Department of Health & Social Care

Regulating healthcare professionals, protecting the public

Executive Summary

Background

1. The case for reforming professional regulation has long been acknowledged. The UK model of regulation for healthcare professionals is rigid, complex and needs to change to better protect patients, support our health services and to help the workforce meet future challenges. In doing so, it needs to be faster, fairer, more flexible and minimise costs to registrants.

2. In 2014, the Law Commissions of England and Wales, Scotland and Northern Ireland published a comprehensive review of the legal framework for professional regulation in the UK. The reforms recommended by the Law Commissions aimed to consolidate and simplify the existing legal framework and introduce greater consistency across the regulatory bodies. In addition, they recommended that the regulators should be given powers to make rules concerning their procedures and processes which are not subject to approval by Government or any Parliamentary procedure.

3. In 2017, the UK Government and devolved administrations consulted on options for reforming the regulation of healthcare professionals in the UK. Promoting professionalism; reforming regulation set out five objectives for the regulatory system to:

    - improve public protection from the risk of harm due to poor professional practice;

    - support the development of a flexible workforce that is better able to meet the challenges of delivering healthcare in the future;

- address concerns about the performance of professionals in a more proportionate and responsive fashion;

- provide greater support to regulated professionals in delivering high quality care; and

- increase the efficiency of the system.

4. In July 2019 the Government published its response to this consultation. This built on the Law Commissions' recommendations and outlined our planned programme of work to provide all UK healthcare regulators with broadly consistent powers. We are now consulting on detailed policy proposals to modernise each of the healthcare professional regulators' legislative frameworks.

5. A number of reports have been published in recent years that have had a particular bearing on proposals for the future of professional regulation of healthcare professionals in the UK. The recommendations from these reports have been considered and reflected in our proposed reforms.

Reports reflected in proposed reforms – table 1

Report/Inquiry	Summary
The Francis inquiry report - Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Feb 2013)	Looked into the serious failings at the Mid Staffordshire NHS Foundation Trust. This inquiry examined the operation of the commissioning, supervisory and regulatory organisations and other agencies, including the culture and systems of those organisations in relation to their monitoring role at Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009, and examined why problems at the Trust were not identified sooner and appropriate actions taken. One of the issues that the inquiry highlighted was that the regulatory regime allowed for overlap of functions that led to a tendency for regulators to assume that the identification and resolution of issues was the responsibility of someone else. Effective accountability to the public demands a simpler regime of regulation.

Lessons Learned Review into the Nursing and Midwifery Council's (NMC) handling of concerns about midwives' fitness to practise at Furness General Hospital (May 2018)	An independent Investigation conducted by Dr Bill Kirkup CBE found serious concerns about the clinical competence and integrity of the midwifery unit at Furness General Hospital. In February 2017, the Secretary of State for Health asked the Professional Standards Authority for Health and Social Care (PSA) to undertake a 'lessons learned' review of the Nursing and Midwifery Council's (NMC) handling of concerns about midwives at the University Hospitals of Morecambe Bay NHS Foundation Trust. To identify lessons for the NMC (and other regulators) about its handling of these cases and its approach to relationships with witnesses and other stakeholders, the PSA looked at: • the NMC's approach to managing the complaints; • the administration of the cases; and • the relationship with witnesses, registrants and other key stakeholders.
Williams review – Gross negligence manslaughter in healthcare (June 2018)	In February 2018 the Secretary of State for Health announced a rapid policy review into gross negligence manslaughter in healthcare. The review was set up to consider the wider patient safety impact resulting from concerns among healthcare professionals that simple errors could result in prosecution for gross negligence manslaughter, even if they occur in the context of broader organisation and system failings. In particular, there was concern that these concerns had had a negative impact on healthcare professionals being open and transparent should they be involved in an untoward event, as well as on their reflective practice, both of which are vital to learning and improving patient care.
Paterson Inquiry (Feb 2020) Report of the Independent Inquiry into the Issues raised by Paterson	The Government commissioned this independent Inquiry to investigate the malpractice of surgeon Ian Paterson. The inquiry looked at a number of key issues including: • how and when information is shared between the NHS, independent sector, and others, including concerns raised about performance and patient

	safety; and • the arrangements for assuring that healthcare professionals maintain appropriate professional standards and competence, including appraisal, revalidation, scope of practice, and the role of hospital providers, professional and quality regulators, and other oversight bodies. The report recommended that the Government should ensure that the current system of regulation and the collaboration of the regulators serves patient safety as the top priority, given the ineffectiveness of the system identified in this Inquiry.
IMMDSR (Cumberlege) Review – July 2020 First Do No Harm, The report of the Independent Medicines and Medical Devices Safety Review	This Review examined how the healthcare system in England responds to reports about harmful side effects from medicines and medical devices and considered how to respond to them more quickly and effectively in the future.

The healthcare regulators

This document sets out proposed changes to the legislative framework of the following healthcare regulators.

Regulator	Governing Legislation
The General Chiropractic Council (GCC)	Chiropractors Act 1994
The General Dental Council (GDC)	Dentists Act 1984
The General Medical Council (GMC)	Medical Act 1983
The General Optical Council (GOC)	Opticians Act 1989
The General Osteopathic Council (GOsC)	Osteopaths Act 1993
The General Pharmaceutical Council (GPhC)	Pharmacy Order 2010
The Health and Care Professions Council (HCPC)	Health Professions Order 2001

The Nursing and Midwifery Council (NMC)	Nursing and Midwifery Order 2001
The Pharmaceutical Society of Northern Ireland (PSNI)	Pharmacy (Northern Ireland) Order 1976

6. In addition, since its introduction in 2013, the PSA's Accredited Registers programme has played an important role in the professional regulation continuum, providing a proportionate means of assurance for unregulated professions that sits between employer controls and statutory regulation. The programme currently includes 26 organisations covering 88,000 practitioners across a range of unregulated professions including public health, counselling and psychotherapy and health sciences. The accredited registers can be used by employers and members of the public to choose a practitioner to meet their needs and be assured that they are safe and competent to practise.

7. The PSA's accreditation assessment determines whether a voluntary register is well run - for example ensuring that registrants are required to meet high standards of personal behaviour, technical competence and, where relevant, business practice. Voluntary registers passing the PSA's assessment can use its quality mark and appear in its list of accredited registers. Between June 2020 and March 2021, the PSA carried out a strategic review of the accredited registers programme to evaluate the scope of the programme and identify how it can become more embedded within the wider healthcare regulatory and employment system.

Our approach to reform

8. When considering reforms to the regulator's legislation, we have followed a number of principles:

    - Public safety is paramount and at the heart of professional regulation;
    - Registrants' rights must remain protected;
    - The system should be able to respond to changing workforce models and developments in health and social care delivery without the need for ongoing legislative change;
    - Regulators should have broadly equivalent powers to maintain a level of consistency and effective public protection;

- Overly detailed legislation should be replaced; and
- Minimising the cost of regulation where possible, provided this is consistent with public protection.

9. The proposed reforms can be split into four key areas. These are:

- Governance and Operating Framework
- Education and Training
- Registration
- Fitness to practise

Governance and Operating Framework

10. Each regulator's legislation sets out how they should operate and what their governance structure is. The current legislation however is too detailed and can inhibit changes needed to respond quickly to new circumstances. In many cases, regulators cannot adapt and change their practices without legislative change, which is a lengthy process. To address this, we are proposing to devolve many of the decisions about day to day procedures to the regulators themselves, whilst ensuring that they continue to meet their overarching objective to protect the public. We also want to strengthen governance arrangements and propose that regulators' current two-tier Council structure is replaced with a unitary board, with regulators reporting annually to each of the UK Government and devolved administrations.

11. The statutory overarching objective of the healthcare professional regulators (excluding the PSNI but shared with the PSA) is to protect the public. This includes:

- To protect, promote and maintain the health, safety and well-being of the public;
- To promote and maintain public confidence in the professions; and
- To promote and maintain proper professional standards and conduct.

12. We do not propose to change these objectives. However, we are proposing that a consistent set of duties should supplement them to improve delivery of the objectives and promote a transparent and collaborative culture.

13. The duties are:

- A duty to co-operate;
- Specific duties in relation to transparency; and
- A duty to assess the proportionality of changes to rules and procedures before they are introduced.

14. We also want to ensure that regulators are equipped with the information they need to meet their statutory objectives and, as part of this, are able to collect, process and disclose relevant information to certain groups.

15. Regulators are self-funding through fees paid by registrants. To keep fees paid by registrants to a minimum, we propose that regulators are able to charge for services they undertake (in proportion to the work carried out), which can include work performed outside of their geographical remit.

16. We also want to make the way registrant fees are set consistent across the regulators. Four regulators are able to set their fees without any Parliamentary oversight and we propose the remaining regulators are given the same power.

17. Finally, the regulators are accountable to the Privy Council (apart from PSNI), and the PSA provides oversight of how they carry out their regulatory functions. The Privy Council has default powers to direct most of the regulators if they fail to deliver their objectives. However, this does not apply to the GDC and GPhC. We propose that the GDC and GPhC are included within the Privy Council's remit.

18. Where a regulator has a role in regulating businesses and premises, any changes to these functions will be considered and consulted on when our reforms are delivered into that regulator's legislation.

Education and Training

19. The regulators set the professional standards which registered professionals must meet. They also set standards relating to education and training. By assuring that these standards are met the regulators ensure that education and training providers deliver registrants who have the right behaviours and the skills, knowledge and experience needed to offer safe and effective care.

20. The education and training standards which regulators set include:

- requirements which learners must meet to enter courses or programmes of training – these provide assurance that only appropriate learners enter courses or programmes of training which lead to registration;

- standards for the outcomes of education and training – these provide assurance that people who complete courses have the necessary skills, knowledge and experience to provide safe and effective care; and

- standards which education and training providers must meet – these provide assurance that providers offer education and training which is best suited to deliver applicants to the register who are equipped to provide safe and effective care.

21. All of the regulators set standards for pre-registration education and training. The GDC, HCPC, GMC, GOC, GPhC and NMC also set additional standards for post-registration education and training.

22. As well as setting standards relating to education and training, the regulators ensure that these standards are met, through their approval and quality assurance of education and training. The GMC also approve postgraduate curricula. The approval and quality assurance of education and training is a vital part of the regulators' public protection role.

23. The proposals set out in this document aim to give regulators greater flexibility to determine how they set standards for, and quality assure, education and training. For example, on the proposal outlined several regulators would gain the power to set standards for and approve specific courses or programmes of training rather than just education and training providers. This builds on the Law Commissions' recommendation that regulators should have greater autonomy over how they regulate education, conduct and practice.[1] This flexibility will allow regulators to adapt to changes in the healthcare environment and to the changing needs of service users and the general public more quickly, providing ongoing assurance that newly qualified professionals are equipped to offer safe and effective care.

Registration

24. Registration refers to the compilation of a list of professionals who have satisfied a regulator that they are appropriately qualified, have the necessary knowledge, experience and skills and are capable of safe and effective practice. All regulators have a duty to keep a register or registers of the professionals they regulate and to

[1] See paragraph 6.13 of the Law Commissions' review of the legal framework for professional regulation in the UK.

make available parts of the register(s) to the public. A robust register is a fundamental part of how a regulator meets its objective to protect the public.

25. There is currently variation in the registration processes that the regulators operate. The changes set out in this document will provide all regulators with the same powers to carry out their registration function. In some areas, current differences will be retained. For example, some of the regulators' legislation, such as the Dentists Act and Opticians Act, contain offences in relation to protection of function in their legislation, whereas others relate solely to protection of title. We do not propose to change these offences.

Fitness to practise

26. Regulated professionals are required to demonstrate that they have the skills, knowledge and experience needed to practise their profession safely and effectively. They are also required to provide evidence or affirmation of their character and health.

27. Where a concern is raised about a professional, the relevant regulator has a duty to assess the concern, and, where necessary, to take action to protect the public. This could result in restrictions being applied to a professional's practice or, in the most serious cases, lead to their removal from the register.

28. Our proposed changes will enable the resolution of more case more quickly. This will deliver protection more quickly, and will also be better for registrants, employers, those who raise a concern about a registrant and the wider public. This change will also enable the regulators to focus more on supporting the professional standards of all registrants.

29. There is considerable variation in the fitness to practise powers currently available to the regulators. Our proposed changes will provide a consistent regulatory framework for fitness to practise across all the regulators.

Regulation of PAs and AAs

30. Strengthening the future NHS workforce is one of the Government's top priorities. The NHS has seen the emergence of new professional roles working within multi-disciplinary teams as part of a continuing drive to provide safe, accessible and high-quality care for patients across the UK. The growth of these professions, including Physician Associates (PAs) and Anaesthesia Associates (AAs), is central to the Government's commitment to develop a more effective, strong and expanding medical workforce to meet future need.

31. We are taking this opportunity to seek views on the introduction of PAs and AAs into statutory regulation by the GMC. Statutory regulation by the GMC will mean that anyone practising as a PA or AA must be registered with the GMC and will be subject to the relevant regulatory requirements. The GMC will be able to take action against individual PAs and AAs who seriously or persistently fall below those standards.

32. Regulation is a significant step towards embedding PAs and AAs in the multi-disciplinary healthcare workforce.

Consultation

33. This document seeks your views on our proposed approach to modernising the legislation of the regulatory bodies.

34. These proposals have been developed in partnership with the professional regulatory bodies, the Professional Standards Authority for Health and Social Care (PSA) and tested with key stakeholders across the health and care system. On a minority of proposals there is a range of views on the preferred approach.

35. Our aim is to put in place a legal framework, which supports responsive and accountable regulation by providing the regulators with greater flexibility and autonomy to set out their operating processes through rules and guidance.

36. Where legislation is overly prescriptive, this will be replaced with more flexible powers that will enable regulators to adapt their operating procedures more efficiently and effectively. This will provide regulators with greater ability to react to unexpected challenges, such as the recent Covid-19 emergency, or to emerging workforce requirements without the need for further legislation.

37. These changes will also put in place safeguards to ensure that regulators work in partnership with each other and with other system partners and operate as part of the wider healthcare system with public safety at the heart of everything that they do.

38. One of the key changes our reforms will deliver will be to modernise the regulators' fitness to practise processes, which will enable the safe and quick conclusion of many cases without the need for expensive and lengthy panel hearings. This will enable the regulators to better support the professionalism of all of their registrants.

39. This consultation sets out our detailed policy proposals for legislative change that will apply to all of the regulators. We intend to implement these changes for each of the healthcare professional regulators through secondary legislation made under Section 60 of the Health Act 1999.

40. This process will start with the introduction of changes to the legislative framework for the General Medical Council, which will also bring into regulation the Physician Associate and Anaesthesia Associate professions. This will be followed by changes to the legislation of the other healthcare regulators.

41. While we are required to hold a public consultation on all draft secondary legislation made using the Section 60 powers, we are taking this opportunity to seek views on the proposals that will, in due course, apply to all the professional regulators and all regulated healthcare professionals.

1. Governance and Operating Framework

Introduction

42. The Governance and Operating Framework is the legal basis which underpins the operation of the health and care professional regulators.

43. This includes the regulators' objectives, the powers that they have to deliver these objectives and the duties that they must meet in doing so. It also includes the accountability and oversight arrangements to ensure that the regulators operate effectively.

44. The legislation that sets out these arrangements varies from regulator to regulator and in many cases is inflexible. This can restrict the regulators' ability to make even simple changes to their day-to-day practice. Statutory requirements to consult and the time taken for the Parliamentary process means that it can take up to two years to implement even relatively small changes. This restricts how the regulators can adapt to changing circumstances.

45. We propose to provide all the regulators with a similar governance and operating framework which balances greater flexibility with effective oversight. Regulators will be provided with powers to set more of their own operating procedures through rules or guidance that do not require the approval of Parliament or the Privy Council.

46. The Professional Standards Authority for Health and Social Care (PSA) will continue to oversee the regulators' performance through its annual reporting cycle, and the Privy Council will retain its power to direct a regulator where the regulator has failed to perform a statutory function.

47. Providing the regulators with greater responsibility for their day to day processes poses a risk that different bodies may take different approaches. In some instances, this may be justified. However, we expect the regulators to continue to work together to develop a common framework of governance and operating rules.

48. These greater freedoms must be balanced with strengthened governance arrangements. We propose that the current Council structure be replaced by a unitary board and that greater accountability to the UK Government and devolved administrations is put in place.

49. The following sections set out:

- Section 1a – Changes to the Governance and Operating Framework, including:

    - The duties of regulators in delivering their objectives;
    - The unitary board;
    - Fee setting arrangements; and
    - Committees, charging for services, power to delegate and data handling; and

- Section 1b – Accountability of the regulators to the UK Government and devolved administrations and the role of the Privy Council.

1a. – Changes to the Governance and Operating Framework

50. The statutory overarching objective of the healthcare professional regulators (excluding the PSNI but shared with the Professional Standards Authority) is to protect the public. This includes:

    - To protect, promote and maintain the health, safety and well-being of the public;
    - To promote and maintain public confidence in the professions; and
    - To promote and maintain proper professional standards and conduct.

51. These objectives will be supplemented by a new set of duties that the regulators must meet in carrying out their regulatory functions.

52. These are:

    - a duty to co-operate;
    - specific duties in relation to transparency; and
    - a duty to assess the proportionality of changes to rules and procedures.

Duty to co-operate

53. Recent reports, such as the Gosport Inquiry and Morecambe Bay Inquiry recommended that regulators work closely with one another and the broader health and care system to provide better public protection.

54. Most regulators are already under a duty to co-operate with other regulators, such as the Care Quality Commission in England, the Regulation and Quality Improvement Authority in Northern Ireland, Healthcare Improvement Scotland and Healthcare Inspectorate Wales.

55. However, this is set out in different ways in legislation.

56. We propose that a new duty to cooperate should apply to all of the regulators. This would place them under a duty to cooperate with organisations that are concerned with:

- the regulation of healthcare professionals;
- the employment, education and training of healthcare professionals;
- the regulation of health and care services; and
- the provision of health and care services.

1. Do you agree or disagree that regulators should be under a duty to co-operate with the organisations set out above? Please give a reason for your answer.

Objective of transparency and related duties

57. Transparency is key to ensuring that regulators maintain public confidence in the regulation of healthcare professionals. Under their current legislation, regulators are generally required to carry out activities such as Council meetings and Fitness to Practise (FtP) hearings in public to ensure transparency, unless it is not in the public interest to do so, for example if there are commercial sensitivities, data protection or confidentiality issues.

58. The PSA's Lessons Learned Review into the NMC's handling of fitness to practise cases at Furness General Hospital emphasised the importance of regulators dealing sensitively with complainants, being open and honest in engaging with patients and service users and being open about their processes.

59. We propose that regulators should have an objective to be transparent when carrying out their functions. They will also have duties to:

- publish information relating to regulatory functions on an annual basis;
- hold open Board meetings (unless confidential matters are being discussed);

- hold hearings in public (unless confidential matters are being discussed);
- make records of board meetings and hearings available to the public (but not in relation to confidential matters); and
- consult on significant changes to rules and standards.

2. Do you agree or disagree that regulators should have an objective to be transparent when carrying out their functions and should have these related duties? Please give a reason for your answer.

Duty to assess the proportionality of changes

60. The Regulatory Policy Committee's Better Regulation Framework paper sets out the Government's expectation that proportionality is integral to effective regulation.

61. Changes to regulators' policies or processes can have a significant impact on patients, service users, registrants, employers, and education and training providers. Regulators should evaluate the impact that changes to their rules, processes and systems will have.

62. We propose to introduce an explicit duty for regulators to assess the impact of changes to their rules, processes and systems before they are introduced.

63. Regulators will need to assess the impact, including the cost, on:

- patients, service users and the public;
- current and prospective health and care professionals; and
- other relevant stakeholders across the health and care system.

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

Unitary Board

64. Regulators currently operate under a two-tier governance structure comprising:

- a General Council, which is responsible for setting the strategic direction of the regulator and having oversight of the executive; and

- an Executive, which is responsible for implementing the strategic direction set by the Council and overseeing the day-to-day running of the regulator.

65. Promoting professionalism, reforming regulation proposed that the current Council structure be replaced by a modernised governance structure. This was supported by 63 per cent of respondents. The response to the consultation set out that the councils of the regulatory bodies would become boards which comprise of executive and non-executive directors, appointed on the basis that they have the skills, knowledge and expertise to ensure the regulator discharges its functions effectively. The non-executive directors will always form the majority of the board. Current and former registrants may be appointed to the board, but they will not form a majority.

66. These new unitary board arrangements will be put in place over two years following legislative change for each regulator, although the Chief Executive/Registrar will sit as a board member with immediate effect.

67. We propose that appointments to the Board are made as follows:

- The non-executive Chair will continue to be appointed by the Privy Council[2];

- Non-Executive Directors will be appointed by the Chair and approved by the Privy Council;

- The Chair and Non-Executive Directors will appoint the Chief Executive and other Executive members to the board.

68. Regulators will set the detail of the Board structure in rules. These must meet the following parameters:

- Each board must include, as a minimum, a non-executive Chair, a Chief Executive, and a Non-Executive Director and have a maximum of 12 members, with non-executive members forming the majority of the board;

- The Chair and Non-Executive Directors must not hold office for more than eight years during any 20-year period for each role they hold;

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[2] or in the case of PSNI will be appointed by the Minister of Health, Northern Ireland

- At least one board member must wholly or mainly work or live in each of the countries in the UK in which the regulator operates – this requirement may be waived with the written consent of the regulator and the relevant country's Minister; and

- Current and former registrants[3] may be appointed to the board (as either executive or non-executive directors) but should not make up more than half of the board members at any time.

69. While regulators will still be able to appoint current or former registrants to their boards, members will still be appointed on merit and there will no longer be a requirement to appoint professional and lay members.

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

Fees and Charging

70. Regulators are funded by fees charged to their registrants. This is central to ensuring their independence from government.

71. Four regulators (the GMC, GDC, GOC and the GPhC) can set registrant fees without any Parliamentary oversight. The remaining regulators can only implement fee changes with the approval of the Privy Council and, in some cases, of the Scottish Parliament.

72. We propose that all regulators should be able to set their fees in rules without Parliamentary oversight. This will make regulators directly accountable to registrants for the fees that they charge. Some regulators that set their own fees have recently introduced reductions in registrant fees. For example, the GMC lowered fees in 2013 and 2018, and the GDC did so in 2019.

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[3] Registrants in this regard will include those who qualify for registration but have never in fact registered and those who have registered with equivalent organisations abroad. For example, someone who is a qualified optician and eligible for registration but never registered with the GOC, or a chiropractor who has worked in France but has never been registered with the GCC would both be regarded as a "registrant" for the purposes of their application.

73. Regulators will be able to set out a longer-term approach to fees, for example setting out a mechanism for the calculation of fees over a number of years. Any fee changes, including those to put in place a longer-term approach, would require consultation. Any changes that were consistent with a longer-term approach would not need to be consulted on.

5. Do you agree or disagree that regulators should be able to set their own fees in rules without Privy Council approval? Please give a reason for your answer

6. Do you agree or disagree that regulators should be able to set a longer-term approach to fees? Please give a reason for your answer.

Committees

74. Current legislation requires each regulator to have a number of committees with specific functions, such as investigations, education standards, registration and fitness to practise. There is little consistency in what statutory committees are required across the regulators, and there is no single committee which is common to all regulators.

75. The Law Commissions recommended that legislation should not specify which committees' regulators have. They recommended that the regulators should be able to establish which committees they require rather than this being set out in legislation.

76. We propose to remove the requirement for regulators to set up specific committees, with all regulators having the power to establish their own committee structure.

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

Charging for services

77. Although regulators are self-funded through the fees paid by registrants, they are not all able to charge for the services they provide to third parties.

78. For example, they cannot charge for the initial assessment of a new application for approval of an education institution or qualification. The cost of assessing these applications is met by the regulator and passed on to registrants.

79. Regulators are also not able to charge overseas education institutions for the assessment, monitoring or approval of that institution and its qualifications. Some UK

medical schools deliver medical degrees outside of the UK, but the GMC is not able to charge a fee for the approval of these courses. We propose to remove such restrictions and enable regulators to set out in rules charges for services they undertake. It would not be permitted to charge for services in respect of fitness to practise functions. Any fees must only cover the costs of the activity carried out.

8. Do you agree or disagree that regulators should be able to charge for services undertaken on a cost recovery basis, and that this should extend to services undertaken outside of the geographical region in which they normally operate? Please give a reason for your answers.

Power to delegate

80. The regulators deliver similar functions in relation to the professions that they regulate. The extent to which these functions can be delegated to another body varies, as does the extent to which a regulator can carry out functions on behalf of another body. The HCPC, for example, can both delegate to, and carry out functions on behalf of, another body. Whereas the GMC cannot do either.

81. We propose that all regulators are provided with a power to:

- delegate the performance of their functions to any other regulator or third party; and
- carry out regulatory functions which have been delegated to them.

82. Where a regulator delegates the performance of a function or part of a function to a third party, it will retain responsibility for the delivery of that function.

83. This will allow the regulators to work together more closely where it is appropriate for them to do so. For example, a number of regulators separately accredit the same training programmes in relation to prescribing. Using delegation powers, a single regulator could approve a prescribing course for several professions across several regulators, reducing duplication and improving consistency.

84. Regulators are not currently permitted to delegate the following functions:

- the holding of a register;
- determining standards of education and training for registration;

- providing advice about standards of conduct and performance; and
- administering procedures relating to misconduct and unfitness to practise.

85. The Working together to improve health and social care for all White Paper set out the Government's intention to remove these exclusions. In these areas, the functions could only be delegated to another regulator and not to a third party.

9. Do you agree or disagree that regulators should have the power to delegate the performance of a function to a third party including another regulator? Please give a reason for your answer.

Data handling, sharing and collection

86. Regulators have a variety of powers and duties relating to receiving and sharing information. Where they share or receive information, this must be done in accordance with data protection legislation.

87. Regulators generally already have the power to require information relating to fitness to practise cases. However, these powers do not extend to their other functions. For example, the GMC has been unable to obtain information about the progress of medical students. Information about the progress of medical students would allow research into undergraduate education.

88. Providing the regulators with a power to require other regulators and external bodies to share data, and for regulators to share information with other bodies, will enable them to better fulfil their public protection role.

89. We propose to provide regulators with the power to obtain, process and disclose information to or from any organisation or person where it is required to fulfil their statutory objectives. This will include:

- another regulator (including health and care system regulators) and the Professional Standards Authority;
- education and course commissioning bodies and providers;
- professional bodies;
- bodies representing students and registrants;
- employers and contractors of services;

- law enforcement bodies; and
- government agencies including those in Wales, Scotland and NI where appropriate.

10. Do you agree or disagree that regulators should be able to require data from and share data with those groups listed above? Please give a reason for your answer.

1b. – Further reforms and details

Accountability to the UK Government and Devolved Administrations

90. It is important that regulators are accountable to each of the countries in which they operate. Currently:

- the UK Parliament is responsible for the regulation of health and care professions in England and Wales;
- Regulation of health and care professionals is a devolved matter in Northern Ireland; and
- Regulation is devolved to Scotland for health professionals which entered regulation after the passing of the Scotland Act 1998.[4]

91. All of the regulators (other than PSNI) have to present an annual report to the Privy Council setting out how they carry out their statutory functions. We propose that regulators should also be required to provide an annual report to the legislature of each country in which they operate.

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[4] The following bodies regulate professions that have entered regulation since 1998 and therefore devolved to Scotland:

- Health and Care Professions Council - operating department practitioners (ODP), practitioner psychologists
- General Dental Council - dental nurses, dental technicians, clinical dental technicians, orthodontic therapists
- General Pharmaceutical Council - pharmacy technicians

11. Do you agree or disagree that regulators should produce an annual report to the Parliament of each UK country in which they operate? Please give a reason for your answer.

Powers of the Privy Council

92. The Privy Council has a power to direct most of the regulators where they have failed to carry out their statutory functions, using what are called ‘default powers’. While these powers have never been used, they provide a mechanism to ensure public protection.

93. These default powers do not apply to the GDC and GPhC. We propose that they are extended to these two regulators.

94. The Privy Council’s 'default powers' will also apply to any additional powers given to the regulators in future.

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

2. – Education and Training

Introduction

95. The regulators set the professional standards which registered professionals must meet. In addition to this, they also set standards relating to pre-registration education and training. These include:

    - requirements which learners must meet upon entry to courses or programmes of training;
    - standards for the outcomes of education and training for individual learners;
    - standards which education and training providers must meet; and
    - standards which specific courses or programmes of training must meet.

96. The GDC, HCPC, GMC, GOC, GPhC and NMC also set additional standards for post-registration education and training.

97. As well as setting standards relating to education and training, the regulators provide assurance that these standards are met through their approval and quality assurance of education and training. The GMC also approves postgraduate curricula. By setting education and training standards and assuring that they are met, the regulators provide assurance that education and training providers deliver registrants who provide safe and effective care.

98. There is considerable variation in the regulators' powers in setting education and training standards and quality assuring education and training of healthcare professionals (see paragraphs 103 and 110). Much of the detail around these powers, including operational procedures, is set out in regulators' rules. Regulators often need to seek approval from the Privy Council (or in the case of the PSNI, the Northern Assembly) for rule changes, including those relating to operational procedures. This limits their ability to respond to changes in the healthcare environment.

99. This section sets out our proposed changes to the healthcare regulators' role in education and training. We propose to:

    - remove overly prescriptive legislation; and

- provide all regulators with broadly equivalent powers to change their operational procedures and to make or amend their rules without having to seek Privy Council/Northern Assembly approval (see section 1).

100. This will give the regulators the ability to adapt their standards, rules and guidance more quickly to respond to future changes in the healthcare environment. For example, regulators will be able to set standards for and approve specific courses or programmes of training, rather than just education and training providers.

101. These education and training proposals will not automatically result in changes to the education and training standards and quality assurance process (with the exception of the need to consider appeals; see paragraphs 115 - 117). Rather, the changes will provide the regulators with the tools that they need to amend education and training requirements to meet the future needs of the healthcare environment.

2a. – Main education and training reforms

102. This section sets out the proposed changes to the regulators' powers around education and training.

Standards

103. All regulators have the power to set standards which providers of courses or programmes of training must meet. However, there is considerable variation in the regulators' powers to set education and training standards:

- The GOC, GPhC, HCPC GMC and NMC have the power to set additional standards which providers of post-registration courses or programmes of training must meet. For example, they set additional standards in relation to prescribing (GOC, HCPC and NMC) and podiatric surgery (HCPC).

- The GDC, has a role in post-registration training, but does not have an explicit power to set additional standards for providers of that training.

- The HCPC, GMC and NMC have the power to set standards which specific post-registration course or programmes of training must meet.

104. Education and training forms the basis for professional registration, as healthcare professionals must complete relevant courses or programmes of training before gaining entry to the professional registers. Education and training standards are thus central to ensuring that newly qualified registered healthcare professionals are equipped to deliver safe and effective care. We propose that all regulators be given a

broadly consistent set of powers relating to education and training standards. This will ensure that all regulators can continue to set appropriate standards and will have the flexibility to quickly adapt their standards to the evolving needs of the healthcare environment.

105. All regulators will retain the power to set education and training standards which providers of courses or programmes of training must meet. In addition, we propose that:

- all regulators have the power to set standards for the outcomes of education and training for individual learners;

- all regulators have the power to set education and training standards for specific courses or programmes of training, including those which lead to registration and, where relevant, post-registration courses which are annotated on the register (see below); and

- where relevant, regulators have the power to set additional education and training standards which providers must meet if they are to grant post-registration qualifications which are annotated on the register.

106. These powers will mean that, in addition to setting standards which providers of courses or programmes of training must meet, all regulators will be able to set specific standards which specify the outcomes that learners should achieve by the end of relevant education and training. These powers will also mean that all regulators have the option to set additional standards which courses must meet if they are to lead to annotation of the register. They will also have the option to set additional standards which a provider must meet if it is to offer such courses. Regulators will have the flexibility to determine the standards that they set and how these are applied. For example, a regulator might set standards for the outcomes for individual learners, for providers, for specific courses or programmes of training, or some combination of these. The GMC will continue to have a duty to set post-registration education and training standards in relation to general practitioners and specialists. (The further power to set standards for continuing professional development (CPD) is discussed in paragraphs 136 - 143.)

107. Granting regulators the power to set standards for specific courses or programmes of training, where it does not already exist, will improve their ability to provide assurance that learners who complete courses or programmes of training which lead to registration or annotation of the register have the specific skills, knowledge and experienced needed to deliver safe and effective care. Setting standards for post-registration courses, programmes of training or course providers is important where a

regulator wishes to annotate its register to reflect the additional skills, experience and knowledge of registrants. For example, an annotation may provide information on whether a registrant has undertaken additional training that means they can prescribe, administer or supply medication, or that they can perform a certain kind of surgery. Annotations can also provide further information, such as when a registrant is visiting from another country. In order to assure public confidence in annotations, regulators should be able to set the education and training standards required. In particular, they should be able to set additional standards which courses must meet if they are to lead to annotation of the register or to set additional standards which a provider must meet if it is to offer such courses.

108. The regulators' increased powers and will be balanced by the duties set out in section 1. For example, these duties will mean that they will need to consider the impact of changes to education and training standards on patients, service users, registrants, employers, and education and training providers, collaborate with other relevant bodies, and consult on meaningful changes.

13. Do you agree or disagree that all regulators should have the power to set:

- standards for the outcomes of education and training which leads to registration or annotation of the register for individual learners;
- standards for providers who deliver courses or programmes of training which lead to registration;
- standards for specific courses or programmes of training which lead to registration;
- additional standards for providers who deliver post-registration courses of programmes of training which lead to annotation of the register; and
- additional standards for specific courses or programmes of training which lead to annotation of the register?

Please give a reason for your answer.

Approvals, warnings and conditions

109. The regulators provide assurance that the education and training of regulated healthcare professionals meets the required standards. To do so, they need to be able to inspect and approve providers and/or courses or programmes of training. They also

need to be able to refuse and withdraw approval and monitor providers and/or courses or programmes of training.

110. There is variation in approval powers between the regulators. For example, some regulators, including the HCPC and NMC, have the power to approve both education and training providers and courses or programmes of training. Others, including the GOsC and GCC, only have the power approve courses or programmes of training. Others, such as the GOC, approve qualifications. We propose that all regulators should have the power to approve, refuse, re-approve, withdraw approval, monitor and quality assure courses, programmes of training, qualifications and education and training providers. Where relevant, these powers should also apply to post-registration courses, programmes of training, qualifications and post-registration education and training providers. The regulators will determine the most appropriate way to exercise these powers.

111. At present, regulators' powers to impose conditions vary. When concerns are identified prior to the point of initial approval, conditions can be attached to initial approvals. Likewise, conditions can be imposed when approval has already been granted. In both cases, continued approval depends upon all standards being met to a timeframe set by the regulator. We propose that all regulators should have the same power to impose conditions and attach conditions to approvals.

112. We also propose that all regulators have the power to issue warnings when concerns are identified. When education institutions are failing to meet standards, regulators will have the option of issuing a warning or making continued approval conditional on the relevant standards being met, in addition to being able to refuse or withdraw approval outright. Regulators will be able to impose conditions in order to assure that particular concerns are addressed.

113. Allowing regulators to impose conditions and issue warnings will provide them with a suite of approval options. In particular, the regulators will all be able to issue warnings or impose tailored conditions in order to incentivise targeted improvement and support education and training providers. They will be able to do so without having to refuse or withdraw approval and cause unnecessary disruption for learners. This proposal is supported by the Law Commissions' recommendation.[5]

[5] See paragraphs 6.10 – 6.13 of the Law Commissions' review of the legal framework for professional regulation in the UK.

114. Regulators will be required to:

- set out in guidance the procedure for approval, refusal and withdrawal of approval of an education and training provider, qualification, course or programme of training;
- set out in guidance the procedure for imposing, modifying and removing conditions;
- publish their procedures for approval, refusal and withdrawal of approval, as well as their procedures for monitoring and quality assurance;
- publish decisions regarding the approval, refusal and withdrawal of approval (including if subject to conditions); and
- maintain a public list of approved courses, qualifications, programmes of training and education and training providers, and also publish any conditions that are imposed on a qualification, course, programme or provider.

14. Do you agree or disagree that all regulators should have the power to approve, refuse, re-approve and withdraw approval of education and training providers, qualifications, courses or programmes of training which lead to registration or annotation of the register? Please give a reason for your answer.

15. Do you agree that all regulators should have the power to issue warnings and impose conditions? Please give a reason for your answer.

Appeals

115. In order to ensure that they are carried out fairly and effectively, education and training providers must have the right to submit observations as part of the regulators' approval decision-making processes. This ensures that all appropriate evidence is considered. Providers should also have a right to appeal decisions when approval is refused or withdrawn. Some of the regulators currently provide internal rights of appeal against approval decisions. This appeal right would not apply when conditions are attached to an approval.

116. Appeals will be considered by the regulators, who will be required to set out in rules the grounds on which such approval decisions can be appealed. These rules will set out either a general process for all appeals or different processes for different categories of cases. An appeal could involve either an internal review or a third party

being brought in to arbitrate, depending on the nature of the appeal and how the regulator considers it should be handled.

117. Education and training providers will not have the right to appeal decisions to attach condition to approvals. This is unnecessary because providers will have the opportunity to show that any requirements imposed by conditions have been met prior to having approval refused or withdrawn. Where approval is refused or withdrawn on the grounds that conditions are not met, providers will retain their right to appeal that decision.

16. Do you agree or disagree with the proposal that education and training providers have a right to submit observations and that this should be taken into account in the decision-making process? Please provide a reason for your answer.

17. Do you agree that:

- education and training providers should have the right to appeal approval decisions;
- that this appeal right should not apply when conditions are attached to an approval;
- that regulators should be required to set out the grounds for appeals and appeals processes in rules?

Please provide a reason for your answer.

2b. – Further details and reforms

118. The following section outlines further details of the proposed education and training reforms.

Variations in regulators' approval and standard setting powers

119. Our proposal is that all regulators should have the powers set out above relating to the quality assurance of education and training. However, some regulators already have more extensive powers. For example:

- the GMC currently has the power to approve specific postgraduate curricula to be followed in general practice and in other recognised medical specialties;
- some regulators set standards for continued participation in education and training which leads to registration;

- some regulators set standards specifying which assessments must be completed by learners on courses or programmes of training which lead to registration; and

- some regulators approve individuals to provide training.

120. Where regulators already have such additional powers, we do not plan to remove them. However, we also do not propose that such powers be made available more broadly than they already are.

121. Education and training powers in relation to AAs and PAs are considered separately in section 5b.

18. Do you agree or disagree that regulators should retain all existing approval and standard setting powers? Please provide a reason for your answer.

Exam and assessment powers

122. The regulators will have the flexibility to determine the required outcomes of education and training which leads to registration or annotation of the register. It is the regulators, as the experts and gatekeepers to each profession, who are best placed to set out the detailed requirements for registration and annotation. Our reforms will ensure that all regulators have the flexibility to set requirements for entry to or annotation of the register. This will include being able to specify if there are examinations or other assessments, in addition to those taken in order to acquire relevant qualifications, which must be passed prior to registration or annotation of the register (see paragraph 193). That is all regulators will all be able to specify if there are additional exams or other assessments which qualified healthcare professionals must pass prior to registration or annotation of the register.

123. Some regulators already have further powers relating to exams and other assessments. For example, the GPhC sets a registration assessment. Passing the registration assessment is part of the GPhC's overall criteria for registration as a pharmacist. The GMC, meanwhile, sets the Professional and Linguistic Assessments Board test for doctors who have qualified abroad, and the GDC sets the Overseas Registration Exam for dentists who have qualified abroad. The NMC uses a Test of Competence to assess the skills and knowledge of international applicants for registration or those seeking to rejoin the register after a period away from practice. The GMC also has the power to quality assure and approve postgraduate exams and other assessments and has oversight of examinations and other assessments which are taken as part of undergraduate courses which lead to registration.

124. We propose that in addition to being able to specify if there are examinations or other assessments which must be passed prior to registration or annotation of the register, over and above those taken to acquire a relevant qualification, all regulators should have the power to set and administer such assessments.

125. It has been suggested that regulators should have an additional power to set the exams or assessments for those courses and programmes of training which are approved by the regulators and completion of which leads to registration or annotation of the register. This would be in addition to the power that some regulators already have to set requirements and standards applying to the exams and assessments conducted by education and training providers. Under our proposals all regulators will be provided with a full range of powers to set standards in relation to the outcomes of education and training, specific courses and programmes of training and education and training providers (see paragraph 105). These powers will provide assurance that approved courses are equipping learners with the skills, knowledge and experience that they need to enter the register. We do not propose that the regulators are given powers to set exams and assessments in relation to approved courses.

19. Do you agree or disagree that all regulators should have the power to set and administer exams or other assessments for applications to join the register or to have annotations on the register? Please provide a reason for your answer.

20. Do you agree or disagree that this power to set and administer exams or other assessments should not apply to approved courses or programmes of training which lead to registration or annotation of the register? Please provide a reason for your answer.

Fees

126. The Governance and Operating Framework proposals set out in Section 1 introduce the power for regulators to charge for services undertaken on a cost-recovery basis (see paragraphs 77- 80). This includes being able to charge a fee in connection with all education and training approval decisions, both in the UK and overseas, and to charge a regular fee for monitoring ongoing approval.

Delegation and methods of assessment

127. Some regulators already delegate education and training functions to other bodies. For example, the NMC currently delegates its education and training approval function to Mott MacDonald. The power to delegate functions (see paragraphs 80 - 85) will apply to the education and training functions of all regulators. This will mean that all

regulators have a power to appoint a person(s) to carry out the quality assurance function on their behalf.

128. In addition to this, we also propose that all regulators should have the power to assess education and training providers, courses or programmes of training in a variety of ways. This might include desktop-based or remote assessments conducted rather than visiting a location. This will help to ensure that regulators deliver their quality assurance function in the most efficient and effective way.

21. Do you agree or disagree that regulators should be able to assess education and training providers, courses or programmes of training conducted in a range of ways? Please provide a reason for your answer.

European requirements for the education and training of healthcare professionals

129. The education and training of five healthcare professions - doctors, nurses, midwives. pharmacists, and dentists – are set out in European legislation, with which UK standards have previously had to comply. These requirements, which define the minimum length of time required to train in a profession, ceased to apply at the 2020. This allows regulators to a more flexible approach to setting education and training standards. For example, in January 2021 the NMC introduced a recovery standard in response to the covid 19 pandemic which allowed student nurses to replace some clinical practice hours with simulated learning where clinical practice was not available or possible. The proposed changes education and training will provide the regulators with the flexibility to take a different approach to education and training standards which focuses on the skills, experience and knowledge required rather than hours of study and practice.

The power to require information

130. In order to play their quality assurance role as effectively and efficiently as possible and ensure that education and training standards are upheld, regulators need education and training providers to share relevant information. Regulators will therefore have the power to require that education and training providers share whatever information is reasonably required for the purpose of quality assurance.

Inter-professional learning

131. It has been suggested that that registered healthcare professionals should be required to engage in inter-professional learning. This is where healthcare professionals from two or more professions learn with, from and about each other to improve collaboration and the quality of care. It can include learning in academic or

work-based settings, either before or after qualification. It is widely acknowledged that inter-professional learning is beneficial.[6] The need for effective inter-professional learning and teamworking was highlighted in the Victoria Climbié Inquiry and the Royal Liverpool Children's Inquiry. The HCPC and NMC's standards require that courses or programmes of training which lead to registration include inter-professional learning. The GMC's standards require that medical school programmes provide the opportunity for inter-professional learning. Although inter-professional learning is known to be beneficial, it is something which the majority of healthcare professionals already benefit from, given the way in which healthcare is delivered. The Law Commissions noted that inter-professional learning is not always appropriate and recommended that, although inter-professional learning should be encouraged, it is not something which should be mandated by legislation.[7] We do not therefore propose that a requirement for inter-professional learning be included in the regulators' legislation. The current proposals will provide regulators with the flexibility to set standards which assure that registered healthcare professionals receive education and training which is best suited to equip them to deliver safe and effective care. This will include regulators being able to require that learners engage in academic, lab-based, practical or inter-professional learning where appropriate.

Certificates of Completion of Training (CCTs)

132. The Medical Act requires the GMC to award Certificates of Completion of Training (CCTs) to confirm that doctors have completed an approved UK specialist or GP training programme. Doctors with a CCT are eligible for entry onto the GP or specialist register. The GMC has a duty to award a CCT to any person who applies to the GMC for that purpose who:

- is a registered medical practitioner; and
- has satisfactorily completed a relevant approved course or programme.

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[6] See, for example, the World Health Organization's Framework for Action on Interprofessional Education & Collaborative Practice and How interprofessional learning improves care.

[7] See paragraph 6.21 – 6.25 of the Law Commissions' review of the legal framework for professional regulation in the UK.

133. We are proposing to replace the specialist and GP registers with a single register where specialist status including being a GP is reflected through an annotation to the register (see section 3). We are proposing to remove the GMC's duty to award CCTs from the Medical Act.

134. We propose that the GMC should instead have a power to make rules setting out the procedure to be followed in relation to, and evidence required in support of, CCTs. The GMC will then be able to assure that the processes by which doctors have specialist or GP qualifications annotated on the register are best suited to serve the needs of service users, the public, the healthcare environment and the regulated professions. For example, if it determines that it is appropriate to do so, the GMC will be able to continue awarding CCTs. If it instead determines that it is no longer necessary to award CCTs before registrants have qualifications annotated on the register then it will be able to adjust its processes.

135. This change relating to CCTs will not entail any immediate change to the way that the GMC regulates education and training. Granting the GMC this power in relation to CCTs enssures that it has the flexibility to regulate education and training efficiently and effectively.

22. Do you agree or disagree that the GMC's duty to award CCTs should be replaced with a power to make rules setting out the procedure in relation to, and evidence required in support of, CCTs? Please give a reason for your answer.

Continuing Professional Development and Revalidation

136. It is essential for public protection that registrants demonstrate that their skills and knowledge are up to date and equip them for the roles that they carry out. A key way regulators ensure this is through systems that assess continuing professional development (CPD) or through revalidation (the process that professionals in the UK must follow to maintain their registration with a regulator).

137. We propose that all regulators should be given a new power to set standards for CPD and/or revalidation. This will ensure that regulators provide assurance that registered healthcare professionals continue to develop their skills and competencies and acquire any new knowledge required for them to continue to deliver safe and effective care.

138. A number of regulators, such as the GOC, set out their registrant's CPD requirements in rules. The GOC sets out a programme of Continuing Education and Training (CET) which is a statutory requirement for all fully qualified optometrists and

dispensing opticians. This is a points-based scheme that runs over a three-year cycle. All registrants must earn a minimum number of CET points and meet a minimum set of requirements by the end of each cycle to remain on the GOC's register.

139. The General Medical Council (Licence to Practise and Revalidation) Regulations set out the GMC's revalidation process. Where a medical practitioner holds a licence to practise, they must successfully revalidate every five years to continue practising in the UK. Medical practitioners do this by participating in local clinical governance systems including regular appraisals which are overseen by a Responsible Officer (these are individuals based within 'designated bodies' who have overall responsibility for making a revalidation recommendation to the GMC so that the registrant can maintain their licence to practise).

140. For the NMC, revalidation is linked to an applicant's registration renewal requirements. The NMC's legislation requires applicants applying to renew their registration to meet certain CPD and practice hours requirements. The number of CPD and practice hours to be completed by registrants is set out in the Nursing and Midwifery Council (Education, Registration and Registration Appeals) Rules 2004.

141. Regulators are best placed to determine what registrants need to demonstrate to prove that they remain safe to practise. We therefore propose that legislation should continue to allow regulators to require registrants to undertake CPD and/or revalidation. In addition, regulators should be given a power to set out the procedure for dealing with non-compliance and a power allowing them to set standards for CPD and/or revalidation.

142. However, the detailed requirements in relation to CPD and revalidation should be set by individual regulators in rules and guidance. When proposing any changes to their existing rules on CPD and/or revalidation, regulators would be required to consult with employers and other key stakeholders.

143. This will allow regulators to make changes to their CPD and/or revalidation processes as and when required. During the COVID-19 pandemic, for example, regulators have postponed or amended CPD and revalidation arrangements. Setting out the detail of CPD and revalidation processes in rules and guidance rather than legislation will support such a flexible approach.

23. Do you agree or disagree that regulators should be able to set out in rules and guidance their CPD and revalidation requirements? Please give a reason for your answer.

3. – Registration

Introduction

144. This section sets out proposed changes to the regulators' registration processes. Registration refers to the maintenance of a list of professionals who have satisfied a regulator that they are appropriately qualified and have the necessary knowledge, experience and skills to be capable of safe and effective practice. A robust register is central to how regulators meet their core objective of public protection.

145. There is variation in the registration processes that the regulators operate and the legislation that underpin these processes. The changes set out in this section aim to introduce greater consistency across the regulators. These changes will provide all regulators with the same powers to carry out their registration function.

146. The proposed approach will also provide the regulators with flexibility in how they exercise their powers. The regulators will be able to set out their registration operational processes in rules and guidance rather than having these set out in legislation or Privy Council approved rules. This will allow registration processes to be adapted to meet the needs of different professions and different requirements over time. We encourage regulators to work together to develop their rules.

147. Section 3a sets out the main proposed changes to the legislative framework, governing registration processes, for all regulators. These are that:

- all regulators will have a duty to hold a single register of professions which can be divided into parts for each profession a regulator regulates;
- a power to annotate entries on the register;
- the introduction of emergency registration powers for all regulators; and
- all regulators will have the same protection of title and registration offences within their legislation so that all registered professions have the same level of protection.

148. Section 3b sets out further detail on the administration of regulators' registers including:

- removal and readmission to a register;
- registration appeals; and

- the role of the Registrar, Deputy Registrar and Assistant Registrar.

149. Section 3c sets out further detail in arrangements for specific groups of registrants including:

- students;
- international practitioners; and
- non-practising professionals.

3a. – Main registration reforms

A duty to hold a single register

150. All regulators have a duty to hold a register (or registers) of professionals they regulate and to make this available to the public. In addition, the GPhC and the PSNI are required to hold registers of pharmacy premises and the GOC is required to hold a register of optical businesses.

151. These registers are central to the regulators' role in protecting the public and patient safety. They provide important information for the public, employers and service users on those professionals who are qualified and capable of safe and effective practice. They also provide information on certain sanctions that have been imposed on a professional as a result of fitness to practise proceedings. Not all of the information held on a regulator's register is required to be published, for example, a registrant's personal details are not available to the public.

152. Regulators currently hold their registers in different ways. Some regulators hold a single register of the profession they regulate, some hold a single register divided into parts for the different professions they regulate, whereas other regulators hold multiple registers. In addition, some regulators such as the GDC and GOC, hold specialist lists. The specialties included in the GDC and GOC's lists are set out in rules. These specialist lists are publicly available and highlight which professionals have specialist skills or qualifications.

153. For example, the GDC holds 13 specialist lists. The GDC's specialist lists set out registered dentists who meet certain conditions and are entitled to use a specialist title.

154. The following table sets out how each regulator holds its register:

Regulator	Register Model	Additional information
GCC	A single register of chiropractors	n/a
GDC	Multiple Registers. These are: • The Dentist Register • Dental Care Professional Register	The Dental Care Professional register is also sub-divided as follows: • Dental Nurse • Dental Hygienist • Dental Therapist • Dental Technician • Clinical Dental Technician • Orthodontic Therapist The GDC holds 13 specialist lists.
GMC	Multiple Registers. These are: • The Medical Practitioners Register • The General Practitioners Register • The Specialist Medical Practitioners Register	The Medical Practitioners register is a list of all medical practitioners in the UK. It includes general practitioners and specialist medical practitioners.
GOC	Multiple Registers. These are: • The Optometrists, Dispensing Opticians and Students Register • Body Corporates Register	The GOC holds 4 specialist lists.
GOsC	A single register of osteopaths.	n/a
GPhC	A single register which is divided into five parts: • Part 1: relating to pharmacists	Part 5 of the register is no longer in use by the GPhC and part 4 of the register will cease to be in effect from mid-summer 2022 (save for Swiss visiting

	other than visiting practitioners • Part 2: relating to pharmacy technicians other than visiting practitioners • Part 3: relating to premises • Part 4: relating to pharmacists who are visiting practitioners • Part 5: relating to pharmacy technicians who are visiting practitioners	pharmacists).[8]
HCPC	A single register divided into parts for each profession the HCPC regulates.	n/a
NMC	A single register which is divided into four parts: • Nurses • Midwives • Nursing associates • Specialist community public health nurses.	The nurses' part of the register is divided into two sub-parts for first[9] and second level[10] nurses (however, the sub-part for second level nurses is now closed to new entrants).
PSNI	Multiple registers. These are: - • Register of students • Register of pharmaceutical	Within the PSNI's governing legislation is a power enabling it to establish and hold a register of druggists. The PSNI has chosen not to establish this type of register.

[8] The citizens' rights agreement that the UK have signed with Switzerland protects the rights of UK and Swiss nationals who have chosen to call each other's countries home. This means that UK and Swiss nationals living in each other's countries after Brexit will continue to enjoy broadly the same rights as they did when the UK was part of the EU. This includes arrangements on residency, access to healthcare, pensions and education, social security coordination and mutual recognition of professional qualifications.
[9] First level nurses also known as registered nurses have completed a three-year programme of education leading to a nursing qualification and an academic qualification.
[10] Second level nurses are registered nurses who have completed a two-year nursing course. However, second-level courses are no longer available to undertake.

	chemists • Register for registered premises • Register of temporary and occasional working practitioners	

155. All regulators will continue to hold and publish a register of the professionals they regulate. However, we propose that this should be a duty to hold and publish a single register of professions which can be divided into parts for each profession a regulator regulates. This will ensure that current practice is reflected within a regulator's register. In addition, it will allow any new professions which may be brought into statutory regulation in the future to be easily and proportionately included as a new part within a regulator's register. Any duties on regulators to hold multiple registers will be removed from legislation.

156. All regulators will be required to publish the following information on their registers about their registrants. The following information will be available to both the public and employers:

- Name
- Profession
- Qualification (this will only be published if the regulator holds this information. For historical reasons not all regulators hold this information about all of their registrants)
- Registration number or personal identification number (PIN)
- Registration status (any measures in relation to fitness to practise on a registrant's registration should be published in accordance with the rules/policy made by a regulator)
- Registration history

157. This will ensure that the registers provide the same basic level of information about all registered professionals. Some regulators also provide additional information about their registrants. For example, the GCC and the GOsC currently publish a registrant's geographical location and the GPhC publishes the registration expiry date. We propose that regulators should continue to be able to collect, hold, process and,

where they see fit, publish such information on the register. The Social Workers Regulations 2018 provide Social Work England with this power and we propose that the power should be extended to all regulators.

158. In addition, to the above information, regulators should also be given a power to be able to request specific information from registrants which may be published on the register by a regulator. The collection and possible publication of this information would only be possible where it is consistent with a regulator's statutory objectives and could include information in relation to a registrant's scope of practice, insurance and indemnity, revalidation and/or continuing professional development requirements. Where a registrant does not provide this information, they could potentially be removed from a regulator's register. However, removal from the register would only take place as a last resort when other steps to obtain the required information have failed. In addition, a registrant would be able to appeal a decision to remove them from the register for this reason.

24. Do you agree or disagree that the regulators should hold a single register which can be divided into parts for each profession they regulate? Please give a reason for your answer.

25. Do you agree or disagree that all regulators should be required to publish the following information about their registrants:

- Name
- Profession
- Qualification (this will only be published if the regulator holds this information. For historical reasons not all regulators hold this information about all of their registrants)
- Registration number or personal identification number (PIN)
- Registration status (any measures in relation to fitness to practise on a registrant's registration should be published in accordance with the rules/policy made by a regulator)
- Registration history

Please provide a reason for your answer.

26. Do you agree or disagree that all regulators, in line with their statutory objectives, should be given a power allowing them to collect, hold and process data? Please give a reason for your answer.

27. Should they be given a discretionary power allowing them to publish specific data about their registrants? Please give a reason for your answer.

Annotation of the single register

159. The GMC, GPhC, HCPC, NMC and PSNI are all able to annotate entries on their registers. We propose that all regulators should be given a power to annotate their register, including the power to amend, remove or restore annotations, in order to provide further information about the skills, knowledge and experience of registrants. Annotations are separate and distinct from fitness to practise sanctions.

160. An annotation is a note against a registrant's entry on a register which provides additional information, over and above that required for basic registration, such as specifying their scope of practice, an area of expertise or restrictions on their practice or registration. The NMC, GPhC, PSNI and HCPC currently annotate their registers to indicate their registrants' prescribing status. Annotation of the register will allow the regulators to indicate where registrants hold specialist qualifications rather than holding separate registers or specialist lists.

161. The power to annotate the register must be used in a way that is consistent with the regulators' public protection function. A regulator's register should ensure patient and public safety is protected and should not become a list of a registrant's qualifications. Examples of how annotations can be used include to indicate specific legislated activities such as prescribing and to provide clarity of scope of practice.

162. All regulators will be required to put in place an annotations policy setting out their approach to annotations. In addition, regulators should be able to charge a fee for making annotations to a register entry. Several regulators have developed their own policies on annotations. For example, the HCPC's policy only allows annotation where it is legally required or in exceptional circumstances where annotation is necessary to protect the public.

163. Where an annotation reflects a decision to restrict a registrant's scope of practice or registration, for example where a registrant only holds temporary or provisional registration rather than full registration, regulators will be required to set out the extent of such restrictions and how they will operate in rules. These rules will be subject to public consultation by the regulator.

164. Registrants will be able to appeal decisions made by a regulator on annotations. Detail on which decisions can be appealed will be set out in a legislation. Further information is available in the registration appeals section (see 213 - 218).

28. Do you agree or disagree that all regulators should be able to annotate their register and that annotations should only be made where they are necessary for the purpose of public protection? Please give a reason for your answer.

Emergency Registration

165. The GMC and GPhC both have emergency registration powers on a permanent basis. The Coronavirus Act 2020 gave the Registrars of the NMC, the HCPC and the PSNI new temporary, time-limited, emergency powers to be able to temporarily register an individual or group of individuals throughout the Covid-19 emergency. It is the Secretary of State for Health and Social Care's role to notify the registrars that an emergency is about to occur, is occurring or has occurred Under the Coronavirus Act 2020, it is the role of the Department of Health Northern Ireland, to advise the PSNI's registrar that an emergency is about to occur, is occurring or has occurred.

166. Emergency registration powers have been used in the following ways during the current Covid-19 pandemic:

- The GMC granted temporary registration to doctors in good standing who had left the register in the last six years;
- the NMC opened a temporary register to nurses and midwives who had left the register in the last five years and overseas nurses already working in the UK who were part-way through the NMC's application process;
- the GPhC and PSNI granted temporary registration to pharmacy professionals in good standing who had left the register in the last three years; and
- the HCPC granted temporary registration to former registrants who had left the register in the last three years and third year students on UK approved programmes who had completed all of their clinical practice placements.

167. As a result, over 47,000 former professionals came forward and offered to return to the NHS to increase workforce capacity and deal with the pressures created by COVID-19.

168. The registration of former professionals on the emergency registers will come to an end when the Secretary of State for Health and Social Care notifies the regulators that the emergency circumstances no longer apply. In Northern Ireland, it is the role of the Department of Health Northern Ireland to advise the PSNI's registrar that the emergency circumstances no longer apply.

169. To ensure that additional health and care professionals can be made available in an emergency situation, we propose that these emergency registration powers should be made available to all regulators on a permanent basis. In line with current legislation, the Secretary of State for Health and Social Care will notify the registrars that an emergency is about to occur, is occurring or has occurred. In Northern Ireland, it will be the role of the Department of Health NI to notify the PSNI's registrar that an emergency is about to occur, is occurring or has occurred.

29. Do you agree or disagree that all of the regulators should be given a permanent emergency registration power? Please give a reason for your answer.

Offences in relation to protection of title and registration

170. The protection of a professional title is a key aspect of public protection. Protecting a title provides assurance to the public that someone using that title is competent and safe to practise. Protected titles include general practitioner, registered nurse, pharmacist and chiropractor.

171. In order to ensure that only an individual who is registered with a regulator can use a protected title, it is an offence for a person to use a title they are not legally permitted to use or to otherwise hold themselves out to be a regulated professional.

172. Some regulators also have offences in relation to regulated premises within their governing legislation. For example, it is an offence to use the term pharmacy in respect of a retail business that is not a registered pharmacy with the GPhC.

173. In addition, there are certain activities and functions which can only be carried out by specific regulated professionals such as medical practitioners, opticians and dentists or dental care professionals. For example, only a registered medical practitioner, optometrist or dispensing optician can fit a contact lens for an individual and only registered dental professionals can perform activities classed as the practice of dentistry. As we amend the legislation of the regulators, we will review their protected functions to ensure they reflect current practice.

174. The Law Commissions' report recommended that all protected titles and functions should be retained in legislation alongside a power to amend or remove a protected title through regulations.

175. We will retain protected titles and offences related to their misuse. We propose that the same set of offences on protection of title and registration should apply to all

regulators. This will ensure all registered professions have the same level of protection.

176. There is currently inconsistency across the regulators as to whether the protection of title offences within their legislation are intent or non-intent offences (which we call strict liability offences). Most criminal offences have some mental element: this means that for a person to be guilty of committing the offence, they need to have had a particular state of mind when they acted. Strict liability offences, however, can result in a conviction without any criminal state of mind: if the person has committed the criminal act they will be guilty of the offence. We propose that all regulators should have protection of title offences in their legislation and that these offences should require some intent to deceive others.

177. If protection of title offences were to be non-intent offences, someone could be guilty of a criminal offence for describing or representing themselves as a person with a protected title (for example, a surgeon, a dental practitioner, or an art therapist), even if they did not know the title was protected in law.

178. We propose that in order to be guilty of a protected title offence, someone would need to have used a protected title they weren't entitled to use and it would also need to be shown that they intended people to have been deceived into thinking they were entitled to use that title. We also propose that people representing themselves in a way that falsely suggests they are registered with a relevant professional regulator, or hold a relevant professional qualification, would be covered by protected title offences.

179. We propose there should also be a further offence of making a false representation about another person in relation to protected titles (or qualifications or registration). Where a person intentionally causes another person to make such a false representation about them, they will have committed an offence, if they intended that someone would be deceived (whether expressly or by implication). This offence would prevent a person evading prosecution because another person made the false representation on their behalf. In addition, if the person who made the false representation did so knowing they were making a false representation on behalf of another person, with intent to deceive, they would also be liable. Such offences are set out in the NMC and HCPC's legislation and we propose to extend these offences to all regulators.

180. We propose that all regulators should have an offence of fraudulently procuring or attempting to procure, the making, amendment, removal or restoration of an entry into a regulator's register, within their legislation.

181. In summary, we propose that all regulators should have intent offences within their governing legislation, so that any person who with intent to deceive (whether expressly or by implication):

- falsely uses a protected title
- falsely claims to be registered as a professional
- falsely claims to hold a qualification which enables a person to practise as a professional
- makes a false representation about another person in relation to protected titles (or professional registration or qualifications)
- causes another person to make a false representation about them in relation to protected titles (or professional registration or qualifications); and/or
- fraudulently procures or attempts to procure, the making, amendment, removal or restoration of an entry into a regulator's register

would be guilty of an offence.

182. Some of the protected titles in the regulators' legislation do not reflect current practice. For example, 'apothecary' is a protected title in the Medical Act, although this term is no longer used. We will review the protected titles to ensure that they are consistent with current practice.

183. All of these proposed offences would be summary offences which would be punishable on conviction by an unlimited fine or, in Scotland and Northern Ireland, a fine not exceeding level 5 on the standard scale.

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

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

3b. – Reforms to the administration of regulators' registers

The Registrar, Deputy Registrar and Assistant Registrars

184. All regulators have a duty to appoint a registrar, who is usually the chief executive. The registrar has statutory responsibility for keeping a register and other duties, as directed by the Council, including the governance of the regulator. The registrar's statutory duty to hold and maintain a register is central to the delivery of public protection. Having a registrar responsible for maintaining and establishing a register creates clear accountability. We therefore propose that the duty on the regulators to appoint a registrar should remain.

185. Some regulators, such as the NMC, can also appoint deputy or assistant registrar(s) whereas other regulators such as the PSNI are unable to do so. Having the ability to appoint deputy or assistant registrar(s) ensures that the required personnel are in place when the registrar is on annual leave or absent due to ill health. Deputy and assistant registrars also play a key role in the day to day running of operations by a regulator. At the NMC, assistant registrars are often involved in decisions where discretion is required. For example, in taking into account considerations relating to any fitness to practise allegations and the interests of the registrant and the public before granting a request from a registrant to be removed from the register.

186. To ensure that all regulators have the required personnel in place to be able to meet their statutory duties we propose that all regulators should have a power to appoint a deputy registrar and/or assistant registrar(s). The deputy registrar and/or assistant registrar(s) would be authorised by the Registrar to act on his or her behalf in any matter.

32. Do you agree or disagree with our proposal that regulators should be able to appoint a deputy registrar and/or assistant registrar, where this power does not already exist? Please give a reason for your answer.

Registration Processes

187. To join a register an applicant needs to apply to a regulator for registration. This applies to both UK and internationally qualified applicants. Having a robust and fair process for joining the register ensures that only those individuals who meet the required standards to practise a given profession are able to do so.

188. There are a number of elements that all applicants for registration have to meet. This includes holding an appropriate qualification, having the right skills, experience

and knowledge to be capable of safe and effective practice, having the right knowledge of English, and satisfying fitness to practise and identity requirements. In addition, all applicants must make sure that they have adequate and appropriate insurance or indemnity arrangements in place covering the full scope of their intended practice in the UK.

189. Legislation generally outlines the different types of registration an applicant can apply for and sets out the process for applying. This can include full registration, conditional registration (where a registrant can practise subject to certain conditions) and temporary registration (this allows regulators to register overseas professionals who are coming to the UK to provide services for a short period of time).

190. The specific requirements for registration vary between professions and it is the regulators, as the experts and gatekeepers to each profession, who are best placed to set out their detailed requirements for registration.

191. Legislation should set out the basic criteria for the regulator's registration processes and regulators should be required to set out in guidance their processes for considering applications.

192. We propose that legislation should set out that individuals applying for registration should meet the following criteria. They will have to:

- provide evidence of their identity;
- hold or have passed all the qualifying examinations or other assessments necessary for obtaining an acceptable UK or international qualification;
- possess the relevant knowledge, skills and experience to practise in the UK;
- have the necessary knowledge of English; and
- meet any other requirements set by a regulator, for example by providing a declaration of fitness practise or by meeting a required standard of proficiency for safe and effective practice.

193. Regulators should have the flexibility to set out in guidance the standards for meeting the above criteria and the process for considering applications from UK and internationally trained professionals. However, to be able to register with a regulator, a professional who has passed all of the qualifying examinations or other assessments necessary for obtaining an acceptable UK or international qualification for the

profession they wish to work in may still be required, by a regulator, to undertake an additional assessment or examination before being eligible for registration.

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

The General Medical Council's registration processes

194. There are a number of differences between the GMC's registration processes and that of other regulators.

195. The Medical Act currently sets out the routes to registration for full and provisional registration of UK graduates and international medical graduates. Medical practitioners are registered either as fully registered (if they have the appropriate knowledge, skill and experience) or provisionally registered (if they have the knowledge and skill, but not the relevant experience). The GMC is the only regulator who routinely offers provisional registration.

196. The Medical Act also allows the GMC to register some medical practitioners temporarily. The GMC may register visiting eminent specialists and medical practitioners who are in the UK temporarily to treat non-UK nationals (for example, members of a non-UK sporting team).

197. In order to practise medicine, medical practitioners in the UK need to hold a licence to practise along with registration. The Medical Act makes provision for the GMC to grant, refuse and withdraw licences to practise, with the detailed arrangements and processes for how this happens set out in rules. It is the licence to practise which entitles medical practitioners to carry out specific clinical activities including prescribing, signing death certificates and treating NHS patients.

198. Provisional registration with a licence to practise allows registrants to take part in an approved Foundation Year 1 Programme in the UK. This is the first year of a two-year programme for doctors who have just graduated from medical school. It allows them to put into practice the key skills and knowledge that they will have learnt during their undergraduate medical education and prepares them for practising as a fully registered doctor in the UK. However, there are limitations to the activities that can be carried out by a registrant with provisional registration.

199. In addition, the GMC also registers medical practitioners without a licence to practise, this includes doctors practising using their medical qualifications and skills

but not undertaking clinical activities and retired medical practitioners who may wish to remain in good standing with the GMC.

200. We propose that the GMC's framework for registration should be consistent with the other regulators. The different routes to registration should be removed from legislation and replaced with registration criteria. All regulators should have the same criteria within their legislation and they should all set out in guidance their standards for meeting the criteria. In addition, annotations should be used to indicate where registrants have restrictions on their practice such as where their registration is provisionally or temporarily restricted.

201. The GMC's registrar currently has a discretion as to whether an applicant should be granted registration or not. There may be circumstances where an applicant meets the GMC's criteria for registration, however, for public protection reasons, the GMC's registrar may choose to refuse to grant an applicant registration. For example, the GMC's registrar may turn down a request for registration if an applicant has had a long break in practice and is unable to provide evidence to demonstrate that this break in practice was mitigated by taking steps to keep their knowledge and skills up to date. An applicant who is refused registration by the GMC's registrar is able to appeal the registrar's decision. Other regulators' registrars do not currently have this discretion. Based on the example given, other regulators may also turn down a request for registration from an applicant who has had a long break in practice, which was not mitigated by taking steps to keep their knowledge and skills up to date. However, an applicant would be refused registration because they failed to meet the regulator's standards in relation to knowledge and skill or revalidation requirements.

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

202. In line with our proposals on registers, we propose that the GMC should hold a single register of medical practitioners which would be annotated to indicate whether a registrant holds any specialist medical qualifications rather than having these qualifications indicated on separate registers. Annotation of the register will allow the GMC and the other regulators to rapidly adapt to the changing NHS landscape and changes in specialist practice. In addition, annotation will allow any developments to be easily and proportionately reflected on a regulator's register.

203. We also propose that the licence to practise should be managed as an annotation which will be set out in rules by the GMC. This would meet our aim of giving the GMC greater flexibility to develop its regulatory approach over time.

204. Information on all annotations should be available to the public, service users and employers on regulators' online registers.

35. Do you agree or disagree that the GMC's provisions relating to the licence to practise should be removed from primary legislation and that any requirements to hold a licence to practise and the procedure for granting or refusing a licence to practise should instead be set out in rules and guidance? Please give a reason for your answer.

Removal, suspension and readmission to the register

205. Regulators are able to remove registrants from their register(s) for fitness to practise and administrative reasons. Removal from the register in relation to fitness to practise is covered in the fitness to practise section of this document. This section considers suspension and removal from the register for administrative reasons.

206. We propose that all regulators should be given a new power allowing them to suspend registrants from their registers for the following reasons:

- failure to pay any relevant fees;
- failure to maintain an effective means of contact and contact details with the regulator;
- failure to provide any information reasonably required by the regulator pursuant to its statutory objectives and functions; and
- failure to meet revalidation and renewal requirements (where these are a requirement of a regulator).

207. A decision to suspend a registrant from the register for one of the above reasons should be appealable.

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

208. We propose that regulators should be able to remove registrants from their registers for the following reasons:

- voluntary removal from the register at the request of a registrant;

- fraudulently obtained or incorrectly made entries in the register;
- on notification of a registrant's death;
- failure to pay any relevant fees;
- failure to maintain an effective means of contact and contact details with the regulator;
- failure to provide any information reasonably required by the regulator pursuant to its statutory objectives and functions; and/or
- failure to meet revalidation and renewal requirements (where these are a requirement of a regulator).

209. In addition, regulators should set out in rules:

- their approaches to removing a registrant from the register or restricting the practise of a registrant due to health or English language concerns where they are no longer safe to practise, or there is agreement to restrict their practise (but where the concern does not meet the threshold for the fitness to practise process); and
- their approach for dealing with voluntary removal requests from the register during a fitness to practise investigation (regulators should be given a power enabling them to determine whether this is permitted, and if so, their process for dealing with requests for removal).

210. A person who has been removed from a regulator's register for administrative reasons can apply to be readmitted (also known as restored) to a regulator's register.

211. Regulators already have some powers to set out certain aspects of their administrative removal and restoration processes in secondary legislation. For example, the General Medical Council (Voluntary Erasure and Restoration following Voluntary Erasure) Regulations Order of Council 2004 make provisions for medical practitioners to be able to apply to the GMC's Registrar to have their names erased from the GMC's medical practitioners register and also makes provisions for medical practitioners to be able to apply to have their names restored to the medical practitioners register following voluntary erasure.

212. In line with our approach of providing regulators with greater freedom to set their own operating procedures, we are proposing that regulators should be given increased

powers to set out their removal and readmission processes in rules which are consistent with the principle of public protection. We encourage regulators to work together to develop their rules so that they are consistent across regulators. For example, in relation to fraudulently obtained or incorrectly made entries in the register, we propose that legislation should provide the registrar with the ability to remove an entry from the register where they are satisfied that it has been incorrectly or fraudulently made. In addition, it should set out that where the registrar decides to remove a person's name from the register for these reasons, the registrant must be notified and that this notification must set out their right to appeal the decision. However, the detailed processes on removal and re-admission to the register should be set out by the regulator in rules and guidance rather than in legislation.

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

Registration Appeals

213. Health professionals must be able to appeal decisions affecting their registration. Registration appeal processes are set out in the legislation of the regulators. These are separate from fitness to practise appeals. The decisions that a person may appeal should continue to be set out in legislation.

214. These include a decision to:

- refuse to register a person;
- suspend a person from the register for administrative reasons;
- remove a person from the register for failure to keep their name and contact details up to date;
- not grant a person voluntary removal from a regulator's register;
- remove a person from the register for failure to meet a condition attached to their registration;
- remove a person from the register for failure to comply with a requirement to meet the professional standards relating to continuing professional training and/or revalidation;

- remove a person's entry from the register where registration renewal has not been made in accordance with the regulator's renewal process;
- remove an entry from the register, where the regulator is satisfied that their registration was fraudulently procured or incorrectly made;
- refuse to readmit/restore an applicant to the register;
- not register, readmit/restore or remove a person's name from the register due to insufficient or inadequate indemnity provisions being in place;
- add or amend an annotation to a person's register entry which leads to a restriction on a person's practice or registration;
- remove an annotation from a person's register entry;
- refuse to add or restore an annotation on a person's register entry; and
- any other decision specified by a regulator in their rules.

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

215. Where regulators, such as the GPhC, also have decisions in relation to premises which can be appealed, for example a decision by a regulator to refuse to enter premises in a part of the register, such appeal rights should continue to be set out in legislation.

216. We propose that registration decisions in relation to the following should not be subject to appeal:

- the registrant failed to pay any fee payable in accordance with rules;
- the registrant failed to apply in accordance with the procedure set out in rules; and
- an annotation is removed from a person's registration entry because any time limit has lapsed.

217. Internal appeal panels should hear an appeal first, with all appellants having a right of appeal beyond this to the Courts. This should be set out in the regulator's

governing legislation along with the powers of such Courts on deciding the appeal. Legislation will also enable the regulators to charge fees for registration appeals which would be refundable in the event of a successful outcome for the appellant.

218. Regulators should have the power to set out aspects of their internal appeals processes in rules. This will include detail on who should hear the initial appeal, the timeline for determining the outcome of the registration appeal and what should happen if an appellant's registration appeal needs to be postponed. Regulators will be required to set out these processes in rules.

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

3c. – Specific cohorts of registrants

Student registers

219. A student register is a list of health and care profession undergraduate students who have been accepted on to relevant approved UK Higher Education Institution courses. Undergraduates are university students who have not yet taken a first degree and who are not yet qualified to practise their chosen profession.

220. The GOC is the only regulator which holds a student register. It is required to keep a register of students undertaking training as optometrists and a register of persons undertaking training as dispensing opticians.

221. The PSNI's governing legislation includes a power enabling it to hold a register of students. However, the individuals registered on the PSNI's student register are postgraduate trainees rather than undergraduates.

222. Undergraduate students are unable to practise unsupervised and are overseen by their education or training provider. These educational institutions are better placed to address any concerns in relation to undergraduate students rather than the regulators.

223. We therefore propose to remove any powers or duties for regulators to hold a register of students, including repealing powers allowing the holding of a student register and removing the duty on the GOC to hold a student register.

224. Postgraduate trainees should continue to be able to apply to the PSNI for registration. However, in line with our proposal that all regulators should hold one

register that is divided into parts for each profession that it regulates, the PSNI's discretionary power to hold a student register should be revoked. Instead, we propose that the PSNI should annotate its register to indicate where registrants are postgraduate trainees.

40. Do you agree or disagree with our proposal that the regulators should not have discretionary powers to establish student registers? Please give a reason for your answer.

Registration of non-practising professionals

225. A non-practising register is a list of qualified individuals who are not currently practising or who do not intend to practise in the future. None of the healthcare regulators hold separate registers of non-practising professionals, even where the power to hold such a register exists. However, the GCC and GOsC annotate their registers to indicate where a registrant is undertaking a break from practice. Non-practising registrants are able to pay a reduced fee to the GCC and GOsC but are still required to meet continuing professional development requirements.

226. Our proposal is that regulators should not have a power to establish separate registers of non-practising professionals.

227. The purpose of regulation is to provide assurance that healthcare professionals are safe to practise. In addition, the registration of these individuals could lead to confusion as to whether an individual's knowledge, skills and experience are up to date.

41. Do you agree or disagree with our proposal that the regulators should not have discretionary powers to establish non-practising registers? Please give a reason for your answer.

Registration of internationally qualified healthcare professionals

228. International healthcare professionals play an important role in the delivery of healthcare in the UK. In 2019/20, 43 per cent of new joiners to the GMC register and 31 per cent of new NMC registrants were internationally qualified professionals.

229. The Interim NHS People Plan and A Healthier Wales: Our Workforce Strategy for Health and Social Care set out a need to increase international recruitment of nurses and doctors while domestic supply is increased.

230. All of the UK healthcare professional regulators have processes for the registration of international healthcare professionals, except the PSNI (international applications to PSNI are processed by the GPhC). The detail of these arrangements are set out in differing levels of detail in primary and secondary legislation.

231. In some instances, the legislative requirements for the registration of internationally qualified applicants are bureaucratic and may deter safe and competent overseas professionals from seeking to practise in the UK. For example, internationally qualified specialist doctors, including GPs, are required to submit large volumes of documentary evidence to demonstrate that their qualification and training is equivalent to that delivered in the UK.

232. Some of the legislative requirements make it difficult for regulators to improve their registration processes for internationally qualified professionals. For example, the process for international dentists to register with the GDC is set in legislation and requires the majority of applicants to sit an Overseas Registration Exam with the exam fee specified in legislation.

233. Removing this level of detail on international registration requirements from legislation and allowing regulators to set these arrangements out in rules will ensure that they have the flexibility to develop effective and streamlined international registration processes which assure public protection in a more proportionate way.

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

4. – Fitness to Practise

Introduction

234. This section sets out our proposed changes to healthcare regulators' fitness to practise processes.

235. Regulated professionals are required to meet the standards for practising their profession safely and effectively. This is one of the principal means by which regulators ensure public protection.

236. Where a concern is raised that a professional does not meet these standards, regulators have a duty to assess the concern, and where necessary to take action to protect the public. This could result in restrictions being applied to an individual's practice or, in the most serious cases, lead to their removal from the register.

237. There is considerable variation in the fitness to practise powers currently available to the regulators. Our proposed changes will put in place consistent fitness to practise arrangements across all the regulators. This will allow some decisions to be made more quickly, ensuring that the steps necessary to protect the public are in place sooner, and provide early resolution for patients, families and professionals.

238. These changes will:

- provide regulators with an amended set of powers, allowing more cases to be concluded earlier through accepted outcome decisions made by case examiners, and through a broader range of measures (including issuing a warning, applying conditions to a registrant's practice, suspending their registration, or removing the registrant from the register);

- provide regulators with the ability to set their operational procedures through rules, removing the requirement for such procedures to be approved by the Privy Council;

- remove the General Medical Council's right to appeal Fitness to Practise panel decisions, as per our commitment to introduce the Williams Review recommendations;

- amend the power to require information in relation to fitness to practise cases to expressly exclude reflective practice material, as per our commitment to introduce

the Williams Review recommendations (the General Optical Council and General Medical Council currently have this power);

- provide a right for anyone to request a review of a fitness to practise decision made by a case examiner, or made at the initial assessment stage of a case; and

- provide all regulators with a power for the Registrar to review a decision made by a case examiner, or at the initial assessment stage of a case.

239. These changes aim to deliver a fitness to practise process that is less adversarial and with more cases resolved without the need for a fitness to practise panel hearing. This will provide benefits to all parties involved in fitness to practise proceedings. It will deliver protection for the public more quickly. It will reduce the stress on registrants and others that are party to the fitness to practise process, and it will increase the likelihood of reflection and learning from cases.

240. Currently, regulators focus much of their effort and resource on the small minority of registrants whose fitness to practise is a concern. These changes will enable regulators to provide a greater level of support to improve the professionalism of all of their registrants.

241. This section sets out the following:

- Section 4a provides a summary of the proposed new fitness to practise process.

- Section 4b sets out further detail on the grounds for action and measures available.

- Section 4c sets out further detail on powers relating to the fitness to practise process.

- Section 4d sets out detail on the different stages of the fitness to practise process.

- Section 4e sets out detail on appeals, restoration and the registrar review power.

4a. – Summary of the revised Fitness to Practise process

Three-Stage Fitness to Practise process

242. Our proposals will introduce a three-stage fitness to practise process for all regulators.

The first stage is the Initial Assessment.

243. The purpose of the initial assessment stage is to determine whether a concern received about a registrant meets the criteria for onward referral in the fitness to practise process.

244. We propose that regulators should be provided with a consistent set of powers concerning the initial assessment stage. Regulators will have a duty to consider any concern that is received about one of their registrants and to determine whether or not there is a basis for onward referral in the fitness to practise process.

245. Any cases that meet the regulator's criteria for onward referral in the fitness to practise process, and which fall under either of the grounds for action (lack of competence, and misconduct), will be referred onwards. Health and English language will not be separate grounds for action but will be considered as part of an assessment of competence.

246. Additionally, in ongoing cases where there is an immediate public protection risk, regulators will be able to impose an interim measure. Typically, an interim measure would restrict the practice of a registrant while an assessment of their fitness to practise is undertaken.

247. Cases that do not meet the criteria for onward referral in the fitness to practise process will be closed at this stage.

The second stage is the Case Examiner Stage.

248. Case examiners will carry out a detailed assessment of the case from the written information and evidence available, and where possible, make a decision based on their assessment of impairment and whether action is needed to protect the public.

249. Where a case examiner determines that a registrant's fitness to practise is impaired, they will have a full suite of measures available (including applying conditions to a registrant's practice, suspending their registration, or removing the registrant from the register) with which they can conclude a case.

250. However, case examiners are only able to conclude such a case through an accepted outcome, where the registrant accepts both the findings (including impairment) and the proposed measure. If the registrant does not accept the findings and/or the proposed measure, the case will proceed to the Fitness to Practise panel stage.

251. Case examiners will be able to impose a decision in limited situations, such as when a registrant has not responded to the case examiner's offer of an accepted outcome.

The final stage is the Fitness to Practise Panel Stage.

252. If a case is referred to a Fitness to Practise panel, the panel is required to make a determination as to whether a registrant's fitness to practise is impaired.

253. Where the Fitness to Practise panel concludes that the registrant's fitness to practise is impaired, it will impose an appropriate measure. In cases where a registrant's fitness to practise is not found to be impaired, the panel may choose to issue a warning.

254. We propose that all regulators will have the same powers in relation to the Fitness to Practise panel stage with greater freedom to set out their operational procedures in rules.

255. Most cases heard by a Fitness to Practise panel will be heard in public. There may be occasions where a hearing, or parts of a hearing will need to be held in private, for example, when discussion concerns a registrant's health.

256. Measures available to case examiners and Fitness to Practise panels include issuing a warning, applying conditions to a registrant's practice, suspending their registration, or removing the registrant from the register. Measures are discussed in more detail below.

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

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

Please give a reason for your answer.

257. Further detail on the stages of the fitness to practise process and related powers is set out in the following sections.

4b. – Grounds for action and available measures

Grounds for action

258. Grounds for action set out the reasons why regulators might need to investigate and take action where there is a concern about a registrant's fitness to practise. Grounds for action help regulators to focus on the most serious concerns; those that could put patients or the public at risk or affect the public's confidence in the profession.

259. All of the regulatory bodies have grounds for action defined in their existing legislation (currently referred to as 'heads of impairment') which enable them to investigate fitness to practise concerns against registrants. However, there is significant variation in how these grounds are defined, which can lead to inconsistency in the way that concerns about registrants in different professions are treated.

260. We propose that the grounds for action should be consistent across all regulators in order to clarify to the public, registrants and the regulators the circumstances in which action can be taken.

261. Under our proposal, all regulators would be provided with the same grounds for action against which they can take forward a fitness to practise investigation. These are:

- Lack of competence, which means the registrant is either unable to or has failed to provide care to a sufficient standard. This would include a lack of the necessary knowledge of English, or a health condition which affects a registrant's ability to practise safely.

- Misconduct – behaviour that may or may not be related to the exercise of professional skills, but which is serious or persistent and represents a significant departure from the required professional standards of conduct; for example, serious dishonesty. This would include, but is not limited to, a conviction or caution for a criminal offence in the UK (other than a listed offence as dealt with in paragraph 302, which would result in automatic removal from the register) and convictions/cautions falling outside of UK, which if committed in the UK would constitute a criminal offence. Determinations by another UK regulatory body to the effect that the registrant's practice is impaired, or a determination by a regulatory body elsewhere to the same effect, may also amount to misconduct.

262. A number of regulators currently have separate grounds for action in relation to English language skills and health concerns. We propose that these should no longer be grounds. Regulators will still be able investigate such concerns and restrict a registrant's practise where concerns about these issues affect a registrant's ability to practise safely.

263. We recognise that there can be advantages to having separate grounds for health and English language. However, our proposed approach is that where a registrant's fitness to practise is called into question, this will always be on the basis that they either do not meet the required standards of conduct, and/or that their level of competence does not meet the required standard.

264. We consider that addressing concerns that do not meet the fitness to practise threshold through the fitness to practise process is disproportionate and unfair.

265. One of the aims of the reforms is that regulators will be freed up to provide a greater level of support towards the professionalism of more of their registrants. Our expectation is that regulators would use the greater freedoms being provided within their legislation to support individuals where there are health or English language concerns that do not meet the threshold for fitness to practise, and that such cases would only be dealt with as a fitness to practise concern where a registrant's conduct or competence fell below the standards set by the regulator.

266. This would enable regulators to handle health concerns more sensitively by working with a registrant, outside of the fitness to practise process, to ensure that they have the support in place to continue to work within a safe scope of practice. Using this mechanism, a regulator and a registrant could agree the lapsing or suspension of a registrant's registration in cases where a health condition meant that they were no longer able to safely practise on a temporary or permanent basis.

44. Do you agree or disagree that:

- All regulators should be provided with two grounds for action – lack of competence, and misconduct?
- Lack of competence and misconduct are the most appropriate terminology for these grounds for action?
- Any separate grounds for action relating to health and English language should be removed from the legislation, and concerns of this kind investigated under the ground of lack of competence?

- This proposal provides sufficient scope for regulators to investigate concerns about registrants and ensure public protection?

Please give a reason for your answers.

Measures available to Case Examiners and Fitness to Practise panels

267. The measures available to case examiners and Fitness to Practise panels need to address the range of scenarios in which a registrant's fitness to practise is found to be impaired, or is below the expected standard, in order to provide effective public protection.

268. Currently there is inconsistency in the range of measures that a healthcare regulatory body can apply/issue/impose. We propose that the following measures are available to all regulators.

Measures in relation to registrants whose fitness to practise is not found to be impaired

269. Warning – Warnings allow a regulator to indicate to a registrant that, while their conduct, practice or behaviour does not meet the threshold for impaired fitness to practise, it is below the expected standard and should not be repeated. They are a formal response from a regulator and must be published by the regulator in order to uphold public confidence in the profession. A warning will not restrict the registrant's practice or registration status.

270. Regulators will be required to publish warnings for a period of two years.

Measures in relation to registrants whose fitness to practise is found to be impaired

271. Conditions - This measure enables a Fitness to Practise panel to impose, or a case examiner to propose via the accepted outcome process, conditions which the registrant is required to follow. For a final conditions measure imposed by a Fitness to Practise panel or proposed by a case examiner and accepted by the registrant, the regulator will be able to review the conditions before the end of the term to which they apply. The maximum period for which a condition could be applied would be 12 months, although this could be extended by review.

272. Suspension Order – This measure prevents a registrant from practising for a set period of time. The maximum period for a suspension order would be 12 months although this could be extended by review.

273. Removal Order - A removal order removes the registrant's name from the register ensuring they can no longer practise in that profession.

Measures in relation to registrants who have been convicted of a listed offence

274. Automatic removal order - Where a registrant is convicted of a listed offence (based on the list in Schedule 3 of the Social Work Regulations), the regulator will be able to remove a registrant from the register automatically. This is the only measure the regulator can impose without an initial assessment. The process for automatic removal must be set out in rules made by the regulator.

275. A registrant subject to an automatic removal order will have the right to appeal the order to the High Court.

276. An automatic removal order must be reversed where the conviction has been overturned or quashed. However, if there are other fitness to practise concerns, the regulator will be able to investigate these.

45. Do you agree or disagree that:

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

Please give a reason for your answers.

277. Regulators will be required to publish decisions (and measures) by case examiners and panels, including the reasons that a particular outcome was reached and, if applicable, why a particular measure was imposed. Publishing measures supports transparency of decisions made by regulators.

278. Measures will come into effect immediately, or after a period of up to 28 days (or on expiry of an existing sanction), at the discretion of the regulator. This would offer flexibility in the outcome that is applied and would address situations where a regulator might currently use an immediate order to ensure risk to the public is minimised.

Review of final measures

279. Regulators will have powers to review a measure at any point before its expiry. Regulators will be required to set out in rules the process they will follow in reviewing a

measure; this could include case examiners or Fitness to Practise panels conducting the review.

Early review of a measure

280. A registrant may request a review of a measure imposed at any point before its expiry. The regulator will set out the process for making and considering such a review in rules.

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

4c. – Rules relating to fitness to practise procedures

281. The regulators will have more flexibility to set out their own rules, under parameters that will be set out in legislation. This will ensure that all regulators are working under a consistent legal framework, but with freedom to adapt their processes to the specific needs of the professions they regulate.

282. Regulators will have the power to makes rules in relation to the following:

Committees

283. Legislation requires regulators to establish various statutory committees and panels relating to their fitness to practise functions. This makes it difficult for regulators to adapt their processes and procedures to changing circumstances.

284. We propose to provide regulators with a general power to establish any committees they consider necessary to assist with the discharge of any of their functions during the course of the fitness to practise process, using the general powers covered in the Governance section (see paragraph 74-76).

285. Regulators will have the power to make rules in relation to the discharge of functions by such committees, including their membership.

Notifications to registrant and person(s) who raise a concern

286. We propose that regulators should have the power to set out the process for notifying registrants and the person(s) who raised the concern in rules. Regulators will be required to notify registrants whenever a substantive decision is being made (this would include an onward referral from the initial assessment stage, interim measure, case examiner decision, referral to a Fitness to Practise panel, Fitness to Practise

panel decision, and when a case is closed following onward referral). The registrant will also have a right to request updates from the regulator about case progression.

287. Rules made by the regulator will cover the procedure for giving notice, the content of the notice, what information should be provided with it, when notice must be given, and how and when service of the notice is deemed to have been made.

288. In particular, the notice must ensure that the registrant is made aware of:

- the seriousness of the proceedings and the consequences of failing to participate (both in terms of the decisions that may be made in the registrant's absence, and the consequences of failing to comply or engage with the fitness to practise process);
- the right to be represented and to make a written submission and make representations in person to an Interim Measures panel and Fitness to Practise panel; and
- the time period within which a response is required, and the ways of making such a response.

289. Regulators will also have a duty to inform the person(s) who raised the concern at key points throughout the fitness to practise process, including whenever a substantive decision has been made, unless the person(s) who raised the concern does not wish to receive these updates. The regulator may also notify other relevant parties, such as employers or others with a direct interest in the concern/case, where they consider it to be appropriate and in line with data protection law.

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

4d. – Detail on Stages

Initial assessment stage

290. The first stage in the fitness to practise process is an initial assessment. This may be the result of a concern being received by the regulator, or the regulator itself choosing to initiate an assessment if it has concerns about a registrant's fitness to practise.

291. We propose that regulators are provided with a consistent set of powers concerning the initial assessment stage. Regulators will have a duty to consider a matter referred to them, and a discretion to determine whether or not there is a basis for onward referral in the fitness to practise process.

292. Regulators will have the following powers to enable an initial assessment of fitness to practise concerns:

- A broad power to assess a registrant's fitness to practise, enabling them to investigate a fitness to practise concern at any stage. This would allow regulators to investigate an initial concern and to consider further information that came to light at a later stage in the process;
- A power to require information from a third party, and to seek an order from the courts requiring information from a third party should they refuse to provide it;
- A power to require information from a registrant. This power will exclude reflective material;
- A power to direct a registrant to undergo an assessment in relation to a fitness to practise investigation;
- A rule making power for regulators to set out the process for assessing a concern and for the onward progression of a case in the fitness to practise system;
- The right for a registrant to provide written submissions to the regulator during the course of the initial assessment. While a registrant would not usually be notified that an initial assessment is underway, they may have raised concerns about their own fitness to practise to the regulator or otherwise be aware that a concern has been raised; and
- A new power for regulators to decide, if appropriate, that there is no further action to be taken and to close the case at this stage.

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

293. Several regulators cannot currently consider fitness to practise concerns which are more than five years old (the five-year rule). While the time since a concern arose is a relevant consideration in assessing fitness to practise, it should not be a limitation on

whether an incident can be considered as the basis for a fitness to practise concern. We therefore propose to remove the five-year rule, allowing regulators greater discretion to consider whether a concern should be considered.

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

Non-compliance

294. The General Medical Council currently has a separate power for dealing with instances where a registrant has failed to comply with a reasonable request to provide information made by the regulator, or with a reasonable direction by the regulator to undergo an assessment in relation to a fitness to practise investigation. This power allows the General Medical Council to refer the matter to a Fitness to Practise panel for a hearing about a registrant's non-compliance.

295. Providing such a power to all regulators would provide an additional mechanism to ensure that non-compliance by a registrant does not impede the regulator's ability to make an assessment of whether a registrant is fit to practise. This power could be used where a regulator considers that such a failure to comply creates a risk to public protection, due to its inability to fully investigate the concerns about a registrant's fitness to practise. In cases of non-compliance, regulators would have the power to conduct a Fitness to Practise panel hearing and impose a measure on a registrant, up to and including erasure from the register.

296. Registrants would have a right to appeal any decision imposed due to non-compliance.

297. Regulators who do not have such a power currently manage non-compliance using existing powers such as "adverse inferences" – i.e. a presumption that if a registrant chooses not to comply with a request to prove they have the required standard of English, their non-compliance could be taken as evidence that they do not.

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

Onward referral following initial assessment

298. If, after an initial assessment, a regulator believes that there is a fitness to practise concern, they will be able to make an onward referral to a case examiner.

299. At any time during or after initial assessment, the regulator may consider the use of an interim measure if immediate action is needed to protect the public (see paragraphs 320 - 333)

300. Regulators will be required to make rules which will set out:

- how they will deal with multiple concerns against a single registrant, at any point in the fitness to practise process; and
- the ability to amend the grounds for action in relation to a case. These rules will need to set out arrangements to provide notice to the registrant and a right for the registrant to make written submissions.

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

Automatic Removal in relation to specified Criminal Offences

301. We are proposing to introduce a new power that will enable regulators to automatically remove a registrant from the Register, if they have been convicted of specified serious criminal offences (known as listed offences). These arrangements already apply in relation to social workers registered with Social Work England. A list of the relevant offences is attached at Annex A.

302. Where a registrant has been convicted of a criminal offence that is not a listed offence, this would not trigger automatic removal but could form a ground for possible action under misconduct. Regulators will decide the appropriate action based on the facts determined by the conviction. Regulators will also be able to refer such cases to an interim measures panel.

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

Final decision-making roles

303. There will be two final decision-making roles in the fitness to practise process: case examiners and Fitness to Practise panels. Both will have the power to make final determinations on whether a registrant's fitness to practise is impaired and to determine any measure that should be applied, such as restricting their practice.

304. These roles will have distinct functions. To ensure broad consistency across all regulators, these two roles will be specified in each regulator's governing legislation; however, regulators will have discretion to name and set up panels and committees as they see fit, to meet the functions performed by these roles.

Case Examiner stage

305. Case examiners undertake a detailed assessment of the case, from the written information and evidence available, and where possible, make a decision based on their assessment of impairment and whether action is needed to protect the public.

306. A number of regulators already use case examiners, but their powers to resolve cases are limited. Other regulators do not have case examiners and many cases currently go straight to a Fitness to Practise panel for consideration. This has led to a process which is time-consuming, expensive, adversarial and often stressful for all parties involved.

307. There is a strong argument for closing more cases at an earlier stage of the fitness to practise process, especially where the registrant accepts the findings and the proposed outcome.

308. We propose that all of the regulators should have the case examiner role as part of their fitness to practise process, with a full suite of measures[11] with which they can conclude a case. This will include powers to conclude a case via an accepted outcome. They will also be able to impose measures upon a registrant who has not responded to the case examiner's offer of an accepted outcome. If a case examiner is not able to make a decision based on the information available to them, they will refer the case to a Fitness to Practise panel.

309. Regulators will set out the detailed process for the case examiner stage in rules.

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[11] For registrants whose fitness to practise is found to be impaired, the measures are: applying conditions to a registrant's practice; suspending their registration; or removing the registrant from the register. For registrants whose fitness to practise is not found to be impaired, the measure available is the issuing of a warning.

310. All case examiner decisions must be made publicly available, unless there are exceptional reasons why they should not be. Published information must include the reasons that a particular outcome was reached and, if applicable, why a particular measure was imposed.

Accepted outcomes

311. All regulators should be provided with powers to conclude cases at the case examiner stage, through an accepted outcomes process. Case examiners will be able to decide that a registrant's fitness to practise is impaired and will have a full suite of available measures with which they can conclude a case. However, they will only be able to conclude cases though an accepted outcomes process where the registrant accepts both the findings and the proposed measure.

312. It is important to stress that the accepted outcomes process is not a negotiation between a registrant and a case examiner. If the registrant does not accept both the finding of impairment and the proposed measure, then the case will proceed to a Fitness to Practise panel for a determination.

313. The case examiner may simultaneously refer the matter to an Interim Measures Panel (see paragraphs 320 - 333 below).

314. The accepted outcome process aims to be less adversarial, and to enable cases to be concluded more quickly; it will also reduce the burden on those who would have been required to attend a hearing - including the registrant, the person(s) who raised the concern, and other witnesses and experts.

315. The introduction of an accepted outcomes process will leave Fitness to Practise panels to consider cases where an outcome is not accepted, or where the case examiner is not able to make a decision on impairment. This could include, for example, where the evidence needs to be tested at a hearing. However, the seriousness of a case alone would not be grounds for referral to a Fitness to Practise panel.

Non-responding registrants at the case examiner stage

316. There may be cases where a registrant does not respond to the case examiner. In order to protect the public, regulators need to be able to conclude these cases in a safe and efficient way, by imposing an appropriate measure.

317. If a registrant does not respond within 28 days of a proposal by the case examiner to conclude the case through an accepted outcome, the proposed measure will come into force.

318. This is not an accepted outcome, but a separate power for the case examiner to impose a measure where a registrant does not respond to the case examiner's accepted outcome proposal. This will only apply where the case examiner concludes that the registrant's fitness to practise is impaired.

319. Where a decision is imposed by a case examiner, registrants must be able to challenge this. We propose that registrants should have a statutory right of appeal against the decision to the High Court in England and Wales, the Court of Session in Scotland, or the High Court in Northern Ireland.

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

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

Please give a reason for your answers.

Interim Measures

320. We propose that all regulators are provided with a consistent set of powers relating to interim measures.

321. Interim measures are not findings of impairment. They are restrictions on a registrant's practice that a regulator can put in place to address a public protection risk and/or a registrant protection risk, while their fitness to practise is under consideration.

322. Regulators will be able to consider a case for an interim measure at any point in the fitness to practise process, from initial receipt of the concern until a final outcome is reached.

323. There are two interim measures available:

- interim conditions order – applies a condition to a registrant's practice
- interim suspension order – suspends a registrant from practising.

324. Regulators will have the power to convene Interim Measures panels, but interim measures may also be considered by Fitness to Practise Panels and case examiners.

325. Interim Measures panels and Fitness to Practise panels will have powers to place the following restrictions on registrants:

- impose an interim measure;
- reduce/extend/revoke imposed interim measures; and
- substitute another interim measure.

326. Case examiners will have the power to:

- propose an interim measure to a registrant;
- make a proposal to reduce/extend/revoke imposed interim measures; and
- make a proposal to substitute another interim measure.

327. Any interim measure proposed by a case examiner will only come into force if it is agreed by the registrant.

328. If a registrant does not accept an interim measure proposed by a case examiner, the case examiner must refer the matter to an Interim Measures panel.

329. Regulators will have the power to set their interim measures process in rules. This must include, but is not limited to:

- the process for determining if an interim measure is required;
- the quorum of an Interim Measures panel;
- the process for determining a review of an interim measure; and
- the process of notifying the registrant and any other appropriate person(s) of an interim measures decision.

330. An interim measure will come into effect at a time set by the regulator. Regulators will be required to notify the registrant of a proposed interim measure and give them the opportunity to make written submissions and/or representations but will not be required to wait for written submissions and/or representations before the interim measure comes into effect.

331. A regulator may put in place an interim measure for a period of up to 18 months. Extending an interim measure beyond its initial term (even where that initial term is less than 18 months) will require an application to the High Court in England and Wales, the Court of Session in Scotland, or the High Court in Northern Ireland for an extension of a maximum of 12 months. A regulator may apply for more than one extension.

332. The registrant will have a right to appeal an interim measure imposed by an Interim Measures panel or Fitness to Practise panel to the High Court in England and Wales, the Court of Session in Scotland, or the High Court in Northern Ireland. An interim measure will remain in place while an appeal is considered.

333. The Interim Measures panel/regulator may notify the person(s) who raised the concern that a case has been referred to an Interim Measures panel and of the outcome, in line with Data Protection law. The regulator may also inform any person(s) it considers appropriate of any interim measures.

Review of interim measures

334. The regulator must review an interim measure at least every six months, while the measure is in place.

335. The regulator may choose to review an interim measure at any time, including where it receives new information or circumstances change to indicate an early review is necessary.

336. The registrant can request an early review of an accepted or imposed interim measure at any time. Such a review is at the regulator's discretion.

337. A review can be conducted by a case examiner, an interim measure panel or a Fitness to Practise panel:

- An interim measure panel or Fitness to Practise panel may reduce, extend, revoke, add an additional interim measure or substitute a current measure with a new interim measure.

- A case examiner may reduce, extend, revoke, add an additional measure or substitute a current measure with a new interim measure, where accepted by the registrant.

- Where the outcome of a case examiner review of an interim measure is not accepted by a registrant, the case examiner must refer the matter to an Interim Measures panel.

338. The process for reviewing interim measures will be set by the regulator in rules.

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

Fitness to Practise panel stage

339. Fitness to Practise panels will make a determination on the question of whether a registrant's fitness to practise is impaired and put in place suitable measures to protect the public.

340. Currently, most fitness to practise concerns are heard by a Fitness to Practise panel. Under our proposals, only fitness to practise concerns that are referred from the Case Examiner stage will reach the Fitness to Practise panel stage. This may be because the registrant did not accept an outcome proposed by a case examiner or a case examiner is unable to make a decision on a case.

341. The legislation will set out:

- the overall powers that a regulator will have in relation to setting up and running a Fitness to Practise panel hearing;

- the responsibilities and duties that a regulator will have in relation to Fitness to Practise panels;

- the role of a Fitness to Practise panel, and the decisions and measures that Fitness to Practise panels will have available to them; and

- what a regulator may set out in rules, and what it must do.

342. We propose that:

- the Fitness to Practise panel will have the power to make a reasonable request for information from anyone that the Fitness to Practise panel considers it appropriate to do so;

- the regulator will have the power to compel witnesses to appear where necessary;

- all registrants will have the right to make representations, and/or written submissions;

- regulators will have the power to set the process for the closing of a case and the taking of no further action in rules;

- where the Fitness to Practise panel determines that the registrant's fitness to practise is impaired, it will be able to impose an appropriate measure;

- where the Fitness to Practise panel has concluded that the registrant's fitness to practise is not impaired, the panel will have the power to issue a warning; and

- the regulator will have the power to set out in rules the process by which a Fitness to Practise panel will impose a measure on a registrant.

343. Once a case has been referred to a Fitness to Practise panel by a case examiner, the case cannot be concluded through an accepted outcome process.

344. Most cases heard by a Fitness to Practise panel will be heard in public. There may be occasions where a hearing, or parts of a hearing will need to be held in private, for example, when discussion concerns a registrant's health.

345. To ensure that fitness to practise procedures are open and transparent, the regulator will be required to establish rules and procedures to ensure that, where appropriate, hearings are held in public.

346. In all cases, Fitness to Practise panel decisions must be made publicly available, unless there are exceptional reasons why they should not be. Published information must include the reasons that a particular outcome was reached and, if applicable, why a particular measure was imposed.

347. A regulator will not have the right to appeal a decision made by a Fitness to Practise panel.

348. The processes to be followed in relation to the functions of Fitness to Practise panels will be set out in rules made by the regulator. The regulator must publicly consult on these rules.

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

4e. – appeals, restoration and registrar review power

Registrant appeals

349. Registrants must have a right to appeal decisions made by a case examiner, Fitness to Practise panel or Interim Measures panel. These appeal rights will apply in the following circumstances, where:

- a case examiner has found a registrant's fitness to practise to be impaired and has imposed a measure due to a non-responding registrant;
- a case examiner has found a registrant's fitness to practise to be impaired, and a registrant has accepted the proposed outcome and measure;
- a Fitness to Practise panel has found a registrant's fitness to practise to be impaired and has imposed a measure; and
- an Interim Measures panel has imposed a measure.

350. Where a registrant has been automatically removed following a criminal conviction, there will also be a right of appeal.

351. Appeals will be heard by the High Court in England and Wales, the Court of Session in Scotland, or the High Court in Northern Ireland.

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

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

Restoration to the register

352. Where a person is removed from the register as a result of a finding of impaired fitness to practise, and that person wishes to be restored to the register, they must make an application for restoration to the Registrar.

353. Registrants should have a right to appeal a decision by the regulator not to permit restoration to the register. The process for considering these appeals will be similar to that for appeals against registration decisions, with the initial appeal being considered internally. We propose that there is a further right to appeal to the High Court in England and Wales, the Court of Session in Scotland, or the High Court in Northern Ireland. Regulators will be required to set out the process for this in rules. These must include:

- the time frame in which an application for restoration may be made;
- the process for determining how the application is reviewed; and
- the internal appeal process for a registrant to challenge a decision not to permit restoration.

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

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

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

Registrar review powers

354. Greater autonomy must be accompanied by greater accountability. This includes effective governance underpinned by openness and transparency in how the regulatory bodies discharge their regulatory functions.

355. While a number of regulators (the General Medical Council, General Dental Council, General Optical Council and Nursing and Midwifery Council) have some powers to close cases via an accepted outcomes process, we are proposing to go

further. All regulators will have accepted outcome powers, enabling case examiners to close cases using a full suite of measures, including removal from the register, where this is accepted by a registrant.

356. The PSA has a right to refer Fitness to Practise panel decisions made by a regulator to court where it considers the action taken by the regulator is insufficient to protect the public, using its Section 29[12] powers. This is treated as an appeal. The PSA's ability to review fitness to practise cases is an important element of public protection, and its right to refer cases resolved by a panel to court will remain.

357. It is important that the oversight of cases closed by accepted outcome is proportionate and sufficient to protect the public. We have considered whether the PSA's power to refer Fitness to Practise panel decisions to the High Court should also apply to decisions made by a case examiner and accepted by a registrant. We are not proposing to extend the PSA's Section 29 powers to cover case examiner decisions.

358. Instead, we will introduce a Registrar Review mechanism for all regulators. This will allow the registrar of each regulator to review a fitness to practise decision made by a case examiner, or a case that was closed at the initial assessment stage. This review power will also apply to interim measures decisions made by a case examiner, which have been accepted by a registrant.

359. The proposed grounds for a registrar review are, that in the judgement of the registrar:

- the decision was materially flawed, either wholly or in part; and/or
- there is new information which would have, wholly or in part, led to a different decision;

But only if one or more of the following grounds are also satisfied:

- the registrar considers that the decision may not be sufficient to protect the public; and/or
- the registrar considers that the review may be necessary for the prevention of injustice to the registrant.

[12] See Section 29 of the National Health Service Reform and Health Care Professions Act 2002 (as amended).

360. Any person(s) will be able to request a registrar review but the regulator will only have a duty to direct a review when a request meets the grounds set out above. The regulator will be required to set out in rules the process for carrying out such a review.

361. Where the registrar review results in a case being reopened which had not reached the Case Examiner stage, the regulator will decide the appropriate stage of the fitness to practise process for this to be reconsidered. This could be initial assessment, Case Examiner or Fitness to Practise panel stage.

362. Where the registrar review results in a case being reopened which had been closed at the case examiner stage, it must be referred to the Fitness to Practise panel stage.

363. In all cases, the Fitness to Practise panel will make the final decision and the outcome will be published. As with all other decisions made by a Fitness Practise panel, these cases could be appealed by the PSA under its existing powers.

364. In any case that is re-opened following a registrar review, an interim measure could, where appropriate, be imposed.

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

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

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

5. – Regulation of Physician Associates and Anaesthesia Associates

Introduction

365. Strengthening the future NHS workforce is one of the Government's top priorities. The NHS has seen the emergence of new professional roles working within multi-disciplinary teams as part of a continuing drive to provide safe, accessible and high-quality care for patients across the UK. The growth of these professions, including Physician Associates (PAs) and Anaesthesia Associates (AAs), is central to the Government's commitment to develop a more effective, strong and expanding medical workforce to meet future need.

The roles

366. Physician Associates (PAs)

- Work in both hospitals and general practice and carry out a number of tasks including taking medical histories, examinations and managing and diagnosing illnesses under the supervision of a medical practitioner.

- As of January 2021, around 2,100 qualified PAs were registered on the Faculty of Physician Associates' (FPA) voluntary register, representing around 90% of all qualified PAs. The number of PAs is projected to grow to around 6,000 by the end of 2023.[13] The further growth of the PA profession is an important part of developing a more effective, strong and expanding general practice to meet future need

367. Anaesthesia Associates (AAs)

- Work in hospitals as deliverers of anaesthesia and critical care in the anaesthetic team, performing pre and post-operative assessment and intervention and providing anaesthesia under the supervision of a consultant anaesthetist.

- As of January 2021, around 130 AAs were voluntarily registered by the Royal College of Anaesthetists (RCoA), representing approximately three quarters of those qualified.

[13] See the Interim NHS People Plan.

Why we are regulating PAs and AAs

368. Statutory regulation protects the public by ensuring that only professionals who meet the standards required for safe and effective practice are registered and permitted to practise that profession.

369. At the end of 2017, the Government consulted on whether to introduce statutory regulation for four medical associate professions (MAPs). These were:

- Physician associates;
- Anaesthesia associates (previously known as physicians' assistants (anaesthesia));
- Surgical care practitioners; and
- Advanced critical care practitioners

370. The Government concluded that the statutory regulation of PAs and AAs is the most effective way of assuring the highest standards of practice and the safety of patients. In February 2019 it announced that it would be introducing statutory regulation of these roles.

371. The GMC was later confirmed as the body that would regulate PAs and AAs on a UK-wide basis. PAs and AAs train and work to a medical or surgical model and work closely with and/or are supervised by medical practitioners. Regulation by the GMC will give the regulator responsibility and oversight of all three professions, allowing it to take a holistic approach to the education, training and standards of the roles.

372. Statutory regulation by the GMC will mean that anyone practising as a PA or AA must be registered with the GMC and will be subject to the relevant regulatory requirements. The GMC will be able to take action against individual PAs and AAs who seriously or persistently fall below those standards.

373. Regulation is a significant step towards embedding PAs and AAs in the multi-disciplinary healthcare workforce. It is also a necessary step towards the longer-term aspiration of extending a form of prescribing responsibilities to these professions in order to maximise their capability. Prescribing responsibilities are only considered for roles that are statutorily regulated and the current inability of PAs and AAs to prescribe is limiting the value of the roles.

374. Alongside the work to regulate PAs and AAs, the Department is working with representatives from the professions, NHS England and NHS Improvement, the

Devolved Administrations and professional bodies with an interest in the PA and AA roles, or prescribing, to develop an initial case for extending appropriate prescribing responsibilities to one or both roles.

5a. – Main reforms

375. Many of the arrangements for changes to professional regulation set out in this consultation document will apply to the PA and AA professions in the same way as they will apply for doctors and other regulated professionals.

376. There will, however, be some differences between PAs and AAs and doctors in the way they are regulated by the GMC to reflect the contexts in which each role practises and the risks posed.

377. Some specific changes will be required to reflect the expansion of the GMC's regulatory remit, as well as transitional arrangements for those PAs and AAs already practising and the development of profession-specific education and training arrangements. The changes will:

- give statutory responsibility to the GMC to regulate the PA and AA professions
- extend the GMC's powers and duties to PAs and AAs, in particular the key functions of:
    - registration of qualified and competent PAs and AAs;
    - setting standards of practice, conduct, education and training, and continuing competence;
    - approving and quality assuring education and training programmes;
    - operating fitness to practise procedures where there are concerns about the fitness to practise of a PA or an AA; and
    - recognising international qualifications for the purpose of registration with the GMC.

378. We propose to extend protection of title offences to include PAs and AAs. Any person who with intent to deceive (whether expressly or by implication):

- uses the professional title PA or AA unless registered with the GMC;

- falsely claims to be on the GMC's register;
- falsely claims to have PA/AA qualifications;
- fraudulently procures or attempts to procure, the making, amendment, removal or restoration of an entry on the GMC's register; or
- causes another person to make a false representation about them in relation to the protected title of PA or AA (or professional registration or qualifications)

will be guilty of an offence.

64. Do you agree or disagree with the proposed approach to the regulation of PAs and AAs? Please give a reason for your answer.

5b. – Further detail and reforms

Fees

379. As set out in section 1, regulators are funded by fees paid by their registrants. The GMC has confirmed that there will be no cross subsidy between medical practitioner's' registration fees and the regulation of PAs and AAs. The GMC will have powers to charge fees in relation to the registration of PAs and AAs. The GMC is already able to set registrant fees for doctors through Rules without parliamentary oversight and we are proposing that this power should be aligned across all the regulators therefore this power will also be extended to PAs and AAs.

380. Regulators will be able to set out a long-term framework for their fees. Any such framework, along with any fee increases which are outside of an existing framework, must be consulted on. Regulators will also have to consider the impact of any fee changes on their registrants. All fee changes and fee frameworks will need to be published. Regulators who do not choose to set out fee frameworks will have to consult on all fee changes. The GMC has indicated that, at the outset of regulation, the annual retention fee for PAs and AAs is likely to be at a similar level to that charged by the Faculty of PAs for membership of its managed voluntary register (currently £209).

Education and training

381. The table below sets out the current education and training arrangements for PAs and AAs.

Current education and training arrangements

Role and current entry requirements	Course type	Post qualification requirements
PA Entrants are usually graduates with a biomedical science degree. Some courses also accept individuals who have health related degrees or are registered healthcare professionals such as nurses	Individuals can complete a two-year postgraduate diploma or MSc or a 4-year undergraduate course.	PAs can join the Faculty of Physician Associates (FPA) managed voluntary register. To be eligible for inclusion on the register, an individual must hold a UK or US PA qualification and pass a national assessment set by the FPA or its US equivalent. To maintain registration, the FPA requires evidence of ongoing CPD and success in a re-certification exam every 6 years.
AA Entrants are either graduates with a biomedical science degree or registered healthcare professionals such as nurses	Individuals complete a 27 month post graduate diploma	UK qualified AAs can join a voluntary register held by the Royal College of Anaesthetists. There is no fee to join the register and no formal post-registration requirements.

382. There are 35 institutions across the UK running courses leading to the award of a PA qualification. The majority of these courses have started within the last five years. There is just one course leading to the award of an AA qualification (run by the University of Birmingham). A second AA course, run by University College London (UCL), is due to start in September 2021.

383. As set out in section 2, the regulators' role in setting standards and outcomes for quality assuring education and training is central to assuring that newly qualified registered healthcare professionals are equipped to deliver safe and effective care. All regulators will have the powers to set appropriate education and training standards that meet the evolving needs of the healthcare environment.

384. Once PAs and AAs are regulated, the GMC will have the powers set out in section 2 in relation to the education and training of these professionals. This will include the

power to approve PA/AA education and training programmes or providers and set and administer exams or other assessments for the purpose of registration.

385. Currently, the Royal College of Physicians (RCP) sets an assessment which PAs must pass in order to gain entry to the voluntary register. This assessment is used as a means of assuring that entrants to the register meet a standard set of requirements to deliver safe and effective care. In the most recent sitting of the PA national exam 94% of candidates passed the knowledge test and just under 80% were successful in the clinical skills exam.

386. Over time, quality assurance (QA) of UK PA and AA programmes will give the GMC assurance about learning and assessment processes within providers. The GMC's QA process includes checking that education and training takes place where patients are safe, the care and experience of patients is good, and education and training are valued. Assurance of an individual's capability at the point of qualification to practise safely requires a different mechanism, which is currently provided by the existing PA national exam. The GMC therefore wishes to maintain this approach and develop an equivalent for AAs.

High- level UK-wide curricula

387. The GMC has asked for an additional power in relation to PAs and AAs which will enable it to approve high-level UK-wide curricula. Programmes leading to the award of a PA or AA qualification would need to follow this UK-wide curriculum in order to be approved by the GMC.

388. Currently, the FPA sets a UK-wide curriculum for PAs which all programmes must follow if the FPA is to grant graduates entry to the voluntary register. The RCoA also sets a UK-wide curriculum for AAs. Granting the GMC the power to approve PA and AA UK-wide curricula will enable it to provide assurance that all PA and AA programmes which lead to registration are providing a consistent standard of education and training and equipping registrants to provide safe and effective care. The GMC standards will also relate to the process by which the curriculum is developed and maintained, not just the quality and content of the curriculum itself.

65. In relation to PAs and AAs, do you agree or disagree that the GMC should be given a power to approve high level curricula and set and administer exams? Please give a reason for your answer.

Transitional arrangements

389. The revised legislation will include transitional arrangements to provide a proportionate route to registration for PAs and AAs who are already qualified and/or practising. The majority of those who will be subject to transitional arrangements will be on either the voluntary register managed by the FPA or the voluntary register held by the RCoA. In order to be included on these registers, individuals will have obtained a UK PA or AA qualification and passed a specified assessment[14].

390. Once PAs and AAs are brought into statutory regulation, the voluntary registers held by the FPA and the RCoA will close to new entrants. Any PAs or AAs who are already practising in the UK, or who hold a PA or AA qualification from a UK university[15], when statutory regulation comes into force will be able to continue to practise and use the relevant professional title without being registered for up to two years from the start of regulation.

391. By the end of that two-year period they must either cease practising and using the relevant title or have applied to the GMC and been admitted to the register. This transition period is in line with the process used for other roles that have recently been brought into regulation, such as dental nurses and dental technicians. It will mean that the rights of those already practising will be protected by allowing them time to meet any requirements that the GMC sets for entry to the register.

392. From the day that regulation starts, PAs and AAs who have not previously practised in the UK or who do not hold a PA or AA qualification from a UK university, must register with the GMC before they can legally work in the UK using the title ‘physician associate’ or ‘anaesthesia associate’.

393. In order to join the register, applicants will need to satisfy the GMC that:

They have the knowledge, skills and experience to work safely as a PA or AA in the UK

394. The default knowledge and skills requirement for PAs and AAs wishing to join the GMC register will be that they must meet the existing criteria for admission to the relevant voluntary register.

[14] In the absence of a national assessment for AAs, the RCoA admits AAs to its voluntary register on the basis of having passed the final summative assessment of any current or previous UK-based AA course.
[15] This means any qualification in Physician Associate, Physician Assistant, Anaesthesia Associate or Physician Assistant (Anaesthesia) studies awarded by a UK university at the level of a postgraduate diploma or above.

395. There may be some practitioners currently working in the UK who do not hold a formal qualification. These individuals will be able to apply for registration with the GMC during the transition period without obtaining a UK qualification if they can show evidence of appropriate knowledge, skills and experience, including demonstrating a breadth and depth of practice consistent with the current UK-wide curricula for PAs or AAs. Additionally, PAs will need to pass the PA national assessment, and AAs may be asked to sit an equivalent assessment[16].

There are no outstanding concerns about their fitness to practise.

396. All applicants for registration will be required to make a self-declaration of fitness to practise and provide evidence of practice within the last two years. Individuals who have neither qualified nor practised as a PA or AA within the two years preceding their application to join the register may be required to demonstrate their knowledge and skills remain up to date, for instance by re-taking the assessment.

397. The purpose of these requirements is twofold: to make sure a practitioner's knowledge and skills are sufficiently current to ensure safe practice, and to provide assurance they have no findings against them relating to fitness to practise, nor any proceedings being contemplated or underway which might raise questions about their fitness to practise.

66. Do you agree or disagree with the transitional arrangements for PAs and AAs set out above? Please give a reason for your answer

Continued competence

398. As set out in section 2, it is essential for public protection that registrants demonstrate that their skills and knowledge are up to date and equip them for the roles that they carry out. The regulators are best placed to determine what registrants need to demonstrate to prove that they remain safe to practise.

399. Revalidation is the process by which doctors currently demonstrate to the GMC that they remain fit to practise. Whilst the same high-level principles around continued competence will apply to PAs and AAs, the practical requirements that these professionals are required to meet, and the surrounding governance may be different

[16] There is a small number of US qualified PAs on the FPA register who are exempted from taking the UK national assessment in recognition of their US qualification and the fact that they will already have taken a US national assessment.

to that which applies to doctors to reflect the different contexts in which the professions work.

400. As with medical practitioners, the GMC will decide on how to assess the continued competence of PAs and AAs. Currently, PAs on the FPA's voluntary register are required to re-certify every six years by sitting the knowledge element of the national exam. AAs currently have no re-certification requirement. Both professions are also expected to have an annual appraisal and undertake CPD.

401. As part of their role regulating PAs and AAs the GMC will have the power to:

- require PAs and AAs to demonstrate on a regular basis that their knowledge and skills remain up to date and that they are fit to practise;
- require an individual PA or AA to provide such evidence or information that the GMC may reasonably require for this purpose (this could include information about prospective, current or past practice or employment or participation in appraisal);
- publish guidance for PAs and AAs setting out the information to be provided, and any other requirements to be satisfied for this purpose; and
- remove a PA or AA from the register where a registrant fails to comply with this requirement. A decision to remove a person's name from the register on these grounds would be subject to appeal.

402. The detailed procedures and processes relating to continued competence of PAs and AAs will be set out in Rules or/and guidance by the GMC.

67. Do you agree or disagree that PAs and AAs should be required to demonstrate that they remain fit to practise to maintain their registration? Please give a reason for your answer.

6. Next steps for the reform of professional regulation

403. This consultation is an important step in the programme to improve the regulation of healthcare professionals. It forms part of a larger reform programme that will improve the regulation of healthcare professionals across the UK. It will lead to a system of regulation that provides better public protection, better supports the professional standards of all registrants and which is able to develop in response to the changing way that health and care is provided to patients. There are several elements to this programme.

404. This consultation sets out detailed proposals for legislative changes that will apply to all the regulators. It builds on the proposals in Promoting professionalism, reforming regulation. Following this consultation, we will bring forward draft legislation to implement these changes in relation to the GMC. This draft legislation will also introduce physician associates and anaesthesia associates into regulation. We plan to consult on this draft legislation in the autumn and for the legislation to come into force in the spring of 2022. We will then bring forward legislation to implement the changes for the other regulators. No decision has yet been taken on which regulator(s) will be next to receive legislative reform.

405. The White Paper Working together to improve health and social care for all set out plans to extend powers to make changes to the regulation of healthcare professionals through secondary legislation. These include:

- The power to remove a profession from regulation;
- The power to close down a regulator;
- The power to extend the ability for regulators to delegate functions through legislation; and
- Clarifying that other groups could be brought into regulation.

406. In order to inform how these additional powers might be used, we are commissioning an independent review of the number of regulators. The Busting Bureaucracy review reported that stakeholders found having 9 separate professional regulators is inefficient and confusing for the public. This review will consider whether the current make-up of the regulatory landscape might be simplified to provide better public protection in a more efficient way.

407. We also intend to commission a review of the professions that are currently regulated in the UK, to consider whether statutory regulation remains appropriate for these professions.

408. The outcomes of these reviews will also be used to inform ongoing discussions around which regulator(s) will follow the GMC in receiving reforms to their legislation.

7. Changes to the international registration processes operated by the GDC and NMC

409. Since the end of 2020, European law relating to the recognition of EEA qualified healthcare professionals no longer applies in the UK. European qualifications in medicine, nursing, midwifery, pharmacy and dentistry will continue to be recognised automatically until the end of 2022, after which regulators will have the flexibility to negotiate Mutual Recognition Agreements with EU equivalent organisations or use existing international recognition routes to recognise EU qualifications. In some instances, legislation sets out arrangements for assessing international qualifications which places requirements on applicants and regulators that are not necessary for public protection. We plan to consult shortly on proposed changes that will provide the GDC and NMC with greater flexibility to amend their processes for assessing applications for registration from all internationally qualified health care professionals including those holding European qualifications.

410. Our planned changes will cover the following areas:

- Most internationally qualified dentists have to sit the GDC's Overseas Registration Exam (ORE). We intend to bring forward changes to allow the GDC to put in place a range of different approaches to assessing the skills, knowledge and experience of overseas qualified dentists and dental care professionals. This will enable more overseas dentists and dental care professionals who wish to practise in the UK to do so, while continuing to provide assurance of the safety and quality of care.

- We will remove prescriptive detail in the NMC's legislation, including the requirement for the NMC to consider whether a person's qualification is of a comparable standard to a UK qualification. This will provide the NMC with greater flexibility in defining the process it follows to assess international applicants.

- The NMC and the GDC will also be provided with a power to make rules to provide for the detail on their international registration processes.

8. The regulators and public body status

411. Currently, the NMC, HCPC and PSA are classified to the public sector and are designated as public bodies. The decision as to whether an organisation is classified to the public sector is based on an independent assessment by the Office National Statistics (ONS). It is possible that the ONS will, in the future, consider whether the remaining regulators should be classified to the public sector and thus also become designated public bodies. If the other regulators were to be designated as public bodies, they would be required to meet the financial and governance standards appropriate to that classification. Any move to public body status would not impact on the regulators' independence in carrying out their regulatory role.

9. – Impact Assessment and Equalities Impact Assessment

Impact Assessment – Costs and benefits analysis

412. The Government has developed an initial impact assessment to assess the costs and benefits of reforming the professional regulators' legislative frameworks and regulating physician associates and anaesthesia associates. To gather further evidence on the potential costs and benefits, we are particularly keen to hear your views as part of this consultation. Our initial assessment of costs and benefits is set out in table A and B. A final impact assessment will be developed post-consultation and will accompany the legislation.

Assessment of benefits – Table A

Benefits of Reform	**Accrues to**
Improved patient safety. More efficient governance Faster resolution of concerns. Greater transparency of processes. Improved cooperation between regulators	Patients/wider public Individual registrants Professional regulators
Registrants better supported through improved standards/CPD Improved public perception of regulated professionals.	Learners undertaking education and training Individual registrants Patients/wider public
Greater autonomy to amend own procedures Cost savings from ability to be more flexible in functions e.g. registration, fitness to practise.	Professional regulators Individual registrants Patients/wider public
Opportunity for more economic use of resources e.g. moving away from focusing on Fitness to Practise and moving towards preventative regulation.	The Professional Standards Authority for Health and Social Care (PSA) Professional regulators Individual registrants Patients/wider public
Lower central administrative costs of maintaining the legislation.	Taxpayers/government.

Benefits of regulation of PAs and AAs	Accrues to
Improved training standards.	PAs, AAs, employers, patients
Pre-employment administration checks.	Employers
Increased patient redress.	Patients and families
Increased patient safety.	Patients and families
Increased scope of responsibility.	PAs, AAs, employers, patients

68. Do you agree or disagree with the benefits identified in the table above? Please set out why you've selected your answer and any alternative benefits you consider to be relevant and any evidence to support your views.

Assessment of costs – Table B

Costs of Reform	Borne by
Upfront costs of delivery of reform (developing policy and legislation)	Taxpayers/government/regulators[17]
Transitional costs involved in implementing changes	Professional regulators[18]
Costs of regulation of PAs and AAs	**Borne by**
Costs to employed individuals for registration fees.	Individual registrants
Administration costs to public sector employers for registration, renewal and revalidation.	Public sector
Initial set-up and transitional arrangement costs.	Taxpayers/government

[17] Regulators are funded in their core activities by the individual professionals they regulate. As such, any cost to the Regulators is likely to be funded through the fees paid by registrants.
[18] Ibid

69. Do you agree or disagree with the costs identified in the table above? Please set out why you've chosen your answer and any alternative impacts you consider to be relevant and any evidence to support your views.

Equalities Impact Assessment

413. The Public Sector Equality Duty ('the General Duty'), at section 149 of the Equality Act 2010, requires public authorities, in the exercise of their functions, to have due regard to the need to meet the three aims of the Equality Act:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

414. The General Duty covers the following protected characteristics:

- age
- disability
- gender reassignment
- pregnancy and maternity
- race (includes ethnic or national origins, colour or nationality)
- religion or belief (includes lack of belief)
- sex
- sexual orientation

415. It also applies to the protected characteristic of marriage and civil partnership, but only in respect of the first aim of the Equality Act: eliminating unlawful discrimination.

416. Section 75(1) of the Northern Ireland Act 1998 requires all public authorities in carrying out their functions relating to Northern Ireland to have due regard to the need to promote equality of opportunity between:

- persons of different religious belief, political opinion, racial group, age, marital status and sexual orientation
- men and women generally
- persons with a disability and persons without
- persons with dependants and persons without

417. In addition, section 75(2) of the 1998 Act requires public authorities without prejudice to their obligations under subsection (1) to have regard to the desirability of promoting good relations between persons of different religious belief, political opinion and racial group.

418. The Department of Health and Social Care in England has completed an initial assessment of the potential impact of our proposals on equality and protected characteristics covered by the duty. As part of this consultation we are seeking any further evidence on whether our proposals could impact (positively or negatively) on any of the protected characteristics. We will use this evidence to inform further development of our assessment in advance of bringing forward the required legislation to implement our policy proposals.

70. Do you think any of the proposals in this consultation could impact (positively or negatively) on any persons with protected characteristics covered by the general equality duty that is set out in the Equality Act 2010, or by Section 75 of the Northern Ireland Act 1998?

- Yes – positively
- Yes - negatively
- No
- Don’t know

Please provide further information to support your answer.

Annex A – Fitness to Practise - Listed offences

The following are listed offences, for which conviction will lead to automatic removal of a registrant from the register:

1. Murder.

2. An offence under any of the following provisions of the Sexual Offences Act 2003—

(a)section 1 (rape),
(b)section 2 (assault by penetration),
(c)section 3 (sexual assault),
(d)sections 5 to 8 (rape and other offences against children under 13),
(e)sections 9 to 12 (child sex offences),
(f)sections 30 to 33 (offences against persons with a mental disorder impeding choice), or
(g)sections 47 to 50 (abuse of children through prostitution and pornography).

3. An offence under any of sections 9 to 12 of the Protection of Children and Prevention of Sexual Offences (Scotland) Act 2005 (sexual services of children and child pornography).

4. An offence under any of the following provisions of the Sexual Offences (Northern Ireland) Order 2008—

(a)article 5 (rape),
(b)article 6 (assault by penetration),
(c)articles 12 to 15 (rape and other offences against children under 13),
(d)articles 16 to 19 (offences against children under 16),
(e)articles 37 to 40 (abuse of children under 18 through prostitution and pornography), or
(f)articles 43 to 46 (offences against persons with a mental disorder impeding choice).

5. An offence under any of the following provisions of the Sexual Offences (Scotland) Act 2009—

(a)section 1 (rape),
(b)section 2 (assault by penetration),
(c)sections 3 to 6 (sexual assault and sexual coercion) committed against a person who is, by virtue of section 17 of that Act (capacity to consent: mentally disordered persons), treated as incapable of consenting,
(d)sections 18 to 26 (rape and other offences against children under 13), or
(e)sections 28 to 33 (offences against older children).
6. An offence under either of the following provisions of the Modern Slavery Act 2015—
(a)section 1 (slavery, servitude and forced or compulsory labour), or
(b)section 2 (human trafficking).

7. An offence under either of the following provisions of the Human Trafficking and Exploitation (Scotland) Act 2015—

(a)section 1 (offence of human trafficking), or
(b)section 4 (slavery, servitude and forced or compulsory labour).

8. Extortion (in Scotland).

9. An offence under section 21 of the Theft Act 1968 (blackmail).

10. An offence under section 20 of the Theft Act (Northern Ireland) 1969 (blackmail).

12. An offence under article 7 of the Sexual Offences (Northern Ireland) Order 2008 (sexual assault).

13. An offence under section 3 of the Sexual Offences (Scotland) Act 2009 (sexual assault).

List of consultation questions

1. Do you agree or disagree that regulators should be under a duty to co-operate with the organisations set out above? Please give a reason for your answer.

2. Do you agree or disagree that regulators should have an objective to be transparent when carrying out their functions and should have these related duties? Please give a reason for your answer.

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

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

5. Do you agree or disagree that regulators should be able to set their own fees in rules without Privy Council approval? Please give a reason for your answer

6. Do you agree or disagree that regulators should be able to set a longer-term approach to fees? Please give a reason for your answer.

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

8. Do you agree or disagree that regulators should be able to charge for services undertaken on a cost recovery basis, and that this should extend to services undertaken outside of the geographical region in which they normally operate? Please give a reason for your answers.

9. Do you agree or disagree that regulators should have the power to delegate the performance of a function to a third party including another regulator? Please give a reason for your answer.

10. Do you agree or disagree that regulators should be able to require data from and share data with those groups listed above? Please give a reason for your answer.

11. Do you agree or disagree that regulators should produce an annual report to the Parliament of each UK country in which they operate? Please give a reason for your answer.

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

13. Do you agree or disagree that all regulators should have the power to set:

    - standards for the outcomes of education and training which leads to registration or annotation of the register for individual learners;
    - standards for providers who deliver courses or programmes of training which lead to registration;
    - standards for specific courses or programmes of training which lead to registration;
    - additional standards for providers who deliver post-registration courses of programmes of training which lead to annotation of the register; and
    - additional standards for specific courses or programmes of training which lead to annotation of the register?

    Please give a reason for your answer.

14. Do you agree or disagree that all regulators should have the power to approve, refuse, re-approve and withdraw approval of education and training providers, qualifications, courses or programmes of training which lead to registration or annotation of the register? Please give a reason for your answer.

15. Do you agree that all regulators should have the power to issue warnings and impose conditions? Please give a reason for your answer.

16. Do you agree or disagree with the proposal that education and training providers have a right to submit observations and that this should be taken into account in the decision-making process? Please provide a reason for your answer.

17. Do you agree that:

    - education and training providers should have the right to appeal approval decisions;

- that this appeal right should not apply when conditions are attached to an approval;

- that regulators should be required to set out the grounds for appeals and appeals processes in rules?

Please provide a reason for your answer.

18. Do you agree or disagree that regulators should retain all existing approval and standard setting powers? Please provide a reason for your answer.

19. Do you agree or disagree that all regulators should have the power to set and administer exams or other assessments for applications to join the register or to have annotations on the register? Please provide a reason for your answer.

20. Do you agree or disagree that this power to set and administer exams or other assessments should not apply to approved courses or programmes of training which lead to registration or annotation of the register? Please provide a reason for your answer.

21. Do you agree or disagree that regulators should be able to assess education and training providers, courses or programmes of training conducted in a range of ways? Please provide a reason for your answer.

22. Do you agree or disagree that the GMC's duty to award CCTs should be replaced with a power to make rules setting out the procedure in relation to, and evidence required in support of, CCTs? Please give a reason for your answer.

23. Do you agree or disagree that regulators should be able to set out in rules and guidance their CPD and revalidation requirements? Please give a reason for your answer.

24. Do you agree or disagree that the regulators should hold a single register which can be divided into parts for each profession they regulate? Please give a reason for your answer.

25. Do you agree or disagree that all regulators should be required to publish the following information about their registrants:

    - Name

    - Profession

- Qualification (this will only be published if the regulator holds this information. For historical reasons not all regulators hold this information about all of their registrants)

- Registration number or personal identification number (PIN)

- Registration status (any measures in relation to fitness to practise on a registrant's registration should be published in accordance with the rules/policy made by a regulator)

- Registration history

Please provide a reason for your answer.

26. Do you agree or disagree that all regulators, in line with their statutory objectives, should be given a power allowing them to collect, hold and process data? Please give a reason for your answer.

27. Should they be given a discretionary power allowing them to publish specific data about their registrants? Please give a reason for your answer.

28. Do you agree or disagree that all regulators should be able to annotate their register and that annotations should only be made where they are necessary for the purpose of public protection? Please give a reason for your answer.

29. Do you agree or disagree that all of the regulators should be given a permanent emergency registration power? Please give a reason for your answer.

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

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

32. Do you agree or disagree with our proposal that regulators should be able to appoint a deputy registrar and/or assistant registrar, where this power does not already exist? Please give a reason for your answer.

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

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

35. Do you agree or disagree that the GMC's provisions relating to the licence to practise should be removed from primary legislation and that any requirements to hold a licence to practise and the procedure for granting or refusing a licence to practise should instead be set out in rules and guidance? Please give a reason for your answer.

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

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

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

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

40. Do you agree or disagree with our proposal that the regulators should not have discretionary powers to establish student registers? Please give a reason for your answer.

41. Do you agree or disagree with our proposal that the regulators should not have discretionary powers to establish non-practising registers? Please give a reason for your answer.

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

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

    - 1: initial assessment

- 2: case examiner stage
- 3: fitness to practise panel stage?

Please give a reason for your answer.

44. Do you agree or disagree that:

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

    Please give a reason for your answers.

45. Do you agree or disagree that:

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

    Please give a reason for your answers.

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

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

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

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

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

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

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

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

    - have the full suite of measures available to them, including removal from the register?

    - make final decisions on impairment if they have sufficient written evidence and the registrant has had the opportunity to make representations?

    - be able to conclude such a case through an accepted outcome, where the registrant must accept both the finding of impairment and the proposed measure?

    - be able to impose a decision if a registrant does not respond to an accepted outcomes proposal within 28 days?

    Please give a reason for your answers.

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

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

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

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

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

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

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

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

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

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

64. Do you agree or disagree with the proposed approach to the regulation of PAs and AAs? Please give a reason for your answer.

65. In relation to PAs and AAs, do you agree or disagree that the GMC should be given a power to approve high level curricula and set and administer exams? Please give a reason for your answer.

66. Do you agree or disagree with the transitional arrangements for PAs and AAs set out above? Please give a reason for your answer

67. Do you agree or disagree that PAs and AAs should be required to demonstrate that they remain fit to practise to maintain their registration? Please give a reason for your answer.

68. Do you agree or disagree with the benefits identified in the table above? Please set out why you've selected your answer and any alternative benefits you consider to be relevant and any evidence to support your views.

69. Do you agree or disagree with the costs identified in the table above? Please set out why you've chosen your answer and any alternative impacts you consider to be relevant and any evidence to support your views.

70. Do you think any of the proposals in this consultation could impact (positively or negatively) on any persons with protected characteristics covered by the general equality duty that is set out in the Equality Act 2010, or by Section 75 of the Northern Ireland Act 1998?

    - Yes – positively
    - Yes - negatively
    - No
    - Don’t know

    Please provide further information to support your answer.

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