider all allegations no matter when they were made. Indeed, some allegations may be so serious that a regulator could not discount them merely on the basis of when the alleged events took place. In effect, the decision whether or not to proceed could depend in all cases on the quality of the evidence available and not on an arbitrary time limit. On the other hand, the consequence of not specifying a time limit may be an increase in the number of ill-founded and stale allegations. We welcome further views on the issue.

Question 8-1: Should the new legal framework remove the concept of an allegation entirely and instead give the regulators broad powers to deal with all information and complaints in such manner as they consider just (subject to a requirement that cases where there are reasonable prospects of proving impairment must be referred for fitness to practise proceedings)?

Provisional Proposal 8-2: The statute should provide that all the regulators will be able to consider any information which comes to their attention as an allegation and not just formal complaints.

Provisional Proposal 8-3: The statute should contain a clear statement that there is no set format for allegations.

Question 8-4: Should the statute prohibit the regulators from setting a time limit for bringing an allegation against a registrant or should there be a consistent time limit for allegations across the regulators (and if so, what should it be)?

INITIAL CONSIDERATION

8.19 Once an allegation has been made, some regulators have formal powers of initial consideration to determine whether or not the case should proceed. A number of regulators have established a formalised "screening" process, while in other cases the powers of initial consideration are vested in the Registrar. But which ever system applies, the decision-maker effectively begins the investigation process and has considerable discretion to dispose of cases.

8.20 The Health Professions Council has the most developed screening method with dedicated rules on the matter.[13] All allegations may be referred to a screening panel which is made up of at least two screeners, including a lay and registrant member. Members of the Fitness to Practise Committee, Council employees or legal, medical or other assessors are prohibited from being screeners. The panel has the task of determining whether power is given under the Health Professions Order 2001 to deal with the allegation.[14] If the panel decides that such power is given, the case can be referred to the Investigatory Committee, the Conduct and Competence Committee or the Health Committee. If there is no power, the panel may close the case. The decision to close the case can only be made by a unanimous or majority decision of panel members. A screening panel can also be requested by a Practice Committee to mediate a case.[15]

8.21 The General Osteopathic Council has powers of preliminary consideration that require a screener to determine whether there is a power under the primary legislation to deal with the complaint. Screeners are given a power to seek information about or observations on the case from any person who might be of assistance.[16] The General Pharmaceutical Council does not use the term screener, but the rules establish a similar procedure whereby the Registrar is given powers to undertake investigations to determine whether an allegation should be referred to the Investigatory Committee or Fitness to Practise Committee. In making this determination they can instruct Council employees to undertake further inquiries.[17]

[13] Health Professions Order 2001, SI 2002 No 254, arts 23 and 24.

[14] Health Professions Council (Screeners) Rules Order of Council 2003, SI 2003 No 1573, rr 4(2) and 5(1).

[15] As above, r 6.

[16] General Osteopathic Council (Investigation of Complaints) (Procedure) Rules Order of Council 1999, SI 1999 No 1847, r 5.

[17] General Pharmaceutical Council (Fitness to Practise and Disqualification Rules) Order of Council 2010, SI 2010 No 1615, r 6.

8.22 Some of the regulators, such as the General Optical Council, lack any express powers to establish screeners and consequently all allegations must be referred to the Investigation Committee, which can create significant administrative challenges.[18] However, a form of screening is implied into all these regulators since the referral of an allegation to the Investigation Committee presupposes that the information received amounts to an allegation.

8.23 Some regulators have moved away from formal screening procedures. For example, the General Dental Council abolished the role of preliminary screeners in 2005.[19] The General Medical Council has replaced screeners with a system of case examiners whose broad powers incorporate elements of the screening role. Case examiners are discussed later in this Part. In addition, under the process of initial consideration the Registrar of the General Medical Council has powers to make any appropriate investigations and can, for example, direct an assessment of professional performance and refer cases directly to an Interim Orders Panel or Fitness to Practise Panel without the case being referred to case examiners.[20] The Registrar is also required to refer cases directly to a Fitness to Practise Panel if the allegation concerns a conviction resulting in a custodial sentence.[21]

8.24 In addition to formal screening procedures, most regulators operate an informal process whereby people who are considering making an allegation are advised whether or not their case is outside the Council's jurisdiction or might be more suitably handled elsewhere, such as the relevant NHS or local authority complaints procedures. This may be undertaken by the provision of information on the website or the advice of office staff.

Referral criteria

8.25 In most cases, the process established by the governing legislation requires the regulator in all cases to determine whether the complaint or information amounts to an allegation and, if so, to refer the matter to the Investigation Committee. However, in some cases the legislation gives screeners and other decision-makers greater flexibility to decide not to refer some allegations, to prioritise serious cases or to refer cases to another organisation. For example, the Registrar of the General Medical Council is given powers to sift out vexatious allegations and refer certain allegations relating to convictions resulting in a custodial sentence directly to a Fitness to Practise Panel.[22]

8.26 The General Pharmaceutical Council is required to refer all allegations to the

[18] See, for example, Council for Healthcare Regulatory Excellence*, Fitness to Practise Audit Report*: *Audit of Health Professional Regulatory Bodies' Initial Decisions* (2011) para 5.5.

[19] General Dental Council (Administration of Core Functions) (Amendment) (Abolition of Preliminary Screener) Rules 2005.

[20] General Medical Council (Fitness to Practice) Rules Order of Council 2004, SI 2004 No 2608, rr 4(4), 6 and 7(3). See also *R (Zia) v General Medical Council* [2011] EWCA Civ 743.

[21] General Medical Council (Fitness to Practice) Rules Order of Council 2004, SI 2004 No 2608, r 5.

[22] As above, r 4(3).

Investigation Committee except if they are of a type specified in threshold criteria, which may be set out in rules, that should not be referred.[23] The threshold criteria have been developed against seven principles, and consist of a series of statements which sit under each of the seven principles. If one or more of the statements are true in relation to an allegation then the allegation must be referred to the Investigation Committee.[24] In addition the Registrar must refer allegations concerning serious criminal offences directly to the Fitness to Practise Committee, cutting out the investigation stage.[25]

Provisional view

8.27 For some regulators, powers of initial consideration will be an important way of ensuring efficiency and providing a proportionate response to complaints received. However, the use of such powers is patchy with some regulators having elaborate screening structures, some having more basic provisions, whilst other regulators have no such powers or have decided against formal procedures. In our view, all the regulators should be given powers to establish a formal process for the initial consideration of allegations. However, whether or not these powers are exercised would be a matter for each regulator to decide. For instance, some of the smaller regulators who receive relatively few complaints may decide that establishing a formal process is unnecessary and an inefficient use of resources. Others may decide not to establish a separate system for initial consideration but instead develop the system of case examiners with powers extending to both initial consideration and investigation.

8.28 We make no provisional proposals for the content of any such rules. In our view, this is a matter best left to each regulator to determine in the light of its circumstances, its resources and the system of initial consideration it decides to implement. The regulators could, for example, give decision-makers powers to seek consent from the complainant, contact employers asking for further information and source clinical and other advice. Alternatively, decision-makers may simply be given powers to sift out inappropriate cases.

8.29 As noted above, the Health Professions Council's system of screening establishes prohibitions on who can undertake this task. This can be seen as a welcome innovation which helps to ensure the perceived and actual independence of the initial consideration process. It would be possible for the statute to codify this approach by prohibiting certain individuals from the initial consideration of cases such as fitness to practise committee members, Council members and legal, medical or other assessors. However, we think on balance that the regulators should be given discretion on this matter. We therefore propose that the regulators should have the ability to prohibit certain individuals from undertaking the task of initial consideration, but they would not be required to do so. The regulators would also be able specify that only certain people can

[23] Pharmacy Order 2010, SI 2010 No 231, art 52(1) and (2).

[24] General Pharmacy Council, *The Threshold Criteria* (2011) and General Pharmacy Council, *Guidance on the GPhC's Threshold Criteria Policy* (2011).

[25] General Pharmaceutical Council (Fitness to Practise and Disqualification) Rules Order of Council 2010, SI 2010 No 1615, r 6.

undertake this task, for example, if they wanted to introduce a system of lay and registrant screeners similar to that established by the Health Professions Council.

8.30 Our provisional view is that the regulators should have powers to specify referral criteria for an investigation. This would help to ensure that, where appropriate such decisions are made against clear criteria, can be audited, and that cases are not closed inappropriately. However, it would be left to each regulator to decide the precise criteria it wanted to adopt. It is important to allow each regulator to determine its own approach to an investigation in the light of its resources and circumstances. Some regulators may wish to provide that all allegations must be referred to an Investigation Committee or case examiners, whilst others may want to specify exceptions. This may include, for example, requiring that convictions resulting in a custodial sentence must be referred directly to a Fitness to Practise Panel. Alternatively, regulators could introduce more elaborate threshold criteria similar to that developed by the General Pharmaceutical Council.

8.31 We appreciate concerns that the above proposal could produce an inconsistent approach to referral criteria across the regulators. Our provisional view is that such consistency is less important on this issue than giving each regulator sufficient flexibility to decide how to manage allegations in the light of their individual circumstances. There may also be concerns that the proposal gives too much power to the regulators to issue any criteria it sees fit, including overly complex criteria or criteria that allows registrants to avoid further investigation inappropriately. The checks and balances on issuing such rules are discussed in detail in Part 2. However, we welcome further views.

Provisional Proposal 8-5: All the regulators should have the power to establish a formal process for the initial consideration of allegations (such as screeners).

Provisional Proposal 8-6: The regulators should have the power to prohibit certain people from undertaking the initial consideration of allegations and specify that only certain people can undertake this task.

Provisional Proposal 8-7: The regulators should have powers to establish referral criteria for an investigation and specify cases which must be referred directly to a Fitness to Practise Panel.

Question 8-8: Should the statute impose more consistency in relation to the criteria used by regulators to refer cases for an investigation or the cases that must be referred directly to a Fitness to Practise Panel?

INVESTIGATION

8.32 Once the regulator has determined that an allegation has been made, it is required to carry out an investigation. Until recently, the only exception was the Pharmaceutical Society of Northern Ireland which was given no specific investigatory powers. Instead, complaints about a registrant's fitness to practise were referred typically to the Department of Health, Social Services and Public Safety. However, the Northern Ireland Assembly has recently legislated to reform many aspects of the Society's legal framework, including the introduction of a new Scrutiny Committee to investigate allegations of impaired fitness to

practise.[26]

Investigation Committees

8.33 Most of the regulators are required by their governing legislation to establish an Investigation Committee. The purpose of this Committee is to decide whether a case should proceed to a fitness to practise hearing, or should be disposed of in some other way. At the General Optical Council, for example, all allegations about fitness to practise must be first considered by the Investigation Committee with a quorum of five members.[27]

8.34 The composition of the Investigation Committees can include professionals and lay persons. For example, the General Optical Council's Investigation Committee is composed of optometrists, dispensing opticians, an ophthalmogist and members of the public.[28] As well as relying on the expertise of its members, Investigation Committees can obtain expert reports in cases when a matter falls outside of its expertise. Practice varies on whether the parties are present, or whether the case is heard solely on the basis of documentary evidence.

Case examiners

8.35 Case examiners are professional or lay persons appointed by the regulator for the purpose of exercising the functions of the Investigation Committee. The use of case examiners has been developed by the General Medical Council with the aim of ensuring that the investigation process is faster, more efficient and reduces the workload of the Investigation Committee.

8.36 The General Medical Council fitness to practise rules provide that the Registrar must refer all allegations, except those that concern a conviction resulting in a custodial sentence, to a medical and lay case examiner. Once the allegation has been considered, the case examiners may decide unanimously that the matter should not proceed, to issue a warning, to refer the case to the Investigation Committee or Fitness to Practise Committee, to invite the registrant to comply with undertakings, or to initiate a referral to the Interim Orders Panel.[29] If the case examiners do not agree, the case is referred to the Investigation Committee. The General Optical Council has published proposals for the introduction of a case examiners process, similar to the system established by the General Medical Council.[30]

[26] Pharmacy (1976 Order) (Amendment) Order (Northern Ireland) 2012.

[27] Opticians Act 1989, s 13D(5) and General Optical Council (Committee Constitution Rules) Order of Council 2005, SI 2005 No 1474, r 10.

[28] General Optical Council (Committee Constitution Rules) Order of Council 2005, SI 2005 No 1474, r 9.

[29] General Medical Council (Fitness to Practice) Rules Order of Council 2004, SI 2004 No 2608, r 8.

[30] General Optical Council, *Amendments to the Fitness to Practise Rules: Consultation* (2011).

Assessments

8.37 Most regulators have a specified procedure for undertaking medical and professional performance assessments. These assessments enable the Investigation Committee to seek such advice and information as they consider necessary to assess the registrant's health or standard of their performance. The approach to these assessments varies between the regulators. For instance, the General Optical Council's rules direct the registrant to submit to examination and that inferences can be drawn from a failure to co-operate. By contrast, the General Osteopathic Council merely invites a registrant to agree to an assessment and the Health Professions Council's Investigation Committee lacks any power to request that a registrant attend a medical examination.[31]

Power to require information

8.38 Most of the regulators are given a general power to require the disclosure of information where the fitness to practise of a registrant is in question. This can apply at the investigation and adjudication stage. This power is seen as particularly useful where a claimant withdraws their co-operation but the case concerns a serious issue which might impact on public protection.[32]

8.39 Although the precise wording varies, the power normally provides that:

(1) a person authorised by the Council may require information relevant to its fitness to practise function from any other person (other than the registrant from whom the information is sought);

(2) as soon as reasonably practical after the matter has been referred to a fitness to practise committee, the Council can require from the registrant the details of their employer or any other person with whom they have an arrangement to provide services;

(3) nothing in this power requires any disclosure of information which is prohibited by any enactment, but where the prohibition relates to information which allows for the identification of an individual, the information can be put in an anonymised form; and

(4) nothing in this provision permits the supplying of information which a person could not be compelled to produce in civil appeals against fitness to practise decisions.[33]

8.40 Some of the provisions contain a statement that it is to be assumed that the

[31] General Optical Council (Fitness to Practise) Rules Order of Council 2005, SI 2005 No 1475, r 8 and General Osteopathic Council (Investigation of Complaints) (Procedure) Rules Order of Council 1999, SI 1999 No 1847, r 13. For a commentary on the lack of powers given to the Health Professions Council's Investigation Committee see Council for Healthcare Regulatory Excellence*, Fitness to Practise Audit Report: Audit of Health Professional Regulatory Bodies' Initial Decisions* (2011) para 11.17.

[32] See, Council for Healthcare Regulatory Excellence*, Fitness to Practise Audit Report: Audit of Health Professional Regulatory Bodies' Initial Decisions* (2011) para 6.11.

[33] For example, Medical Act 1983, s 35A and Pharmacy Order 2010, SI 2010 No 231, art 49.

disclosure of personal data is required. This is for the purposes of section 31(1) of the Data Protection Act 1995, which sets out the disclosures required by law made in connection with legal proceedings. Some also provide that if the information is not supplied within 14 days or any longer period which the Council may specify, the Council may seek an order of the relevant court.[34]

8.41 Once the information has been acquired, there is no barrier to such information being shared internally. For example between the Registrar and the Investigation Committee, and the Investigation Committee and the Fitness to Practise Panel even if for example the patients from whom the information has been obtained object to this disclosure. In such cases there is no obligation to obtain an order of the court. However, these statutory provisions must be read subject to any Article 8 rights of the patients in question. Thus any disclosure must be considered in the light of the case as a whole, pursue legitimate objectives, and be lawful and necessary in a democratic society.[35]

Provisional view

8.42 The Investigation Committee is a central part of current fitness to practise procedures. Most of the regulators are required to establish an Investigation Committee and there are detailed rules governing how they are constituted and how they should operate. At some regulators all cases must be referred to the Committee. However, it is not evident that the establishment of a specific committee to carry out investigations always represents the most efficient or effective way of organising investigations. This appears to be reflected by the development of case examiners and to a lesser degree screeners (see earlier discussion), who perform some of the functions normally associated with an Investigation Committee.

8.43 Furthermore, the costs of taking a case to an Investigation Committee can be significant. For example, the General Dental Council has estimated that it costs £1500 per case (which includes the costs of the meeting itself and the cost of staff resource to prepare the case) and that cases referred take approximately six months to get to an Investigation Committee.[36] We welcome views on the effectiveness or otherwise of the Investigation Committee structure. As set out in Part 4, our provisional view is that the regulators should be given a power, but would not be required, to establish a central Investigation Committee.

8.44 Under our proposed structure, each regulator would be able to delegate its investigative function to the Registrar (who would have further powers to delegate this function), any other individual (such as a member of staff, professional or a lay person) or a committee/panel consisting of two or more persons. This would enable the regulators to establish a range of different investigative structures such as:

[34] For example, Pharmacy Order 2010, SI 2010 No 231, art 49(3) and (4).

[35] *General Dental Council v Savery* [2011] EWHC 3011 (Admin).

[36] General Dental Council, *Fitness to Practise – Operational, Policy and Legislative Change* (2011) para 20.

(1) an Investigation Committee which carries out all inquiries;

(2) investigations by the Registrar or another individual;

(3) two or more case examiners who carry out all investigations; or

(4) a combination of individuals, case examiners, and an Investigation Committee carrying out inquiries.

8.45 In effect, each regulator would be given greater flexibility to establish an investigation structure which best suits its circumstances, and the ability to adopt a more proportionate approach to regulation.

8.46 It is important for all the regulators to be able to initiate specialist assessments if appropriate, including but not limited to medical and professional performance assessments. We therefore propose that all the regulators should have the ability to establish a procedure for undertaking assessments during an investigation. We do not make any proposals on the content of the rules or whether the power should be exercised which would be left to the regulators to decide.

8.47 We also propose that the statute should give all the regulators a general power to require the disclosure of information where the fitness to practise of a registrant is in question. As a matter of public law, an express provision is unnecessary because it can be implied into the regulators' broad investigation function.[37] But the express inclusion of such a power is a useful way of reinforcing and clarifying this power. For example, in *General Dental Council v Savery* the statutory power to require information was described as indicating that the public interest in the regulator undertaking an investigation was so strong that it overrode private interests of preserving confidentiality.[38] We propose that the content of the power should include all the different aspects of the existing powers mentioned in the earlier discussion. We welcome further views on whether all of these aspects are useful and sufficiently clear in practice.

8.48 Some aspects of the existing powers to require information have been the subject of judicial criticism. In particular it has been questioned why a regulator is given powers to obtain information from any person other than the registrant whose fitness to practise is in question, who is "the very person who might be thought to have the best information and documents relating to the allegation which falls to be examined".[39]

8.49 One of the reasons why the power to require information is not extended to include the registrant in question, may be the registrant's right against self-incrimination. However, any privilege against self-incrimination is not absolute and would need to be balanced for example against the need to protect the public. It is notable that in Australia the equivalent power to require information does apply to the registrant in question but that the legislation also provides that

[37] *Attorney-General v Great Eastern Ry Co* (1880) 5 App Cas 473.

[38] *General Dental Council v Savery* [2011] EWHC 3011 (Admin) at [48].

[39] As above, at [37].

a reasonable excuse for not providing the required information can include that this would incriminate the person.[40]

8.50 A further possible concern which may arise through requiring the registrant to provide information is that it may delay or impede the investigation process should the registrant fail to cooperate. However, the regulators would have discretion to require information and would no doubt take into account any possible delay that may result. We welcome further views on the proposals regarding powers to require information and submissions from registrants. Our provisional view is that the power to require information should be extended to include the registrant in question. However, an alternative solution to this problem, long adopted by the Bar Council, is to make non-responsiveness or non-disclosure itself professional misconduct.

8.51 Finally, the current duty to require information has been criticised for lacking teeth. For example, in other Commonwealth jurisdictions penalties can be attached for failures to provide information.[41] We welcome further views on whether any powers should be attached to the power to require information.

Provisional Proposal 8-9: The statute should enable but not require the regulators to establish an Investigation Committee.

Provisional Proposal 8-10: The regulators should be given broad rule and regulation-making powers concerning how and by whom an investigation is carried out.

Provisional Proposal 8-11: The statute should give all the regulators a general power to require the disclosure of information where the fitness to practise of a registrant is in question.

Question 8-12: Are the existing formulations of the power to require disclosure of information useful and clear in practice?

Provisional Proposal 8-13: The power to require information should be extended to include the registrant in question.

Question 8-14: Should any enforcement powers be attached to the power to require information?

[40] Health Practitioner Regulation National Law (Australia) Act 2009, sch 5(1) and (2).

[41] As above, sch 5(2).

THRESHOLD TEST

8.52 Having undertaken the appropriate inquiries, the regulator must decide whether or not to refer the case to a Fitness to Practise Panel. Some regulators make this decision by reference to a threshold test stated in the legislation itself; for example, whether there is a "real prospect" that the regulator will be able to establish at a hearing that the registrant's fitness to practise is impaired or whether there is a "case to answer".[42] The other regulators do not have a specific test stated in their legislation.[43]

8.53 However, the practice adopted by all the regulators, irrespective of whether or not this is stated in their legislation, is to use the "real prospect test".[44] That test is derived from *Swain v Hillman* where Lord Woolf MR noted:

> The words "nor real prospect" do not need any amplification, they speak for themselves. The word "real" distinguishes fanciful prospects of success … or, as [Counsel] submits, they direct the court to the need to see whether there is "realistic" as opposed to a "fanciful" prospect of success.[45]

8.54 Most cases do not make it to a final stage fitness to practise hearing because during the investigation stage the regulator decides that the complaint does not meet the threshold test.[46] As described in Part 10, the Council for Healthcare Regulatory Excellence has powers to audit the regulators' decisions not to refer individual cases.

Provisional view

8.55 Our provisional view is that the statute should state the threshold test for a referral to a Fitness to Practise Panel. This test is an essential part of the fitness to practise procedures, and it is important that the public and practitioners are clear about what the test is and when it applies. In practice all the regulators have adopted the real prospect test. In our view, this is relatively straightforward and easy to understand and apply.

8.56 We therefore provisionally propose that statute should state clearly that the test for referrals to all Fitness to Practise Panels is whether there is a real prospect that the registrant's fitness to practise will be found to be impaired. This test will be consistent across the regulators. The Council for Healthcare Regulatory

[42] For example, the General Pharmaceutical Council (Fitness to Practise and Disqualification etc) Rules Order of Council 2010, SI 2010 No 1615, refers to a "real prospect" (r 9(7)(a)) and the Nursing and Midwifery Order Council Order 2001, SI 2002 No 254, refers to "case to answer" (art 26(2)(d)(i)).

[43] The General Dental Council, General Medical Council, and General Optical Council do not specify a test.

[44] See, for example, Health Professions Council, *Practice Note: Case to Answer Determinations* (2011) p 1.

[45] [1999] EWCA Civ 3053, [2001] All ER 91 at [7].

[46] Council for Healthcare Regulatory Excellence, *Fitness to Practise Audit Report: Audit of Health Professional Regulatory Bodies' Initial Decisions* (2011) para 2.8.

Excellence's powers to audit decisions not to refer individual cases for a fitness to practise hearing would also continue (see Part 10).

Provisional Proposal 8-15: The statute should provide that the test for all referrals to a Fitness to Practise Panel across the regulators is the real prospect test.

DISPOSAL OF CASES

8.57 Most of the regulators have broad powers to dispose of cases at the investigation stage. Although Investigation Committees are not given formal powers to issue sanctions, they can issue warnings (including published warnings) where conduct has fallen below acceptable standards but the case is not being referred to a Fitness to Practise Committee. In addition some Investigation Committees can issue Interim Orders (these are discussed in more detail in Part 9).

8.58 A small number of the regulators also have powers to issue advice to a practitioner or any other party on any issue arising during the course of the investigation. The availability of the formal powers of Investigation Committees across the regulators is summarised in table 6 below.

	Warnings	**Interim order**	**Advice**
GCC	No	Yes	No
GDC	Yes	No	Yes
GMC	Yes	No	No
GOC	Yes	No	No
GOsC	No	Yes	No
GPhC	Yes	No	Yes
GSCC	No	Yes	No
HPC	No	Yes	No
NMC	No	Yes	No
PSNI	Yes	No	Yes

Table 6: Powers of investigation committees

8.59 Although the Investigation Committees of the General Medical Council and General Dental Council do not have powers to issue interim orders, they may refer the matter to an Interim Orders Panel or Committee. In the cases of the Nursing and Midwifery Council, General Osteopathic Council, General Chiropractic Council and General Social Care Council, practitioners are given a right to a hearing if the Investigation Committee is considering an interim order.

Consensual disposals

8.60 At some regulators, it is possible for a case to be dealt with by consent with the registrant, namely through undertakings that are agreed between the regulator and the registrant. Undertakings can restrict a registrant's practice or ensure that the registrant agrees to undertake further supervision or training. Some

regulators accept undertakings given at a Fitness to Practise Panel hearing, while others agree undertakings at the investigative stage as an alternative to a full hearing.

8.61 The Health Professions Council's consent arrangements have been in place since 2009 and allow the disposal of suitable cases without the need for a contested hearing. All proposals for disposal by consent must be approved by a Fitness to Practise Panel. In considering such proposals for disposal of a case by consent both the Council and the Panel must be satisfied that the appropriate level of public protection is being secured in the case before it and there is no detriment to the wider public interest.[47] In the period 2010 to 2011, 17 cases were disposed of through the consent arrangements.[48] There are also provisions in a limited number of cases for the registrant to enter into a voluntary removal agreement whereby they can resign from the register if the Council is satisfied this would adequately protect the public. That agreement also provides for an agreed statement of facts to be published on the Council's website.[49]

8.62 The General Medical Council's system of consensual disposal allows a matter to be concluded at the case examiner stage or Fitness to Practise Panel with the registrant doctor giving formal written undertakings about future practice. Except where they relate exclusively to the doctor's health, the undertakings will appear on the register and may be disclosed to their employer, potential employer or any other person enquiring.[50] The relevant guidance states that undertakings are appropriate only if the doctor demonstrates personal insight into their previous failings, and they cannot be agreed if there is a realistic prospect of erasure.[51]

8.63 In a small number of cases the General Medical Council can agree with the doctor that their name should be removed from the register under its "voluntary erasure" provisions.[52] It is estimated that the Council only agrees undertakings or grants voluntary erasure in 2% of fitness to practise cases a year.[53]

8.64 The General Medical Council has put forward proposals to increase the use of consensual disposals (including voluntary erasure) by encouraging greater cooperation and discussion with doctors in all cases where there is no significant dispute about the facts, thus avoiding the need for a full public hearing. It is also proposed that the term "voluntary erasure" will be replaced with "erased by mutual agreement" to reflect the fact that in such cases the General Medical

[47] Health Professions Council, *Practice Note: Disposal of Cases by Consent* (2003).

[48] Health Professions Council, *Fitness to Practise Annual Report 2011* (2011) p 42.

[49] Health Professions Council (Registration and Fees) Rules Order of Council 2003, SI 2003 No 1574, r 12.

[50] General Medical Council (Fitness to Practise) Rules Order of Council 2004, SI 2004 No 2608, r 17(2)(m).

[51] General Medical Council, *Guidance on Undertakings* (2009) paras 24 to 25.

[52] General Medical Council, *Reform Of The Fitness To Practise Procedures At The GMC: Changes To The Way We Deal With Cases At The End Of An Investigation: A Paper For Consultation* (2011) p 21.

[53] As above, p 17.

Council believes it is appropriate that the doctor's registration is restricted or removed and the doctor accepts this proposal.[54]

8.65 The increased use of consensual forms of disposals has proved controversial. For example, the Patients Association has argued the default position should be "that public examination of the facts is required" so that patients have confidence that when professional standards are not upheld "a thorough investigation is carried out and the necessary steps taken to protect the public".[55]

Provisional view

8.66 The range of powers available at the investigation stage to dispose of cases varies between the regulators. Our provisional view is that all the regulators should have access to the same powers. This would not only assist legal clarity and certainty, but help to ensure that cases can be dealt with efficiently and that the public can be protected. We therefore propose that the regulators should have statutory powers to issue or agree the following at the investigation stage:

(1) warnings;

(2) undertakings;

(3) voluntary erasure; and

(4) advice to any person with an interest in the case.

8.67 The regulators would also be given broad powers to make rules governing the use of such powers. This would include rules governing who or which body can issue them and the circumstances in which the powers can be agreed or imposed. For example, the regulators could establish a public interest test for consensual disposals similar to that established by the Health Professions Council. Alternatively, regulators could require that only panels or committee should have powers to make the final decision on sanctions.

8.68 As noted above, under our proposals there would be no requirement to establish investigation committees. It would therefore be possible for such powers to be issued by, for example, case examiners, Council officials or a single decision-maker. We welcome views on whether the statute should require that any decision under these powers must be made or approved by a Fitness to Practise Panel or an equivalent committee. Alternatively, the powers of the Council for Healthcare Regulatory Excellence to refer decisions of Fitness to Practise Panels to the High Court (see Part 10) could be extended to cover disposals at the investigation stage.

8.69 We welcome further views on the use of consensual disposals (including removal from the register) either at the investigation stage or at the adjudication stage. Concerns have been raised that many such cases are not subject to public

[54] As above, p 21.

[55] Patients Association, *Evidence to the Health Select Committee (GMC 08)* (2010) para 11.

hearings or other safeguards, especially in cases which may affect public confidence in the regulatory system.[56] There may be ways in which the statute could provide additional safeguards, for example by ensuring that the regulators maintain an audit trail to ensure public confidence in cases where there is no public hearing. This could include, for example, a record appearing in the register and/or on the website. We accept that there may be concerns that this may discourage registrants from entering into consensual disposals. There may also be ways in which the legal framework could encourage a fuller disclosure of information and the proposed sanction or outcome at an earlier stage in the investigation by the regulator.

8.70 In order to future proof the new legal framework, we believe there should be a mechanism to allow new powers to be added and for powers to be removed. In our view, this is a decision best left to Government due to the public interest in such matters. Furthermore, there would be concerns about giving the regulators such a broad-ranging and unchecked power to, for example, introduce any form of power at the investigation stage. We, therefore, propose that the Government should be given a regulation making power to add new powers to the above list, or remove any powers. Since any such regulations must take the form of a statutory instrument, Parliament would have oversight over such matters.

8.71 We are conscious that Parliamentary Counsel will choose the appropriate language to be used in the legislation, but in some areas the implications of certain terms carry important messages for the public and practitioners. One such area is the language used in relation to sanctions. In Part 9 we invite further views on the nomenclature used for the sanctions available to Fitness to Practise panels at the adjudication stage. We also welcome views on the terminology used in our proposed list above to describe the powers available to the regulators at the investigation stage.

Provisional Proposal 8-16: The regulators should have powers to issue or agree the following at the investigation stage: (1) warnings; (2) undertakings; (3) voluntary erasure; and (4) advice to any person with an interest in the case.

The regulators would be given broad powers to make rules governing the use of such powers. This would include rules governing who or which body can issue them and the circumstances in which the powers can be agreed or imposed.

Question 8-17: Should the statute require that any decision to use any power listed in provisional proposal 8-16 at the investigation stage must be made or approved by a formal committee or Fitness to Practise Panel? Alternatively, should the powers of the CHRE to refer decisions of Fitness to Practise Panels to the High Court be extended to cover consensual disposals?

[56] See, for example, The Shipman Inquiry Fifth Report: Safeguarding Patients, Lessons from the Past – Proposals for the Future (2004) Cm 6394, para 25.253 and Council for Healthcare Regulatory Excellence, *Performance Review of the Medical Council of New Zealand* (2010) para 7.31.

Provisional Proposal 8-18: The Government should be given a regulation-making power to add new powers to those listed in provisional proposal 8-16, and to remove any powers.

Question 8-19: Does the language used in the proposed list of powers contained in provisional proposal 8-16 convey accurately their purpose?

MEDIATION

8.72 Mediation is used in the civil justice system and is increasingly popular when dealing with competence and conduct matters in other sectors, such as law and accountancy. It normally involves the appointment of a trained neutral mediator who assists parties to the dispute to narrow the differences and agree on a negotiated outcome. Mediation can also involve an element of restorative justice with an emphasis on acknowledging and apologising for harm and allowing the person harmed to describe how they were affected and to participate in the discussion of remedial steps.

8.73 Some critics argue that mediation is inappropriate in systems where there is a public interest in investigation and prosecution because the adjudication process and outcome would not be transparent, and the outcome may not be in the public interest. For example, the General Medical Council has argued that mediation is not appropriate where a doctor is facing allegations that their fitness to practise is impaired since the sanction appropriate to protect the public should not be open to negotiation.[57] Furthermore, mediation tends to be used in disputes involving individuals and is not used commonly by regulatory bodies that do not have personal grievances which need to be explored in the same way as individuals or groups who have experienced poor standards of care.

8.74 On the other hand, research has indicated that the use of mediation can assist in fitness to practise cases if certain conditions apply:

> Mediation needs to be offered early in the process, with an emphasis on face-to-face communication between the complainant and registrant, to facilitate explanation, apology (where appropriate and genuine) and plans for future learning and prevention. A "mediation manager" plays a significant part in the success of those schemes that have been widely used, effectively acting as "champion" during the introduction of an approach that may be unfamiliar or even regarded with suspicion by potential participants.[58]

8.75 This research suggests that there are two points at which mediation may be most effective. First, immediately after the allegation has been received where the registrant appears to have made a mistake or omission that is unlikely to be

[57] General Medical Council, *Reform Of The Fitness To Practise Procedures At The GMC: Changes To The Way We Deal With Cases At The End Of An Investigation: A Paper For Consultation* (2011) p 20.

[58] Health Professions Council, *Alternative Mechanisms for Resolving Disputes: A Literature Review* (2011) p 1.

repeated. Second, following an investigation where an allegation about fitness to practise has been upheld by a Panel where the claimant and registrant can participate in discussion about the appropriate remedial steps.[59]

8.76 The Health Professions Council and Nursing and Midwifery Council have a specific power to mediate allegations with the registrant.[60] At the Health Professions Council, screeners or any of the practice committees including the Investigation Committee can conduct mediation.[61] Screeners may be requested by the Investigation Committee to undertake mediation and may adopt any procedure that it sees fit.[62] The legislation also provides for mediation after an allegation has been investigated and declared to be well-founded.[63] The relevant practice note recognises that although mediation is not appropriate in serious cases which the public interest requires should be resolved openly, it may be relevant for matters such as low levels of impairment where an apology is being sought, complaints about overcharging, agreements between practitioners and poor communication.[64]

8.77 The General Medical Council has proposed the introduction of facilitators, rather than mediators, to assist in discussions with doctors about the appropriate sanction to protect the public. It is argued that the role of a facilitator focuses on the need to foster constructive dialogue without taking any role in the outcome of the discussion.[65]

Provisional view

8.78 Mediation will only be appropriate for use in a limited number of fitness to practise cases. Indeed, it is likely that the extent to which it is used will depend on the sector and the availability of other forms of dispute-resolution, such as complaints procedures at local levels, which may be more inclined to provide a mediation service. Nonetheless, mediation can be a useful option in certain cases, and it is our provisional view that all regulators should be given rule-making powers to introduce a system of mediation if they wish to do so. Any system of mediation introduced would be subject to the annual performance review carried out by the Council for Healthcare Regulatory Excellence (see Part 10).

8.79 The power to introduce mediation would be sufficiently broad to enable each regulator to make rules on a variety of matters. This could include who can undertake mediation, at what stages in the investigation and fitness to practise

59 As above, p 56.

60 For example, Nursing and Midwifery Order 2001, SI 2002 No 253, arts 26(6) and 29(4) and Health Professions Order 2001, SI 2002 No 254, arts 26(6) and 29(4).

61 Health Professions Order 2001, SI 2002 No 254, arts 26(6) and 29(4).

62 Health Professions Council (Screeners) Rules Order of Council 2003, SI 2003 No 1573, r 6.

63 Health Professions Order 2001, SI 2002 No 254, art 29(3).

64 Health Professions Council, *Practice Note: Mediation* (2009), p 3.

process it is available and the role of the mediators. The regulators could, for example, restrict the role of mediators to facilitating constructive dialogue without taking any role in the outcome of the discussion. This would allow the development of alternative forms of mediation, such as facilitators. However, we welcome views on the use of mediation and whether it is appropriate for use at all in fitness to practise procedures.

Question 8-20: Is the use of mediation appropriate in the context of fitness to practise procedures?

Provisional Proposal 8-21: All regulators should be given rule and regulation-making powers to introduce a system of mediation if they wish to do so.

REVIEWS

8.80 Some of the governing legislation empowers the regulator in question to review certain decisions made at the investigation stage. The review is undertaken at some of the regulators by the Registrar, but elsewhere the review is undertaken by the Investigation Committee or the Interim Order Committee.[66] The review of interim orders is considered separately in Part 9.

8.81 The subject of the review includes decisions not to refer a case for a formal investigation, not to refer cases to a Fitness to Practise Panel, to issue warnings or agree undertakings.[67] However the General Dental Council is unique is having powers to review decisions to refer cases to a Panel. At many regulators, the review can be initiated by a wide range of individuals and bodies, including the Registrar, practitioner, complainant, or any other person with an interest in the decision. The ability to initiate a review elsewhere is more limited; for example, at the Health Professions Council and Nursing and Midwifery Council only the Investigations Committee can initiate the review.

8.82 In most cases, the grounds for a review are that there has been a decision which is materially flawed or there is new information which has come to light. However, some regulators have wider grounds for a review. For example, the General Dental Council can review cases "if appropriate".

8.83 Some regulators impose a time restriction on the ability to initiate a review. For instance at the General Medical Council a review cannot take place more than two years after the initial decision, except in exceptional circumstances.[68]

[65] General Medical Council, *Reform Of The Fitness To Practise Procedures At The GMC: Changes To The Way We Deal With Cases At The End Of An Investigation: A Paper For Consultation* (2011) p 20.

[66] For example, at the General Medical Council the review is undertaken by the Registrar, but at the Health Professions Council it is undertaken by the Investigation Committee.

[67] See, for example, General Medical Council (Fitness to Practice) Rules Order of Council 2004, SI 2004 No 2608, r 12.

[68] As above, r 12(4).

Provisional view

8.84 The current powers of the regulators to review investigation decisions are limited to a small number of decisions. We think this should continue to be the case in our new framework. But to ensure the appropriate degree of legal certainty, it is also important for the review powers to be included in the statute itself.

8.85 First, we propose that the ability to initiate a review should apply when a decision is made following an investigation:

(1) not to refer a case for an investigation following initial consideration;

(2) not to refer the case to a Fitness to Practise Panel;

(3) to issue a warning; or

(4) to cease consideration of a case where undertakings have been agreed.

8.86 The right to a review would not extend to decisions to refer cases to a Fitness to Practise Panel, as provided for at the General Dental Council. This is on the basis that the Fitness to Practise Panel provides an appropriate forum for such cases.

8.87 Second, we propose that the grounds for review should be that:

(1) new evidence has come to light which makes review necessary for the protection of public; or

(2) the regulator has erred in its administrative handling of the case and a review is necessary in the public interest.

8.88 Third,, we propose that anyone else who has an interest in the decision should be able to initiate a review including but not limited to the Registrar, registrant, complainant and Council for Regulatory Healthcare Excellence. However, to protect the registrant from vexatious review requests, the ability to initiate a review would not be of right but would require an application to the regulator who would consider the merits of the request.

8.89 Finally, we propose that the statute should give the regulators broad powers to make rules and regulations on all other aspects of the review process. This would give the regulators flexibility to decide, for example, who must carry out the review, such as the Registrar or a formal panel/committee. However, we welcome views on whether any aspects of the review process would benefit from greater consistency, such as a time-limit imposed by the statute beyond which decisions cannot be reviewed (except in exceptional circumstances).

Provisional Proposal 8-22: The statute should provide for a right to initiate a review of an investigation decision in relation to decisions: (1) not to refer a case for an investigation following initial consideration; (2) not to refer the case to a Fitness to Practise Panel; (3) to issue a warning; or (4) to cease consideration of a case where undertakings are agreed.

Provisional Proposal 8-23: Anyone who has an interest in the decision should be able to initiate a review of an investigation decision, including but not limited to the Registrar, registrant, complainant and CHRE.

Provisional Proposal 8-24: The grounds for a review of an investigation decision should be that new evidence has come to light which makes review necessary for the protection of the public or the regulator has erred in its administrative handling of the case and a review is necessary in the public interest.

Provisional Proposal 8-25: The statute should give the regulators broad rule and regulation-making powers on all aspects of the process for the review of an investigation decision, except those matters specified in provisional proposals 8-22, 8-23 and 8-24.

PART 9
FITNESS TO PRACTISE: ADJUDICATION

9.1 Adjudication is when the registrant appears before the regulator to answer allegations. This often involves a formal hearing before a Fitness to Practise Panel which is the final stage of the fitness to practise process.[1] But adjudication can also be undertaken by other bodies such as a Health Committee or an Interim Orders Panel. This Part considers the following matters:

(1) Article 6 compliance;

(2) separation of investigation and adjudication;

(3) case management;

(4) Panel composition;

(5) conduct of hearings;

(6) Interim Orders;

(7) final sanctions and other disposals;

(8) review hearings;

(9) should regulators be able to reconsider their decisions?; and

(10) appeals.

9.2 This Part does not discuss restoration hearings or error and fraudulent register entry hearings. These are dealt with in Part 5.

ARTICLE 6 COMPLIANCE

9.3 The need for procedural fairness has long been recognised as an important requirement in disciplinary proceedings. Common law requirements of natural justice have been supplemented by the incorporation into domestic law of Article 6 of the European Convention on Human Rights with which the regulators must comply.[2] Article 6 provides that "everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law".

9.4 Before a registrant can seek to rely on the procedural protections of Article 6, it must be shown that Article 6 is engaged. The principal test is whether the

[1] The relevant legislation uses several terms for this body that include Fitness to Practise Committee, Professional Conduct Committee or Competence and Conduct Committee. In this Part we use the term Fitness to Practise Panel.

[2] This is because the regulators are public authorities within the meaning of section 6 of the Human Rights Act 1998. See *Tehrani v UK Central Council for Nursing, Midwifery and Health Visiting* [2001] ScotCS 19, [2001] IRLR 208 at [31].

outcome of the particular procedure is capable of affecting a practitioner's ability to continue working in their chosen profession.[3] Accordingly, the applicability of Article 6 varies throughout the different stages of the fitness to practise process; it is not engaged at the early stages involving screening and investigation, but will be engaged at the adjudication stage.[4] This would include interim order proceedings relating to an interim suspension.[5]

9.5 Several court cases have been brought alleging non compliance with Article 6 on the basis that adjudication is undertaken by the regulators and not an independent body. The courts have rejected such claims because the legislation provides for subsequent control of the fitness to practise decision by the High Court in England and Wales, the Court of Session in Scotland and the High Court in Northern Ireland on both issues of fact and law. In effect, the decision of the regulator is subject to a court of full jurisdiction which therefore satisfies the requirements of Article 6.[6] Moreover, in *Sadler v General Medical Council* the court stated that the General Medical Council's fitness to practise adjudication process at that time was in itself Article 6 compliant without even having to consider whether the process was subject to review by a court of full jurisdiction.[7]

Provisional view

9.6 It is vital that the fitness to practise process secures the requirements of procedural fairness guaranteed by Article 6. These include but are not limited to securing the right to a hearing within a reasonable time, access to legal representation, an opportunity to attend the hearing, adequate time for the preparation of the individual's defence, a public hearing and a public pronouncement of the judgment. Arguably, the legal frameworks for fitness to practise cases adopted by the regulators have improved significantly in recent years and are now Article 6 compliant even without relying on the availability of review by a court of full jurisdiction.

9.7 Nevertheless the role of the higher courts as courts of full jurisdiction over the regulators' decisions means that Fitness to Practise Panels procedures in most cases will not fail the Article 6 test. That said, we think that it is best to ensure that all proceedings are Article 6 compliant without taking into account the right to appeal to a court of full jurisdiction.

9.8 One way of achieving this would be to attempt to specify in statute law which measures and procedures must be adopted by each regulator to ensure Article 6 compliance. However, we think this is not possible given the sheer range of requirements arising potentially under Article 6, each of which will vary in the light

[3] *R (Wright) v Secretary of State for Health* [2009] UKHL 3, [2009] 1 AC 739. For a summary of recent authorities see *Re B* [2011] EWHC 2362 (Admin) at [38] to [99].

[4] *David v General Medical Council* [2004] EWHC 2977 at [35].

[5] *Madan v General Medical Council* [2001] EWHC Admin 577, [2001] Lloyd's Rep Med 539.

[6] See, for example, *Tehrani v UK Central Council for Nursing, Midwifery and Health Visiting* [2001] ScotCS 19, [2001] IRLR 208 at [52] and *Ghosh v General Medical Council* (2001) 1 WLR 1915 at [31].

[7] *Sadler v General Medical Council* [2003] UKPC 59, [2003] 1 WLR 2259 at [80].

of the individual circumstances of the case. But even if this were possible, the statute would only be able to set out certain minimum standards needed to comply with Article 6. This might encourage the regulators to look towards achieving these minimum standards, rather than encouraging them to promote actively the rights guaranteed by the Convention. We also think it is unnecessary to attempt to set out the need to ensure compliance when the regulators are already required to comply with Article 6 at the adjudication stage.

9.9 An alternative would be for the statute to simply require the regulators to ensure that they establish a structure which is Article 6 compliant without taking into account the role of the higher courts. This would give the regulators discretion on how to implement this requirement, while also encouraging the regulators to promote actively Convention rights. We welcome further views on the correct approach to adopt.

Question 9-1: Should the statute require the regulators to ensure that they establish a structure which is compliant with Article 6 of the European Convention on Human Rights without taking into account the role of the higher courts?

THE SEPARATION OF INVESTIGATION AND ADJUDICATION

9.10 In law, the regulators are responsible for the investigation and adjudication of allegations of impaired fitness to practise. This has led to criticism that as setter of standards and prosecutor, the regulators' independence as an adjudicator is open to question. In 2004, the Fifth Report of the Shipman Inquiry recommended the clear separation of adjudication from the General Medical Council's other functions through the establishment of an independent judicial body.[8] This recommendation was accepted in principle by the previous Government.

Office of the Health Professions Adjudicator

9.11 The 2007 White Paper, *Trust, Assurance and Safety* set out the intention to transfer the adjudication functions of the General Medical Council to a new independent body called the Office of the Health Professions Adjudicator.[9] This would be a separate body responsible for recruiting and training panellists, running hearings and adjudication. It was to be funded by fees paid by the referring regulator. The benefits were said to include "conspicuous independence and hence greater public confidence", as well as consistency across the regulators and "efficiency gains from both the introduction of modern tribunal practices and through economies of scale".[10]

9.12 The Health and Social Care Act 2008 provided for the Office of the Health

[8] The Shipman Inquiry Fifth Report: Safeguarding Patients, Lessons from the Past – Proposals for the Future (2004) Cm 6394, paras 27.204 to 27.210.

[9] Trust, Assurance and Safety – the Regulation of the Health Professions in the 21 Century (2007) Cm 7013, paras 4.36.

[10] Office of the Health Professions Adjudicator, *Written Evidence to the Health Select Committee (GMC 09)* (2011) para 2.2.

Professions Adjudicator to take over adjudication of fitness to practise hearings in relation to General Medical Council and General Optical Council cases, subject to provision for review by the higher courts on issues of fact and law. That Act also made provision to enable its jurisdiction to be extended to other regulators by means of an order under section 60 of the Health Act 1999.

9.13 The Office of the Health Professions Adjudicator became a legal entity in January 2010 but did not commence any adjudication functions. Following the General Election, the Coalition Government reviewed the case for an independent adjudicator. The Department of Health consulted on the matter, indicating that its preferred option was to abolish the Office of the Health Professions Adjudicator and take steps to enhance the General Medical Council's processes. The rationale for this was that such steps would deliver substantially the same benefits that an independent adjudicator would have delivered, but in a more cost effective manner. Following consultation, the Government confirmed that it would proceed with its preferred option and repeal the relevant statutory provisions through the Health and Social Care Bill 2011.

9.14 The effect of the Office of the Health Professions Adjudicator's abolition is that the regulators will continue to carry out adjudication at the first instance in fitness to practise hearings, subject to existing provisions in their governing legislation for review by the higher courts on issues of both fact and law.

General Medical Council Reforms

9.15 In 2011 the General Medical Council published proposals for the establishment of the Medical Practitioners Tribunal Service to assume responsibility for adjudication, including hearing cases that are currently heard by interim orders panels and fitness to practise panels. It is stated that the Tribunal Service would be operationally separate from the rest of the General Medical Council and would be responsible for the appointment and removal of tribunal members and case managers, the appointment of special advisers, and the appointment, training and assessment of legal advisers. The Council have proposed a right of appeal against tribunal decisions where it is desirable for the protection of the public. The Tribunal Service would be required to report directly to Parliament on an annual basis.[11] It is expected that the Tribunal Service will be set up in shadow form by the summer of 2012 pending the introduction of new legislation in 2013.[12]

Provisional view

9.16 In our view, Article 6 does not require a separate fitness to practise adjudicator. The test is whether sufficient guarantees exist to exclude any legitimate doubt of impartiality, applying an objective standard.[13] This test enables the fitness to

[11] General Medical Council, *Reform of the Fitness to Practise Procedures at the GMC: The Future of Adjudication and the Establishment of the Medical Practitioners Tribunal Service: A Paper For Consultation* (2011).

[12] General Medical Council, *Summary of responses to our Consultation: The Future of Adjudication and the Establishment of the Medical Practitioners Tribunal Service* (2011), para 49.

[13] *Findlay v UK* (1997) 24 EHRR 221, 245.

practise process to be considered in the round. Regard must be had, amongst other matters, to the manner of the appointment of Panellists and their terms of office, the existence of safeguards against outside pressures and the question of whether it presents an appearance of independence.[14]

9.17 Moreover, as noted earlier in this Part, several court cases have considered arguments that fitness to practise adjudication by the regulators fails to secure the requirements of an independent and impartial court under Article 6, and have rejected them on the basis that the legislation provides for subsequent control of the fitness to practise decision by a court of full jurisdiction. Such judicial control on issues of both fact and law will continue to apply after the abolition of the Office of the Health Professions Adjudicator in the case of each regulator.

9.18 Notwithstanding the Article 6 argument, we think there are substantial benefits to be gained from the separation of investigation from adjudication, not least of which is ensuring public and professional confidence in the decisions of the adjudicator. We therefore believe that the new legal framework should ensure such separation. The Office of the Health Professions Adjudicator represents the high water mark for securing an independent adjudicator. This model could clearly be seen as attractive in law reform terms, but as the Government has come to a firm decision not to pursue the proposal, we have not considered it. The rest of the discussion in this Part therefore assumes that the regulators will continue to have formal responsibility for adjudication.

9.19 We believe that the legal framework should ensure that the regulators' fitness to practise procedures establish some degree of separation between investigation and adjudication. The precise ways that this could be achieved relate mainly to the appointment process for Panel members and prohibitions on Panel membership. These are discussed in detail later in this Part.

9.20 In addition, the General Medical Council has published proposals to reinforce the separation of the investigation and adjudication functions, including the establishment of a Medical Practitioners Tribunal Service. Although the Tribunal is not fully independent of the General Medical Council and some have questioned whether the proposed governance arrangements will separate effectively the Tribunal from the day-to-day management of the Council,[15] we believe that the proposed reforms would introduce a high degree of independence into the adjudication of fitness to practise cases. Furthermore, the new system would reflect many of the policy ambitions and procedural changes proposed by the Office of the Health Professions Adjudicator.[16]

[14] *Bryan v UK* (1995) 21 EHRR 342 at [37].

[15] See, for example, Administrative Justice and Tribunals Council, *Fitness to Practise Adjudication for Health Professionals: Assessing Different Mechanisms for Delivery* (2010) (letter to the Department of Health) and Office of the Health Professions Adjudicator, *Written evidence to the Health Select Committee (GMC 09)* (2011) para 3.2.

[16] Office of the Health Professions Adjudicator, *Reform of the fitness to practise procedures at the GMC: The future of adjudication and the establishment of the Medical Practitioners Tribunal Service: A Paper for Consultation* (2011).

9.21 Our proposals would enable the General Medical Council to establish and maintain their new structure. This in turn raises the question of whether other regulators should adopt this system. Arguably, it is unjust that doctors have access to a more independent fitness to practise adjudication process, while other professionals do not. However, establishing such a system would have significant cost implications and is therefore a matter for each regulator to decide.

9.22 Nonetheless, it is important for the new legal framework to allow for the development of future policy and enable the regulators to develop a new adjudication system along the lines of that proposed by the General Medical Council, or indeed any other new system which enhances the independence of fitness to practise adjudication. It is also possible that, in time, the Medical Practitioners Tribunal Service could be used by the other regulators in order to "realise the benefits of increased independence, consistency and economies of scale".[17]

9.23 It may also be possible that in the future other regulators may develop adjudication processes that other regulators may want to use in order to realise these benefits. In Part 12, we therefore propose that the statute should allow each regulator to enter into a partnership arrangement with one or more of the other regulators to for example establish a joint adjudication process.

9.24 We also welcome views on whether the statute should leave open the option of transferring fitness to practise adjudication to the Unified Tribunals System established by the Tribunals, Courts and Enforcement Act 2007. There are already analogous jurisdictions within the Tribunals Service, including the:

(1) First-tier Tribunal (Primary Health Lists), which deals with appeals by GPs, dentists and other health professionals against Primary Care Trusts' decisions about local performers' lists (which often include fitness to practise issues); and

(2) First-tier Tribunal (Care Standards), which deals with appeals from people included in lists of individuals regarded as unsuitable to work with children and vulnerable adults and appeals against conduct decisions by the General Social Care Council.

9.25 Under our proposed system, the decision to join the Tribunal Service could be a matter which is left the regulators to initiate but the final decision would rest with the Government who would need to undertake its own impact assessment and legislate in order to extend the remit of the Tribunal service.

9.26 However, the Government has recently considered and discounted this option on the basis that "any transfer of powers would be a new development in terms of adjudication of professionals" and it would be a "complicated and lengthy process

[17] Council for Healthcare Regulatory Excellence, *Fitness to Practise Adjudication for Health Professionals: Assessing Different Mechanisms for Delivery: CHRE Response to the Department of Health Consultation* (2010) para 7.

to set up and the new arrangements would take a number of years to establish".[18] This may mean that in practice this option is unlikely to be taken forward.

Question 9-2: Should the new legal framework ensure the separation of investigation and adjudication, and if so how?

Question 9-3: Should the statute allow for the option of the regulators' adjudication systems joining the Unified Tribunals Service?

CASE MANAGEMENT

9.27 Pre-hearing case management is a process by which the issues in dispute are identified at an early stage, arrangements are put in place to ensure that evidence (whether disputed or not) is presented clearly, the needs of witnesses are taken into account and a timetable is established for the conduct of the proceedings. Some regulators have specific case management provisions in their legislation.

9.28 The Health Professions Council's governing legislation requires that fitness to practise proceedings must be conducted "expeditiously" and, for that purpose, enables its practice committees to give directions for the conduct of cases and for the consequences of failure to comply with such directions (which may include the making of an order or refusal of an application if the failure to comply was without reasonable excuse).[19] The Council has issued standard directions which apply automatically as default directions in every case. Those standard directions relate to the exchange of documentation, notices to admit facts, notices to admit documents, notice to admit witness statements and the withdrawal of admissions.[20] The Council is reviewing the information that is provided to panels and registrants in bundles, including the provision of a skeleton argument in all final hearing cases.[21]

9.29 The General Medical Council's case management rules allow for the appointment of one or more legally qualified case managers who may issue directions to the parties on a range of matters such as the disclosure of evidence, witness details and skeleton arguments. Where a party fails to comply with a direction, the Fitness to Practise Panel may draw an adverse inference; for example it can place less weight on evidence that is presented late.[22] In practice, this power is used rarely, and there are no other sanctions available if parties refuse to engage with a direction. The Council has put forward proposals to allow evidence to be excluded which is sought to be introduced in breach of directions and introduce a

[18] Department of Health, *Fitness to Practise Adjudication for Health Professionals: Assessing Different Mechanisms for Delivery: Consultation Report* (2010) p 11.

[19] Health Professions Order 2001, SI 2002 No 254, art 32(3).

[20] Health Professions Council, *Practice Note: Case Management and Directions* (2011).

[21] Health Professions Council, *Fitness to Practise Adjudication for Health Professionals: Assessing Different Mechanisms for Delivery: A Review of the HPC's Approach* (2011) para 2.2.4.

[22] General Medical Council (Fitness to Practise) Rules Order of Council 2004, SI 2004 No 2608, r 16.

power to make cost orders.[23]

9.30 The use of cost orders, which can be used to enforce case management directions, is discussed later in this Part.

Provisional view

9.31 Case management can help to ensure an effective and efficient hearing, as well as securing the right to a hearing within a reasonable time provided for in Article 6(1). However, only some of the regulators currently have powers of case management. We provisionally propose that the statute should give all the regulators a broad power to establish rules for case management. The power could be used, for example, to allow the panels or case managers to give directions for the conduct of cases and for the consequences of failure to comply with such directions (such as making an order or the refusal of an application). It would also allow for standard directions to be issued.

9.32 We welcome views on whether the statute should include a requirement that the regulators must conduct their fitness to practise proceedings expeditiously. We think that a better approach would be to provide that the overriding objective of the Civil Procedure Rules is made part of the regulators' fitness to practise procedures. This objective provides that courts must deal with cases justly, which includes amongst other matters ensuring that cases are dealt with expeditiously and fairly and in ways which are proportionate to for example the costs and complexity of the case.[24] The overriding objective has already been incorporated in various forms in almost all court rules.

Provisional Proposal 9-4: The statute should give all the regulators a broad power to establish rules for case management.

Provisional Proposal 9-5: The statute should provide that the overriding objective of the Civil Procedure Rules – that cases must be dealt with justly – is made part of the regulators' fitness to practise procedures.

COMPOSITION OF PANELS

9.33 All of the regulators are required to constitute and make rules governing the size and membership of Fitness to Practise Panels. At some regulators Panel appointments are undertaken by a separate appointments committee. Although these committees are appointed by the regulator, they often cannot include a Council member, member of a Committee or a Council employee.[25] Other regulators have entered into arrangements with the Appointments Commission to

[23] General Medical Council, *Reform of the Fitness to Practise Procedures at the GMC: The Future of Adjudication and the Establishment of the Medical Practitioners Tribunal Service: A Paper For Consultation* (2011) paras 79 to 91.

[24] Civil Procedure Rules, rr 1.1 and 1.2.

[25] See, for example, General Pharmaceutical Council (Statutory Committees and their Advisers Rules) Order of Council 2010, SI 2010 No 1616.

oversee their Panel appointment process.[26]

9.34 The common position across the regulators is that a Panel is made up of at least three people, comprising both professionals and non-professionals. For example, the General Dental Council's quorum is three members including at least one lay person, one registered dentist and in relevant cases, a dental care professional.[27] In practice, individual panellists may sit on panels for more than one regulator.

9.35 Some of the rules set out procedures for the appointment of and give specific responsibilities to the chair of the Panel. Chairs may be legally qualified but this is not a common requirement across the regulators. The General Medical Council is proposing to introduce legally qualified chairs in all or in certain complex cases.[28]

Prohibitions on membership

9.36 Some judicial criticism has been directed at arrangements which allow members of Fitness to Practise Panels to perform other roles within the Council. For example, the Court of Session found no breach of Article 6 of the European Convention on Human Rights but questioned the impartiality and independence of arrangements which allowed the same members to sit on both the Preliminary Proceedings Committee and the Professional Conduct Committee, although not in respect of the same case.[29] Similarly, the Privy Council criticised the General Dental Council's rules which allowed the President to act as both the preliminary screener of complaints and Chair of the Professional Conduct Committee.[30] There has also been Government criticism of rules that allow Council members to sit on Fitness to Practise panels on the basis that Council members "should not be engaged in operational matters where impartiality and independence are paramount".[31]

9.37 Most regulators have since addressed these criticisms by establishing certain prohibitions on Panel membership. For example, most regulators now prevent Panellists being members of the General Council or Investigation Committee.[32] Some regulators have a general rule preventing Panellists from being members

[26] See, for example, Health Professions Order 2001, SI 2002 No 254, sch 1, 19(5).

[27] General Dental Council (Constitution of Committees) Rules Order of Council 2009, SI 2009 No 1813, r 4.

[28] General Medical Council, *Reform of the Fitness to Practise Procedures at the GMC: The Future of Adjudication and the Establishment of the Medical Practitioners Tribunal Service: A Paper For Consultation* (2011) paras 92 to 97.

[29] *Tehrani v UK Central Council for Nursing, Midwifery and Health Visiting* [2001] ScotCS 19, [2001] IRLR 208 at [85].

[30] *Preiss v General Dental Council* [2001] UKPC 36 at [20].

[31] Trust, Assurance and Safety – the Regulation of the Health Professions in the 21 Century (2007) Cm 7013, para 4.34.

[32] See, for example, General Medical Council (Constitution of Panels and Investigation Committee) Rules Order of Council 2004, SI 2004 No 2611, r 3(2).

of any other statutory committee.[33]

Advisers

9.38 Most of the regulators make provision for the appointment of legal and professional advisers as a source of expertise for the Panel. Some rules provide that the advice given by the legal or professional adviser must be given in the presence of the parties or if advice was given in private, the parties must be notified.[34]

9.39 Not only must the legal adviser give advice to the Panel on any question of law referred to them, but they must also intervene to advise the Panel in cases where procedural or legal problems may be arising.[35] The legal adviser's role includes a duty to identify points which might assist the absent practitioner.[36] The courts have confirmed that in some cases the advice of the legal adviser must be disclosed and the defendant should be given an opportunity to comment on such advice in order to afford the equality of arms required by Article 6 of the European Convention on Human Rights.[37]

9.40 Some regulators make provision for the appointment of other advisers, such as specialist performance advisors at the General Medical Council.[38]

Provisional view

9.41 In Part 4 we provisionally propose that the existing systems of statutory committees should be abolished and instead the regulators should be able to determine their own governance arrangements, including a power (but not a duty) to establish committees. However, the main exception to this approach is in relation to Fitness to Practise Panels where we think that the law should be more prescriptive.[39] We propose that the statute should require each regulator to establish Fitness to Practise Panels of at least three members for the purpose of adjudication. This reflects the importance of such hearings and their significant impact potentially on a professional's ability to practise. Although not a strict requirement of Article 6, the establishment of such Panels has a long history in health care professional regulation and has the advantages of efficiency, expert knowledge and expedition.

9.42 In addition, we think there are some matters which should be consistent across

[33] See, for example, Nursing and Midwifery Council (Midwifery and Practice Committees) (Constitution) Rules Order of Council 2008, SI 2008 No 3148, r 6(3).

[34] See for example, General Dental Council (Fitness to Practise) Rules Order of Council 2006, SI 2006 No 1663, rr 63 and 64.

[35] *R (Sinha) v General Medical Council* [2008] EWHC 1732 (Admin).

[36] *Compton v General Medical Council* [2008] EWHC 2868 (Admin).

[37] *Nwabueze v General Medical Council* [2000] 1 WLR 1760

[38] General Medical Council (Fitness to Practise) Rules Order of Council 2004, SI 2004 No 2608, r 14.

[39] The other exceptions are in relation to interim order hearings and review hearings, which are discussed later in this Part.

the regulators to ensure that Panels are seen to be fair and impartial. These are:

(1) the establishment of a body which is responsible for all aspects of the Panel appointment process (including terms of appointment and the removal of Panellists) and which is separate from the Council – for example an appointments committee or panel;

(2) a prohibition on Council members and members of the Investigation Committee or any other individuals charged with the investigation of cases (such as case examiners) from being Panellists; and

(3) a requirement that the Panel always has a lay member.

9.43 These matters were referred to expressly in *Sadler v General Medical Council* (discussed earlier in this Part) in support of the view that the General Medical Council's fitness to practise adjudication was in itself Article 6 compliant.[40] Our provisional view is that these matters are of sufficient importance that the statute should require all the regulators to implement them. Indeed, most of these measures have already been established by the majority of the regulators. However, we welcome further views on whether these measures are comprehensive and effective ways of ensuring that Panels are seen to be fair and impartial, as well as any resource implications of this proposal.

9.44 On all other aspects of the constitution of Panels, the regulators would have broad powers to establish rules. This would include matters such as the appointment of advisers (including legal and professional advisers), deputising arrangements, remuneration, additional prohibitions on membership and chairs. So, for example, a regulator could require legally qualified chairs in all or some cases, if it wished to do so.

9.45 Finally, it is important to note that under our proposed reforms the regulators could implement the duty to establish Fitness to Practise Panels by entering into partnership arrangements with other regulators to establish separate adjudication systems. These arrangements are discussed in more detail in Part 12.

Provisional Proposal 9-6: The statute should require each regulator to establish Fitness to Practise Panels of at least three members for the purpose of adjudication.

Provisional Proposal 9-7: The statute should: (1) require the regulators to establish a body which is responsible for all aspects of the Fitness to Practise Panel appointment process and which is separate from the Council; *and* (2) prohibit Council members and investigators from membership of Fitness to Practise Panels; *and* (3) require that each Fitness to Practise Panel must have a lay member.

[40] *Sadler v General Medical Council* [2003] UKPC 59, [2003]1 WLR 2259 at [78].

Provisional Proposal 9-8: Other than on those matters specified in provisional proposals 9-6 and 9-7, the regulators should have broad powers to make rules on the constitution of their Fitness to Practise Panels.

CONDUCT OF HEARINGS

9.46 Most of the regulators have explicit and detailed rules governing the conduct of hearings. These rules can cover the minutiae of fitness to practise procedures, such as the way in which a registrant is notified of a hearing (for example, by post) and the manner in which voting should take place (for example, by raising hands). Our focus here is on certain broader issues of principle.

Health cases

9.47 Some regulators have a separate Health Committee to consider cases where the registrant's fitness to practise may be impaired due to health reasons. For example, the General Chiropractic Council, General Dental Council, General Osteopathic Council, Health Professions Council and Nursing and Midwifery Council have a Health Committee, while others use a modified procedure for the Fitness to Practise Panel.

Civil procedures

9.48 Proceedings before a Fitness to Practise Panel are civil in nature, although there are differences between civil proceedings and fitness to practise proceedings as highlighted by Sir Anthony Clarke MR in *Meadow v General Medical Council*:

> In fitness to practise proceedings the Fitness to Practise Panel is concerned to protect the public for the future and not to determine the rights and obligations of the parties in the same way as in a civil action. This introduces a further public interest which is not present in the ordinary civil suit.[41]

9.49 At most regulators the civil rules of evidence apply, whereby a Panel cannot admit evidence that would not be permissible in civil proceedings, but at some regulators the criminal rules apply. The relevant civil or criminal rules are those that apply in the part of the UK in which the hearing takes place. However, the strict rules of evidence do not apply to fitness to practise and Panels are given discretion to admit a wide range of evidence. For instance, most of the fitness to practise rules state that Panels can admit any evidence they consider to be "fair" and "relevant" to the case before them, whether or not such evidence would be admissible in a court of law. Where evidence would not be admissible, the Panel cannot admit such evidence unless (sometimes on the advice of the legal adviser) it is satisfied that their duty of making "due inquiry" into the case before them makes its admission desirable. The regulators tend to rely on this rule when for example applying to admit a witness statement when the witness is unable (or unwilling) to attend and the Panels are asked to apply the appropriate weight to the evidence.

[41] *Meadow v General Medical Council* [2006] EWCA Civ 1390, [2007] 1 QB 462 at [33].

9.50 For most regulators the fitness to practise rules specify that the standard of proof is the civil standard, on the balance of probabilities. For some regulators the standard is not specified. However, section 112 of the Health and Social Care Act 2008 inserted section 60A into the Health Act 1999 which imposed a requirement for all the health regulators to use the civil standard of proof. This standard applies only to findings of fact. Whether those facts amount to the statutory ground of the allegation and constitute impairment is not a matter which needs to be proved but is a matter of judgment for the Panel.[42] Case law has confirmed that there is no flexible civil standard of proof and the seriousness of the allegation has no special significance.[43]

Hearings in public

9.51 The default position for most of the regulators is that hearings should be in public, meaning that non-parties can attend. This can apply to all or part of the hearing. However, the default position can be reversed in certain cases. Some of the regulators have a broad provision that hearings can be held in private where this is in the interests of any person, or the person concerned and any third party. At other regulators the Panels are required to consider matters of principle such as whether the circumstances of the case outweigh the public interest of a public hearing, or whether the interests of justice demand a private hearing. Some of the rules require that before holding a private hearing the Panel must invite representations from parties and/or obtain advice from the legal adviser.

9.52 Most of the regulators have rules which specify that health cases must be in private except if a public hearing is appropriate or in other cases similar to those described above. Some fitness to practise rules also extend to interim order cases the default position of a private hearing.

Location of hearings

9.53 Most regulators have discretion about where Panel hearings can take place. However, the Health Professions Council is required to hold hearings in the UK country in which the registrant is situated or resides.[44]

Vulnerable witnesses

9.54 Where a person is classified as being a "vulnerable witness", special measures can be introduced to assist the giving of evidence. Most regulators' rules define who is a vulnerable witness by reference to whether the person has a mental disorder, impaired intelligence or physical disabilities, the allegations are of a sexual nature or the witness has been intimidated. Some regulators are required to treat any witness under 18 as being a vulnerable witness, whilst for others the age is under 17. At the General Chiropractic Council and General Osteopathic Council there are no express provisions for vulnerable witnesses.

[42] *Council for the Regulation of Healthcare Professionals v General Medical Council* [2006] EWHC 464 (Admin).

[43] *Re B* [2008] UKHL 35 at [13] to [16] and [69] to [73] and *Re Doherty* [2008] UKHL 33 at [27] to [29] and [44] to 52].

[44] Health Professions Order 2001, SI 2002 No 254, art 22(7).

Procedural efficiencies

9.55 The Council for Healthcare Regulatory Excellence has reported that some of the regulators' fitness to practise rules are cumbersome procedurally and inefficient. They suggest building on the work of the Office of the Health Professions Adjudicator which had adopted the following:

(1) enabling the substitution of Panel members where a Panel becomes inquorate, with the consent of both parties;

(2) removing the requirement to read out the allegations at the start of the hearing;

(3) allowing Panels in the confirmed absence of the parties to decide the outcome based on only the papers;[45] and

(4) enabling the panel to be able to deliver decisions orally.[46]

Provisional view

9.56 The discussion above illustrates some of the wide variation in the rules that apply to fitness to practise hearings. Some have argued that in order to secure consistency an overarching set of rules should be introduced for all regulated professionals; the example of the Heath Professions Council, which registers a wide range of professionals, being cited as an example of how this could work.[47]

9.57 However, in many cases the differences in fitness to practise procedures will reflect the resources available to the regulator in question and the number of complaints they receive, as well as the different characteristics of each profession including the different risks presented to the public. On this basis, our provisional view is that the statute should not impose the standardisation of the rules across the regulators. But it would be possible under our proposed legal framework for two or more of the regulators to decide to harmonise processes, such as the shared appointment, training and appraisal of panel members, a common pool of panellists and the production of unified and consolidated procedural rules. This is discussed in Part 12.

9.58 We provisionally propose that all regulators should be given broad rule making powers on most aspects of fitness to practise hearings, including but not limited to matters such as the representation at hearings, attendance of the registrant, adjournment and postponing hearings, location of hearings, joinder, order of proceedings and the pronouncement of judgment. We do not make any proposals on the content of those rules, which would be a matter for the regulators to determine having regard to the requirements imposed by Article 6. However, the introduction of such broad powers will, amongst other matters,

[45] The original proposal by the Office of the Health Professions Adjudicator related only to cases where the parties were in agreement about the outcome.

[46] Council for Healthcare Regulatory Excellence, *Modern and Efficient Fitness to Practise Adjudication: CHRE's Advice for Secretary of State* (2011) para 4.6.

[47] As above, para 5.3.

enable the regulators to deliver many of the efficiencies identified by the Council for Healthcare Regulatory Excellence (see above).

9.59 We did consider whether the statute should require that hearings must take place in the UK country in which the registrant is situated or resides. On balance, we think that this should be a matter which is left to the discretion of the regulator, but we welcome further views on this point.

9.60 In Part 4, we propose that the regulators should have broad discretion to establish their own governance arrangements. Accordingly, the regulators would have powers (but would not be required) to establish a Health Committee.

Provisional Proposal 9-9: All regulators should be given broad rule-making powers on most procedural aspects of fitness to practise hearings.

Question 9-10: Should the statute require that fitness to practise hearings must take place in the UK country in which the registrant is situated or resides?

9.61 There are four exceptions to the approach set out above where due to the importance of the relevant provision it is our view that the statute itself should provide for greater consistency across the regulators. These exceptions relate to the rules of evidence, standard of proof, hearings in public and vulnerable witnesses. We welcome views on whether there should be consistency on any other procedural issues across the regulators.

Rules of evidence

9.62 As noted previously, some regulators apply criminal rules of evidence, while others apply civil rules. There is also variation in the rules that govern the Panel's discretion to admit evidence whether or not such evidence would be admissible in a court of law. In our view, the rules of evidence are an important aspect of fitness to practise procedures and it is in the interests of the public and professionals that a consistent approach is established. We believe that the civil rules should be the starting point in all cases, given that disciplinary hearings are by their nature civil in character. This would also be more consistent with the move to the application of the civil rather than criminal standard of proof. The relevant civil rules would be those that apply in the part of the UK in which the hearing takes place.

9.63 The various existing rules enable Panels to admit evidence which would not be admissible in court proceedings, although the reasons for admitting such evidence vary between the regulators. This appears to be a useful provision for ensuring that a wide range of evidence can be admitted (for example, to admit a witness statement when the witness is unable (or unwilling) to attend). Most of the regulators who use the civil rules of evidence refer to the tests of fairness and relevance. The exceptions are the General Dental Council, whose rules refer to such evidence being "helpful" and "in the interests of justice", and the Health Professions Council, whose rules refer to such evidence being "necessary to protect the public".

9.64 In our view, the tests of relevance and fairness are relatively straightforward and easy to understand, and in practical terms is the same as the criteria used by the

General Dental Council. The test applied at the Health Professions Council has the advantage of clarity and is focused clearly on the primary duty of public protection. However, there may be concerns that it may restrict unnecessarily the discretion of Panels. We welcome further evidence on this point. On balance, we propose that Panels should be able to admit evidence which would not be admissible in court proceedings if the admission of such evidence is fair and relevant to the case.

Provisional Proposal 9-11: The statute should apply the civil rules of evidence to fitness to practise hearings. The relevant rules should be those that apply in the part of the UK in which a hearing takes place.

Provisional Proposal 9-12: Fitness to Practise Panels should be able to admit evidence which would not be admissible in court proceedings if the admission of such evidence is fair and relevant to the case.

Standard of proof

9.65 In our view, our scheme should retain the civil standard of proof in fitness to practise hearings. This is already required by virtue of section 60A of the Health Act 1999 although it is not always specified in the relevant legislation. In our view, there are strong public protection arguments for adopting the civil standard. The criminal standards implies that someone who is more likely than not to be a danger to the public should be allowed to continue practising, just so long as the panel is not *sure* that he or she is a danger to the public. It seems to us that professional regulation is quite different from the criminal context, where the state is required to make sure that someone has committed a crime before taking the extreme and punitive step of imprisoning him or her. Public protection is, of course, *an* element in criminal justice, but primarily at the sentencing stage, not in terms of findings of guilt.

Provisional Proposal 9-13: The statute should require the civil standard of proof in fitness to practise hearings.

Hearings in public

9.66 In our view the statute should establish a clear position across the regulators on whether hearings are held in public or in private. This is an important matter and in our view the interests of the public and professionals are best served by having clear and consistent criteria. At most of the regulators the default position is that hearings should be in public. But there are various exceptions to this position which vary between the regulators.

9.67 We provisionally propose that the fitness to practise rules should be brought into line with the Civil Procedure Rules on this matter. In effect, there would be a general rule that a hearing is to be in public unless one or more of the specified exceptions apply. Of those exceptions, the following would be most relevant to fitness to practise hearings:

(1) publicity would defeat the object of the hearing;

(2) it involves confidential information and publicity would damage that confidentiality;

(3) a private hearing is necessary to protect the interests of any child or protected party;[48]

(4) it is a hearing of an application made without notice and it would be unjust to any respondent for there to be a public hearing; or

(5) the court considers this to be necessary, in the interests of justice.[49]

9.68 If any of these exceptions apply, the hearing or any part of it may take place in private. Furthermore, the Panel would have the power to order that the identity of any party or witness must not be disclosed if it considers non-disclosure necessary in order to protect the interests of that party or witness.

9.69 Currently, most of the regulators' rules specify that health and interim order cases must be held in private unless certain exceptions apply. There are strong arguments for private hearings in health cases since they are essentially rehabilitative in nature and often consider information of a private and personal nature. The main arguments for private hearings in interim order cases are that there is no proof of wrong-doing at that stage and to have details of serious allegations laid out in public could result in professionals having their reputations damaged irreparably, even when the allegations are not later proved. In our view these arguments are less convincing to those applied to health cases, but we welcome further views.

9.70 In any event, under our proposed approach based on the Civil Procedure Rules it would not be necessary to specify a general rule that health or interim order cases must be in private. The Panel would be required to proceed from the starting point that all hearings must be in public, unless one of the exceptions listed above applies. In most health cases, for example, it is likely that hearing would be in private on the basis that it involves confidential information, notwithstanding that rights under Article 8 of the European Convention on Human Rights would be engaged.[50] We therefore do not propose to establish a separate general rule that that health or interim order cases must be in private.

Provisional Proposal 9-14: The statute should require that all fitness to practise hearings must be held in public unless one or more of the exceptions in the Civil Procedure Rules apply.

Vulnerable witnesses

9.71 In our view, the statute should establish a central definition of a vulnerable witness. It is not acceptable that some regulators do not have any express provision for vulnerable witnesses. Furthermore some of the definitions we have

[48] A protected party is a person who lacks capacity to conduct the proceedings, see Civil Procedure Rules, r 21(1).

[49] Civil Procedure Rules, r 39.2.

reviewed are outdated and potentially discriminatory; for example some establish that all disabled people are automatically *vulnerable* and will require special arrangements.

9.72 We propose that the definition of a vulnerable adult should be closely modelled on the approach taken in the Youth Justice and Criminal Evidence Act 1999 which provides that in criminal proceedings any witness is eligible for assistance:

(1) if under the age of 17 at the time of the hearing; or

(2) if the court considers that the quality of evidence given by the witness is likely to be diminished as a result of the following circumstances:

(a) the witness suffers from mental disorder or otherwise has significant impairment of intelligence and social functioning; or

(b) the witness has a physical disability or is suffering from a physical disorder.

In addition, a witness is eligible for assistance if the court is satisfied that the quality of the evidence given by the witness is likely to be diminished by reason of fear or distress in connection with testifying in the proceedings.[51]

9.73 It would also be possible for the statute to provide for special measures that can be directed by the Panel in relation to witnesses eligible for assistance, such as screening witnesses from the accused, evidence by live link, evidence in private, video recoded evidence, video cross examination, examination through intermediary, and aids to communication.[52] We welcome further views.

Provisional Proposal 9-15: The statute should provide that a witness is eligible for assistance if under 17 at the time of the hearing if the Panel considers that the quality of evidence given by the witness is likely to be diminished as a result of mental disorder, significant impairment of intelligence and social functioning, physical disability or physical disorder. In addition, a witness should be eligible for assistance if the Panel is satisfied that the quality of the evidence given by the witness is likely to be diminished by reason of fear or distress in connection with testifying in the proceedings.

[50] *E v UK* (2001) 34 EHRR 529 at [39] and *Independent News and Media Ltd v A* [2010] EWCA Civ 343, [2010] 1 WLR 2262 at [39]. See also, C Murphy, "Disciplinary Proceedings in the Health Professions and the European Convention on Human Rights" (2011) 16 *Bar Review* 6, 124.

[51] Youth Justice and Criminal Evidence Act 1999, ss 17 to 19.

[52] As above, ss 22 to 30.

Question 9-16: Should the statute provide for special measures that can be directed by the Panel in relation to witnesses eligible for assistance, such as screening witnesses from the accused, evidence by live link, evidence in private, video recoded evidence, video cross examination, examination through intermediary, and aids to communication?

INTERIM ORDERS

9.74 All of the regulators have powers to impose and review Interim Orders. These orders typically enable temporary sanctions to be imposed on a practitioner while the regulator investigates the allegation made against them or while a case is adjourned, even though no case has been proved against them.

Types of Interim Orders

9.75 There are two types of Interim Orders.

(1) an order for interim conditional registration which allows the registrant to continue practising but in a limited capacity; and

(2) an interim suspension order which prevents the registrant from practising at all until there is a final determination of their case.

9.76 At most of the regulators, Interim Orders take effect immediately, can be imposed for up to 18 months, and must be reviewed every 6 months or where new evidence comes to light. In addition, some regulators allow for early reviews to take place in certain cases and/or enable the practitioner to request an early review following a set period of time. If the General Medical Council wishes to extend an order beyond the period initially set, then it must apply to the court.[53]

Hearings

9.77 All of the regulators provide for a formal hearing when an Interim Order is being imposed or reviewed. As noted above, hearings are usually in private but they can be held in public in certain circumstances. At some regulators there is a dedicated Interim Orders Panel. These panels are typically the same in composition as Fitness to Practise Panels, and as well as applications for Interim Orders, they undertake reviews of Interim Orders. Some regulators do not have a dedicated Panel, and Interim Orders are considered only by the Fitness to Practise Panel, Health Committee and/or Investigation Committee.[54] A Fitness to Practise Panel may impose such orders if, for example, it adjourns a case and considers that it is necessary to do so pending its resumed consideration of the matter.

9.78 At many regulators the rules provide that no person may give oral evidence unless the panel thinks that such evidence is desirable.[55] This is on the basis that

[53] Medical Act 1983, s 41A(6).

[54] For example, the Health Professions Council and Nursing and Midwifery Council.

[55] See, for example, General Medical Council (Fitness to Practise) Rules Order of Council 2004, SI 2004 No 2608, r 27(2).

the Panels do not make findings of fact or resolve disputes of fact.[56] Normally a Panel will hear evidence from the registrant but is less likely to hear evidence from a witness.[57]

Criteria for Interim Orders

9.79 The Panel imposing or reviewing an Interim Order is not charged with determining whether the allegations are in fact true.[58] In most cases the test for an Order is whether it is necessary in order to protect the public. But some of the regulators can also impose or maintain an Interim Order if it is otherwise in the public interest or in the interests of the registrant or the person concerned. The public interest ground was introduced following the Shipman Inquiry (see Part 1) and has been characterised as aimed at giving Panels "a discretion as broad as the courts would permit". Indeed, the enlarged power was accompanied by an increase in usage by the General Medical Council with only four Interim Orders being made between 1980 and 1996, compared to 455 in 2009 alone.[59] This is despite guidance issued by the Council that Interim Orders should only be used in extreme cases and rarely on the grounds of public interest alone.[60] The validity of this guidance has been confirmed by the courts.[61]

Right of Appeal

9.80 The right of appeal against an Interim Order is to the High Court in England and Wales and the Court of Session in Scotland and the High Court in Northern Ireland. The governing legislation in most cases gives the court powers to review Interim Orders on issues of both fact and law, including powers to revoke/terminate the order; vary, revoke or remove any condition; or substitute a different time period.[62]

Provisional view

9.81 The power to suspend or place conditions on a registrant pending the investigation of an allegation is an important precautionary tool in the protection of patients. It also gives registrants the opportunity to reflect on their conduct and time to prove that they have remedied their professional shortcomings. Interim Orders also help to "counter the allegation that the final sanction is devalued because of the passage of time between the incidents triggering the complaint

[56] General Medical Council, *Imposing Interim Orders: Guidance for the Interim Orders Panel and the Fitness to Practise Panel* (2009) para 17.

[57] As above.

[58] *R (Ali) v General Medical Council* [2008] EWHC 1630 (Admin).

[59] P Case, "Putting Public Confidence First: Doctors, Precautionary Suspension, and the General Medical Council (2011) 19 *Medical Law Review* 3, 344 to 345.

[60] General Medical Council, Interim Orders Committee: Referral Guidance (2009). See also *R (Shiekh) v General Dental Council* [2007] EWHC 2972 (Admin) and *R (Sosanya) v General Medical Council* EWHC 2814 (Admin).

[61] *Yeoung v General Medical Council* [2009] EWHC 1923 (Admin) at [60] to [61].

[62] See, for example, Medical Act 1983, s 41A(10).

and final sanction".[63] We therefore propose that the statute should require the regulators to establish a system for imposing and reviewing Interim Orders.

9.82 As noted above, we have proposed to give each regulator a power (but not a duty) to establish committees. However, we believe that Interim Order hearings are an exception to this approach (in addition to Fitness to Practise Panels). We therefore propose that the statute should require the regulators to set up a formal panel hearing of at least three people for Interim Order hearings. This reflects the importance of Interim Orders and their significant impact potentially on a professional's ability to practise. Moreover, Panel hearings in such cases are a long established feature of the fitness to practise process and bring various benefits such as expertise and efficiency. Regulators could decide to implement this duty by establishing a dedicated Interim Orders Panel, while others may decide to refer all cases to a Fitness to Practise Panel or another panel or committee.

9.83 We also propose that the same requirements we propose in relation to Fitness to Practise Panels (see provisional proposal 9-7) should apply to Interim Order Panels. In other words, Interim Order panels must be appointed by a body which is separate to the Councils and is responsible for all aspects of appointments, there would be a prohibition on Council members and investigators from membership of Interim Orders panels and each Interim Orders Panel must include a lay member.

9.84 It would also be possible for the statute to prohibit Interim Order panellists sitting on a Fitness to Practise Panel (either in relation to the same case or more generally). We think there are arguments for and against such prohibitions. On the one hand, prohibitions may ensure that both Panels are perceived to be independent. On the other side, the Fitness to Practise panel often has access to the same evidence as an Interim Order panel and so in practice the prohibitions may make less difference. We welcome further views on this point.

9.85 At present the criteria for an Interim Order varies. At some regulators the test is public protection, but others can also impose or maintain Orders in the public interest or in the interests of the registrant or the person concerned. We propose that in accordance with the paramount duty of the regulators (see Part 3) the test for imposing an Interim Order should be to protect, promote and maintain the health, safety and well-being of the public (and maintain confidence in the profession). Whilst arguably this test may be narrower than is the case at some regulators, it is notable that the equivalent criteria for Interim Orders in other Commonwealth jurisdictions are far narrower than for the UK regulators and more

[63] P Case, "Putting Public Confidence First: Doctors, Precautionary Suspension, and the General Medical Council (2011) 19 *Medical Law Review* 3, 351.

focused on public protection.[64]

9.86 On all other matters, the regulators would have powers to issue rules. This includes the criteria for review hearings (such as timescales and the availability of new evidence), powers of the Panel (for example, to revoke vary or issue a different type of Interim Order), time periods of orders and renewals, rights of the person concerned to appear before the panel, rights of representation, and the process for notification of Interim Orders. It would not be necessary for a regulator to have to apply to the court to extend an order beyond the period initially set. We welcome views on whether the legislation should provide certain guarantees for registrants to give evidence at Interim Order hearings.

9.87 The right of appeal against an Interim Order will continue to be to the High Court in England and Wales, the Court of Session in Scotland and the High Court in Northern Ireland. The statute will continue to provide that the court has powers to review Interim Orders on issues of both fact and law, including powers to revoke/terminate the order; vary, revoke or remove any condition; or substitute a different time period.

9.88 Later in this Part we seek views on whether the regulators should be given powers to establish an internal appeals system. We welcome views on whether such a system should include Interim Order cases.

Provisional Proposal 9-17: The statute should require the regulators to establish a system for imposing and reviewing Interim Orders.

Provisional Proposal 9-18: The statute should require each regulator to establish panels of at least three members for interim order hearings (including a lay member). In addition, Interim Order panels must be appointed by a body which is separate to the Council and there would be a prohibition of Council members and investigators from sitting on such Panels.

Question 9-19: Should the statute prohibit Interim Order Panellists sitting on a Fitness to Practise Panel (either in relation to the same case or more generally)?

Provisional Proposal 9-20: The test for imposing an Interim Order should be that it is necessary to protect, promote and maintain the health, safety and well-being of the public (and maintain confidence in the profession).

Provisional Proposal 9-21: On all procedural matters in relation to Interim Order hearings (except for those specified in provisional proposal 9-18) the regulators should have broad rule-making powers.

[64] For example, the Health Practitioner Regulation National Law (Australia) Act 2009 provides for interim orders only where the registrant poses a serious risk and it is necessary to take immediate action to protect the public (ss 155 to 156). The Regulated Health Professions Act 1991 in Canada authorises interim orders where the conduct of the professional exposes or is likely to expose their patients to harm or injury (Sch 2, r 37).

Question 9-22: Should the statute guarantee the right of registrants to give evidence at Interim Order hearings?

Provisional Proposal 9-23: The right of appeal against an Interim Order should continue to be to the High Court in England and Wales, the Court of Session in Scotland and the High Court in Northern Ireland.

FINAL SANCTIONS AND OTHER DISPOSALS

9.89 All Fitness to Practise Panels have powers to impose sanctions following a finding that a professional's fitness to practise is impaired. It is well established in case law that the purpose of sanctions is not punitive but to protect the public, although they may have a punitive effect.[65] However, commentators have pointed out that the rationales for sanctions and punishments share much common ground, such as seeking to communicate to society the unacceptability of a given conduct.[66] In addition, some Panels have powers to agree consensual forms of disposal.

9.90 As discussed in Part 7, the final decision as to whether a registrant should be the subject of a formal sanction is informed by an assessment of whether or not their fitness to practise is impaired at the time of the hearing.[67] The system therefore allows for factors such as insight, contrition and remediation to be taken into account. Even if the professional's fitness to practise is found to be impaired, the Panel may take no action, for example where they have demonstrated considerable insight and undertaken remedial action. But in the overwhelming majority of cases a sanction will be imposed.

Erasure

9.91 Erasure from the register is the most severe sanction available to a Panel. The effect of erasure is that the registrant is not able to practise during the period of erasure. The General Medical Council's guidance suggests that in accordance with the principle of proportionality, this sanction is available only where this is the only means of protecting the public and the wider public interest.[68] In most cases, erasure is not an option available where the allegations relate solely to health. The Health Professions Council and the Nursing and Midwifery Council also do not have a power to erase in most cases relating solely to performance.[69] Former registrants whose registration entry has been erased can apply to be restored to the register once a minimum period has passed (see Part 5).

[65] See, for example, *Raschid v General Medical Council* [2007] 1 WLR 1460 at [18] and *Meadow v General Medical Council* [2006] EWCA Civ 1390, [2007] 1 QB 462 at [32].

[66] See F Zacharias, "The Purpose of Lawyer Discipline" (2003) 45 *William and Mary Law Review* 2, 675.

[67] *Zygmunt v General Medical Council* [2008] EWHC 2643 (Admin).

[68] See, General Medical Council, *Indicative Sanctions Guidance for the Fitness to Practise Panel* (2009) para 77.

[69] Health Professions Order 2002, SI 2002 No 254, art 29(6) and Nursing and Midwifery Order 2001 SI 2002 No 253, art 29(6).

Suspension

9.92 Nearly all of the regulators have powers to suspend registrants for a specified period of time. Suspension is often used in cases of serious misconduct or deficient performance but where for example there has been an acknowledgment of fault and the registrant has taken steps to mitigate their actions. Unlike the sanction of erasure, suspension is widely available in health cases.

9.93 Most regulators can suspend a registrant for up to a year, but for others the period is two or three years. Normally the regulator will have the option of extending the period of suspension at a review hearing. There will often be a requirement for a review hearing before the period of suspension ends, in order for the panel to determine if the individual is fit to return to practice.

9.94 In some cases the original panel will outline measures that the individual should undertake during their period of suspension, in order to address the areas of impairment, such as undergoing training. However, formal conditions cannot be imposed on individuals who are suspended. At the General Medical Council a Panel can suspend registration indefinitely in certain health cases where the registrant has been suspended for two or more years.

Conditions

9.95 Most of the regulators have powers to allow a registrant to practise but only subject to certain conditions. These may restrict the type of work that the registrant is able to undertake or set out requirements for further training. Conditions are likely to be imposed in cases involving the registrant's health, performance, a single incident or where there is evidence of shortcomings in a specific area of practice.

9.96 Conditions must be expressed precisely and be workable.[70] The General Medical Council has developed a "conditions bank" to indicate the appropriate wording for conditions and to ensure that Panels distinguish between restrictions on a doctors' practice and restrictions for their treatment.[71]

9.97 There will normally be a review hearing before the period of conditions comes to an end, to consider whether the registrant is fit to return to unrestricted practice. Some regulators can review the case early if there is evidence that the registrant has not complied with conditions.

Financial penalties and cost orders

9.98 A less common sanction available to the regulators is the ability to fine registrants. Currently this power is available only to the General Dental Council in relation to companies, and to the General Optical Council.[72]

9.99 However, some of the regulators have powers to award costs against a registrant

[70] *Daraghmeh v General Medical Council* [2011] EWHC 2080 (Admin), [2011] All ER (D) 272.

[71] General Medical Council, *FTP Conditions Bank* (2011).

[72] Dentists Act 1984, ss 43B and 44 and Opticians Act 1989, s 13H.

found to be unfit to practise.[73] Where cost orders are available, the rule in civil litigation that costs follow automatically the event does not apply to regulatory bodies because they are performing a public protection role. Decisions for costs are discretionary and the Panel must consider all relevant facts and circumstances.[74] Cost orders can include those which order that the costs of a legal representative be disallowed by reason of their conduct of the proceedings.

9.100 The Council for Healthcare Regulatory Excellence has argued that the ultimate effectiveness of case management is dependent on having enforcement procedures in place, such as the use of cost orders for "culpable non-compliance".[75] Further, it has been argued that the award of costs should be routine on the basis that it is "absurd for the vast majority of registrants to subsidise the small number who are found unfit to practise".[76]

9.101 Not all of the regulators seek a costs jurisdiction. For example, the Health Professions Council argues that the use of cost orders is "disproportionate and not sufficiently aligned to the purpose of those proceedings". This is on the basis that they are bureaucratic and expensive to implement, and are indicative of a retributive model of justice rather than a system based on public protection. Moreover, it is argued that a key component of fitness to practise proceedings is involvement with those proceedings and insight, both of which would be undermined if the registrant was facing costs.[77]

Warnings

9.102 Most of the regulators have powers to issue warnings.[78] In formal terms these are not sanctions since they do not constitute a restriction on registration, but they do appear on the public registers. Warnings are used in cases where conduct has fallen below acceptable standards but there is no need for erasure or conditions.

9.103 For the majority of regulators warnings are available only following a finding of impaired fitness to practise. However, the General Medical Council can only issue warnings where there is no finding of impairment, while other regulators such as the General Pharmaceutical Council have powers to issue warnings where there is a finding of impairment.[79]

9.104 Warnings often appear on the register for a set period of time: for example, at the

[73] For example, General Dental Council (Fitness to Practise) Rules Order of Council 2006, SI 2006 SI 1663, r 19(6) and General Pharmaceutical Council (Fitness to Practise and Disqualification Rules) Order of Council 2010, SI 2010 No 1615, r 46.

[74] *Beresford v Solicitors Regulation Authority* [2009] EWHC 315 (Admin).

[75] Council for Healthcare Regulatory Excellence, *Modern and Efficient Fitness to Practise Adjudication: CHRE's Advice for Secretary of State* (2011) para 8.6.

[76] General Optical Council, *New FTP Rules (Council Paper)* (2011) p 4.

[77] Health Professions Council, *CHRE Report*: *Modern and Efficient Fitness to Practise Adjudication: CHRE's Advice for Secretary of State* (2011) para 9.2.

[78] Several different terms are used across the regulators, including cautions, warnings and admonishments. This Part uses the term "warning" to describe all of these sanctions.

[79] Pharmacy Order 2010, SI 2010 No 231, art 54(2)(a).

Health Professions Council and the Nursing and Midwifery Council this can be between one and five years.[80] Other regulators do not have a time limit.

Consensual disposals

9.105 At many regulators, Fitness to Practise Panels have powers to agree undertakings as an alternative to a formal sanction. Some panels can also agree to voluntary removal from the register. Consensual disposals are discussed in more detail in Part 8.

Immediate Orders

9.106 Most of the regulators have powers to take interim measures pending a direction of a Fitness to Practise Panel taking effect. A sanction does not take effect during the appeal period, normally 28 days, or if an appeal is lodged, until that appeal has been disposed of. During this time the professional's registration is fully effective unless the Panel also imposes a further order. At the General Medical Council this is known as an immediate order which can be imposed where this is necessary for the protection of the public, in the public interest, or in the registrant's interests.[81] At other regulators, such as the Health Professions Council an Interim Order can be used for this purpose.[82] At most Councils, such action can only be taken after certain sanctions have been imposed, normally erasure and suspension.

Pharmaceutical Society of Northern Ireland

9.107 Until recently, a notable feature of the law has been the limited powers of the Pharmaceutical Society of Northern Ireland to deal with fitness to practise matters. For instance, the Society was only able to use the single sanction of removal from the register in fitness to practise cases. However, the Northern Ireland Assembly has legislated recently to reform many aspects of the Society's legal framework, including the introduction of a range of sanctions.[83]

Provisional view

9.108 The range of sanctions available varies across the different regulators. It is our view that harmonising these sanctions would help to promote legal clarity, and further safeguard patients and the public by giving each of the regulators a full range of powers to deal with cases. In effect, the statute would provide that all Fitness to Practise Panels across the different regulators would have the same powers to issue a full range of sanctions. The Council for Healthcare Regulatory Excellence also concluded that the harmonisation of sanctions available to the regulators would help to deliver "better regulation that is proportionate,

[80] Health Professions Order 2001, SI 2002 No 254, art 29(5)(d) and Nursing and Midwifery Order 2001 SI 2002 No 253, art 29(5)(d).

[81] For example, Medical Act 1983, s 38.

[82] Health Professions Order 2001, SI 2002 No 254, art 31(c).

[83] Pharmacy (1976 Order) (Amendment) Order (Northern Ireland) 2012.

accountable, consistent, transparent and targeted".[84]

9.109 The only exception to this approach is in relation to powers to issue financial penalties and costs awards. The availability of such powers is not widespread amongst the regulators, although in the legal and financial regulatory sectors the use of cost awards, in particular, is more widespread.[85] However, the use of financial penalties and cost orders in health regulation is contentious. It may be argued that fitness to practise proceedings are conducted in the public interest, and are properly funded not by costs against individuals but rather by the fees of registrants as a whole. However, on the other side it may be difficult to justify the increasing burden on registrants and to say why good professionals should be expected to subsidise the miscreant. This also raises issues in relation to fairness and in particular equality of arms, including in relation to access to legal representation.[86] Costs orders may not be effective for the regulators of low-paid professions, where obliging the regulators to engage in a detailed assessment of the individual's financial means is in itself a costly exercise. Moreover, the availability of a costs regime against the regulator is similarly a contentious issue, and generally the courts have been keen to restrict the availability of costs awards against regulators on the basis of the "chilling effect on the exercise of [the regulator's] regulatory obligations on the public advantage".[87] We welcome further views on the use of financial penalties and cost awards in health and social care professional regulation. On balance, we think that their introduction should be a matter for Government to decide through a regulation-making power.

9.110 We therefore propose that Fitness to Practise Panels across the regulators should have powers to impose the following:

(1) erasure from the register;

(2) suspension;

(3) conditions; and

(4) warnings.

9.111 In addition, we propose that all Panels should have powers to agree undertakings and voluntary erasure. We also propose that the regulators should be given powers to introduce immediate orders. The regulators would be given powers to make rules governing such orders including which sanctions such orders apply to. Alternatively, the regulators could use their Interim Order rule making powers (see above) in order to achieve a similar outcome.

[84] Council for Healthcare Regulatory Excellence, *Harmonising Sanctions: CHRE Position* (2008) para 7.

[85] Cost awards are available, for example, for the relevant Panels of the Institute and Faculty of Architects, the Institute of Chartered Accountants in England and Wales and the Solicitors Disciplinary Committee.

[86] B Kemp and B Lloyd, "Costs in regulatory proceedings: a contentious subject?" (2011) *The Regulator* (Autumn 2011) 3, 3 to 5.

[87] *Baxendale-Walker v Law Society* [2009] EWHC 643 (Admin) at [21].

9.112 In accordance with the main duty of the regulators (see Part 3), we propose that the test for imposing any of the sanctions listed above should be to protect, promote and maintain the health, safety and well-being of the public (and maintain confidence in the profession).[88]

9.113 We also propose that the regulators should be given broad powers to make rules for issuing sanctions and agreeing consensual forms of disposal. For example, the regulators could establish that erasure is not available in health cases, cautions are available where there is no finding of impairment or some sanctions can only be extended by for example a year at a time. In addition, the regulators will continue to have powers to issue Indicative Sanctions Guidance.

9.114 We appreciate concerns that the rules for imposing the same sanction or agreeing consensual forms of disposal could vary across the regulators. In our view, consistency on these matters is less important than giving each regulator flexibility to decide which provisions are most appropriate in the light of their individual circumstances. An alternative approach would be for the statute to take a more prescriptive approach to certain aspects of the rules for issuing sanctions. However, this would be difficult to achieve in practice because all of the regulators currently have such varied requirements.

9.115 In order to future proof the new legal framework, we believe there should be a mechanism to allow new sanctions to be added and for sanctions to be removed (and consensual forms of disposal). In our view, this is a decision best left to Government due to the public interest in such matters. Furthermore, there would be concerns about giving the regulators such a broad-ranging and unchecked power to, for example, introduce any form of sanction or consensual disposal. We, therefore, propose that the Government should be given a regulation making power to add new sanctions to the above list, or remove any sanctions. Since any such regulations must take the form of a statutory instrument, Parliament would have oversight over such matters. This power would also apply similarly to consensual disposals.

Terminology

9.116 We are conscious that Parliamentary Counsel will choose the appropriate language to be used in the legislation, but in some areas the implications of certain terms carry important messages for the public and practitioners. One such area is the language used in relation to sanctions. Just as there is variety in the availability of different sanctions between the regulators, there is also variety in the terms used to describe similar sanctions. The introduction of a single statute offers an opportunity to harmonise the language used to describe the various sanctions. This would help to ensure a common shared language across the regulators and assist legal clarity.

9.117 We welcome views on the nomenclature used in our proposed list of sanctions

[88] The precise form of words will depend on the eventual approach that is taken to the main duty of the regulators (see Part 3).

above. The Council for Healthcare Regulatory Excellence has reviewed this area and made its own recommendations on some common terms.[89] In particular, the report concluded that "striking off" was to be preferred to alternative terms such as "erasure" and "removal" because it was seen by the public as reassuring and authoritative.[90] Alternatively, "striking off" may have punitive connotations and might not provide clarity about the purpose of the sanction which is to remove a registrant from their practice environment to ensure patient safety.

9.118 There are also various terms used to describe warnings across the regulators, such as caution, admonishment or reprimand. In our view, the terms caution and warning are more readily understandable than admonishment or reprimand. We believe the most appropriate term is warning because this has a more formal connotation, whilst a caution can be interpreted as a slap on the wrist. We also welcome views on the terms used to describe consensual forms of disposal.

Provisional Proposal 9-24: All Fitness to Practise Panels should have powers to impose the following: (1) erasure from the register; (2) suspension; (3) conditions; and (4) warnings.

Provisional Proposal 9-25: The Government should be given a regulation-making power to introduce systems of financial penalties and cost awards.

Provisional Proposal 9-26: All Fitness to Practise Panels should have powers to agree undertakings and voluntary erasure.

Provisional Proposal 9-27: The regulators should have powers to introduce immediate orders (or use Interim Orders for this purpose).

Provisional Proposal 9-28: The test for imposing any of the sanctions listed in provisional proposal 9-24 and consensual disposals in 9-26 should be to protect, promote and maintain the health, safety and well-being of the public (and maintain confidence in the profession).

Provisional Proposal 9-29: The regulators should be given broad powers to make rules in relation to the sanctions listed in provisional proposal 9-24 and consensual disposals in provisional proposal 9-26.

Provisional Proposal 9-30: The Government should be given a regulation-making power to add new sanctions and consensual disposals to those listed in provisional proposals 9-24 and 9-26, and to remove any sanctions and consensual disposals.

Question 9-31: Does the language used in the proposed list of sanctions and consensual disposals contained in provisional proposals 9-24 and 9-26 convey accurately their purpose?

[89] Council for Healthcare Regulatory Excellence, *Harmonising Fitness to Practise Sanctions: Common Terms* (2009).

[90] As above, p 2.

REVIEW HEARINGS

9.119 Most of the regulators are required to review conditions and suspension orders before they expire. In addition, some regulators have powers to review other sanctions such as warnings. Review hearings form a significant proportion of fitness to practise hearings. For example, in 2010 to 2011 the Health Professions Council's Fitness to Practise Committee considered 504 cases, of which 99 were review hearings.[91] The regulators' rules will normally specify when sanctions such as suspensions must be reviewed, or when individuals can apply to the regulator to have their sanction removed. Some regulators can require professionals to undergo a health or performance assessment before agreeing to restore them to the register to ensure that they are fit to practise.

9.120 At a review hearing, Panels will need to consider whether the person's fitness to practise is impaired and whether he or she has complied with any conditions. There will also need to be consideration of whether the practitioner shows insight into their shortcomings, has not re-offended, and has maintained their clinical skills and knowledge. The range of options available to the Panel includes erasure, suspension, extending the conditions, revoking or varying the conditions, agreeing undertakings, conditional registration or resumption of practice.

9.121 At the General Medical Council, all review decisions must be taken by a Fitness to Practise Panel or an Interim Orders Panel, even where the doctor agrees with its proposal to extend an existing order. The Council has published proposals to reform this system to provide that only for cases where there is a dispute about the existing sanctions would a hearing be required.[92]

Provisional view

9.122 All of the regulators have some provision for review hearings. In our view this is an important part of the fitness to practise process which must be provided for in the statute. We provisionally propose that our new legal framework should require all the regulators to establish a system of review hearings for conditions of practise and suspension orders. In addition, the regulators would have powers but would not be required to establish review hearings for warnings and undertakings. Review hearings would be carried out by Fitness to Practise Panels, as constituted in accordance with provisional proposal 9-7.

9.123 We propose that the regulators should have broad rule-making powers to establish the procedures for such hearings, such as assessments, how often reviews should take place and other circumstances that will trigger a review (for example, a request by the practitioner and new evidence coming to light) and the range of options available to the Panel at a review hearing.

[91] General Medical Council, *Reform of the Fitness to Practise Procedures at the GMC: The Future of Adjudication and the Establishment of the Medical Practitioners Tribunal Service: A Paper For Consultation* (2011) para 98.

[92] Council for Healthcare Regulatory Excellence, *Performance Review Report: Changing Regulation in Changing Times 2010/11* (2011) para 15.2.

Provisional Proposal 9-32: The statute should require all the regulators to establish a system of review hearings for conditions of practise and suspension orders. In addition, the regulators should have powers but would not be required to establish review hearings for warnings and undertakings.

Provisional Proposal 9-33: The regulators should have broad rule-making powers to establish the procedures for review hearings.

SHOULD REGULATORS BE ABLE TO RECONSIDER THEIR DECISIONS?

9.124 Once a Panel has announced its decision it has, as a general rule, no power to reconsider it or to reopen the case unless its decision is quashed by the High Court. However, there is an exceptional power to reopen a case where the decision is given in ignorance that something has gone wrong. This power should be used sparingly in cases involving for example slips, accidental mistakes or miscarriages of justice.[93]

9.125 Thus, in *R (Jenkinson) v Nursing and Midwifery Council* it was held that a Professional Conduct Committee could review its own decision even where such statutory powers are not conferred, where it was founded on a mistake. In that case a nurse had been convicted of causing grievous bodily harm with intent, and consequently her name was erased from the register, but the Court of Appeal later set aside this conviction.[94]

9.126 However, it is unclear whether, in the absence of the kind of mistake considered in this case, a regulator can quash a decision which it considers to be unlawful. In a different context, Lord Kerr has stated that the application of an unlawful policy will render any decision reached as being unlawful and therefore void rather than voidable.[95] On the other side, *De Smith's Judicial Review* argues that there is still a presumption of lawfulness that can only set aside by a competent authority. The authors state that there is good reason for this, which is to prevent people from taking the law into their own hands.[96]

Provisional view

9.127 Whilst the presumption of lawfulness that can only be set aside by a competent authority applies clearly where the individual disagrees with the decision-maker, it arguably carries less force where the decision-maker agrees that its decision was unlawful. In other words, where all parties are in agreement that a decision is unlawful there may be little justification to incur the cost and delay of an application to the High Court. We welcome views on whether the regulators should be given an express power to quash or review a Panel decision where both the regulator and the parties agree that the decision was unlawful.

9.128 If such a system of reconsideration were introduced, it is possible that only the

[93] Wade and Forsyth, *Administrative Law* (2007) p 230.

[94] *R (Jenkinson) v Nursing and Midwifery Council* [2009] EWHC 1111 (Admin).

[95] *Walumba Lumba v Secretary of State for the Home Department* [2011] UKSC 12 at [247].

[96] H Woolf, J Jowell and A Le Sueur, *De Smith's Judicial Review* (6th ed 2007) p 207.

registrant or the regulator could seek reconsideration of a decision. However, this might be viewed as unfair by the complainant and other interested parties who might be opposed to any form of reconsideration. We welcome views on whether the complainant and any other interested parties should have the right to prevent or contribute to any decision to use this power.

Question 9-34: Should the regulators be given an express power to quash or review the decision of a Fitness to Practise Panel where the regulator and the relevant parties agree that the decision was unlawful? If so, should complainants and other interested parties be able to prevent or contribute to any decision to use this power?

APPEALS

9.129 A professional is entitled to appeal against any sanction affecting their his or her registration. Appeals lie in most instances to the High Court in England and Wales, the Court of Session in Scotland and the High Court in Northern Ireland.[97] The basis of the appeal can include issues of fact and law. As set out earlier in this Part, even if a body determining disputes over civil rights and obligations does not comply with Article 6, there is no breach of the Article if the proceedings before the body are subject to subsequent control by a judicial body that does provide guarantees of Article 6.[98] In effect, the ability of a practitioner to appeal to the higher courts ensures overall fairness in fitness to practise processes in circumstances where individual elements do not comply with Article 6. As Lord Mackay has stated, "a right of appeal to a court of full jurisdiction does not purge a breach of the Convention. It prevents such a breach from occurring in the first place".[99] This is in contrast to the investigation where the only remedy for a defect in the process is through judicial review.

9.130 However, there are limitations to the exercise of the full jurisdiction appeal. There is judicial consensus that respect for the decision of the Fitness to Practise Panel is the starting point.[100] There are two main explanations for this. First, while appeals are invariably on the basis of written submissions and evidence, the Panel will have had the benefit of hearing and seeing the witnesses give evidence in person.[101] Second, the Panel is viewed as the body best qualified to assess the seriousness of the misconduct in the light of its experience and its knowledge of the measures required to maintain the standards and reputation of the profession.[102] However, if the court, despite paying such respect, is satisfied

[97] The only exception is the General Social Care Council where there is a right to appeal to the First-tier (Care Standards) Tribunal.

[98] See, for example, *Tehrani v UK Central Council for Nursing, Midwifery and Health Visiting* [2001] ScotCS 19, [2001] IRLR 208 at [52] and *Ghosh v General Medical Council* (2001) 1 WLR 1915 at [31].

[99] *Tehrani v UK Central Council for Nursing, Midwifery and Health Visiting* [2001] ScotCS 19, [2001] IRLR 208 at [55].

[100] *Meadow v General Medical Council* [2006] EWCA Civ 1390, [2007] 1 QB 462.

[101] As above.

[102] *Marinovich v General Medical Council* [2002] UKPC 36.

that the sanction is clearly inappropriate, then it must interfere.[103] The correct approach of the court was summarised in the following terms by Lord Millett:

> The board will afford an appropriate measure of respect to the judgment in the committee whether the practitioner's failing amount to serious professional misconduct and on the measures necessary to maintain professional standards and provide adequate protection to the public. But the board will not defer to the committee's judgment more than is warranted by the circumstances.[104]

Provisional view

9.131 The right to appeal to a court of full jurisdiction is an important aspect of the fitness to practise process. It ensures that professionals receive a full reconsideration of their case based on issues of fact and law, and that the fitness to practise system as a whole is compliant with the European Convention on Human Rights. All health care practitioners have consistent arrangements for appeal. Social workers will also be brought within this system when the functions of the General Social Care Council are transferred to the Health Professions Council. We therefore provisionally propose that under the Act all professionals should have the right of appeal to the High Court in England and Wales, the Court of Session in Scotland and the High Court in Northern Ireland.

Provisional Proposal 9-35: All professionals should continue to have a right of appeal against the decision of a Fitness to Practise Panel to the High Court in England and Wales, the Court of Session in Scotland and the High Court in Northern Ireland.

[103] *Salsbury v Law Society* [2009] 1 WLR 1286 at [30] by Jackson LJ.

[104] *Ghosh v General Medical Council* [2001] 1 WLR 1915, 1923G.

PART 10
THE COUNCIL FOR HEALTHCARE REGULATORY EXCELLENCE

10.1 The Council for Healthcare Regulatory Excellence (CHRE) currently oversees the work of the nine UK health care regulators. It is an overarching body whose roles include supervising and scrutinising the work of the regulators, sharing good practice and knowledge with the regulators, and advising the four UK government health departments on issues relating to the regulation of health professionals. It is a non-departmental public body, funded by the Department of Health and accountable to Parliament. The legal framework of the CHRE is contained currently in the NHS Reform and Health Care Professions Act 2002.

10.2 In this Part, we consider:

(1) the role of the CHRE;

(2) governance;

(3) functions, powers and duties of the CHRE;

(4) complaints about regulatory bodies; and

(5) references to the higher courts.

ROLE OF THE CHRE

10.3 The CHRE has been described as both a "meta-regulator" and a "super-regulator".[1] Meta-regulation refers to the activity of regulating those bodies or institutions that are already performing a regulatory function. The concept of meta-regulation has been developed largely outside the framework of health care regulation, for example in the contexts of corporate business and environmental regulation.[2] Meta-regulation covers a wide range of approaches. The term was coined originally to refer specifically to an overseer for the system of regulation but has since been expanding to broader usage.[3] Indeed, the CHRE does not view itself as being a regulator but rather an oversight and audit body with the aim of improving regulation. Thus, the CHRE does not see its job as managing the regulators, but to review and comment on what they are doing in order to raise standards.

10.4 The need for a meta-regulator often arises in situations where bodies perform a self-regulatory role and there is a subsequent failure to perform that role. Meta-regulation can occur as the state responds to the failures in self-regulation by intervening to regulate the regulators. As described in Part 1, the movement

[1] J Black "Tensions in the Regulatory State" (2007) *Public Law* 58, 63 and A Heppinstall "Publication Review: Fitness to Practise: Health Care Regulatory Law, Principle, and Process" (2006) 14(2) *Medical Law Review* 277, 278.

[2] C Parker, *The Open Corporation* (2002) and N Cunningham, *Smart Regulation* (1998).

[3] See C Scott, "Regulatory Capitalism, Meta-Regulation and Accountability for Regulation" (2011) [unpublished paper].

away from self-regulation in health care was in part the result of a series of high profile instances of regulatory failure, such as those set out by the Bristol Royal Infirmary, Alder Hey and Shipman inquires.

10.5 Prior to the establishment of the CHRE, the Government performed a similar role to that of a meta-regulatory role insofar as it was the Department of Health that had general oversight of the regulators and was involved in any changes to the regulators' rules. However, the final report of the Bristol Royal Infirmary Inquiry argued that there was a need for a body to perform the meta-regulatory role in a more systematic manner since the Department of Health was said not to be performing that role with appropriate vigour, efficiency or independence.[4] Accordingly, the report made a recommendation that had already appeared in *The NHS Plan* to create an overarching body to co-ordinate and act as a forum for the regulators.[5]

10.6 The creation of the CHRE has highlighted an alternative approach to health care regulation which has been described as a "systemic model" of regulation rather than a "discrete case model".[6] A discrete case model is primarily concerned with being reactive to individual cases and adopts a fault-based standard by focusing on the role of individual practitioners. It is argued that the regulators tend to adopt this model. However, a systemic model focuses on the lessons that can be learned from individual cases and seeks out the reasons behind systemic failures. The CHRE's position allows it to take a bird's eye view of the regulators and so undertake a systemic approach.

10.7 However, the benefits of having a body which is separate from Government to perform this role arise from the independent scrutiny that such a body can provide. The CHRE is therefore frequently justified as an alternative to direct Government intervention since it performs a supervisory role that might otherwise fall to Government, such as reviewing the performance of the regulators. This can be seen historically in the history of health care regulation where, as set out in Part 1, the state has stepped in to alter the structures and procedures of the regulators and thereby has in practice performed the role of a meta-regulator.

10.8 The Health and Social Care Bill 2011 proposes to reform the CHRE. It will be renamed the Professional Standards Authority for Health and Social Care and will be financed through a levy on the regulatory bodies that it oversees. It will also be able to generate income from other activities, such as the accreditation of voluntary registers. The CHRE will no longer come under the ambit of the Department of Health or any other department, and hence will no longer be a non Departmental Body or Arms Length Body. It is possible that this will make CHRE a Public Corporation, but this will be determined by the Office of National Statistics once the Act has Royal Assent. The reformed CHRE will

[4] Learning from Bristol: the Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984 -1995 – Final Report (2001) Cm 5207, p 315.

[5] Department of Health, *The NHS Plan: a plan for investment, a plan for reform* (2000).

[6] L Mulcahy, "Health Care Professions: A Case Study in Regulatory Dilemmas" (2011) [unpublished paper].

continue to be subject to scrutiny by the National Audit Office and continue to present its reports and accounts to Parliament.[7]

Provisional view

10.9 As a meta-regulator, the CHRE performs a valuable role in providing oversight of the health care regulators. This role is particularly useful due to the large number of regulators responsible for many different professions, as the experience of one regulator may provide learning points for the other regulators. There may also be added value because the CHRE is separate from the Government, since this may provide it with a more authoritative position from which to challenge the regulators, free from any direct political influence. We welcome views on how effective the CHRE is performing the role of scrutinising and overseeing the work of the regulators.

10.10 Our starting point is that the current role of the CHRE should be maintained as far as possible (including the reforms introduced by the Health and Social Care Bill 2011). However, this starting point is subject to changes to the role of the CHRE that may arise as a result of the provisional proposals we make in this consultation paper. For example, in the future CHRE may become involved in monitoring the partnership arrangements discussed in Part 12. Therefore, we provisionally propose that whilst the current position of CHRE is maintained as far as possible, aspects of CHRE's legal framework may need to be altered as a result of our provisional proposals for law reform.

Question 10-1: How effective is the CHRE in performing the role of scrutinising and overseeing the work of the regulators?

Provisional Proposal 10-2: The current powers and roles of the CHRE (including those introduced by the Health and Social Care Bill 2011) should be maintained in as far as possible.

GOVERNANCE OF THE CHRE

10.11 The legislation provides that the Council of the CHRE has nine members who consist of a chair appointed by the Privy Council, three non-executive members from Scotland, Wales and Northern Ireland appointed by the devolved administrations, three non-executive members appointed by the Secretary of State and two executive members who are employees of the Council.[8] However, in practice there are only eight members since one of the executive member seats has never been filled.

10.12 The appointment and remuneration of members of the Council is currently the responsibility of the Secretary of State. Regulations have been made which determine the conditions of appointment and tenure of Council members, whilst the Secretary of State determines their level of remuneration.[9] The Secretary of State also has a role to play in payments and loans to the Council. The Council

7 Council for Healthcare Regulatory Excellence, *Proposals for CHRE's new roles and responsibilities* (2010).

8 NHS Reform and Health Care Professions Act 2002, sch 7, paras 4 and 11.

may appoint employees and has a wide power to delegate functions or seek assistance in the discharge of its functions as well as the keeping of accounts.[10]

10.13 The Health and Social Care Bill 2011 which is currently before Parliament proposes to change some of these governance arrangements. These proposed changes would mean that the Privy Council will have responsibility for appointing the three non-executive members currently appointed by the Secretary of State, whilst there will be one executive member rather than two. The power of the devolved administrations to appoint non-executive Council members would remain. The CHRE is also going to be given responsibility for developing standards for appointments made by the regulators.[11]

Provisional view

10.14 As a result of the reforms that are likely to be introduced by the Health and Social Care Bill 2011, the Privy Council will appoint the Council of the CHRE. However, in Part 2 we have argued that the role of the Privy Council is effectively performed by central Government. The Privy Council will therefore cease to be involved in professional regulation. In relation to appointments to the CHRE this presents us with two principal options.

10.15 First, the CHRE could be given overall responsibility for appointing its own Council members, supplemented by a power to determine the composition of their Council. In Part 4 we have proposed giving the regulators the power to appoint their own Council members and determine the composition of their Councils, and arguably the same approach should apply to the CHRE. However, it should be recognised that the CHRE is in a different position to the regulators. As noted previously in this Part, the CHRE exists at a higher level in the regulatory framework and so is not overseen in the same way as the regulators. Therefore, it may be desirable to for an independent body to make or oversee appointments to the CHRE.

10.16 Alternatively, the Government could be given direct responsibility for appointing CHRE Council members. Such a role could apply either to the three non-executive members, the appointment of whom the Health and Social Care Bill would pass to the Privy Council, or could apply to all of the non-executive members. A role for Government in this process could be justified as properly reflecting the Government's ultimate responsibility to ensure that the regulators act in the public interest. The Government has experience in making appointments to the CHRE through its role of adviser to the Privy Council. While there may be concerns that this option would have implications for CHRE's perceived independence, as set out in Part 2 we do not think that the current system of formal Privy Council appointment affords any such independence. Under this option, the Government could, if it so wished, delegate responsibility

9 Council for Healthcare Regulatory Excellence (Appointment, Procedure etc) Regulations, SI 2008 No 2927.

10 NHS Reform and Health Care Professions Act 2002, sch 7.

11 Council for Healthcare Regulatory Excellence, *Proposals for CHRE's new roles and responsibilities* (2010).

for the appointment process to the CHRE itself, while retaining the final say, and the ability to take the process back unto itself should the need arise.

10.17 There is a third option. Parliament could be given responsibility for appointing CHRE's Council members, which could be exercised by the Health Select Committee or indeed, should it prove practical, by a Joint Committee on health and social care professional regulation, as discussed in Part 2. Parliament has in recent times taken more responsibility in relation to certain appointments. Most recently, the Treasury Committee has been given statutory responsibility for the appointment and dismissal of members of the Office for Budget Responsibility. In certain circumstances, the Committee must consent to members being added to or removed from this body.[12] However, such a system would only be practicable for CHRE in the context of a general change in Parliament's role in relation to scrutiny of arms length regulators (see the discussion in Part 2). That in turn would have significant resource implications for how Parliament undertook its business. We therefore provisionally reject this option. This conclusion, however, could appropriately be revisited should Parliament evince an intention to move towards greater direct scrutiny of regulators.

10.18 We think that the appointment of non-executive members by the devolved administrations is a useful and positive mechanism to express the devolved administrations' responsibilities for both health services and education, and should be retained in either system.

10.19 As to the choice between Government or CHRE appointment of the other three non-executive members, the arguments are, we think, finely balanced. But on balance we provisionally propose that the Government should be given the responsibility. The role of the Government in this respect can be seen as one of the important links between the different regulatory systems – such as the systems regulators and internal NHS processes – which should be retained. Appointments would be made in accordance with the standards for appointments to the health and social care regulators made by CHRE, and the process could be delegated to CHRE itself.

10.20 A possible further stage would be to mirror the approach we have adopted for the regulatory councils, by providing for the establishment of a constitution for CHRE. The constitution would specify, amongst other matters, the size and composition of its Council, how appointments will be made, the duration of membership, mechanisms for the removal of members and education and training requirements. If we were to provisionally propose that appointment should be made by CHRE itself, then allowing CHRE to regulate its own constitution in this way would be attractive, on the model we are proposing for the regulatory councils. However, if the preferred option is for the Government to make appointments, on the basis set out above, then it would be more appropriate for the matters which would otherwise be in the constitution to continue to be set out in statute. To give the Government the power to change the basic structure of the CHRE at will, without Parliamentary oversight, would not be appropriate.

[12] Budget Responsibility and National Audit Act 2011, sch 1.

Provisional Proposal 10-3: Appointments to the CHRE's General Council should be made by the Government and by the devolved administrations. Appointments would be made in accordance with the standards for appointments to the health and social care regulators made by the CHRE.

FUNCTIONS, POWERS AND DUTIES OF THE CHRE

10.21 A major difference between the legal framework of the CHRE and that given to the health care regulators is that the CHRE's legal framework does not consist of statutory powers and functions which are detailed elsewhere in rules and regulations. Instead the powers and functions of the CHRE are detailed in broad terms on the face of the NHS Reform and Health Care Professions Act 2002. The only exception is in relation to complaints where the Secretary of State is given regulation making powers (see below).

10.22 Section 25 of the NHS Reform and Health Care Professions Act 2002 contains the general functions of the CHRE. These are to:

(1) promote the interests of patients;

(2) promote best practice in the performance of the regulators;

(3) formulate principles relating to good professional self-regulation; and

(4) promote co-operation between regulatory bodies; and between them, or any of them, and other bodies performing corresponding functions.

10.23 This section also inserts a main objective of the CHRE in relation to the exercise of the functions 2, 3 and 4 listed above, which is "to promote the health, safety and well-being of patients and other members of the public". Main objectives and general functions are discussed in more detail in Part 3.

10.24 CHRE's general functions are accompanied by a number of general powers and duties. With certain exceptions, the CHRE is empowered to do "anything which appears to it to be necessary or expedient for the purpose of, or in connection with, the performance of its functions". This may include investigating and reporting on how each health care regulator is performing its functions (including where a health care regulator is performing functions which correspond to another body) and recommending to a health care regulator that it changes the way it performs its functions. The CHRE also has a power to give directions to the health care regulators requiring rules to be made if it is desirable to do so for the protection of the public.[13]

10.25 An exception to this general power is in relation to individual cases in which there are, will be or have been proceedings (including where an allegation has been made which may give rise to such proceedings).[14] However, reports on the performance of the regulators can still be made and the CHRE's power to refer a case to the higher courts still applies (see below). There is also an exception to the power as regards the Pharmaceutical Society of Northern Ireland in relation

[13] NHS Reform and Health Care Professions Act 2002, ss 26 and 27.

[14] As above, s 26(3).

to its functions that do not relate to health care regulation, such as its benevolent functions.[15]

10.26 The CHRE is required to provide advice and investigate and report on matters relevant to its functions when requested to do so by the Secretary of State or devolved administrations. The CHRE also has duties to provide information about the exercise of its functions and to seek the views of members of the public and patient interest groups. The CHRE must also prepare an annual report.[16]

10.27 The general powers and duties of the CHRE have been exercised in practice through the publication of documents which aim to share good practice as well as conducting research into professional health care regulation. A focus of CHRE's output has been the production of annual performance reviews of the regulators. These review the performance of the regulators against agreed standards, and make recommendations on points where there could be improvements. CHRE also audits the initial stages of regulators' fitness to practise processes. These audits consider a sample of the decisions made by each regulator to close a case without referral to a formal hearing in front of a fitness to practise panel or committee. The CHRE also reviews all final decisions made by the regulators' fitness to practise panels and committees. In the last financial year it reviewed over 2000 decisions.[17]

10.28 The Health and Social Care Bill 2011 includes a requirement on the CHRE to publish an annual strategic plan and clarifies that the duty to give advice will extend to matters connected to social work. The CHRE will also be given powers to provide advice and auditing services to bodies such as the regulators and where advice is given to a body, that body will be required to pay a fee. There will also be a power to accredit voluntary registers.[18]

Provisional view

10.29 Statute law gives the CHRE several general functions. These are not subject to further detail in rules or regulations. Instead, the functions, powers and duties of the CHRE are stated broadly, which arguably gives the CHRE a good deal of flexibility to perform its supervisory role.

10.30 In Part 3 we considered statements of general functions for the regulators and concluded that the need for general functions disappears in our proposed scheme. However, this analysis does not extend to the CHRE's general functions. Unlike the regulators, the powers and duties of the CHRE are not detailed elsewhere in statute law but are contained entirely in this provision. In other words, they are a self-contained description of the powers of the CHRE which are not expanded elsewhere. Arguably, the use of general duties is more appropriate when dealing with the broad public functions given to a meta-regulator like the CHRE, rather than for bodies tasked with dealing with the cases of individual professionals. We therefore provisionally propose that CHRE's

[15] As above, s 26(6).

[16] As above, ss 26A and 26B and sch 7, para 16.

[17] Council for Healthcare Regulatory Excellence, *Written Evidence to the Health Select Committee* (2011) para 1.2.

[18] Health and Social Care Bill 2011, cls 223 to 226.

general functions should be retained, but modernised and reworded to be given increased precision where appropriate.

10.31 The CHRE does have more specific powers to give directions which can be used to require compliance with anything it considers desirable for the protection of members of the public. Although the regulations for the procedure to give directions have not been created, it is likely that such a power remains of value as a last resort that can be used to negotiate changes between the CHRE and the regulators.[19] Accordingly, we propose to retain this power, although we would welcome views on whether this power is still necessary.

10.32 Our proposal to retain the existing functions, powers and duties of the CHRE extends to the changes proposed by the Health and Social Care Bill 2011. Under our scheme, these amendments would be retained.

Provisional Proposal 10-4: The CHRE's general functions should be retained, but modernised and reworded where appropriate.

Question 10-5: Is the CHRE's power to give directions still necessary?

COMPLAINTS ABOUT REGULATORY BODIES

10.33 Section 28 of the NHS Reform and Health Care Professions Act 2002 gives the Secretary of State the power to make regulations for the investigation by the CHRE into complaints made to it about the way in which a regulator has exercised its functions. This power reflects one of the original stated purposes of the CHRE to provide a form of "ombudsman service" that would allow "complaints of maladministration to be made against a regulatory body in the performance of its regulatory functions" in relation to "allegations of maladministration only, for example delay".[20]

10.34 Although section 28 is in force, regulations have not yet been made and so the CHRE does not have a formal complaints mechanism. Nevertheless, the CHRE receives complaints from members of the public and it has dealt with this by reading into its general function of promoting good practice in the performance of the health care regulators, a policy of trying to reach consensual conclusions that both help the complainant and develop any learning points.[21] Categories of complaint that are taken forward on an informal basis include unacceptable delays, failure to adhere to rules and poor customer service. However, unlike an ombudsmen service section 28 appears to envisage a more formalised process which may include hearings and oral evidence.[22]

10.35 In *Enabling Excellence* the Government indicated that it proposes to issue regulations under section 28 on the basis that:

> There is a need to strengthen the accountability of the regulatory

[19] See NHS Reform and Health Care Professions Act 2002, s 27(13).

[20] Department of Health, *Modernising Regulation in the Health Professions* (2001) para 4.1.

[21] Council for Healthcare Regulatory Excellence, *Complaints about the Health Professions Regulatory Bodies Policy* (2010).

[22] NHS Reform and Health Care Professions Act 2002, s 28(3).

> bodies to those using the services of their registrants and the wider public, by creating a route to raise concerns about the policies and approach of the regulators with the CHRE about those bodies falling within its remit.[23]

10.36 However, the scope of the section 28 complaints mechanism will be limited initially to considering only administrative and policy issues with the regulators to prevent overwhelming CHRE with "complaints from individuals who simply disagree with the decisions reached by the regulators".[24] The CHRE is in the early stages of providing its advice to the Department of Health on how a scheme might work, but we understand that it proposes to investigate concerns relating to maladministration that indicate a systemic problem and raise wider public protection issues. The CHRE will provide advice to the Government on detailed proposals for the commencement of section 28 by March 2012. The Department of Health then intends to consult on draft regulations later in 2012.

Provisional view

10.37 In our view section 28 should be retained in our system. In effect, the Government will continue to have powers to make regulations for the investigation by the CHRE into complaints about the way in which a regulator has exercised its functions. The Government has decided that it will implement the section 28 power but the remit of the CHRE will be limited. We envisage that any new regulations introduced would continue to apply under our system.

10.38 In the future, the Government could decide to widen or narrow further the section 28 power. We believe that it is appropriate that this decision continues to rest with Government. In our view, the section 28 power will become one of the ways in which the regulators can be held to account and therefore there is a significant public interest in its use. It will be particularly important that any decision to extend or reduce the section 28 power is seen to be made independently from the regulators who in the future will be responsible for funding the CHRE.

10.39 Additionally, this is an area where the provision of information about the regulators' internal complaints systems has a role to play. In particular, it is important that members of the public are aware of alternative avenues through which to pursue their concerns. This would help prevent complaints being made to the CHRE prematurely. A duty to provide information is discussed in Part 2.

Provisional Proposal 10-6: The existing power for Government to make regulations for the investigation by the CHRE into complaints made to it about the way in which a regulator has exercised its functions should be retained.

REFERENCES TO THE HIGHER COURTS

10.40 Section 29 of the NHS Reform and Health Care Professions Act 2002 gives the CHRE a power to refer decisions of fitness to practise panels to the High Court in England and Wales, the Court of Session in Scotland and the High Court in Northern Ireland. This power can only be used where the CHRE considers that

[23] Enabling Excellence: Autonomy and Accountability for Health and Social Care Staff (2011) Cm 8008, para 3.11.

the imposition of a relevant sanction has been "unduly lenient" or in relation to a decision not to take any or restore a person to the register, that the decision "should not have been made". In addition, a referral must be desirable for the protection of members of the public.[25] However, the "should not have been made" criterion has been interpreted as implying undue leniency.[26] The test of undue leniency has been defined by the Court of Appeal as being whether the decision "is one which a disciplinary tribunal, having regard to the relevant facts and to the object of the disciplinary proceedings, could reasonably have imposed".[27]

10.41 The CHRE has 40 days to make a referral after the relevant decision has become final. The referral is to be treated as an appeal, which distinguishes it from an application for judicial review where the court would only intervene if there was an error of law. Instead, the court can dismiss the appeal, allow the appeal and quash the decision, substitute the relevant decision for one that could have been made, or remit the case to the fitness to practise panel to dispose of the case in accordance with the court's directions.[28] The court will allow the appeal where the relevant decision was "wrong", which requires probing whether the fitness to practise panel performed its task correctly.[29]

10.42 During the passage of the NHS Reform and Health Care Professions Act 2002, the Government indicated that it anticipated the section 29 power being used "extremely sparingly".[30] A possible reason for this may be the element of double jeopardy inherent within section 29. Since the first referral in 2004, there have been approximately 44 referrals made using section 29, which have resulted in 18 reasoned judgments. A referral to higher courts is normally initiated as a result of the CHRE's annual review of all fitness to practise decisions. The proportion of cases referred to the higher courts is normally less than 1% of the cases reviewed and the number of cases referred has decreased over time.[31]

10.43 Neither *Enabling Excellence* nor the Health and Social Care Bill 2011 propose changes to the substance of section 29. However, an issue has arisen in light of the General Medical Council's proposed Medical Practitioners' Tribunal Service (see Part 9). An element of this is a proposed right of appeal for the General Medical Council in cases where it considered that a decision of the tribunal was unduly lenient. This mirrors the wording and approach of section 29.[32]

[24] As above.

[25] NHS Reform and Health Care Professions Act 2002, s 29(4).

[26] *Council for the Regulation of Health Care Professionals v Ruscillo* [2004] EWCA Civ 1356; [2005] 1 WLR 717 at [68] to [69].

[27] As above, at [76].

[28] NHS Reform and Health Care Professions Act 2002, s 29(6) to (8).

[29] *Council for the Regulation of Health Care Professionals v Ruscillo* [2004] EWCA Civ 1356; [2005] 1 WLR 717 at [70].

[30] *Hansard* (HL), 31 January 2002, vol 631, col 356, Lord Hunt.

[31] Council for Healthcare Regulatory Excellence, *CHRE Review 2007-08* (2008), p 21.

[32] General Medical Council, *The Future of Adjudication and the Establishment of the Medical Practitioners Tribunal Service* (2011).

Provisional view

10.44 In our view the present system that allows the CHRE to refer cases to the higher courts has proved a useful tool for the purposes of public protection. This function is consonant with the CHRE's supervisory role over the regulators since it provides a hard-edged check on whether fitness to practise decisions have been made in a way that promotes the health and wellbeing of the public. Although this system has an inherent element of double jeopardy, it has been accepted that this is justified because of the importance of public safety.[33]

10.45 The CHRE's section 29 power has had several years to bed down with fewer recent cases making their way to a final hearing. This may be indicative of the current legal framework operating efficiently or it may be for other reasons. The CHRE has stated that financial considerations have not been a relevant consideration. We welcome further evidence on this point. We propose that the present section 29 should be retained.

10.46 The General Medical Council's proposed right of appeal – which has received support from the Health Select Committee – may also need to be provided for in our scheme.[34] The Council has argued that the right of appeal would reinforce the clear separation of the investigation and adjudication functions, whilst helping to create an independent identity for the new tribunal service.[35] Furthermore, it has been said that such an appeal would be a solution in cases where fitness to practise panels make decisions that do not stand up.[36]

10.47 The CHRE has argued that the proposed right of appeal would create confusion arising from the potential for duplication of efforts, resources and overlapping responsibilities.[37] The CHRE has also raised concerns about how the right of appeal would work in practice, particularly if both the CHRE and General Medical Council wished to appeal the same decision. The CHRE has suggested that a way to reconcile these issues is to provide for a method whereby the General Medical Council could formally refer a case to the CHRE. The CHRE would then consider the referral along with the other cases it was considering.

10.48 In our view, pragmatic solutions could be found to the potential practical problems raised by the coterminous exercise of two separate processes, although doing so could have cost implications. More difficult is the question of principle – *should* both bodies have essentially the same power; and if not, which should lose it?

10.49 The problem arises because the same (in effect) right of appeal provides each body with a solution to quite different problems. For the CHRE, it provides an important tool for practical oversight of the operation of the regulators; for the General Medical Council it is both a consequence of and reinforces the

[33] *Council for the Regulation of Health Care Professionals v Ruscillo* [2004] EWCA Civ 1356; [2005] 1 WLR 717 at [41] to [42].

[34] Annual Accountability Hearing with the General Medial Council, Report of the House of Commons Health Committee (2010-12) HC 1429, para 40.

[35] General Medical Council, *The Future of Adjudication and the Establishment of the Medical Practitioners Tribunal Service* (2011), paras 72.

[36] Regulatory Bodies, Report of the Health Select Committee (2010-11) HC 1203-i.

[37] Council for Healthcare Regulatory Excellence, *The Establishment of the Medical Practitioners: CHRE response to the GMC consultation* (2003), para 14.

independence of the new Medical Practitioners' Tribunal Service (see Part 9). That might suggest that it was rational to allow both appeals, and find practical solutions to any practical problems.

10.50 On the other hand, the emergence of the Tribunal might mean that this particular power of the CHRE is now otiose. If the power previously existed to provide oversight as a *substitute* for a perceived lack of independence, the accomplishment of that independence would make it unnecessary. If this view were taken, then perhaps the system should provide for section 29 to apply to regulators until such time as the Government was satisfied that a regulator's adjudicative system was sufficiently independent to make it unnecessary. At that time, the Government could by order disapply section 29 and in substitution provide for a right of appeal by the regulator. The question in this specific case would then become whether the proposed Medical Practitioners' Tribunal Service was sufficiently independent.

10.51 The alternative position is also tenable. It might be that the Council for Healthcare Regulatory Excellence's oversight role requires retention of its section 29 power regardless of the independence of the regulator. The power is concerned not just with procedural independence, but also with ensuring appropriate outcomes, both in individual cases and systemically. It might be argued that, it is the CHRE, as the overseeing body, which is in the right position to assess which cases should be reviewed by the Court, not the General Medical Council, standing as it does in these issues as one of the parties to the proceedings. The point could be taken further – not only does the Council for Healthcare Regulatory Excellence need section 29, but the existence of a right of appeal by the General Medical Council inappropriately confuses the lines of accountability and oversight in part provided by section 29. The CHRE has argued that the proper relationship between overseer and overseen would be better preserved if the General Medical Council were to be able to propose that a reference be made under section 29, but not to formally initiate one on its own account.[38]

10.52 We invite views on which of these is the better way forward. In doing so, we acknowledge that it is likely that the Government will take a determinate position and legislate in advance of our recommendations being finalised.[39] That again will have an impact on the balance of advantage.

Question 10-7: Should the CHRE's power to refer cases to the High Court in England and Wales, the Court of Session in Scotland and the High Court in Northern Ireland: (1) be retained and exercised alongside a regulator's right of appeal, in cases when the regulator's adjudication procedure is considered to be sufficiently independent; *or* (2) be removed when a regulator's right of appeal is granted in such circumstances; *or* (3) be retained and rights of appeal should not be granted to regulators, although regulators should have a power to formally request the CHRE to exercise its power?

[38] As above, para 16.

[39] The legislation referred to is in relation to the proposals for reform of the General Medical council's fitness to practise adjudication process through a pending section 60 order.

PART 11
BUSINESS REGULATION

11.1 Health and social care regulation makes individual registrants responsible for their standards of professional practice. In addition, some regulators have powers to regulate businesses with the aim of ensuring that the infrastructure supports proper standards of practice. This Part considers how commercial settings may affect the regulatory task and how the legal framework should approach the task of business regulation. Specifically, it covers:

(1) regulation in a commercial setting;

(2) premises regulation;

(3) register of bodies corporate;

(4) consumer complaints; and

(5) extending business regulation.

REGULATION IN A COMMERCIAL ENVIRONMENT

11.2 Some of the regulators are responsible for regulating professionals who practise outside formal NHS structures and work primarily in commercial settings. These settings range from small high street firms providing, for example, pharmacy or opticians services, to multinational corporations. Some practitioners, such as dentists, may undertake some NHS work while also undertaking private practice, which is not subject to external regulatory apparatus such as clinical governance.

11.3 The extent to which professionals work in a commercial environment may have an impact on how, and the frequency with which, regulation is undertaken. For example, regulators may need to consider the particular burdens that are placed on practitioners working in small commercial settings, such as single handed practices. These burdens can include the duplication of information that is required by Government, the professional regulators and other regulators. The potential regulatory overlap in the private sector includes but is not limited to systems regulators, such as the Care Quality Commission in England, the Care Inspectorate, Healthcare Improvement Scotland, the Regulation and Quality Improvement Authority in Northern Ireland and the Health Inspectorate Wales, as well as other regulators, such as the Health and Safety Executive, Human Tissue Authority, and Medicines and Healthcare Products Regulatory Agency.

11.4 Some practitioners working in the commercial rather than NHS environment will be running their own businesses. It is of course possible to be both a business and a profession – law, accounting and surveying are all examples. However, there can be tension. This tension may be particularly acute where the professional is working in a business where the professional activity is incidental. Some regulators who are responsible for significant numbers of self-employed professionals, who operate in commercial settings, may also need to be vigilant to the possibility of business disputes being brought to their attention spuriously in the guise of a complaint.

11.5 However, it may be that the context of a commercial setting makes little difference in practice to the regulatory task. In principle, standards should not be lowered on the basis that, for example, the practitioner is based in a small business setting, although there will be a need to take into account the burdens that are placed on business. Moreover, the public sector faces commercial pressures. Recent reforms aimed at ensuring market-based approaches in the NHS in England have included the introduction of payment by results, devolution of spending decisions to GP practices, expansion of the role of the independent sector through nationally awarded contracts, creation of NHS foundation trusts and the ending of the ability of Primary Care Trusts to provide their own services.[1] The Health and Social Care Bill 2011 proposes that Monitor, currently the licensing authority for foundation trusts, will be given wide-ranging powers to impose licence conditions to prevent anti-competitive behaviour, to apply sanctions to enforce competition law, and to refer malfunctioning markets to the Competition Commission.[2]

11.6 We are interested in views on whether regulation in a commercial context makes a significant difference to the task of regulation. We also welcome views on the suggestion that much of the existing legal structure for professional regulation is designed primarily with the NHS in mind and its relationship to practitioners, who operate in alternative settings, is not straightforward.

Question 11-1: To what extent does regulation in a commercial context make a difference to how the regulators approach the task of professional regulation and does the law provide adequately for professional regulation in a commercial context?

PREMISES REGULATION

11.7 A small number of the regulators are given powers to regulate businesses as well as individual practitioners. By far the most detailed legal framework for regulating business is provided by the Pharmacy Order 2010, which gives the General Pharmaceutical Council responsibility for the setting of standards for owners and superintendents[3] carrying on retail pharmacy business at a registered pharmacy as well as a range of powers in relation to inspection and enforcement. In effect, the legislation establishes the General Pharmaceutical Council as a systems regulator in addition to its role as a regulator of individual registrants. This makes the Council unique amongst the other regulators.

The register

11.8 The legal framework for the business register is set out in the Medicines Act 1968 and the Pharmacy Order 2010. The General Pharmaceutical Council is required to establish and maintain a register of premises at which the applicant is conducting a retail pharmacy business under section 74A and 74J of the

[1] See, for example, Civitas, *The Impact of the NHS Market* (2010) and Kings Fund, *Economic Regulation in Health Care: What Can We Learn from Other Regulators?* (2011).

[2] Health and Social Care Bill 2011, Part 3.

[3] A superintendent pharmacist is a pharmacist who is a superintendent of a retail pharmacy business owned by a body corporate. In hospitals this may be the chief pharmacist.

Medicines Act 1968.[4] The definition of a retail pharmacy business is any business that includes the sale of medicinal products other than those on a general sales list.[5]

11.9 The relevant rules require that the register must contain certain information such as the address of the premises, the name and address of the person carrying on a retail pharmacy business at the premises and any conditions to which registration is subject.[6] The rules also specify the contents of the application form for registration and renewal, and the procedures for annotation and voluntary removal from the register.[7] Other aspects of the legal framework include statutory powers for the Registrar to remove a registered pharmacy from the register if it fails to meet the relevant standards or its entry has been fraudulently procured or incorrectly made, and restore it to the register.[8]

Standards

11.10 The General Pharmaceutical Council is required to make rules about the standards that are to be met for carrying on a retail pharmacy business at a registered pharmacy. Owners and superintendent pharmacists are responsible for ensuring that the published standards for retail pharmacy business are met. These standards apply to matters such as record keeping, operating procedures, staff training, incident reporting, handling and storage of medicinal products, the condition of the premises, conducting of clinical procedures, and management of waste.[9] Any question about the fitness to practise of individuals operating within the premises is dealt with by the normal fitness to practise procedures, although all professionals operating within the retail pharmacy must comply with the set standards. Thus the standards for retail pharmacy business detail what is required within the retail pharmacy business, rather than simply the duties of the owner or superintendent. The Council also makes rules specifying the standards needed in order for an annotation in the register in respect of a specialism.[10]

11.11 The General Pharmaceutical Council must also make provision in rules requiring any person carrying on a retail pharmacy business to provide information to the Council. Such information includes the details of the person carrying on the retail pharmacy business and any relevant criminal offences that such an individual has been charged with whether or not the charge has resulted in a caution or conviction.[11]

11.12 Although the General Pharmaceutical Council is not a product regulator, the regulation of medicines is an important aspect of the overall legal framework for standard setting through the provisions of the Medicines Act 1968 and Poisons

4 Pharmacy Order 2010, SI 2010 No 231, art 19(1).

5 Medicine Act 1968, s 132.

6 General Pharmaceutical Council (Registration Rules) Order of Council 2010, SI 2010 No 1617, r 6(1).

7 As above, rr 21 to 30.

8 Pharmacy Order 2010, SI 2010 No 231, arts 29(3)(b) and 37(2).

9 As above, art 7(1).

10 As above, art 27(1)(f).

11 As above, art 7(4) to (7).

Act 1972. For example, the Medicines Act 1968 provides that a registered pharmacist, known as the responsible pharmacist, must be in charge of a registered pharmacy and must establish, maintain and review pharmacy procedures designed to secure the safe and effective running of the pharmacy.[12]

Inspection

11.13 The General Pharmaceutical Council is required to establish an inspectorate which is responsible for enforcing the standards, assisting the Council in any fitness to practise investigations, securing compliance with Parts 3 and 4 of the Medicines Act 1968 (which contain provisions about dealings with medicinal products and about pharmacies) and the Poisons Act 1972, and to enforce the criminal justice provisions relating to the register.[13] The inspectorate may conduct inspections of registered pharmacies and has the power to enter any registered pharmacy or other premises, including through the use of reasonable force if for example admission is refused or is likely to be refused or in urgent cases.[14]

11.14 The inspectors have wide powers to inspect and search premises, remove from the premises any items and require access to documents including electronic documents or records. An inspector also has power to do "anything which is calculated to facilitate the discharge of the inspector's functions or which is incidental or conducive to the discharge of those functions". These powers are supported by a series of criminal offences in relation to those who obstruct or fail to assist an inspector.[15]

Enforcement

11.15 Where there is a failure to meet the relevant standards set by the General Pharmaceutical Council, the inspectorate can issue an improvement notice which specifies the measures that must be taken in order to rectify the failure within a period of not less than 28 days.

11.16 A person carrying on a retail pharmacy business at a registered pharmacy who fails to comply with an improvement notice commits a criminal offence and is liable on summary conviction to a fine. In addition, the inspector is required to inform the Registrar (whether or not proceedings are brought against the person) who may remove the person from the register or suspend them pending compliance with any requirements or conditions. There is a right of appeal to the Appeals Committee. In the case of offences committed by a partnership, proceedings are brought against the partnership.[16]

The Pharmaceutical Society of Northern Ireland

11.17 The Pharmaceutical Society of Northern Ireland is responsible for the registration of pharmacy premises under section 75 of the Medicines Act 1968. The responsible pharmacist regulations described above also apply in

[12] Medicines (Pharmacies) (Responsible Pharmacist) Regulations 2008, SI 2008 No 2789.

[13] Pharmacy Order 2010, SI 2010 No 231, art 8.

[14] As above, arts 9 and 10.

[15] As above, arts 11 and 12.

[16] As above, arts14 and 15.

Northern Ireland.[17] The Department of Health, Social Services and Public Safety has responsibility for inspection and enforcement. This role is assumed by the Medicines Inspection and Investigation Team within the Department. The Department also has powers to appoint inspectors for the purposes of the Pharmacy (Northern Ireland) Order 1976. The inspectors have powers to enter at all reasonable times any registered pharmacy and undertake any examinations and inquiries and do such other things as may be necessary for ascertaining whether the Order is being complied with. It is an offence to wilfully delay or obstruct the Pharmacy Inspector, or fail to give any information.[18]

Provisional view

11.18 As a minimum, our reforms would consolidate the existing position whereby the General Pharmaceutical Council would continue to have responsibility for the setting of standards for owners and superintendents carrying on retail pharmacy business at a registered pharmacy as well as a range of powers in relation to inspection and enforcement. Due to the nature of the legal powers involved – which place requirements on other bodies and are enforceable through the criminal justice system – much of this would continue to be specified in the statute itself. In addition, the current regulatory powers given to the Pharmaceutical Society of Northern Ireland would be maintained.

11.19 We welcome views on whether additional reforms are needed. For example, the regulators could be given powers to disclose any sanction or fine issued against a business to the shareholders. This might encourage the shareholders to hold the board to account, rather than relying entirely on action against a named individual, such as a superintendent, who may not be at fault directly. Furthermore, powers might be needed to establish a business fitness to practise regime similar to that of the General Optical Council (see below). This would allow the regulators to investigate allegations against those who are responsible for businesses that have failed to meet established standards and failed to comply with improvement notices, with a view to deciding if their fitness to carry on a business is impaired.

Provisional Proposal 11-2: The statute should retain the existing premises regulation regimes of both the General Pharmaceutical Council and the Pharmaceutical Society of Northern Ireland.

Question 11-3: Are any further reforms needed to the premises regulation regimes of the General Pharmaceutical Council and the Pharmaceutical Society of Northern Ireland?

REGISTER OF BODIES CORPORATE

11.20 A small number of the regulators are given more limited powers to regulate businesses compared to those given to the General Pharmaceutical Council. For example, the General Optical Council is required to maintain a register of bodies corporate carrying on a business in the UK as an optometrist and/or a dispensing optician. In general terms, a business can register if it satisfies the Council that it

[17] Medicines (Pharmacies) (Responsible Pharmacist) Regulations 2008, SI 2008 No 2789.

[18] Pharmacy (Northern Ireland) Order 1976, SI 1976 No 1213, art 24.

is fit to carry on such a business and a majority of its directors are registered practitioners. Where only a minority of the business relates to testing sight and fitting optical appliances, the business can only be registered if these activities are undertaken under the management of a registered professional.[19]

11.21 If a body corporate is using a protected title it must be registered. These are defined as ophthalmic optician, optometrist, dispensing optician and registered optician. Additionally, if a company takes or uses a name that implies that it is registered, then it must ensure that it is registered. The Opticians Act 1989 makes it clear that if a company uses the title "optician", it will be presumed to be implying that it is registered. Any body corporate which uses a registered title when it is not registered or falsely implies that it is registered or otherwise pretends it is registered is liable on summary conviction to be fined. A "responsible officer" (such as a manager, director or secretary) can also be deemed guilty of the offence and liable to be proceeded against and punished.[20]

11.22 Not all businesses are required to be registered. Only bodies corporate who fulfil certain requirements and use a protected title must register. Thus, sole traders and most partnerships are not included in the register, except in Scotland.[21] Furthermore, whereas each individual outlet of franchise businesses such as Specsavers may be required to register, a large body corporate such as Boots or Vision Express may only need to register its head offices. The General Optical Council currently registers 1,545 businesses.[22]

11.23 The Council is required to publish standards of conduct and performance required for business registrants.[23] The *Code of Conduct for Business Registrants* sets out the standards expected of all business registrants and a failure to comply with the duties and responsibilities set out in this document will put registration at risk.[24] Allegations against a business registrant's fitness to practise are considered by the Investigation Committee and potentially, the Fitness to Practise Committee.

11.24 The Opticians Act 1989 provides that a business registrant's fitness to carry on business can be impaired on the basis of:

(1) misconduct by the business registrant or a director;

(2) practices or patterns of behaviour occurring within the business which the registrant knew or ought reasonably to have known of, and amount to misconduct or deficient professional performance;

(3) the instigation by the business registrant of practices or patterns of behaviour within the business where that practice or behaviour amounts,

[19] Opticians Act 1989, s 9.

[20] As above, ss 28 and 30.

[21] As above, s 36(1).

[22] General Optical Council, *Annual Report 2010-11* (2011) p 11.

[23] Opticians Act 1989, s 13A(2)(a).

[24] General Optical Council, *Code of Conduct for Business Registrants* (2010).

or would if implemented amount, to misconduct or deficient professional performance;

(4) a conviction or caution in the "British Islands" of the business registrant or one of the directors (and certain court determinations other than a complete acquittal);[25] or

(5) a determination by any other UK health regulatory body that the business registrant's fitness to carry on business as a member of that profession is impaired, or the fitness of a director of the business registrant to practise that profession is impaired.[26]

11.25 As in the case for fitness to practise determinations in relation to individual registrants, there is no statutory definition of impairment of fitness to practise and fitness to practise determinations consists of two distinct stages – the fact finding stage and the fitness to practise finding (see Part 7). If fitness to practise is shown to be impaired, the Fitness to Practise Committee may impose a financial penalty order, conditional registration, suspension or erasure.[27]

11.26 The Dentists Act 1984 also contains provisions for a system of business regulation but these have only been partially implemented.[28] In the past, the General Dental Council maintained a list of 28 Dental Bodies Corporate. This list is no longer in force and any corporate body can now carry out the business of dentistry provided that it can satisfy the requirements in relation to directors of bodies corporate set out in the Dentists Act 1984. However, legislation does provide for some protection of title for business registrants. For example, a body corporate commits an offence if a majority of its directors are not registered dentists or registered dental care professionals, and a person commits an offence if he or she have been erased or suspended from the register of any of the health care regulatory bodies.[29] Furthermore, the use of the terms "dental" and "dentistry" are specified for the purposes of the Companies Act 2006, and to use these terms in the name of a company, an individual must obtain the support of the General Dental Council before applying to register a company.[30] The terms "dentist", "dental surgeon" and "dental practitioner" are controlled by section 39 of the Dentists Act 1984 (see Part 5).

Provisional view

11.27 A number of difficulties can be identified with the current systems for the regulation of bodies corporate. For example, the requirement to register does not

[25] These are an order under s 246(2) or (3) of the Criminal Procedure (Scotland) Act 1995 discharging the person absolutely (admonition and absolute discharge); a conditional offer under s 302 of the Criminal Procedure (Scotland) Act 1995 (fixed penalty: conditional offer by procurator fiscal); and agreement to pay a penalty under s 115A of the Social Security Administration Act 1992 (penalty as alternative to prosecution).

[26] Opticians Act 1989, s 13D(3).

[27] As above, s 13F.

[28] Dentists Act 1984, ss 43A to 44B.

[29] As above, s 43.

[30] Company, Limited Liability Partnership and Business Names (Sensitive Words and Expressions) Regulations 2009, SI 2009 No. 2615.

extend to all businesses or to all individual high street outlets, which can lead to confusion for both registrants and members of the public as to the purpose and coverage of business registration. Furthermore, the fitness to practise regime when applied to this area can be a heavy handed mechanism for dealing with businesses that are not meeting the required standards. In effect, the emphasis is on formal procedures in the small number of cases when things go seriously wrong, as opposed to a more proactive system to monitor and ensure that high standards are being maintained by businesses.

11.28 We welcome further views on whether the current systems for the regulation of bodies corporate are effective and useful in practice. It would be possible for a statutory solution to retain the existing systems of both the General Optical Council and the General Dental Council, while also addressing any existing deficiencies in the current systems. Alternatively, our scheme could repeal these systems and enable the regulators to put in place alternative arrangements (this option is discussed in more detail later in this part).

Question 11-4: Should the statute retain the existing systems for the regulation of bodies corporate?

CONSUMER COMPLAINTS

11.29 The regulators do not have powers to deal with consumer complaints. However, the General Optical Council has powers to allocate resources to any individual or body set up to investigate and resolve consumer complaints in relation to the supply of goods and services by registrants.[31]

11.30 The Council has contracted with the Optical Consumer Complaints Service to deal with such consumer complaints. The Optical Consumer Complaints Service describes itself as "essentially a mediation service", which deals primarily with matters of a contractual nature and within the remit of consumer legislation.[32] In 2010, it received 1,640 contacts and opened 883 cases. The main issues dealt with by the Optical Consumer Complaints Service are poor service and practice, and conflicts between professional and commercial interests.[33]

11.31 In addition the General Dental Council has established and funds a Dental Complaints service which provides a UK wide complaints resolution service for private dental patients. This is described as a department of, but operationally at arms length from, the General Dental Council.[34]

Provisional view

11.32 It has long been accepted that the proper role of professional regulation is to protect the public and not to provide redress to a complainant.[35] Therefore, we believe it would not be appropriate for the regulators to have powers to run their

[31] Opticians Act 1989, s 32.

[32] Optical Consumer Complaints Service, *Position Statement* (2011) paras 4 and 5.

[33] Optical Consumer Complaints Service, *OCCS Annual Report 2010* (2011) p 5.

[34] http://www.dentalcomplaints.org.uk/pages/index.asp?area=2 (last visited 15 February 2012).

[35] See, for example, *R (Zia) v General Medical Council* [2011] EWCA Civ 743 at para 35.

own consumer complaints service. But the ability to fund a consumer complaints service is arguably different on the basis that the service is run by another organisation. However, the arguments may be more finely balanced in the case of the General Dental Council which is organisationally responsible for this service albeit on an arms length basis. We welcome further views on this point.

Question 11-5: Should the regulators have powers to finance or establish a complaints service?

EXTENDING BUSINESS REGULATION

11.33 Many of the provisional proposals contained in this Part are aimed at consolidating the existing legal position. However, the discussions contained therein raise a more fundamental question, namely whether the same legal framework for business regulation should be made available to all the regulators.

11.34 It would be possible to give all regulators a power to implement a regime similar to that given to the General Pharmaceutical Council, if they wished to do so. Furthermore, the regulators could be given powers to implement a system of registration of bodies corporate similar to that of the General Optical Council. Any new system could build in some flexibility by allowing the regulators to pick and choose which elements of the business regulatory framework they will implement. For example, regulators could issue standards for premises but not undertake full premises inspection powers. Others may wish to introduce teams of inspectors who would be tasked with giving advice and working in partnership with businesses, but without the full legal powers of rights of entry or compliance orders.

11.35 Of course, it is unlikely that many regulators would want to introduce such a system. Premises regulation would not be suitable for most regulators, especially those where a majority of registrants are working in a NHS setting. However, for some there may be advantages to implementing a form of premises regulation. One of the key benefits is that it allows for a holistic approach to regulation and enables the regulator to consider the many issues which put the public at risk but not the responsibility of an individual registrant for say the design of the premises, lack of training or poor handling procedures.

11.36 Despite the regulatory overlap identified at the beginning of the Part, there may also be gaps which arise which some regulators may wish to fill. For example, in the context of dental laboratories, while the Medicines and Healthcare Products Regulatory Agency has responsibility for medical equipment (such as sterilisers and x-ray machinery) and the Health and Safety Executive and local authority has responsibility for occupational hazards, there is no premises regime which ties these systems together.

11.37 A key challenge in developing such a regulatory framework would be to ensure that the regulation of individual registrants dovetails with the regulation of registered premises. Moreover, it is important to ensure that any framework does not lead to duplication of the regulatory requirements of other regimes. As noted previously, the potential regulatory overlap in the private sector includes but is not limited to the Government, systems regulators and other regulators. However, these challenges might be addressed, at least in part, by the development of joint working protocols between the regulators. For example, in England the Dental

Council and Care Quality Commission have published a memorandum of understanding in an attempt to provide clarity and avoid overlap. Among other matters, this provides that in the case of a sole trader the Council is identified as the lead body, while the Care Quality Commission will track trends in General Dental Council complaints as part of the bigger picture.[36]

Provisional view

11.38 Any extension of business regulation, depending on how it was implemented, could have significant resource implications not only for the regulators themselves (and passed on to registrants) but also for businesses in the form of information and inspection requirements. Businesses are of course subject to a lot of other rules including on the sale and supply of goods and services. Moreover, businesses require certainty on matters such as regulation. We therefore do not think it is appropriate to give the regulators powers themselves to implement any form of business regulation if they wish to do so.

11.39 But we can see that some flexibility in the legal framework would be desirable. There may be benefits in allowing a small number of the regulators to develop new systems of business regulation, depending on the likely impact on business and whether any such system is necessary in the public interest. In our view, this is a matter that should rest with the Government. We therefore provisionally propose that the Government should be given a regulation-making power to extend any of the powers of the General Pharmaceutical Council or the General Optical Council to another regulator.

Provisional Proposal 11-6: The Government should be given a regulation-making power to extend to any regulator the powers given to the General Pharmaceutical Council or the General Optical Council to regulate businesses.

[36] General Dental Council and Care Quality Commission, *Memorandum of Understanding Between the General Dental Council and Care Quality Commission* (2010).

PART 12
OVERLAP ISSUES

12.1 As noted throughout this consultation paper, health and social care professional regulation does not exist in a vacuum. The functions of the regulators frequently cross organisational and legal boundaries. Often the same function or a similar function is undertaken by different organisations, and in recent years there has also been growing emphasis on achieving greater integration and co-operation between all the relevant agencies. This Part considers how our proposed statute should facilitate joint working. It considers the following areas:

(1) interfaces with other systems;

(2) joint working; and

(3) duties to cooperate.

INTERFACES WITH OTHER SYSTEMS

12.2 Numerous reports have highlighted the need for clarity about the respective responsibilities of the professional regulators and the other organisations and systems responsible for health and social care regulation.[1] The complex interface between the regulators and other bodies responsible for ensuring proper standards of education, practice and conduct is described in detail in Part 6. The overlapping systems that apply to business regulation are set out in Part 11.

12.3 There is also a complicated landscape governing patient and service user complaints about health and social care professions. As well as the regulators' fitness to practise procedures there are locally managed systems such as employment disciplinary processes, the NHS and social care complaints procedures, and the Performers List system. National regulators such as the Care Quality Commission and Health Service Ombudsman handle individual complaints, as well as publishing reports and good practice guides which draw attention to poor performance trends across the sectors. Furthermore, conduct and performance issues may give rise to a serious untoward incident, a safeguarding investigation, a serious case review or a criminal prosecution. The civil and criminal justice system can also hear allegations of medical and clinical negligence, murder, manslaughter and assault charges. Indeed, criminal cases are often undertaken in parallel with practise proceedings.

12.4 A 2011 report by the Council for Healthcare Regulatory Excellence noted widespread confusion about the different channels for complaining and the links between them, and in particular a lack of understanding of the role and functions of the professional regulatory bodies.[2] This complex interface is also recognised

[1] For example, Department of Health, *Good Doctors, Safer Patients: Proposals to Strengthen the System to Assure and Improve the Performance of Doctors and to Protect the Safety of Patients* (2006) and Department of Health, *The Regulation of Non-Medical Healthcare Professions: A Review by the Department of Health* (2006).

[2] Council for Healthcare Regulatory Excellence, *Modern and Efficient Fitness to Practise Adjudication: CHRE's Advice for Secretary of State* (2011) paras 6.5 to 6.6.

in the 2011 White Paper *Enabling Excellence*:

> There may also be duplication of effort from local systems of management and clinical governance and regulatory oversight, which carries a risk of confusion about who is responsible for addressing concerns about poor practice. An over-reliance on a centralised national system of regulation can weaken local responsibility for managing problems effectively and promptly. The right balance needs to be achieved between national regulation and effective local governance and scrutiny.[3]

12.5 There have been several calls for a reassessment and clarification of the role of professional regulation in this complex field.[4] The advantages of more effective interfaces can include the reduction of unnecessary costs, meeting service user expectations, facilitating learning within health care organisations and improving the ability of the system as a whole to deliver public protection.[5]

12.6 Many of the regulators have developed systems to encourage more effective interfaces. For example, some of the regulators have agreed a memorandum of understanding with the Care Quality Commission.[6] The General Medical Council recognises a four layer model of medical regulation involving personal regulation, team-based regulation, workplace regulation and professional regulation, on the basis that effective regulation requires the support and co-operation of others.[7] This strategy has led to the introduction of UK wide employer liaison advisers to provide support to medical directors, employers and Responsible Officers with their concerns about individual doctors and when to refer cases to the Council.

Provisional view

12.7 The regulatory landscape is extremely fragmented in the field of health and social care. A radical option for reform would be to consolidate all the different systems into a single overarching legal framework. However, this option can be described as at best extremely ambitious, and would raise significant practical and resource issues given the wide range of disparate systems that would potentially fall within scope. In any event, it is beyond the remit of our review to consider the entry thresholds to the different complaints and other processes detailed above.

12.8 Alternatively, the statute could attempt to define precisely which matters are lawfully the responsibility of the regulators and which matters are outside their remit. Currently, the law gives the regulators general functions – maintaining registers, setting standards for education, conduct and practice, and undertaking investigations and adjudicating allegations of impaired fitness to practise – and a

[3] Enabling Excellence: Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers (2011) Cm 8008, para 1.5.

[4] For example, Kings Fund, *Building Effective Interfaces: Systems for Complaints, Litigation, Regulation, Discipline and Clinical Governance* (2002).

[5] As above, p 1.

[6] The General Dental Council, the General Medical Council, General Social Council and the Nursing and Midwifery Council.

[7] General Medical Council, *Corporate Strategy 2010-2013* (2010) p 20.

main duty of public protection. But even if it were possible to construct a more precise boundary for the regulators, this would in our view be an unduly prescriptive solution that would result in unnecessary and protracted legal arguments about whether or not a particular complaint or task falls within the relevant legal criteria. We think that the current approach is preferable.

12.9 Nonetheless, our proposed reforms would assist in clarifying the role of the regulators within the overall regulatory landscape. For example, the statute would require the regulators to publish information or inform the public more generally about their role and responsibilities (provisional proposal 2-11). In relation to setting standards for education, conduct and standards, there would be powers for the regulators to reduce their regulatory activity or withdraw from a specific task, especially where the impact is marginal and other agencies are undertaking similar tasks (see Part 6). Other reforms aimed at simplifying the regulatory landscape are discussed in the rest of this Part, such as joint working and duties to cooperate. However, we welcome further views on how the legal framework might encourage clearer interfaces between the various regulatory systems.

12.10 We also welcome further evidence about the practical difficulties that may arise as a result of parallel criminal and fitness to practise proceedings.

Question 12-1: How could the legal framework establish clearer interfaces between the various regulatory systems?

Question 12-2: What practical difficulties arise as a result of parallel criminal and fitness to practise proceedings?

JOINT WORKING

12.11 One of the ways that the legal framework could help to simplify the complex regulatory landscape would be to encourage greater joint working. This includes joint working among the regulators themselves and joint working between the regulators and other organisations. Examples of the latter include, as noted above, the memoranda of understanding which have been agreed between some of the regulators and the Care Quality Commission and the introduction of the employer liaison service by the General Medical Council. Other examples include information sharing between the regulators and other organisations to identify patterns and sources of risks to the public.[8]

12.12 However, examples of joint working between the regulators are less evident. Several of the regulators have reported to us a strong desire to undertake some of their regulatory functions and tasks jointly with the other regulators. This approach is seen as particularly attractive because of its potential to achieve economies of scale and reduce the costs of regulation. However, it has been suggested that in some cases the governing legislation is not clear on whether certain activities can be undertaken jointly, or the legislation prohibits such sharing of functions.

[8] See, for example, S Lloyd-Bostock, "The Creation of Risk-Related Information: The UK General Medical Council's Electronic Database" (2010) 24 *Journal of Health Organisation and Management* 584.

12.13 The Council for Healthcare Regulatory Excellence has identified business and support as one of the main areas of activity with the potential for joint working. This includes procurement of services such as legal advice, information technology, human resources, finance and accounting, premises, facilities management, support staff and general administration support. It was suggested, for example, that the regulators could move to a centralised system for recruitment, training, performance evaluation, payroll, employee relations, and development. The report found that most regulators showed an appetite for sharing functions but they expressed concerns about the practicalities.[9]

12.14 Some of the regulators have also expressed an interest in the joint implementation of certain core regulatory tasks or functions. Examples might include joint consultations on new guidance and rules; joint registers; a single location for the processing of registration applications; joint standards for practice (such as codes of conduct and ethical guidelines); common portals among the regulators where information could be made available to the public; and joint approval of education and training standards.

12.15 Another potential area for joint working is in the adjudication of fitness to practise cases. The Council of Healthcare Regulatory Excellence has identified the joint training of panellists, shared use of hearing rooms and the production of unified and consolidated sets of procedural rules as potential areas where the regulators could achieve greater efficiencies.[10] A more radical option would be for the regulators to be able to develop joint fitness to practise adjudication systems. As discussed in Part 9, it is possible that, in time, the Medical Practitioners Tribunal Service proposed by the General Medical Council could be used by other regulators to hear their fitness to practise cases. Alternatively, some of the other regulators may wish to join together to establish their own joint fitness to practise adjudication systems.

Provisional view

12.16 In our view, there are numerous potential benefits for the sharing functions, including but not limited to reducing the cost of regulation, and at the very least our statute should enable the regulators to undertake their functions jointly with the other regulators and/or other organisations if they wish to do so.

12.17 Under our proposed reforms, all professional regulators would be brought into the same system contained in a single statute. For example, each would be subject to the same paramount duty (see Part 3). Arguably, this structure would promote the development of joint working between the regulators since they will all be working towards the same goal.

12.18 There are numerous regulatory tasks and functions that could be undertaken jointly between the regulators, and between the regulators and other organisations. In most cases, the regulators already have powers to work jointly, and greater cooperation and collaboration could be achieved without legislative

[9] Council of Healthcare Regulatory Excellence, *Shared Functions* (2009).

[10] Council of Healthcare Regulatory Excellence, *Modern and efficient Fitness to Practise Adjudication: CHRE's Advice for Secretary of State* (2011) paras 5.6 and 8.4 to 8.5.

reform. For example, the regulators can already involve other persons or organisations in carrying out their functions, and a regulator may contract with another body to carry out specific tasks on its behalf, subject to the regulator retaining liability for the exercise of the functions and possessing the factual and other information necessary to enable it to do so.[11]

12.19 For some regulators there may be a deep-seated reluctance to engage in shared activities. In part, this may reflect a fear that greater joint working across the professional regulators may strengthen arguments for merger. The sharing of functions may also be seen as limiting a regulator's ability to adapt to new developments in the profession it is regulating. We welcome further views on the perceived practical and legal difficulties associated with joint working.

12.20 While the current legal framework may contain few barriers to collaboration, it may be more accurate to say that the legislation is essentially silent or neutral on this issue. In other words, the law does not support or provide incentives to collaborate. Given the inherent risk that regulators may err on the side of caution, in our view there is a need for our proposed framework to promote rather than simply allow joint working. We therefore provisionally propose that the statute should include a permissive statement to the effect that each regulator may carry out any of its functions jointly with any other regulators or organisations. This would help to encourage informal joint working by making it clear that such activity is lawful.

12.21 We also propose that the statute should enable more formal partnership arrangements to be entered into between the regulator and one or more other organisations in relation to the exercise of their statutory functions. The prescribed arrangements may include arrangements:

(1) authorising other organisations to carry out any of the prescribed functions of the regulator;

(2) for payments to be made to the organisations to carry out the prescribed tasks; and

(3) for the provision of staff, goods or services in connection with any arrangement.

12.22 The statute would also provide that any such arrangements do not affect the liability of the regulator for the exercise of any of its statutory functions. By establishing such a formal procedure for joint arrangements we expect that the regulators would feel more confident about the legal basis for undertaking joint working, especially for more complex tasks and those that involve their core functions. Examples of the use of this power might include authorising the maintenance of the register by a commercial company; the recruitment of Council members, panel members and staff by a recruitment agency; the investigation of fitness to practise cases by a firm of lawyers; and the adjudication of fitness to practise by another regulator or an outside body.

[11] D Feldman (ed), *English Public Law* (2004) p 730.

12.23 We welcome views on the examples provided above, and on how appropriate and useful such arrangements would be in practice. It is important to emphasise that the use of this power in specific cases would be subject to the duty to consult specified in provisional proposal 2-7.

Question 12-3: What are the practical and legal difficulties associated with joint working?

Provisional Proposal 12-4: The statute should include a permissive statement to the effect that each regulator may carry out any of its functions in partnership with another organisation.

Provisional Proposal 12-5: The statute should enable formal partnership arrangements to be entered into between any regulator and one or more other organisations (including the other professional regulators) in relation to the exercise of their statutory functions. The statute should provide that any such arrangements do not affect the liability of the regulator for the exercise of any of its statutory functions.

DUTIES TO COOPERATE

12.24 As noted previously, in order to carry out their statutory functions the regulators depend significantly on other bodies and individuals to provide them with information. This can include information relating to the registrant's professional performance and conduct, and standards in educational institutions. Statute law can and has been used to encourage cooperation between organisations.

12.25 Most of the governing legislation places a general duty on the regulator in question to cooperate "as far as is appropriate and reasonably practicable" with public and other bodies and individuals concerned with the:

(1) employment of registrants;

(2) education and training of registrants;

(3) regulation or co-ordination of the regulation of other health or social care professionals;

(4) regulation of health services; and

(5) provision, supervision or management of health services.[12]

12.26 Also, most of the legislation specifies that in carrying out its duty to cooperate the Council must have regard to any differing considerations in relation to professional practice which apply in England, Scotland, Wales or Northern Ireland.[13]

[12] See, for example, Chiropractors Act 1994, sch 1 para 1D; Dentists Act 1984, s 2A; and Medical Act 1983, sch 1 para 9A.

[13] See, for example, Opticians Act 1989, sch 1 para 11A(2) and Osteopaths Act 1993, sch 1 para 1D(2).

12.27 The duty to cooperate is a target duty since it does not specify which actions constitute co-operation. This is significant in legal terms because general duties are difficult to enforce and it is generally left to the authority in question to decide when, and to what extent, the duty has a practical effect.[14] It is likely that a court would find a breach of this duty only in extreme circumstances, such as where there has been an express refusal to cooperate on unreasonable grounds.

12.28 Elsewhere, the governing legislation sets out more specific duties to cooperate. Some of these are placed on the regulator itself, while others are placed on external bodies. For example:

(1) requirements to consult specific organisations and internal committees when the regulators undertake certain tasks such as the issuing of guidance, codes of conduct, regulations, rules, competencies and standards (see Part 2);

(2) duties on the regulators to publish their standards and requirements for the approval of education qualifications, and make copies available for the relevant institutions (see Part 6);

(3) requirements on the regulators to follow certain steps when withdrawing their approval from education courses, such as notifying the relevant body and providing reasons within a specified time scale (see Part 6);

(4) duties on education institutions to comply with any reasonable request for information made by the regulator, and if the institution refuses then the regulator may consider refusing or withdrawing approval from the relevant course (see Part 6); and

(5) specific powers for the regulators to require the disclosure of information in cases where the fitness to practise of a registrant is in question (see Part 8).

12.29 The main difference between these requirements and the general duty to cooperate relates to their enforceability. The requirements listed above in most cases make it clear who has the duty, to whom the duty is owed and how the duty must be carried out. Some of the requirements also specify negative consequences that may arise from a failure to undertake the required action. In this sense, many of these requirements are better categorised as duties to undertake certain actions to ensure joined-up working, rather than duties to cooperate. In contrast, general duties to cooperate are more difficult to enforce.

12.30 Also, the Council for Healthcare Regulatory Excellence is placed under a general duty to promote co-operation between regulatory bodies, and between them, or any of them, and other bodies performing corresponding functions (see Part 10).

Other existing statutory duties to cooperate

12.31 Statute law in other areas has developed alternative mechanisms for encouraging co-operation between agencies. For example, the NHS Act 2006

[14] *R v Secretary of State for Social Services ex p Hincks* [1980] 1 BMLR 93.

places a general duty to cooperate on NHS bodies and local authorities in England and Wales.[15] This is a target duty which has a similar status to the duties to cooperate placed on the regulators. In contrast, the Children Act 2004 establishes a general duty to cooperate but its terms are far more specific. For example, it requires children's services authorities to make arrangements to promote co-operation and gives examples of such arrangements, identifies a lead organisation and provides a list of partner agencies.[16]

12.32 Section 47(3) of the NHS and Community Care Act 1990 provides an example of an invitation to cooperate. If a community care assessment discloses a possible housing or medical need, the local authority is required to notify the relevant housing or health authority and invite them to assist. There is no requirement for the health or housing authority to cooperate with the local authority, but a failure to respond, or a failure to respond within a reasonable time or in a reasonable manner, may be vulnerable to judicial review. In contrast, the equivalent duty in section 27 of the Children Act 1989 enables a local authority to request the help of another organisation and specify the action in question. A requested authority must comply with the request if it is compatible with its own duties.

12.33 Section 3 of the Carers (Equal Opportunities) Act 2004 provides an example of an enhanced duty to request. Where a local authority requests another authority to assist it in planning the provision of services to a carer or cared-for person, the requested authority must give "due consideration" to the request. In addition, if a local authority has undertaken a carer's assessment and forms the view that the carer's ability to provide and to continue to provide care for the person cared for might be enhanced by the provision of services by another authority, the assessing authority can request that authority to provide any such services and the requested authority must give due consideration to the request.

Provisional view

12.34 It is important to recognise the limitations of a legal analysis of duties to cooperate. The extent of cooperation between agencies will depend on a wide range of factors, including resources, Government policy, professional cultures, institutional structures and processes, inter-professional relationships and the informal routines of individual professional workers. Many of these issues apply irrespective of the law or whether existing duties to cooperate can be enforced. Therefore, the law is only one factor, albeit an important one, in ensuring greater co-operation between agencies.

12.35 Our analysis of the various duties to cooperate suggests that there are certain characteristics that help to define an effective duty. These are listed below:

(1) It must be clear to whom the duty applies. The law must specify which bodies have a duty to cooperate and a clear lead agency, rather than requiring organisations to cooperate generally with each other.

(2) The duty should have wide coverage. Most of the legislation considered above recognises that multi-agency co-operation is vital and, therefore,

[15] NHS Act 2006, s 82.

provides an extensive list of relevant organisations. However, it is important that wide coverage is balanced with the first characteristic, which is being clear about to whom the duty applies.

(3) It should be clear when the duty applies. Some statutes are unclear on this point: for example, the regulators are required to cooperate "in exercising their functions", which can be described as high-level and difficult to tie to specific actions.

(4) Some form of action should be required by all bodies. Duties that require a two-way flow of obligations appear to be more effective than those that require no response.

(5) The action that is required must be as specific as possible. Thus, the existing duties to cooperate placed on the regulators are weakened significantly by their failure to identify what constitutes co-operation.

12.36 In the light of these characteristics, we provisionally propose that our statute should set out two duties to cooperate. First, we propose that a general duty should be imposed on each regulator to make arrangements to promote co-operation with other relevant organisations or other persons, including those concerned with the employment of registrants; education and training of registrants; regulation or co-ordination of the regulation of other health or social care professionals; regulation of health or social care services; and provision, supervision or management of health or social care services.

12.37 The statute could provide examples of arrangements that could be made under this duty, such as sharing information, undertaking joint consultations, sharing facilities and resources, joint rules and regulations, and partnership arrangements (see above) and other joint implementation of regulatory tasks or functions (including fitness to practise adjudication). This duty would help to encourage the regulators to be proactive in establishing a general framework that will encourage joint working. We welcome further suggestions on the types of arrangements that might be specified.

12.38 Second, we propose that there should be a specific duty to cooperate, which applies when the regulator in question is:

(1) considering an application for registration or renewal of registration;

(2) undertaking activities connected to the approval of pre-registration and post-registration education and training;

(3) monitoring and ensuring proper standards of practice and conduct; and

(4) undertaking an investigation into a registrant's fitness to practise.

12.39 This duty would apply to the same list of relevant organisations or other persons covered by the general duty to cooperate. The requested authority would be

[16] Children Act 2004, s 10.

required to give due consideration to any such request made by the regulator, and if it refuses to cooperate, must give written reasons. We welcome views on this proposal, and whether there are any other circumstances in which this duty should apply and whether the duty should apply to any other bodies.

12.40 We do not propose that the legislation should specify that in carrying out its duty to cooperate the Council must have regard to any differing considerations in relation to professional practice which apply in England, Scotland, Wales or Northern Ireland. In our view, this adds little of practical significance to the duty..

12.41 It should also be noted that our reforms would retain most of the specific requirements to undertake certain actions to ensure joined-up working listed earlier in this Part. These are discussed at various points in this consultation paper. In addition, the Council for Healthcare Regulatory Excellence's general duty to promote co-operation would be retained (see Part 10).

Provisional Proposal 12-6: The statute should impose a general duty on each regulator to make arrangements to promote cooperation with other relevant organisations or other persons, including those concerned with the:

(1) employment of registrants;

(2) education and training of registrants;

(3) regulation of other health or social care professionals;

(4) regulation of health or social care services; and

(5) provision/supervision/management of health or social care services.

Question 12-7: Should the statute specify or give examples of the types of arrangements that could be made under provisional proposal 12-6?

Provisional Proposal 12-8: The statute should impose a specific duty to cooperate, which would apply when the regulator in question is:

(1) considering registration applications and renewals;

(2) undertaking the approval of education and training;

(3) ensuring proper standards of practice and conduct; and

(4) undertaking an investigation into a registrant's fitness to practise.

This duty would apply to the same list of organisations and persons contained in provisional proposal 12-6. The requested authority would be required to give due consideration to any such request made by the regulator, and if it refuses to cooperate, must give written reasons.

Question 12-9: Are there any other circumstances in which the specific duty to cooperate contained in provisional proposal 12-8 should apply?

PART 13
CROSS BORDER ISSUES

13.1 The management of cross border issues is an important activity for the health and social care professional regulators with a significant number of overseas-qualified practitioners wishing to register in the UK.[1] In addition, the work of the regulators impacts on those outside the borders of mainland UK. In this Part, we explore the issues that arise from this, and specifically consider:

(1) registrants entering from within the European Economic Area;

(2) registrants entering from beyond the European Economic Area; and

(3) regulating outside the UK.

13.2 This Part does not discuss cross border issues that arises from the devolution settlements between the devolved administrations in Northern Ireland, Scotland and Wales. Our approach to devolution is set out in Part 1.

REGISTRANTS ENTERING FROM WITHIN THE EEA

13.3 When a health or social care professional from the European Economic Area (EEA)[2] wishes to move to another country that is also in the EEA, there is a system for the mutual recognition of professional qualifications. This is provided for by Directive 2005/36/EC, often called the "Qualifications Directive". The intention of the Directive is to make it easier for qualified professionals to practise their professions in EEA countries other than their own and in doing so, allow for freedom of movement within the EEA.

13.4 The Directive was implemented in UK law by the European Qualifications (Health and Social Care Professions) Regulations 2007.[3] These regulations insert detailed and extensive provisions into the regulators' governing legislation. For example, the provisions set out matters such as which primary qualifications in the Qualifications Directive qualify as primary qualifications for the purposes of registration and different criteria for registration based on whether the EEA national is seeking full, temporary or provisional registration.

13.5 The Directive distinguishes between doctors, dentists, nurses, midwives and pharmacists, which are termed the "sectoral professions", and the remaining health and social care professions which are termed "general systems professions". The distinction is important because the general systems

[1] For instance, 38% of doctors qualified overseas (General Medical Council, *The State of Medical Education and Practice in the UK* (2010), p 27).

[2] The EEA was established in 1994 to allow some members of the European Free Trade Association – Iceland, Liechtenstein and Norway – to participate in the internal market of the European Union (EU). In return, these countries agreed to adopt almost all European Union legislation. Accordingly, the Directive applies to all nationals from the 30 European Union Member States, plus Iceland, Liechtenstein and Norway. Our use of the term EEA includes Switzerland which has adopted the Directive despite not being part of the EEA.

[3] SI 2007 No 3101.

professions are not subject to the same system of automatic recognition of qualifications as the sectoral professions. Another key distinction that runs throughout the Qualifications Directive is between those who wish to work in another EEA country on a temporary or permanent basis. The primary difference is that a temporary worker will be able to practise without having to undergo the same system of checks as would be required for those intending to offer services permanently.

13.6 The Qualifications Directive requires professionals wishing to work temporarily in another EEA country to submit a declaration and accompanying documents, such as proof of nationality and evidence of professional qualifications. If the individual is seeking work in a sectoral profession they can practise immediately after submitting the declaration. General systems professionals may have their declaration checked by the regulators or even be required to comply with additional measures.

13.7 By contrast, if a professional will be practising on a permanent basis, they must apply for recognition of their qualifications. This will entail providing various documents, such as proof of nationality, proof of qualifications and proof of experience, as well as documents relating to good character, financial standing and insurance cover. The sectoral professions are also required to submit further documents such as a certificate of compliance from the original member state. For the general systems professions, once the relevant documents are submitted the regulator examines them to determine whether the professional's qualifications can be recognised in the UK. The regulator can take into account subsequent experience and training, or require an aptitude test or supplementary training to be undertaken. However, this is different for the sectoral professions who are entitled under the automatic recognition system to start work without having their qualifications checked. A decision to refuse to recognise an individual's qualifications can be appealed to the county court.

13.8 After an individual's qualifications have been recognised, the regulator is able to check language skills by reference to documents provided by the individual. Under the Qualifications Directive, an individual is required to have knowledge of languages necessary for practising in the relevant profession.[4] However, regulators are not permitted to make individuals systematically sit language examinations as this may prevent freedom of movement. As a result, ensuring language competence can become the responsibility of the employer. This is different from the systems that the regulators use for practitioners coming from beyond the EEA, which usually include a language test that must be passed to a specified level. [5]

13.9 Concerns have been raised that regulators are not able to test language competencies at the point of registration. In a proposed amendment to the Qualifications Directive, the health care regulators would be given a limited right to carry out language testing where requested by the NHS or in case of self-

[4] Directive 2005/36/EC, art 53.

[5] At the Nursing and Midwifery Council and the General Pharmaceutical Council, a score of 7 is required on the International English Language Testing System (IELTS).

employed professionals not affiliated to the NHS system, by representative national patient organisations.[6]

13.10 Part of the scheme of the Qualifications Directive is a five yearly periodic review. The first such review was initiated in March 2010 and the European Commission adopted a proposal to amend the Directive in December 2011.[7]

Provisional view

13.11 The Qualifications Directive is an essential part of the legal framework for health and social care regulation. As a Directive, it has a legal status which overrides domestic law. Accordingly, it is beyond our remit to make proposals to amend the substance of the Directive.

13.12 However, we are in a position to consider the implementation of the Directive into domestic law. We note that there is no legal requirement that a Directive must be implemented into domestic law by way of primary legislation. The only requirement is that the effect of a Directive must be implemented by provisions that have binding force, and with enough precision and clarity to satisfy legal certainty.[8]

13.13 As set out in Part 2, the structure we are provisionally proposing will involve giving the regulators greater autonomy to make rules and regulations setting out how they will carrying out their statutory functions. At present, the provisions, which implement the Qualifications Directive, are in primary legislation, are highly detailed and vary considerably between the regulators. We therefore believe that these provisions should be provided at a level where such detail is more appropriate, such as in rules or regulations made by the regulators. Indeed, it is highly unlikely that the new statute could consolidate all these provisions effectively, whilst at the same time recognising the different aspects that apply to the various regulated professions.

13.14 We therefore provisionally propose that the statute should require the regulators to specify in rules which qualifications would entitle an applicant to be registered including overseas qualifications. This would be part of the general function of the regulators to establish and maintain a register, the proposed framework for which is set out in Part 5.

13.15 We recognise that in this area there is a strong argument for maintaining a role for Government. This is because it is the Government who will ultimately be held liable for failures to implement a Directive properly.[9] However, in our view the risk of the Government being held liable for failures to implement the Directive is very low because the threshold for state liability to individuals in EU law is that a

6 European Commission, *Proposal for a Directive of the European Parliament and of the Council amending Directive 2005/36/EC* (2011).

7 See, European Commission, *Proposal for a Directive of the European Parliament and of the Council amending Directive 2005/36/EC* (2011).

8 See Case C-159/99 *Commission v Italy* [2001] ECR I-400 7 at para 32.

9 Case 77/69 *Commission v Belgium* [1970] ECR 237 at para 15.

breach must be sufficiently serious.[10] This is a high threshold and will usually only attach to systemic failures to implement a Directive.[11] A similar approach is taken to state liability to the European Commission and other Member States, whereby only a systemic failure to transpose a Directive would attract liability.[12] Furthermore, in the unlikely event that liability was found, the Government is able to require the regulators to contribute to any fines which were imposed.[13]

13.16 Nonetheless we accept that it is important for the Government to have powers to intervene at an early stage to avoid any failures. The effects of litigation, in which the Government would be enjoined, are likely to be damaging to international relations and resource intensive. We therefore propose that the default powers of the Government (see Part 2) should include the ability to intervene in cases where there is likely to be or has been a failure to implement the Directive properly.

Provisional Proposal 13-1: The statute should require the regulators to specify in rules which qualifications would entitle an applicant to be registered, including overseas qualifications.

Provisional Proposal 13-2: The default powers of the Government should include the ability to intervene in cases where there is likely to be or has been a failure to implement the Qualifications Directive properly.

REGISTRANTS ENTERING FROM BEYOND THE EEA

13.17 Health and social care professionals entering the UK from beyond the EEA give rise to issues similar to those addressed above, although their resolution is different. These differences arise primarily from a less detailed legal framework to allow for the recognition of qualifications. The main issue for the regulators is whether an individual satisfies the requirements for registration, which involves determining whether foreign qualifications can be taken as equivalent to UK qualifications. Non-EEA applicants are often required to undertake some form of assessment.

13.18 Most of the other regulators follow a similar framework of assessing individual applicants and then requiring some form of additional training to introduce the applicant to practise in the UK. For instance, at the Nursing and Midwifery Council a non-EEA applicant must supply evidence of personal details such as passport and birth certificate, as well as references from employers and transcripts of training forms. There are language, practice and education requirements as well as specific requirements for both nurses and midwives. If an applicant then satisfies these requirements, they must then take a supplementary

[10] Case C-393/93 *British Telecommunications* [1996] ECR I-1631 at para 39.

[11] See particularly, Joined Cases C-46/93 and C-48/93 *Brasserie du Pêcheur SA v Federal Republic of Germany; R v Secretary of State for Transport ex parte Factortame Limited* [1996] I-1131; *Carswell v The Secretary of State for Transport, The Motor Insurers' Bureau* [2010] EWHC 3230 (QB); and *Negassi v Secretary of State for the Home Department* [2011] EWHC 386 (Admin) at para 25.

[12] For example, see *Commission of the European Communities v Germany* (29/84) [1985] E.C.R. 1661 and *Commission of the European Communities v UK* (556/08).

[13] Localism Act 2011, ss 48 to 57.

course such as the Overseas Nurses Programme or the Adaptation to Midwifery Programme.[14] Similarly, at the General Medical Council there is a requirement to demonstrate certain qualifications and then a two-stage test that includes a written exam and practical test. The Council has 14 overseas assessment centres which include Cairo, Lagos and Islamabad.[15]

13.19 An assessment is not necessarily part of the process at the Health Professions Council where two assessors can accept an application to join the register on the basis of documents provided. These requirements depend on the standards of proficiency for the particular professional register that is being applied for.[16]

Provisional view

13.20 Registering health and social care professionals that have qualifications from countries beyond the EEA is a complicated task for the regulators. Currently, this task is performed without the support of a detailed legal framework. However, we would be concerned about imposing a framework on the regulators, not least because the size of the task of recognising international qualifications depends on the profession involved. Furthermore, the regulators are best placed to determine the equivalence of qualifications and the content of any supplementary training or assessment.

13.21 In our view, the retention of enabling powers in this area would strike the right balance between the competing values of legal certainty and flexibility in practice. Therefore, we provisionally propose that the statutory solution should include broadly-worded powers for the regulators to register those from non-EEA countries. As indicated above, this would include a power to set requirements as to the language, practice and education that an applicant would be expected to demonstrate as well as a power to oversee any supplementary assessment or training regime.

Provisional Proposal 13-3: The statute should include broad powers for the regulators to register those from non-EEA countries, including powers to set requirements as to the language, practice and education requirements.

REGULATING OUTSIDE THE UK

13.22 As well as facing challenges in terms of potential registrants entering from abroad, the work of the regulators also has an impact on those outside the borders of mainland UK. Here we focus on three issues which arise in this context: the extent of the regulators' jurisdictions, accreditation of courses abroad and distance service provision.

[14] Nursing and Midwifery Council, *Registering as a nurse or midwife in the United Kingdom: for applicants from countries outside the European Economic Area* (2011).

[15] See http://www.gmc-uk.org/doctors/plab/advice_part1.asp#1 (last visted 15 February 2012).

[16] See http://www.hpc-uk.org/apply/international/assessing (last visited 15 February 2012).

Extent of the regulators' jurisdictions

13.23 The regulators' legislation extends to the UK, except for the Pharmacy Order 2010, which extends only to Great Britain, and the Pharmacy (Northern Ireland) Order 1976. The definition of the UK excludes the Channel Islands and the Isle of Man, although these are included as part of the British Islands.[17] Citizens of the Channel Islands and the Isle of Man are British citizens.[18] An Act of Parliament must state specifically that it applies to these locations to have effect there.[19]

13.24 Accordingly, the regulatory framework for the health and social care professions in the UK does not extend to the Channel Islands and the Isle of Man. However, in the islands a form of registration exists that reflects some of the features of UK regulation. For instance, a doctor on Jersey can only be registered with the Department for Health and Social Services if they are also registered under the Medical Act 1983.[20] If a doctor is erased or suspended from the register of the General Medical Council, there is a procedure to erase a doctor from the Jersey register.[21] A doctor's registration may be cancelled if he or she has been "guilty of infamous or disgraceful conduct" although the doctor must have had an opportunity to answer these charges.[22] There is similarly worded legislation for dentists, opticians and a wide class of "registrable professions", which includes most of the health and social care professions that are regulated in the UK.[23] For pharmacists and pharmacy technicians, obligations to maintain and manage a register have been put directly on the Minister for Health and Social Services. Amendments to the scheme for doctors have been adopted which would include placing an obligation on Jersey's Minister for Health and Social Services to maintain a register of medical practitioners as well as introducing powers to make Orders on fitness to practise.[24] However, these amendments are not yet in force.

13.25 In Guernsey, a similar arrangement is in place whereby doctors, dentists and pharmacists must be registered as qualified practitioners in the UK.[25] This allows registration with the Department for Health and Social Services in Guernsey. A practitioner can only be erased from the register if they cease to be qualified in the UK.[26] Similar provision is made for nurses, midwives and health visitors.[27]

[17] Halsbury's Laws of England, *Vol 6: Commonwealth* (4th ed 2003), paras 725 and 734.

[18] British Nationality Act 1981, ss 1, 11, 50(1).

[19] See Halsbury's Laws of England, *Vol 6: Commonwealth* (4th ed 2003), para 726.

[20] Medical Practitioners (Registration) (Jersey) Law 1960, art 6.

[21] As above, arts 8(1) and 9(1).

[22] Medical Practitioners (Registration) (Jersey) Law 1960, art 10.

[23] Dentists (Registration) (Jersey) Law 1961; Opticians (Registration) (Jersey) Law 1962; and Health Care (Registration) (Jersey) Law 1995.

[24] Medical Practitioners (Registration) (Amendment No 4) (Jersey) Law 201-.

[25] Doctors, Dentists and Pharmacists Ordinance 1987.

[26] As above, s 3.

[27] Nurses, Midwives and Health Visitors Ordinance 1987.

13.26 On the Isle of Man, there are arrangements for the maintenance of lists of doctors, dentists, nurses, midwives and opticians.[28] These professions have their own Acts passed by the Isle of Man legislature which prescribe the requirements for registration and cross-references the relevant UK legislation. Practitioners can be removed from a list if they cease to be eligible or if continued inclusion would be "prejudicial to the efficiency of the services in question".[29]

Provisional view

13.27 The legislative framework for health and social care professional regulation in the Channel Islands and the Isle of Man is formally outside the remit of our review. However, concerns have been brought to our attention that for example certain health and social care professions are left unregulated in these jurisdictions, and that the fitness to practise regimes are insufficiently comprehensive and robust in order to protect the public in the islands, who in most cases will be British citizens. It has also been pointed out that a significant number of professionals who practise in the Channel Islands and the Isle of Man will also practise in the UK. It is therefore in the interests of the UK regulators to be able to take into account any fitness to practise concerns raised against such professionals.

13.28 It would be possible in theory for the Government to decide to extend the UK regulatory frameworks to include the Channel Islands and the Isle of Man by bringing these islands within the jurisdiction of our statute. On a technical level, this would be straightforward because the UK Parliament retains the ability to legislate for the islands. All that would be required would be a provision that specifies that the Act applies to the islands. However, there are constitutional issues that would arise from the UK Parliament legislating for islands that are, as a matter of convention, free to create their own laws. Also, extending the jurisdiction of the regulators would necessarily have some resource implications. Although making recommendations on this matter is outside the scope of our review, we welcome further views on this political option.

13.29 We also welcome views on how the legal framework could address the interface between the regulatory systems in the UK and the Channel Islands and the Isle of Man. For example, it might be possible to encourage the regulators to cooperate or enter into partnership arrangements (see Part 12). Alternatively the statute could authorise the issuing of, for example, joint standards or codes by the different regulators (see Part 12). We welcome views on these or any other suggestions.

Question 13-4: Would there be benefits in the same regulatory arrangements applying in the Channel Islands and the Isle of Man? If so, would the best way to achieve this be parallel legislation or a single statute?

Question 13-5: How could the new legal framework address the interface between the regulatory systems in the UK and the Channel Islands and the Isle of Man?

[28] NHS Act 2001.

[29] As above, s 13.

Accrediting courses abroad

13.30 For some regulators, an important area of activity is accrediting courses which are conducted abroad. For instance, the General Optical Council is increasingly being asked to visit and approve European training, and in particular has approved the European Council of Optometry and Optics diploma as a partial route to UK registration.[30] The General Pharmaceutical Council also accredits those courses that are part of its Overseas Pharmacists' Assessment Programme that award a postgraduate diploma following a conversion course for non-EEA qualified pharmacists, as well as some masters courses delivered in part overseas.[31] For instance, Cardiff University runs an MPharm degree course in collaboration with Taylor's University College in Kuala Lumpur, Malaysia. Additionally, most regulators are involved in European initiatives such as the Health Professionals Crossing Borders scheme, which involves competence assurance and an assessment of the educational standards of different countries.

13.31 The regulators identify several advantages in being able to accredit courses which are delivered outside the borders of the UK. First, it can help the regulators perform their obligations under EU law described above because it allows regulators to be sure of the provenance of qualifications awarded from certain institutions. This reduces the need for regulators to perform a full investigation into the nature of the qualifications of those applying to enter the relevant register. Secondly, accrediting international courses is indicative of the generally positive reputation of UK health and social care regulation. We understand that some regulators are asked to accredit courses because to have approval from a UK-based regulator is considered a badge of honour in other countries. Thirdly, some UK universities are involved in running courses overseas and so it is useful for the regulators to be able to supervise how these are delivered.

13.32 On the other hand, the need for the regulators to accredit courses overseas may not arise by choice but when education institutions open branches overseas which provide UK qualifications.[32] In such cases there may be practical difficulties in the requirement on the regulators to quality assure these institutions and courses.

Provisional view

13.33 In our view all the regulators should be given the ability to accredit overseas courses or institutions which they can use if they wish to do so. We therefore provisionally propose that the regulators should be given an express power to approve and accredit overseas education institutions and courses and issue rules and guidance for the purpose of such activity. It would be left to the regulators whether or not they wish to undertake this task, and if so how they go about accrediting and quality assuring courses and institutions abroad.

[30] General Optical Council, *Celebrating 50 Years of Optical Regulation* (2008), p 8.

[31] See http://www.pharmacyregulation.org/education/approval-courses/accreditation-and-recognition-reports (last visted 15 February 2012).

[32] For example, Newcastle University has opened a medical school in Malaysia to provide UK medical qualifications.

13.34 We welcome views on the practical difficulties which arise as a result of the requirement to quality assure UK qualifications which are awarded by institutions based overseas.

Provisional Proposal 13-6: The regulators should be given an express power to approve and accredit overseas education institutions and courses and issue rules and guidance for the purpose of such activity.

Question 13-7: What are the practical difficulties which arise as a result of the requirement to quality assure UK qualifications which are awarded by institutions based overseas?

Distance service provision

13.35 There is an increasing trend towards the remote provision of certain health care services.[33] An obvious example of this is the internet in the pharmaceutical context, which allows prescription medicines and other drugs to be ordered online and delivered directly to individuals' homes.

13.36 This presents a regulatory challenge, particularly for the General Pharmaceutical Council and the Pharmaceutical Society of Northern Ireland given the growth of internet pharmacies. The General Pharmaceutical Council deals with this issue by operating a scheme which allows approved pharmacies to use a logo to identify them as registered pharmacies.[34]

13.37 However, the problem remains that non-UK based websites may still provide prescription-only medicines without a prescription, or without checking whether the medicine is suitable for the person concerned. Although an individual can raise a concern with the Medicines and Healthcare products Regulatory Agency, its remit is limited by resources and the difficulties of enforcement outside of the EU. This is particularly difficult because not all prescription drugs are "controlled drugs" for the purposes of the Misuse of Drugs Act 1971. Individuals may personally import non-controlled drugs without a licence.[35]

13.38 A further example of distance service provision is the development of telehealth and telecare. These terms refer to the use of technology to allow health and social care services to be delivered into patients' and service users' homes without needing a practitioner to be physically present. This can take a variety of forms. For instance, a patient could take a photo of themselves using a digital camera and then send the image to a doctor. The doctor could then remotely diagnose the patient and suggest a treatment. Similarly, devices can be used to monitor health signs remotely and readings are sent to a practitioner who can then decide whether to intervene, without the patient needing to attend a clinic.

[33] For instance, see Social Care Institute for Excellence, *Ethical Issues in the use of Telecare* (2010) p 2 and Parliamentary Office of Science and Technology, *Postnote: Changing Role of Pharmacies* (2005).

[34] See http://www.pharmacyregulation.org/registration/internet-pharmacy (last visited 15 February 2012).

[35] C George, "Internet Pharmacies: Global Threat Requires a Global Approach to Regulation" *Hertfordshire Law Journal* 4(1), p 12 to 25.

13.39 The potential advantages of telehealth and telecare are said to include low admission rates to hospital and lower mortality rates.[36] The Government has indicated its continued support for such applications of technology.[37]

Provisional view

13.40 Distance provision of services can undoubtedly bring benefits to those who may not be able to access easily the services they need, such as disabled people. However, the use of the internet or remote devices raises regulatory concerns because of the way in which those services may be delivered.

13.41 In terms of internet pharmacy, it is arguable that the availability of unregulated products should not be a primary concern for professional regulatory bodies, particularly where the Medicines and Healthcare products Regulatory Agency already exists. However, we acknowledge that the professional regulators have a legitimate concern where individuals are providing potentially harmful services or products. The issue for us is whether our statute can or should help the regulators deal with the issues that arise from the provision of such services. It may be that the role of domestic law is limited in being able to address an issue which arises at the international level or that other agencies are best placed to address this issue.

13.42 In terms of telehealth and telecare, the principal regulatory concern is that the individual making clinical decisions is appropriately qualified to give advice and suggest certain treatments. This may be relatively straightforward when the advice is being provided by a practitioner based in the UK, but this may be more difficult to monitor where the practitioner is overseas. There would clearly be public safety risks associated with inappropriately qualified individuals performing this function. Other problems that may arise include matters of confidentiality and disclosure.

13.43 We welcome suggestions about how our statute may enable the regulators to manage these issues, or whether they are issues for the regulators at all.

Question 13-8: How might our statute enable the regulators to manage the issues that arise from distance service provision?

[36] Department of Health, *Whole System Demonstrator Programme: Headline Findings - December 2011* (2011).

[37] HM Government, *Investing in UK Health and Life Services* (2011) p 13.

APPENDIX A
PROVISIONAL PROPOSALS AND CONSULTATION QUESTIONS

PART 2: THE STRUCTURE OF REFORM AND ACCOUNTABILITY

Provisional Proposal 2-1: All the existing governing legislation should be repealed and a single Act of Parliament introduced which would provide the legal framework for all the professional regulators.

Provisional Proposal 2-2: The new legal framework should impose consistency across the regulators where it is necessary in order to establish the same core functions, guarantee certain minimum procedural requirements and establish certain core requirements in the public interest. But otherwise the regulators should be given greater autonomy in the exercise of their statutory responsibilities and to adopt their own approach to regulation in the light of their circumstances and resources.

Provisional Proposal 2-3: The regulators should be given broad powers to make or amend rules concerning the exercise of their functions and governance without any direct oversight, including Privy Council approval and Government scrutiny (subject to certain safeguards).

Question 2-4: Would the perceived status of legal rules be less clear or certain without Parliamentary approval? Should the CHRE be given an active role in scrutinising new rules, or should a limited number of the rules be subject to Secretary of State approval and contained in a statutory instrument?

Provisional Proposal 2-5: The power of the regulators to issue standing orders should be abolished.

Provisional Proposal 2-6: The regulators should have the ability to implement their statutory powers by making rules, instead of a mixture of rules and regulations.

Provisional Proposal 2-7: The statute should require the regulators to consult whenever issuing or varying anything which is binding, anything which sets a benchmark or standard, and a competency. The regulators should be required to consult such persons it considers appropriate, including:

(1) members of the public, patients and service users;

(2) registrants (including business registrants);

(3) employers of registrants;

(4) the other health and social care professional regulators, the CHRE, the health and social care inspectorates, the independent safeguarding authorities and any other regulatory bodies;

(5) the Department of Health, Northern Ireland Executive, Scottish Government and Welsh Government;

(5) professional bodies that represent registrants;

(6) persons or bodies commissioning or funding the services provided by registrants or at a registered premises/business.

Provisional Proposal 2-8: The formal role of the Privy Council in relation to health and social care professional regulation should be removed entirely.

Provisional Proposal 2-9: The House of Commons Health Committee should consider holding annual accountability hearings with the regulators which should be coordinated with the CHRE's performance reviews. The Scottish Parliament, National Assembly for Wales and Northern Ireland Assembly should also consider instituting similar forms of accountability.

Provisional Proposal 2-10: The Secretary of State should be given formal powers to make decisions on matters that require a political policy decision to be made, including matters where there is a sufficient public interest and matters that give rise to questions about the allocation of public resources.

Provisional Proposal 2-11: The statute should place a duty on each regulator to provide information to the public and registrants about its work.

Provisional Proposal 2-12: Each regulator and the CHRE should be required to lay copies of their annual reports, statistical reports, strategic plans and accounts before Parliament and also in all cases the Scottish Parliament, the National Assembly for Wales and the Northern Ireland Assembly.

Provisional Proposal 2-13: The statute should not require the regulators to send a copy of their accounts to the Comptroller and Auditor General or to the Auditor General for Scotland.

Provisional Proposal 2-14: The order making power in section 60 of the Health Act 1999 should be repealed and instead the Government should be given regulation-making powers on certain issues.

Provisional Proposal 2-15: The Government should be given a regulation-making power to abolish or merge any existing regulator, or to establish a new regulatory body. This power would also enable the Government to add new professional groups to, or remove professional groups from, statutory regulation.

Question 2-16: Should the CHRE be given a power to recommend a profession for statutory regulation, or the removal of a profession from statutory regulation? If the Government decided not to comply, it would be required to issue a report setting out its reasons.

Provisional Proposal 2-17: The Government should be given powers to issue a direction in circumstances where a regulator has failed to perform any of its functions, and if the regulator fails to comply with the direction, the Government may itself give effect to the direction (see also provisional proposal 13-2).

Provisional Proposal 2-18: The Government should be given powers to take over a regulator which is failing to carry out its functions.

Provisional Proposal 2-19: The Government should not have express powers in the statute to initiate a public inquiry. This would continue to be provided for under other existing Government powers.

Provisional Proposal 2-20: If the Scotland Bill 2010 does not become law, any use of the proposed regulation-making power set out in provisional proposal 2-13 in respect of a profession for which the Scottish Parliament has legislative competence, must be consulted on by Scottish Ministers and laid before the Scottish Parliament as well as the UK Parliament.

Question 2-21: Should the Pharmacy (Northern Ireland) Order 1976 be reconstituted and retained as a separate part of the new statute?

Question 2-22: Should the proposed regulation-making power set out in provisional proposal 2-15 include a general provision to incorporate the Pharmaceutical Society of Northern Ireland into the main legal framework of the new statute (following approval by the Northern Ireland Assembly)?

Question 2-23: Which, if any, of the specific proposals which follow in this consultation paper should be applied to the Pharmaceutical Society of Northern Ireland?

Question 2-24: How should the new legal framework deal with cases left over from the previous legal regimes? What practical difficulties are likely to arise from the repeal of existing legislation and rules?

PART 3: MAIN DUTY AND GENERAL FUNCTIONS OF THE REGULATORS

Question 3-1: Should the statute specify the paramount duty of the regulators and the CHRE is to: (1) protect, promote and maintain the health, safety and well-being of the public by ensuring proper standards for safe and effective practice; or (2) protect, promote and maintain the health, safety and well-being of the public and maintain confidence in the profession, by ensuring proper standards for safe and effective practice?

Provisional Proposal 3-2: The statute should not include a statement setting out the general or principal function(s) of the regulators.

Question 3-3: Should the statute include guiding principles which would apply to all decisions made by the regulators, and if so what should they be?

Question 3-4: Should the statute include a general power for the regulators to do anything which facilitates the proper discharge of their functions?

PART 4: GOVERNANCE

Question 4-1: Should the statute: (1) reform the existing structure to encourage Councils to become more board-like; *and/or* (2) reform the existing structure by establishing a statutory executive board consisting of the chief executive and senior directors; *and/or* (3) establish a unitary board structure which would move away from a two-tier approach based on a Council and officials?

Provisional Proposal 4-2: The statute should establish each Council as a body corporate. The regulators should continue to be able to apply to become registered with the Charity Commission if they wish to do so.

Provisional Proposal 4-3: The statute should require that each Council must be constituted by rules issued by the regulators.

Provisional Proposal 4-4: Each regulator should be required to issue rules on the appointment of Council members and chairs, terms of office, duration of membership, grounds for disqualification, quorum for meetings, circumstances in which members (including chairs) cease to hold office, are removed or are suspended, education and training of Council members, and attendance requirements of Council members.

Question 4-5: Is an additional form of oversight required over the appointment of the General Council members? For example, should the Government have powers to remove members in certain circumstances?

Question 4-6: Should: (1) the statute specify a ceiling for the size of the Councils of and the proportion of lay/registrant members; *or* (2) the Government be required to specify in regulations the size of Councils and the proportion of lay/registrant members; *or* (3) the regulators be given general powers to set the size and composition of their Councils and the Government be given default powers to intervene if this is necessary in the public interest?

Provisional Proposal 4-7: The statute should define a lay member of the Council as any person who is not and has not been entered in the register of that particular regulatory body, and a registrant member as any person who is entered in the register of that particular regulatory body.

Question 4-8: Should Council members be prohibited from concurrent membership of another Council?

Provisional Proposal 4-9: The regulators should be given broad rule-making powers to determine their own governance arrangements, including the ability to establish committees if they wish to do so.

Provisional Proposal 4-10: The regulators should be able to make rules for committees or any other internal groups it establishes, including their size and membership.

Provisional Proposal 4-11: Each Council should be given powers to delegate any of its functions to any Council member, officer or internal body. Any delegations must be recorded in publicly available scheme of delegation. There should continue to be a prohibition on delegating any power to make rules.

PART 5: REGISTERS

Provisional Proposal 5-1: The statute should set out a core duty on all the regulators to establish and maintain a professional register.

Provisional Proposal 5-2: The regulators should have the ability but not a duty to appoint a Registrar.

Provisional Proposal 5-3: The statute should specify which registers must be established by the regulators, including any different parts and specialist lists. The Government would be given a regulation-making power to add, remove or alter the parts of the register and specialist lists.

Provisional Proposal 5-4: The Government should be given a regulation-making power to introduce compulsory student registration in relation to any of the regulated professions.

Question 5-5: Should student registration be retained in the new legal framework, and/or how can the legal framework help to ensure that the principles and practices of professionalism are embedded in pre-registration training?

Question 5-6: Should the regulators be given powers to introduce voluntary registers?

Question 5-7: If the regulators are given powers to introduce voluntary registers, should the CHRE be given a formal power to recommend to the regulator in question that a group should become or cease to be voluntarily registered? If the regulator decided not to comply, it would be required to issue a report setting out its reasons.

Question 5-8: Should non-practising registers be retained or abolished?

Provisional Proposal 5-9: The regulators will be required to register applicants on a full, conditional or temporary basis. In addition, the regulators will be given powers to introduce provisional registration if they wish to do so.

Provisional Proposal 5-10: The statute will provide that if the Secretary of State advises that an emergency has occurred, a regulator can make certain temporary changes to the register.

Provisional Proposal 5-11: The statute should specify that in order to be registered on a full or temporary basis the applicant must be appropriately qualified, be fit to practise, have adequate insurance or indemnity arrangements (except for social workers), and have paid a prescribed fee. The regulators should have broad rule-making powers to specify the precise detail under each of these requirements.

Provisional Proposal 5-12: The regulators should be given powers to establish separate criteria for the renewal of registration and for registrants proceeding from provisional to full registration.

Question 5-13: Should the statute provide that in order to be registered an applicant must demonstrate that they are a “fit and proper person” to exercise the responsibilities of their profession.

Question 5-14: Should the legislation state that applicants are entitled to be registered provided that they satisfy the relevant criteria or that the regulator must register the applicant provided that they satisfy the relevant criteria? Does either formulation make any difference in practice?

Provisional Proposal 5-15: The statute should require the regulators to communicate expeditiously with registrants and potential registrants. The regulators would be given broad rule-making powers concerning the processing of registration applications.

Provisional Proposal 5-16: The statute should require each regulator to establish an appeals process for when registration applications are refused. The regulators would have broad powers to decide the precise process it wants to introduce.

Provisional Proposal 5-17: The statute should provide a right of appeal when registration applications are refused, to the High Court in England and Wales, the Court of Session in Scotland, and the High Court in Northern Ireland.

Provisional Proposal 5-18: The regulators should have broad powers to establish rules concerning the upkeep and publication of the register.

Provisional Proposal 5-19: The statute should require each regulator to establish process for dealing with fraudulently procured or incorrectly made entries. The regulators would have broad powers to decide the precise process it wishes to introduce.

Provisional Proposal 5-20: The statute should provide a right to appeal against registration decisions relating to fraudulently procured or incorrectly made entries, to the High Court in England and Wales, the Court of Session in Scotland, and the High Court in Northern Ireland.

Provisional Proposal 5-21: The statute should provide that applications for restoration in cases where a registrant's entry has been erased following fitness to practise proceedings must be referred to a Fitness to Practise Panel or similar committee.

Provisional Proposal 5-22: The statute should provide a right to appeal against restoration decisions by a Fitness to Practise Panel to the High Court in England and Wales, the Court of Session in Scotland, and the High Court in Northern Ireland.

Question 5-23: Should the statute set a consistent time period before which applications for restoration cannot be made (in cases where a registrant's entry has been erased following fitness to practise proceedings), or should this matter be left to the regulators to determine?

Provisional Proposal 5-24: The statute should require each regulator to establish in rules a process for considering applications for restoration in cases which are not related to fitness to practise proceedings. The regulators would be given broad discretion to determine the precise process it wishes to adopt.

Provisional Proposal 5-25: The regulators should have broad powers to make rules concerning the content of the registers. The only exception to this approach would be that set out in provisional proposal 5-27.

Question 5-26: Should the regulators be given broad powers to annotate their registers to indicate additional qualifications or should this power be subject to certain restrictions?

Provisional Proposal 5-27: The statute should require all current fitness to practise sanctions to appear in the public register.

Provisional Proposal 5-28: The regulators should have discretion to include details of undertakings, warnings and interim orders in the public register (subject to the main duty of the regulators to protect the public by ensuring proper standards).

Question 5-29: Should the regulators be required to publish information about professionals who have been struck off, for at least 5 years after they have been struck off?

Question 5-30: Should the regulators be required to include in their registers details of all previous sanctions?

Provisional Proposal 5-31: All the existing protected titles and functions that are contained currently in the governing legislation should be specified in the new statute.

Provisional Proposal 5-32: Government should be given a regulation-making power to add to or remove any of the protected titles and functions.

Question 5-33: How appropriate are the existing protected titles and functions?

Provisional Proposal 5-34: The regulators will have powers to bring prosecutions and will be required to set out in a publicly available document their policy on bringing prosecutions (except in Scotland).

PART 6: EDUCATION, CONDUCT AND PRACTICE

Question 6-1: Should our proposals go further in encouraging a more streamlined and coordinated approach to regulation in the areas of education, conduct and practice? If so, how could this be achieved?

Provisional Proposal 6-2: The statute should require the regulators to make rules on:

(1) which qualifications are approved qualifications for the purposes of pre-registration and post-registration qualifications;

(2) the approval of education institutions, courses, programmes and/or environments leading to an award of approved qualifications and the withdrawal of approval;

(3) rights of appeals to an individual or a panel against the decision of the regulator to refuse or withdraw approval from an institution, course or programme;

(4) the quality assurance, monitoring and review of institutions, courses, programmes and/or environments; and

(5) the appointment of visitors and establishment of a system of inspection of all relevant education institutions.

Provisional Proposal 6-3: The statute should require the regulators to establish and maintain a published list of approved institutions and/or courses and programmes, and publish information on any decisions regarding approvals.

Provisional Proposal 6-4: The statute should require education institutions to pass on to the regulator in question information about student fitness to practise sanctions.

Question 6-5: Should the powers of the regulators extend to matters such as a national assessment of students?

Question 6-6: Should the regulators be given powers over the selection of those entering education?

Question 6-7: Could our proposals go further in providing a framework for the approval of multi-disciplinary education and training, and if so how?

Question 6-8: Is too much guidance being issued by the regulators and how useful is the guidance in practice?

Provisional Proposal 6-9: The statute should require the regulators to issue guidance for professional conduct and practice.

Provisional Proposal 6-10: The statute should provide for two separate types of guidance: *tier one guidance* which must be complied with unless there are good reasons for not doing so, and *tier two guidance* which must be taken into account and given due weight. The regulators would be required to state in the document whether it is tier one guidance or tier two guidance.

Question 6-11: How should the legal framework deal with the regulators' responsibilities in relation to professional ethics?

Provisional Proposal 6-12: The statute will require the regulators to ensure ongoing standards of conduct and practice through continuing professional development (including the ability to make rules on revalidation).

PART 7: FITNESS TO PRACTISE: IMPAIRMENT

Question 7-1: Should the statute: (1) retain the existing two-stage approach for determining impaired fitness to practise; *or* (2) implement the recommendations of the Shipman report; *or* (3) remove the current statutory grounds which form the basis of an impairment and introduce a new test of impaired fitness to practise based on whether the registrant poses a risk to the public (and that confidence in the profession has been or will be undermined)?

Question 7-2: If a list of statutory grounds of impaired fitness to practise is retained, should it refer to a broader range of non-conviction disposals?

Question 7-3: How adequate are the powers of the regulators to require disclosures from the Independent Safeguarding Authority and Disclosure Scotland? What practical difficulties, if any, arise as a result of differences between the protection of vulnerable groups schemes in England, Wales, Northern Ireland and Scotland?

PART 8: FITNESS TO PRACTISE: INVESTIGATION

Question 8-1: Should the new legal framework remove the concept of an allegation entirely and instead give the regulators broad powers to deal with all information and complaints in such manner as they consider just (subject to a requirement that cases where there are reasonable prospects of proving impairment must be referred for fitness to practise proceedings)?

Provisional Proposal 8-2: The statute should provide that all the regulators will be able to consider any information which comes to their attention as an allegation and not just formal complaints.

Provisional Proposal 8-3: The statute should contain a clear statement that there is no set format for allegations.

Question 8-4: Should the statute prohibit the regulators from setting a time limit for bringing an allegation against a registrant or should there be a consistent time limit for allegations across the regulators (and if so, what should it be)?

Provisional Proposal 8-5: All the regulators should have the power to establish a formal process for the initial consideration of allegations (such as screeners).

Provisional Proposal 8-6: The regulators should have the power to prohibit certain people from undertaking the initial consideration of allegations and specify that only certain people can undertake this task.

Provisional Proposal 8-7: The regulators should have powers to establish referral criteria for an investigation and specify cases which must be referred directly to a Fitness to Practise Panel.

Question 8-8: Should the statute impose more consistency in relation to the criteria used by regulators to refer cases for an investigation or the cases that must be referred directly to a Fitness to Practise Panel?

Provisional Proposal 8-9: The statute should enable but not require the regulators to establish an Investigation Committee.

Provisional Proposal 8-10: The regulators should be given broad rule and regulation-making powers concerning how and by whom an investigation is carried out.

Provisional Proposal 8-11: The statute should give all the regulators a general power to require the disclosure of information where the fitness to practise of a registrant is in question.

Question 8-12: Are the existing formulations of the power to require disclosure of information useful and clear in practice?

Provisional Proposal 8-13: The power to require information should be extended to include the registrant in question.

Question 8-14: Should any enforcement powers be attached to the power to require information?

Provisional Proposal 8-15: The statute should provide that the test for all referrals to a Fitness to Practise Panel across the regulators is the real prospect test.

Provisional Proposal 8-16: The regulators should have powers to issue or agree the following at the investigation stage: (1) warnings; (2) undertakings; (3) voluntary erasure; and (4) advice to any person with an interest in the case.

The regulators would be given broad powers to make rules governing the use of such powers. This would include rules governing who or which body can issue them and the circumstances in which the powers can be agreed or imposed.

Question 8-17: Should the statute require that any decision to use any power listed in provisional proposal 8-16 at the investigation stage must be made or approved by a formal committee or Fitness to Practise Panel? Alternatively, should the powers of the CHRE to refer decisions of Fitness to Practise Panels to the High Court be extended to cover consensual disposals?

Provisional Proposal 8-18: The Government should be given a regulation-making power to add new powers to those listed in provisional proposal 8-16, and to remove any powers.

Question 8-19: Does the language used in the proposed list of powers contained in provisional proposal 8-16 convey accurately their purpose?

Question 8-20: Is the use of mediation appropriate in the context of fitness to practise procedures?

Provisional Proposal 8-21: All regulators should be given rule and regulation-making powers to introduce a system of mediation if they wish to do so.

Provisional Proposal 8-22: The statute should provide for a right to initiate a review of an investigation decision in relation to decisions: (1) not to refer a case for an investigation following initial consideration; (2) not to refer the case to a Fitness to Practise Panel; (3) to issue a warning; or (4) to cease consideration of a case where undertakings are agreed.

Provisional Proposal 8-23: Anyone who has an interest in the decision should be able to initiate a review of an investigation decision, including but not limited to the Registrar, registrant, complainant and the CHRE.

Provisional Proposal 8-24: The grounds for a review of an investigation decision should be that new evidence has come to light which makes review necessary for the protection of the public or the regulator has erred in its administrative handling of the case and a review is necessary in the public interest.

Provisional Proposal 8-25: The statute should give the regulators broad rule and regulation-making powers on all aspects of the process for the review of an investigation decision, except those matters specified in provisional proposals 8-22, 8-23 and 8-24.

PART 9: FITNESS TO PRACTISE: ADJUDICATION

Question 9-1: Should the statute require the regulators to ensure that they establish a structure which is compliant with Article 6 of the European Convention on Human Rights without taking into account the role of the higher courts?

Question 9-2: Should the new legal framework ensure the separation of investigation and adjudication, and if so how?

Question 9-3: Should the statute allow for the option of the regulators' adjudication systems joining the Unified Tribunals Service?

Provisional Proposal 9-4: The statute should give all the regulators a broad power to establish rules for case management.

Provisional Proposal 9-5: The statute should provide that the overriding objective of the Civil Procedure Rules – that cases must be dealt with justly – is made part of the regulators' fitness to practise procedures.

Provisional Proposal 9-6: The statute should require each regulator to establish Fitness to Practise Panels of at least three members for the purpose of adjudication.

Provisional Proposal 9-7: The statute should: (1) require the regulators to establish a body which is responsible for all aspects of the Fitness to Practise Panel appointment process and which is separate from the Council; *and* (2) prohibit Council members and investigators from membership of Fitness to Practise Panels; *and* (3) require that each Fitness to Practise Panel must have a lay member.

Provisional Proposal 9-8: Other than on those matters specified in provisional proposals 9-6 and 9-7, the regulators should have broad powers to make rules on the constitution of their Fitness to Practise Panels.

Provisional Proposal 9-9: All regulators should be given broad rule-making powers on most procedural aspects of fitness to practise hearings.

Question 9-10: Should the statute require that fitness to practise hearings must take place in the UK country in which the registrant is situated or resides?

Provisional Proposal 9-11: The statute should apply the civil rules of evidence to fitness to practise hearings. The relevant rules should be those that apply in the part of the UK in which a hearing takes place.

Provisional Proposal 9-12: Fitness to Practise Panels should be able to admit evidence which would not be admissible in court proceedings if the admission of such evidence is fair and relevant to the case.

Provisional Proposal 9-13: The statute should require the civil standard of proof in fitness to practise hearings.

Provisional Proposal 9-14: The statute should require that all fitness to practise hearings must be held in public unless one or more of the exceptions in the Civil Procedure Rules apply.

Provisional Proposal 9-15: The statute should provide that a witness is eligible for assistance if under 17 at the time of the hearing if the Panel considers that the quality of evidence given by the witness is likely to be diminished as a result of mental disorder, significant impairment of intelligence and social functioning, physical disability or physical disorder. In addition, a witness is should be eligible for assistance if the Panel is satisfied that the quality of the evidence given by the witness is likely to be diminished by reason of fear or distress in connection with testifying in the proceedings.

Question 9-16: Should the statute provide for special measures that can be directed by the Panel in relation to witnesses eligible for assistance, such as screening witnesses from the accused, evidence by live link, evidence in private, video recoded evidence, video cross examination, examination through intermediary, and aids to communication?

Provisional Proposal 9-17: The statute should require the regulators to establish a system for imposing and reviewing Interim Orders.

Provisional Proposal 9-18: The statute should require each regulator to establish panels of at least three members for interim order hearings (including a lay member). In addition, Interim Order panels must be appointed by a body which is separate to the Council and there would be a prohibition of Council members and investigators from sitting on such Panels.

Question 9-19: Should the statute prohibit Interim Order Panellists sitting on a Fitness to Practise Panel (either in relation to the same case or more generally)?

Provisional Proposal 9-20: The test for imposing an Interim Order should be that it is necessary to protect, promote and maintain the health, safety and well-being of the public (and maintain confidence in the profession).

Provisional Proposal 9-21: On all procedural matters in relation to Interim Order hearings (except for those specified in provisional proposal 9-18) the regulators should have broad rule-making powers.

Question 9-22: Should the statute guarantee the right of registrants to give evidence at Interim Order hearings?

Provisional Proposal 9-23: The right of appeal against an Interim Order should continue to be to the High Court in England and Wales, the Court of Session in Scotland and the High Court in Northern Ireland.

Provisional Proposal 9-24: All Fitness to Practise Panels should have powers to impose the following: (1) erasure from the register; (2) suspension; (3) conditions; and (4) warnings.

Provisional proposal 9-25: The Government should be given a regulation-making power to introduce systems of financial penalties and cost awards.

Provisional Proposal 9-26: All Fitness to Practise Panels should have powers to agree undertakings and voluntary erasure.

Provisional Proposal 9-27: The regulators should have powers to introduce immediate orders (or use Interim Orders for this purpose).

Provisional Proposal 9-28: The test for imposing any of the sanctions listed in provisional proposal 9-24 and consensual disposals in 9-26 should be to protect, promote and maintain the health, safety and well-being of the public (and maintain confidence in the profession).

Provisional Proposal 9-29: The regulators should be given broad powers to make rules in relation to the sanctions listed in provisional proposal 9-24 and consensual disposals in provisional proposal 9-26.

Provisional Proposal 9-30: The Government should be given a regulation-making power to add new sanctions and consensual disposals to those listed in provisional proposals 9-24 and 9-26, and to remove any sanctions and consensual disposals.

Question 9-31: Does the language used in the proposed list of sanctions and consensual disposals contained in provisional proposals 9-24 and 9-26 convey accurately their purpose?

Provisional Proposal 9-32: The statute should require all the regulators to establish a system of review hearings for conditions of practise and suspension orders. In addition, the regulators should have powers but would not be required to establish review hearings for warnings and undertakings.

Provisional Proposal 9-33: The regulators should have broad rule-making powers to establish the procedures for review hearings.

Question 9-34: Should the regulators be given an express power to quash or review the decision of a Fitness to Practise Panel where the regulator and the relevant parties agree that the decision was unlawful? If so, should complainants and other interested parties be able to prevent or contribute to any decision to use this power?

Provisional Proposal 9-35: All professionals should continue to have a right of appeal against the decision of a Fitness to Practise Panel to the High Court in England and Wales, the Court of Session in Scotland and the High Court in Northern Ireland.

PART 10: THE COUNCIL FOR HEALTHCARE REGULATORY EXCELLENCE

Question 10-1: How effective is the CHRE in performing the role of scrutinising and overseeing the work of the regulators?

Provisional Proposal 10-2: The current powers and roles of the CHRE (including those introduced by the Health and Social Care Bill 2011) should be maintained in as far as possible.

Provisional Proposal 10-3: Appointments to the CHRE's General Council should be made by the Government and by the devolved administrations. Appointments would be made in accordance with the standards for appointments to the health and social care regulators made by the CHRE.

Provisional Proposal 10-4: The CHRE's general functions should be retained, but modernised and reworded where appropriate.

Question 10-5: Is the CHRE's power to give directions still necessary?

Provisional Proposal 10-6: The existing power for Government to make regulations for the investigation by the CHRE into complaints made to it about the way in which a regulator has exercised its functions should be retained.

Question 10-7: Should the CHRE's power to refer cases to the High Court in England and Wales, the Court of Session in Scotland and the High Court in Northern Ireland: (1) be retained and exercised alongside a regulator's right of appeal, in cases when the regulator's adjudication procedure is considered to be sufficiently independent; *or* (2) be removed when a regulator's right of appeal is granted in such circumstances; *or* (3) be retained and rights of appeal should not be granted to regulators, although regulators should have a power to formally request the CHRE to exercise its power?

PART 11: BUSINESS REGULATION

Question 11-1: To what extent does regulation in a commercial context make a difference to how the regulators approach the task of professional regulation and does the law provide adequately for professional regulation in a commercial context?

Provisional Proposal 11-2: The statute should retain the existing premises regulation regimes of both the General Pharmaceutical Council and the Pharmaceutical Society of Northern Ireland.

Question 11-3: Are any further reforms needed to the premises regulation regimes of the General Pharmaceutical Council and the Pharmaceutical Society of Northern Ireland?

Question 11-4: Should the statute retain the existing systems for the regulation of bodies corporate?

Question 11-5: Should the regulators have powers to finance or establish a complaints service?

Provisional Proposal 11-6: The Government should be given a regulation-making power to extend to any regulator the powers given to the General Pharmaceutical Council or the General Optical Council to regulate businesses.

PART 12: OVERLAP ISSUES

Question 12-1: How could the legal framework establish clearer interfaces between the various regulatory systems?

Question 12-2: What practical difficulties arise as a result of parallel criminal and fitness to practise proceedings?

Question 12-3: What are the practical and legal difficulties associated with joint working?

Provisional Proposal 12-4: The statute should include a permissive statement to the effect that each regulator may carry out any of its functions in partnership with another organisation.

Provisional Proposal 12-5: The statute should enable formal partnership arrangements to be entered into between any regulator and one or more other organisations (including the other professional regulators) in relation to the exercise of their statutory functions. The statute should provide that any such arrangements do not affect the liability of the regulator for the exercise of any of its statutory functions.

Provisional Proposal 12-6: The statute should impose a general duty on each regulator to make arrangements to promote cooperation with other relevant organisations or other persons, including those concerned with the:

(1) employment of registrants;

(2) education and training of registrants;

(3) regulation of other health or social care professionals;

(4) regulation of health or social care services; and

(5) provision/supervision/management of health or social care services.

Question 12-7: Should the statute specify or give examples of the types of arrangements that could be made under provisional proposal 12-6?

Provisional Proposal 12-8: The statute should impose a specific duty to cooperate, which would apply when the regulator in question is:

(1) considering registration applications and renewals;

(2) undertaking the approval of education and training;

(3) ensuring proper standards of practice and conduct; and

(4) undertaking an investigation into a registrant's fitness to practise.

This duty would apply to the same list of organisations and persons contained in provisional proposal 12-6. The requested authority would be required to give due consideration to any such request made by the regulator, and if it refuses to cooperate, must give written reasons.

Question 12-9: Are there any other circumstances in which the specific duty to cooperate contained in provisional proposal 12-8 should apply?

PART 13: CROSS BORDER ISSUES

Provisional Proposal 13-1: The statute should require the regulators to specify in rules which qualifications would entitle an applicant to be registered, including overseas qualifications.

Provisional Proposal 13-2: The default powers of the Government should include the ability to intervene in cases where there is likely to be or has been a failure to implement the Qualifications Directive properly.

Provisional Proposal 13-3: The statute should include broad powers for the regulators to register those from non-EEA countries, including powers to set requirements as to the language, practice and education requirements.

Question 13-4: Would there be benefits in the same regulatory arrangements applying in the Channel Islands and the Isle of Man? If so, would the best way to achieve this be parallel legislation or a single statute?

Question 13-5: How could the new legal framework address the interface between the regulatory systems in the UK and the Channel Islands and the Isle of Man?

Provisional Proposal 13-6: The regulators should be given an express power to approve and accredit overseas education institutions and courses and issue rules and guidance for the purpose of such activity.

Question 13-7: What are the practical difficulties which arise as a result of the requirement to quality assure UK qualifications which are awarded by institutions based overseas?

Question 13-8: How might our statute enable the regulators to manage the issues that arise from distance service provision?

APPENDIX B
MAIN DUTIES OF THE REGULATORS

GENERAL CHIROPRACTIC COUNCIL

It shall be the duty of the General Council to develop and regulate the profession of chiropractic.[1]

GENERAL DENTAL COUNCIL

N/A

GENERAL MEDICAL COUNCIL

The main objective of the General Council in exercising their functions is to protect, promote and maintain the health and safety of the public.[2]

GENERAL OPTICAL COUNCIL

The main objective of the Council in exercising such of the Council's functions as affect the health and safety of members of the public is to protect, promote and maintain the public's health and safety.[3]

GENERAL OSTEOPATHIC COUNCIL

It shall be the duty of the General Council to develop and regulate the profession of osteopathy.[4]

GENERAL PHARMACEUTICAL COUNCIL

The main objective of the Council (including its staff and committees) in exercising such of its functions as affect the health, safety or well-being of members of the public is to protect, promote and maintain the health, safety and well-being of members of the public, and in particular of those members of the public who use or need the services of registrants, or the services provided at a registered pharmacy, by ensuring that registrants, and those persons carrying on a retail pharmacy business at a registered pharmacy, adhere to such standards as the Council considers necessary for the safe and effective practice of pharmacy.[5]

1 Chiropractors Act 1994, s 1(2).

2 Medical Act 1983, s 1(1A).

3 Opticians Act 1989, s 1(2A).

4 Osteopaths Act 1989, s 1(2).

5 Pharmacy Order 2010, SI 2010 No 231, art 6(1).

GENERAL SOCIAL CARE COUNCIL

It shall be the duty of the Council to promote high standards of conduct and practice among social care workers; and high standards in their training.[6]

It shall be is the duty of the Council to carry out its functions effectively, efficiently and economically.[7]

HEALTH PROFESSIONS COUNCIL

The main objective of the Council in exercising its functions shall be to safeguard the health and well-being of persons using or needing the services of registrants.[8]

NURSING AND MIDWIFERY COUNCIL

The main objective of the Council in exercising its functions shall be to safeguard the health and well-being of persons using or needing the services of registrants.[9]

PHARMACEUTICAL SOCIETY OF NORTHERN IRELAND

The objects of the Society shall be to:

(a) advance chemistry and pharmacy;

(b) promote pharmaceutical education and the application of pharmaceutical knowledge;

(c) maintain the honour and safeguard and promote the interests of the members of the Society in their exercise of the profession of pharmacy;

(d) provide relief for distressed persons including members, former members, surviving partners and orphans.[10]

COUNCIL FOR HEALTHCARE REGULATORY EXCELLENCE

The main objective of the Council is to promote the health, safety and well-being of patients and other members of the public.[11]

6 Care Standards Act 2000, s 54(2).

7 Care Standards Act 2000, sch 1, para 4.

8 Health Professions Order 2001, SI 2002 No 254, art 3(4).

9 Nursing and Midwifery Order 2001, SI 2002 No 253, art 3(4).

10 Pharmacy (Northern Ireland) Order 1976, SI 1976 No 1213, art 3(3).

11 NHS Reform and Health Care Professions Act 2002, s 25(2A).

APPENDIX C
STATUTORY COMMITTEES

GENERAL CHIROPRACTIC COUNCIL

(1) Education Committee

(2) Health Committee

(3) Investigating Committee

(4) Professional Conduct Committee

GENERAL DENTAL COUNCIL

(1) Health Committee

(2) Interim Orders Committee

(3) Investigating Committee

(4) Professional Performance Committee

(5) Professional Conduct Committee

(6) Registration Appeals Committee

GENERAL MEDICAL COUNCIL

(1) Fitness to Practise Panel(s)

(2) Interim Orders Panel(s)

(3) Investigation Committee

(4) Registration Appeals Panel(s)

(5) Registration Panel(s)

GENERAL OPTICAL COUNCIL

(1) Companies Committee

(2) Education Committee

(3) Fitness to Practise Committee

(4) Hearings Panel

(5) Investigation Committee

(6) Registration Committee

(7) Registration Appeals Committee

(8) Standards Committee

GENERAL OSTEOPATHIC COUNCIL

(1) Education Committee

(2) Health Committee

(3) Investigating Committee

(4) Professional Conduct Committee

GENERAL PHARMACEUTICAL COUNCIL

(1) Appeals Committee

(2) Investigating Committee

(3) Fitness to Practise Committee

GENERAL SOCIAL CARE COUNCIL

(1) Conduct Committee

(2) Preliminary Proceedings Committee

(3) Restoration Committee

HEALTH PROFESSIONS COUNCIL

(1) Conduct and Competence Committee

(2) Education and Training Committee

(3) Health Committee

(4) Investigating Committee

NURSING AND MIDWIFERY COUNCIL

(1) Conduct and Competence Committee

(2) Health Committee

(3) Investigating Committee

(4) Midwifery Committee

PHARMACEUTICAL SOCIETY OF NORTHERN IRELAND

(1) Statutory Committee (which is the equivalent of a Fitness to Practise Committee)

(2) Scrutiny Committee (which is the equivalent of an Investigation Committee)

APPENDIX D
PROTECTED TITLES

GENERAL CHIROPRACTIC COUNCIL

(1) Chiropractic

(2) Chiropractic practitioner

(3) Chiropractitioner

(4) Chiropractic physician

(5) Any other kind of chiropractor

GENERAL DENTAL COUNCIL

(6) Dentist

(7) Dental surgeon

(8) Dental practitioner

(9) Clinical dental technician

(10) Clinical dental technologist

(11) Denturist

(12) Dental nurse

(13) Dental surgery assistant

(14) Dental technician

(15) Dental technologist

(16) Orthodontic therapist

(17) Orthodontic auxiliary

(18) Dental hygienist

(19) Dental therapist

GENERAL MEDICAL COUNCIL

(20) Physician

(21) Doctor of medicine

(22) Licentiate in medicine and surgery

(23) Bachelor of medicine

(24) Surgeon

(25) General practitioner

(26) Apothecary

(27) Titles implying GMC registration

GENERAL OPTICAL COUNCIL

(28) Optometrist

(29) Dispensing optician

GENERAL OSTEOPATHIC COUNCIL

(30) Osteopath

(31) Osteopathic practitioner

(32) Osteopathic physician

(33) Osteopathist

(34) Any other kind of osteopath

GENERAL PHARMACEUTICAL COUNCIL

(35) Pharmacist

(36) Pharmacy technician

GENERAL SOCIAL CARE COUNCIL

(37) Social worker

HEALTH PROFESSIONS COUNCIL

(38) Art psychotherapist

(39) Art therapist

(40) Drama therapist

(41) Music therapist

(42) Biomedical scientist

(43) Chiropodist

(44) Podiatrist

(45) Clinical scientist

(46) Dietician

(47) Occupational therapist

(48) Operating department practitioner

(49) Orthoptist

(50) Paramedic

(51) Physiotherapist

(52) Physical therapist

(53) Practitioner psychologist

(54) Registered psychologist

(55) Clinical psychologist

(56) Educational psychologist

(57) Forensic psychologist

(58) Occupational psychologist

(59) Sport and exercise psychologist

(60) Health psychologist

(61) Counselling psychologist

(62) Prosthetist

(63) Orthotist

(64) Radiographer

(65) Diagnostic radiographer

(66) Therapeutic radiographer

(67) Speech and language therapist

(68) Speech therapist

NURSING AND MIDWIFERY COUNCIL

(69) Registered nurse

(70) Midwife

PHARMACEUTICAL SOCIETY OF NORTHERN IRELAND

(71) Pharmacist

APPENDIX E
PROTECTED FUNCTIONS

General Dental Council

The Dentists Act 1984 prevents a person who is not a dentist or a registered dental care professional from practising dentistry. Dentistry is defined as including the performance of any such operation and the giving of any such treatment, advice or attendance as is usually performed or given by dentists. This includes anything done in connection with the fitting, insertion or fixing of dentures, artificial teeth or other dental appliances.[1]

General Medical Council

The Medical Act 1983 provides for certain privileges of registered practitioners. These are: an entitlement to recover fees for attending or giving medical advice in a court of law or the performance of any operation; the authority to hold an appointment as a physician, surgeon or other medical officer in the navy, military or air service, in a mental hospital, in a prison or in any other public body, institution or society for providing relief in sickness infirmity or old age; the validation of certificates which are required to be signed by a physician, surgeon, licentiate in medicine and surgery or other medical practitioner.[2]

General Optical Council

The Opticians Act 1989 regulates certain functions in relation to registered medical practitioners, optometrists and dispensing opticians. Only registered medical practitioners and optometrists can test the sight of another person. Only registered medical practitioners, optometrists and dispensing opticians can fit contact lenses. The sale and supply of optical appliances can only occur under the supervision of a registered medical practitioner, an optometrist or a dispensing optician.[3]

Health Professions Council

The Health Professions Order 2002 provides that a person who is not a registered hearing aid dispenser must not perform the functions of a registered hearing aid dispenser. The functions include the assessing or testing of an individual's hearing or prescribes a hearing aid with a view to sale.[4]

Nursing and Midwifery Council

The Nursing and Midwifery Order 2002 provides that no-one except a registered midwife or a registered medical practitioner shall attend a woman in childbirth.[5]

1 Dentists Act 1984, ss 37 and 38.

2 Medical Act 1983, ss 46 to 48.

3 Opticians Act 1989, ss 25 to 25, and 27.

4 Health Professions Order 2001, SI 2002 No 254, art 39A and sch 3, para 1A.

5 Nursing and Midwifery Order 2001, SI 2002 No 253, art 45.