Agenda

1.0 Welcome & Apologies

Apologies received from:

1. Mark McCrudden

2.0 Deputations

3.0 Conflicts of Interest

4.0 Tabling of Any Other Business

FOR APPROVAL

5.0 Minutes and Key Actions arising from last meeting

For Approval

Council is asked to approve and adopt the Minutes of meeting dated 05th December 2023 as a true and accurate record of events.

Final Public Council Meeting Minutes 5.12.24MM.pdf ***Page 1***

6.0 Report on Progress against Strategy

For Approval

Council is asked to approve the amended Corporate Strategy based on the recommendations of the Task & Finish group. Council is also asked to decide on the timeframe during which the amended Corporate Strategy will apply pending the launch of the new Corporate Strategy.

Copy of Corporate Strategy - Council Progress Report - Dec 2023.pdf ***Page 10***

FOR DECISION

7.0 Updates to CPD functionality for 2024 report

For Decision

Council is asked to decide if minor amendments can be made to Council's CPD framework without triggering the need for Consultation.

Council Paper February-March 2024 - CPD Framework 2021 update (002).pdf ***Page 28***

Tracked Changes - CPD Framework 2021 changes (002).pdf ***Page 31***

FOR INFORMATION ONLY

8.0 President's Report

For Information

Verbal Report

9.0 CEO's Report

For Information

Verbal report.

10.0 Update on Code of Conduct consultation

For Information

Verbal Update

FOR NOTING ONLY

11.0 PSA Consultation

To Note

PSA is currently undertaking a Consultation on accepted outcomes and rulemaking for healthcare regulators. Please find below the link to the Consultation details and also attached are the substantive documents being consulted on.

PSA consultation | Good practice guidance documents on accepted outcomes and rule-making (professionalstandards.org.uk)

psa-draft-guidance-for-regulators-on-the-rulemaking-process.pdf ***Page 39***

psa-draft-guidance-for-regulators-on-accepted-outcomes-in-fitness-to-practise-guidance.pdf ***Page 54***

FOR INFORMATION ONLY

12.0 Correspondence Log

For Information

None

13.0 Any Other Business

For Information

14.0 Date of next Council Public Meeting

For Information

The next Council Public meeting is scheduled for 13th June at 10:00

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Minutes of the Council Public Meeting

05 December 2023 @ 10:00

	Agenda Item - Present	**Council Members:** Dr Geraldine O'Hare (President) Mr Jonathan Patton (Vice President) Ms Alison Ragg Ms Carol Moore Prof Patrick Murphy Mr Brendan Garland Mr Gary McMurray Mr Scott Gill Mr Barry Mimnagh **Visitors:** Mr Christopher Pawluczyk– PSA **In Attendance:** Ms Michaela McAleer (Chief Executive) Ms Joan Duffy (Director of Business Operations) Ms Zulema Horner (Executive Assistant) Mr Stephen Moohan (Business Support Manager)	**Apologies** Mr Mark McCrudden Ms Chanel Jones Mr Philip Knox Mrs Laura Hughes Ms Colleen Duffy
1.0	Welcome & Apologies	The President welcomed Council members to the meeting and Christopher Pawluczyk PSA.	
2.0	Deputations	The President was in attendance throughout. No deputation required.	
3.0	Conflicts of Interest	No conflicts of interest were raised.	

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4.0	Tabling of Any Other Business	No other business was tabled.	
5.0	Minutes & Key Actions from last meeting **For Approval**	Minutes: Council approved and adopted the Minutes of the Public meeting of 19 September 2023 as a true and accurate record of events. Actions: 1. Additional Council meeting on the 30 July with a 7pm start. 2. Members to consider attending the NICON conference. The CEO attended the most recent conference, and the Vice President was present in another capacity. 3. The Vice President to give an update on the Task and Finish group in relation to the Refresh Corporate Strategy. He stated that the document is finished and it will be sent to the President and CEO in February. **Key Decision / Action:** Council approved and adopted the Minutes of the Public meeting of 19 September 2023 as a true and accurate record of events. Actions were noted and agreed. VP to provide the Task and Finish Group Refresh on Corporate Strategy.	Proposed by: Mr Brendan Garland Seconded by: Mr Gary McMurray
6.0	Finance & Performance Committee **For Approval**		

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6.1	Budget 2024-25	Gary McMurray, Finance & Performance Chair, addressed the meeting and gave a summary of the draft budget slides previously distributed to the panel. He drew attention to the draft budget summary version 2, which contains a comparative analysis between the 2024-25 and the 2023-24 budget. The Chair discussed the cash projections slides and communicated that the main variance in terms of expenditure is that the draft budget shows expenditure of £83,000 which is greater than the projection for this year. He explained the reasons for this. The Chair reported that the committee has also sought assurance from the executive team for the Fitness to Practise (FtP) costs savings that have been previously identified. The committee has been assured they are and will remain on track. The significant deficit on operating costs for projects will be discussed in the 3-year financial outlook, together with decisions we need to consider ensuring our financial position is protected. Council approved the Draft Budget Plan 2024-25. **Key Decision / Action:** Council approved the Draft Budget Plan 2024-25	Proposed by: Mr Patrick Murphy Seconded by: Mr Scott Gill

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6.2	Direct Debit Collection	Gary McMurray, Finance & Performance Chair, talked through the Direct Debit (DD) papers. He discussed costs in the initial development stage and transaction charges based on volume. He also discussed the potential loss of interest in terms of the cash available to the society in stages as opposed to one lump sum. Council discussed the papers including: • Whether the option to pay upfront was still available • Whether registrants will be asked to sign an undertaking that they will honour their DD choice • Whether payment would be monthly or quarterly • Whether more than one registrant could be paid for via one direct debit arrangement • Whether there were any exceptions to paying or partially paying the registrant fee • Electronic notification of the renewal fee • The regulations required and the process for approving those regulations to enable electronic service and direct debit payments. Council noted the benefits that the direct debit would offer individual registrants and the cost savings if notified electronically rather than by post. Council also noted that amended regulations would be needed and this was through negative resolution and would not therefore be prevented by the lack of an Assembly. **Key Decision / Action:** **Council agreed to pursue direct debits and electronic renewal notices**	Proposed by Barry Mimnagh Seconded by Scott Gill

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7.0	Consultation **For Approval**	The CEO gave a brief overview of the Consultation paper due for review in May 2020. A review of our policy was undertaken, and the document has set out key recommendations. The recommendations that were briefly discussed at the meeting were: • Ensure we have a clear and improved standard principle with regards to the consultations statement. • A new Council approval framework for policy development and public consultations. • Increase the normal consultation time period to 12 weeks from 8 weeks. • Amendment to the policy to reflect the willingness of the Society to offer knowledge & capacity building with external stakeholders to improve engagement and public participation. • Appropriate training on the consultation process, communication with people with disabilities and plain English writing skills. • Establish an EDI working group (the CEO noted this is already underway). Council asked that the document be reworked to make clear how recommendations are tracked. They drew reference to the contents of section 4.3.6 and 4.3.7 of the main paper. Council asked that references to individual job holders be removed to future proof documents, and this should be a standard style within all policy documents. Council approved the document and the President asked for the modified document to come back to Council on 5th March.	Proposed by: Mr Brendan Garland Seconded by: Ms Alison Ragg
		Key Decision / Action: Council approved the Consultation papers, modified document due back to Council March meeting.	

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8.0	NICPLD comments Standards FTY 2024/25 **For Noting**	The CEO noted that there were no significant matters or concerns to be raised.	
9.0	Pharmacy Futures Phase 3 – Summary for Council **For Noting**	The CEO gave a brief summary of the paper. The paper sets out PF budget, expenditures and output material and outcomes. Video links have also been uploaded so Council could see first-hand PF activities in terms of pharmacy futures at W5 event. The CEO highlighted that this work forms part of a wider strategy initiative (the DoH's Pharmacy Workforce Review) and that is hard for PF to segregate the impact based on the number of people. Council discussed measurable outcomes and how work such as this could be measured both quantitively and qualitatively. The Vice President offered that it would be useful to circulate major calendar events e.g. World Pharmacists Day, Pharmacist Technician Day to Council in advance to allow for them to set time aside in their diaries. The President agreed and said it is important that we have a calendar of activities and key events. The CEO agreed to progress this. **Key Decision / Action:** **Schedule of Events and important dates to be drawn up and shared with Council.**	

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10.0	Finance & Performance Committee **To Note**		
10.1	Cash Projection	Gary McMurray, Finance & Performance Chair, spoke to the graphs and gave a brief overview of the budgets. He discussed the two main variances in the analysis page which were staff salaries underspent because of vacancies and Fitness to Practise.	
11.0	Presidents Report **For Information**	The President updated Council on her meetings and invitations, as follows: • Corporate Strategy Session this afternoon • Agreement on the 30th July evening meeting • President and CEO met with Cathy Harrison on the 22nd November • Council Appointments, DOH assures they are working on the Recruitment Drive • Centenary Committee first meeting on the 8th January • Alan Clamp, CEO, PSA, will attend the council meeting on the 5th March • GPHC has been invited to come to a future Council meeting.	
12.0	CEO's Report **For Information**	The CEO updated the Council as follows: • The statement for the Covid 19 inquiry is coming to the final stages and will be published shortly. • The Knowledge of English consultation closed in September and feedback report to go to council. • EDI working group has been established including council representation and has had its first meeting	
13.0	Report on Progress against Strategy **For Information**	The CEO took members through the following changes: • 1D- Referencing that there is a 3-year plan to consider; • 2A- Updated to reflect the changes on the code; • 3A -Update on the deep dive Fitness to Practise changes;	

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		• 3C- Minor changes to the narrative to reflect that we are continuing to work on the voluntary and statutory register; • 4D- Update on CPD processes and strategies; • 4E- changes to the narrative; • 5C- 3 year plan has been agreed at the F&P committee meeting; • 5F- changes to the narrative for the staff handbook; and • 6D -addresses the review to the policy procedure.	
14.0	CPD **To Note**	The CEO shared that Council introduced a new CPD framework in 2021. Problems experienced by registrants in terms of the IT platform are being considered and registrant feedback has been sought through focus groups. The President referred to the importance of a communication strategy for CPD and offered that it is critical we have this in place. She asked if we could have this as a standing agenda at each Council Meeting. **Key Decision / Action:** Communications to be a standing agenda item on each Council Meeting going forward.	
15.0	Correspondence Log **For Information**	None	
16.0	Any Other Business **For Information**	None	

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17.0	Date of next Council Public Meeting **For Information**	The next Public Council meeting is schedule for 5th March 2023 @ 9.30	

CORPORATE STRATEGY PROGRESS REPORT - March 2024						
Objective 1: To deliver high quality pharmacy regulation that is proportionate and cost-effective						
No	**Goals**	**Current Status**	**Tending towards**	**Update - Dec 2023**	**SMT**	
a	We will meet all performance standards in annual PSA appraisals in at least 4 of the next 5 years.			18/19 – Met 22 out of 24 Standards – PSA Report published Sept 2020 19/20 – Met 15 out of 18 Standards (PSA introduced revised Standards of Good Regulation) – PSA Report published July 2021 20/21 – Met 17 out of 18 Standards – June 2022 21/22 – Met 18 out of 18 Standards 22/23 pending outcome Publishable end of March 2024	MM	Updated
b	We will secure policy agreement with DoH to make legislative and non-legislative changes required to modernise pharmacy regulation and, following policy agreement, develop an implementation plan for delivery, including delivery of actions specified by May 2023. (Revised 10/1/22).			Policy agreement has been secured with the Department in relation to the following legislative and non-legislative reforms: IETP Reform, Pharmacy Technicians.. The return of the assembly enables legislative reform to progress.	MM	Updated
c	We will secure policy agreement with DoH for the statutory regulation and registration of technicians and, following approval, consult upon entry routes to the register.			Work on by the Pharmacy Technicians oversight Board has continued from March 2023 and the return of the Assembly allows the progression of the statutory regulation of technicians as envisaged by the Minister in 2022 albeit with an affected timescale.	MM	Updated

d	We will employ a financial strategy (to be reviewed annually to increase efficiency and cost-effectiveness and report against targets therein bi-annually.			Council considered the 3 year plan at its dec meeting in committee and is revisiting the projections and assumptions contained within that plan.	JD	updated
e	We will collaborate with other relevant Regulators and PSA to effect change designed to maximise use of shared principles and practices.			We continue our membership of CEORB and partnership working with other regulators. We will meet with the PSA the week after every council meeting moving forward.	MM	same
f	We will deliver reforms developed as a consequence of Rebalancing Medicines Legislation and Pharmacy Regulation, including the issue of criminal prosecution for dispensing errors and delivery of standards and guidance around RPs and SPs.			Premises Standards were approved by Council in 2018. The commencement of the Premises Standards has been further delayed due to the Department requiring an IT solution to carry out inspections applying the standards. An estimate of 18 months for this work to be completed was put forward by the Dept. The two recent Pharmacy Orders commenced on 1st December 2022. We will need to seek agreement with DOH with regards to bringing this work forward.	MM	same

CORPORATE STRATEGY PROGRESS REPORT - March 2024						
Objective 2: To set pharmacy standards that are evidence-based, output-focused, achievable and necessary for patient and public safety						
No	Goals	Current Status	Tending towards	Update - Dec 2023	SMT	
a	~~We will review and, where appropriate, enhance the current set of pharmacy standards. We will complete a full review of the Code by May 2023 followed in next corporate strategy by phased review of Standards related to the Code.~~			~~Review has been completed and the revised code has been consulted on; the consultation closed on 18 December 2023. The feedback report will be prepared for council considertation shortly. The remainder of this year's standards work will focus on commencing the refresh of the Independent Prescribing standards and the Online Pharmacy standards.~~	MM	remove
b	~~We will test the ongoing efficacy of pharmacy standards in context of the newly emerging HSC reform programme as part of Goal 2(a).~~			~~The HSC reform programme and the impact on Pharmacy service provision remains unclear. However, we continue to liaise with the Strategic Performance and Planning Group of the Department of Health in regards to the new developments.~~	MM	remove
c	~~We will test and report on the feasibility of developing and applying new standards over and above Minimum Standards designed to encourage improved service quality to ensure that they remain fit for current and future practice. Subject to review at the next Corporate Strategy review.~~			~~This remains difficult until the developments in 2b are clearer.~~	MM	remove

CORPORATE STRATEGY PROGRESS REPORT -March 2024						
Objective 3: To conduct Fitness to Practise processes that are robust, timely and fair						
No	**Goals**	**Current Status**	**Tending towards**	**Update - Dec 2023**	**SMT**	
a	We will improve timeliness, efficiency and cost of Fitness to Practise processes and report on progress made.			In keeping with the financial strategy objectives a review of FTP costings has been completed and a number of actions have taken or planned to be taken which will see signficant savings in Ftp cases. This is continuing to be monitored. A review of our Ftp processes is also underway to ensure these are simplified and stremalined where possible to result in the timely handling of FtP matters.	MM/JD	Updated
b	~~We will ensure regular reports on learning from Fitness to Practi~~			~~Reminders being placed on Facebook and key learnings shared via the regula~~	MM	Remove
c	~~We will develop Fitness to Practise processes for Pharmacy Tech~~			~~Agreement on legislation needs to be secured with the Department in relatic~~	MM	Remove

CORPORATE STRATEGY PROGRESS REPORT - March 2024						
Objective 4: To ensure that pharmacy education and professional development is fit for purpose						
No	Goals	Current Status	Tending towards	Update - Dec 2023	SMT	
a	~~We will review the Pre-Registration Framework and implement necessary improvements~~ ~~including developing a plan for, and commencing transition to a Foundation Training Year.~~			~~The first year of FTY has been completed and an assurance report from NICPLD received and council informed.~~	MM	Remove
b	~~We will review and improve undergraduate and accreditation standards with our partners.~~ ~~We will work with our partners on delivery of the implementation plan for undergraduate and accreditation standards.~~			~~Accreditation completed and reports to council have been provided.~~	MM	Remove
c	~~We will explore the feasibility of developing a joint education strategy with both NI Universities and GPhC.~~ ~~We will lead on the development of the new IET Standards and their implementation.~~			~~Please revert to 1b in relation to the legislative barrier to this work and timelines being met with regards to the annotation of future registrants as Independent Prescribers.~~	MM	Remove

d	~~We will review CPD processes and develop a strategy for the establishment of a continuing Fitness to Practise regime. We will undertake to engage with stakeholders in relation to the development of a Continuing Fitness to Practise Strategy.~~			~~A review of the IT system supporting the CPD framework including obtaining focus group feedback from registrants is being finalised. Changes to the IT system and any minor changes to the framework will be operationalised in the CPD 2024 cycle.~~	MM	Remove
e	Post Registration Education and Training. Develop a PSNI policy position and implementation strategy for Post Registration Education and Training arrangements for pharmacists and pharmacy technicians, when registered, operating within Northern Ireland. (Added 10/1/22).			An update has been sought on this work and will be reported at the next council meeting with a view to determining whether this goal should remain in the strategy.	MM	Update

CORPORATE STRATEGY PROGRESS REPORT - March 2024						
Objective 5: To be an accountable organisation with effective governance and operations						
No	**Goals**	**Current Status**	**Tending towards**	**Update - Dec 2023**	**SMT**	
a	~~We will establish effective deputising arrangements for the Registrar.~~			~~As reported under Goal 1(f), this came into operation in December 2022. Examination of the Deputy Registrar role and how it should be integrated into the PSNI's structure will form part of a wider piece of work looking at our structures, processes and people. The HR structural review is at an advanced stage.~~	MM	remove
b	We will secure policy agreement with DoH on resolving the current Pharmacy Professional Leadership linkage with the Regulatory function. We will agree a plan to deal with the link between the Leadership and Regulatory functions.			In the absence of any progression on a policy agreement with DOH, a short life working group, chaired by a council member has been agreed to take forward the outworkings of an internal audit looking at the relationship between the PSNI and the Pharmacy Forum.	MM	same
c	We will annually review audit schedules, risk management processes and performance measurement organisationally and implement necessary changes for improvement.			We have agreed the 3 year audit plan for 23-26 Business plan objectives for 23-24 are in place in relation to risk management strategy. A new performance dashboard is also planned which will see the development of new metrics to measure success and outcomes to improve committee and council oversight of operations.	MM	same
d	~~We will develop a new IT Strategy and deliver against relevant goals, reporting to Performance and Finance Committee at least twice per year.~~			~~IT strategy implemented 2019, Full review completed 2021, approved by Council Nov 2021. Actions reviewed by the Finance & Performance Committee.~~	JD	remove

CORPORATE STRATEGY PROGRESS REPORT - March 2024						
Objective 5: To be an accountable organisation with effective governance and operations						
No	**Goals**	**Current Status**	**Tending towards**	**Update - Dec 2023**	**SMT**	
e	We will review and improve organisational governance.			Planned review of corporate governance handbook planned for Q4 23-24.	MM	change
f	We will formulate and implement a new HR Strategy to improve organisational resilience, efficiency and effectiveness and deliver against relevant goals, reporting to Perfomance and Finance committee at least twice per year.			A full review of the staff handbook has been completed and has been released to staff. A programme of staff engagement has begun and will continue to be delivered in the remainder of 23-24. HR review to be discussed at a future REMCOM meeting.	MM	update
g	We will work with Government and other relevant agencies to ensure robust arrangements are in place to manage the effects upon pharmacy regulation in NI resulting from the UK's exit from the EU - including the provision of suitable transition arrangements. Key issues around recognition of qualifications and recent MHRA approach to PSNI re development of guidance on medicines use in N.I.(NIMAR).			the goal needs to be reworked to allow for current issues given the passage of time since brexit.	MM	same

CORPORATE STRATEGY PROGRESS REPORT - March 2024						
Objective 6: To communicate effectively, be accessible and responsive						
No	**Goals**	**Current Status**	**Tending towards**	**Update - Dec 2023**	**SMT**	
a	We will improve and report on communications effectiveness.			Within 23-24 it is planned to produce a Communications and Stakeholder Engagement Plan to include social media strategy, webinars and live events. We will also create and publish a register of activities. This is an urgent goal	MM	update
b	We will develop a new strategy designed to enhance the public, pharmacy, media and political profile of the organisation. We will implement our Communicatons Strategy and report on its effectiveness including the response to and effectiveness of our Reach Out programme.			The Comms Strategy was updated and delivered to Council in Nov 2021. See planned activity for 23-24 as noted at objective 6(a)	MM	same
c	~~We will develop a "Reach Out" Programme to better engage with the public and pharmacists on regulation (What, Why, When and How).~~			~~See planned activity for 23-24 as noted at objectives 6(a) &(b)~~	~~MM~~	same
d	~~We will review our current public consultation protocols.~~			~~A review of the Policy and Procedure for Carrying out a Public (Major) Consultation and the Policy and Procedure on Equality Screening and Equality Impact Assessments has been completed and forms part of this council meeting agenda.~~	~~MM~~	~~Remove~~
e	~~We will review and improve external and internal complaints processes.~~			~~This item forms part of the council meeting agenda~~	~~MM~~	~~remove~~

Pharmaceutical Society NI Council Paper

28 February 2024

Title: Update on Review of CPD Framework 2021 and associated resources

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Type of Paper: For Update and Information

Action required by Council

For approval- Council to approve minor amendment to its CPD framework (2021) without the need for consultation

Purpose of paper

The purpose of this paper is to:

1. Update Council on the current project to review the CPD Framework 2021, including all supporting resources available to registrants, to include:

   - CPD Framework 2021 document.
   - Annual CPD Portfolio – A Guide to Completion, Submission & Assessment.
   - Generally acceptable circumstances, generally unacceptable circumstances (extenuating circumstances) resource documentation.
   - Documentary evidence resource documentation.

2. Update Council on the three key areas of work required to complete the project, which are:

   - Review the Continuing Professional Development Framework for Pharmacists in Northern Ireland 2021 by 30 November 2023.
   - Finaliseamendments to the Framework document and develop associated documentation to support these amendments by mid-January 2024
   - Develop and implement the revised CPD Framework processes and IT systems by end March 2024.

   Undertake minor revision to the CPD framework based on feedback and user experience to date

Completion of work to date

- Current Continuing Professional Development Framework for Pharmacists in Northern Ireland Framework 2021 document and supporting documentation has been reviewed including tracked changes of the proposed minor amendment.
- Annual CPD Portfolio – A Guide to Completion, Submission and Assessment has been reviewed and a first draft written. Tracked changes document is currently being

compiled. This piece of work remains fluid as changes to the CPD portal are tested and implemented.

- Generally unacceptable circumstances, updated within the first draft of CPD Framework 2021 as above.
- Documentary Evidence updated within the first draft of CPD Framework 2021 as above.
- Review and rewrite of 'Unscheduled' cycles is ongoing.
- Creation of a suite of new best practice exemplars created for community pharmacy, hospital pharmacy, GP practice pharmacy. Work is continuing to develop exemplars for academia and industry – these are much more niche and difficult to source.
- Feedback from registrants and assessors has informed IT revised build. Programming is complete and currently undergoing pen and technical testing by Fortesium. Fortesium hope to hand over the test site to PSNI for testing first week of March – this date is fluid as hand over date is dependant on any issues detected and he timeframe to correct.

Next steps

- Production of best practice exemplars of Unscheduled Cycles
- Review and update as necessary feedback statements from assessor to registrant following assessment of portfolio – supporting Annual CPD Portfolio – A Guide to Completion, Submission and Assessment
- Review and update as necessary frequently asked questions - supporting Annual CPD Portfolio – A Guide to Completion, Submission and Assessment
- Develop and agree a CPD communication strategy to enhance the profile of CPD. Implement as part of the overall Communications Strategy and report on its effectiveness. All communications must fall in line with corporate policy and approval will be sought through SMT prior to dissemination to the profession.
- Targeted updates provided to Council, as appropriate, both verbal updates and written papers
- Stakeholders to be advised of changes/introduction of changes/amendments.
- In tandem with the above points, PSNI will be testing the new build. Plan to complete by end March.
- Launch of revised IT system with a clear timeline and communications on when this will happen.
- Ongoing resolution of issues as they are raised during bedding in period with clear communications.
- Ongoing resolution as issues arise prior to 2024- 25 CPD year.

Action required by Council

Approval of minor amendments to CPD framework without the need for consultation

Appendix 1 – Draft CPD Framework 2021 document

Appendix 2 – Draft CPD Framework 2021 tracked changes

For further information

Sharon Bell
Post Registration CPD Quality Assurance Facilitator

CPD Framework 2021 – Tracked changes

Para.	Proposed amendments	Notes
1	No changes	
2	Reword to "The primary purpose of the organisation is to ensure that practising pharmacists in Northern Ireland are: • Fit to practice. • Keep their skills and knowledge up to date, current and relevant. • Deliver high quality, safe care to patients and the public."	
3	Reword beginning of sentence to "It is the responsibility of the regulator"	Possibly look at the ordering of the bullet points – switch the last two around?
4	Title change to "**Why the need for Continuing Professional Development?**" Reword to "CPD is the way in which you continue to learn and develop throughout your career, so you keep your skills and knowledge up to date and you are able to practise safely and effectively. CPD is a process you will carry out throughout your whole career. It ensures you track and document your skills, knowledge and experience gained both formally and informally, beyond your initial education and training. CPD is not only formal courses but any activity from which you learn and develop."	
5	Reword to "CPD helps you to keep your practice and proficiency current in order that you maintain standards, improving patient and public confidence in the profession."	
6	Reword "CPD is a requirement of your registration with the Pharmaceutical Society NI, so you need to meet our CPD standards to remain registered. As a legal requirement for all registered pharmacists in Northern Ireland, every registered pharmacist must meet the requirements of **Standard 5 of the Pharmaceutical Society NI's Code: Professional standards of conduct, ethics and performance for pharmacists in Northern Ireland – to maintain and develop professional knowledge, skills and competence."**	
7	No changes	

8	Reword to "The Framework sets the standard that is required for a registered pharmacist to maintain in order to continue to meet the standards of proficiency for the safe and effective practice of pharmacy."	
9	Reword to "The Framework outlines the statutory obligations of a pharmacist in relation to what they must do, how to do it and by when. It also outlines the process which commences if a CPD submission does not meet the standard required upon assessment."	
10	Reword – change "make" to "complete" Reword – change "(see points 15 & 16)" to "(for more information regarding extenuating circumstances see pages 4 & 5)	
11	No changes	
12	Reword to "The RegulatorOnLine portal allows for the collation and submission of CPD portfolios for the majority of the CPD year with the new CPD year submission period opening on 08 June (or nearest working day thereafter) and closing at midnight on 31 May."	Consider adding in one line from the current document at the end of this suggested reworded paragraph – "Submission commences 1 April and ends midnight on 31 May."
	Reword to "Pharmacists who wish to submit a hard copy CPD portfolio must seek permission to do so from the Registrar by emailing their request, giving reasons for not wishing to submit via the ROL portal, to cpd@psni.org.uk."	Consider adding in one line from the current document at the end of this paragraph – "Submission starts 1 April and ends at midnight on 31 May"
	Reword to "Pharmacists submitting hard copy portfolios must ensure that the portfolio is received, by prior arrangement with the CPD department, before 5.00pm on 31 May, or last working day before that date."	
	No changes	
	Title change to "**What happens if a pharmacist fails to comply with the CPD Framework?**"	
17	No changes	
18	Career break and unemployment removed from the list	

19	Career break and unemployment added to the list	
20	No changes	
21	No changes	
22	No changes	
23	No changes	
24	No changes	
25	No changes	
26	Bullet 1 – unchanged Reword bullet point 2 to "all late CPD submissions" Reword bullet point 2 to "all portfolios submitted by pharmacists who have changed their scope of practice in the past 12 months" Reword bullet 3 to "all portfolios submitted by pharmacists who have changed their scope of practice in the past 12 months" Remove bullet point 4 completely	Bullet point 2 – current process is to assess all late CPD submissions. Bullet point 3 – change current wording to reflect balancing the risk factors. Bullet point 4 – not necessary as those recently rejoined having not practised for a period of 12 months or more are captured in Early CPD submission.
27	Reword – change "any" to "each"	
28	No changes	
29	No changes	
30	Add a reference at the start of paragraph regarding standard met, followed by existing text currently in this paragraph here and renumber all paragraphs from this point on. Wording – "If the IA concludes that the required standard has been met, the CPD portfolio will be marked as met standard." Followed by current wording which remains unchanged.	Question – Is it necessary to add to the start of this paragraph for context and completeness?
31	Add sentence at end of current paragraph - "The registrant will move to Reassessment 1."	Check if this is better placed somewhere else in the document
32	No changes	
33	No changes	
34	Reword – change "A defined number of" to "Two randomly selected"	Do we want to be this specific?

35	No changes	
Fig 1	Diagram to be reworked – addition of sphere between Scope of Practice and Scheduled/Unscheduled – Evaluation Minimum of 75% of cycles must be evaluated in current practice	
36	Remove unnecessary text. To read – "Pharmacists must keep their CPD portfolio of evidence properly documented and must submit in the for and manner outlined by the Pharmaceutical Society NI."	Text referring to CPD Resources not relevant in this paragraph
37	Wording changed to "Pharmacists must ensure that the recording format required by the Pharmaceutical Society NI. Those registrants wishing to submit a hard copy portfolio must follow the process as outline at paragraph 13."	
38	Differentiate between scheduled and unscheduled and requirements for completion of domains when agreed	
39	Additional wording: "… by the deadline specified, by emailing their evidence to the CPD Department at cpd@psni.org.uk "	
40	No changes	
41	Change heading to read "Current Scope of Practice and Evaluation" Reword paragraph to "Pharmacists who change their scope of practice during the CPD year should include and evaluate CPD learning for both their former and new scope of practice."	
42	No changes	
43	Additional wording at beginning of paragraph, as follows, "The majority of CPD learning (at least 75%) must be evaluated directly in practice ie within the pharmacist's working environment during the CPD year." Additional wording after "simulated test or environment" add "(maximum 25%)".	
44	Reword to "in the case of reassessment at least 66% (2 cycles) must be directly evaluated within pharmacists' current practice and environment."	What is the preferred wording – remediation or reassessment?
45	Reword to "This allows up to 25% of the total number of cycles to have the learning outcomes evaluated using simulated practice or by evaluating their application to a situation in future practice or sectors. In the case of reassessment, up to 33% (1 cycle) can be directly evaluated within pharmacists' current practice and environment."	Again what is the preferred wording – remediation or reassessment?

46	No changes	
47	Change heading to read "Scheduled and Unscheduled Learning"	
48	Reword - "Planned" should read "Pre-planned".	
49	No changes	
50	Add full stop after "day to day working". Replace remainder of paragraph with "This often requires immediate planning, action, activity and outcomes. It is the immediacy of the planning that distinguishes the Unscheduled cycle from the Pre-planning of the Scheduled cycle."	
51	Reword to reflect that only those domains that relate to unscheduled require to be completed. See para 38 above	
52	No changes	
53	Add the following to the end of the paragraph: "CPD activity must not include activity that is deemed as an application of learning".	
54	Add the following to the end of the paragraph: "CPD activity must not include activity that is deemed as an application of learning."	
55	Addition to the start of 1st sentence: "Although there is no limit to the number of CPD hours or cycles that pharmacists can record and save in their ROL portfolio, …"	
56	Remove paragraph and renumber remaining paragraphs from this point forward. This is addressed in paragraph 55.	
56	Remove "However, from the beginning of the sentence. (previously 57)	
57	Change wording from "(see point 38) to "(see paragraph 38)". (previously 58)	
58	No changes (previously para. 59)	
59	Change word "remediation" to "reassessment" (previously para. 60)	Again do we use the word remediation or reassessment?
60	No changes (previously para. 61)	

61	No changes (previously para. 62)	
62	Bullet 3 – "in the Register" should read "on the Register". Previously para. 63	
63	No changes (previously para. 64)	
64	No changes (previously para. 65)	
65	No changes (previously para. 66)	
66	No changes (previously para. 67)	
67	No changes (previously para. 68)	
68	No changes (previously para. 69)	
69	No changes (previously para. 70)	
70	No changes (previously para. 71)	
71	No changes (previously para. 72)	
72	No changes (previously para. 73)	
73	No changes (previously para. 74)	
74	No changes (previously para. 75)	
75	No changes (previously para. 76)	
76	No changes (previously para. 77)	
77	No changes (previously para. 78)	
78	Reword - The Registrar has they" should read "The Registrar has the" (previously para. 79)	
Fig. 2	No changes	
79	No changes (previously para. 80)	
80	Reword bullet 3 "a timeframe for the submission of a personal development plan" (previously para. 81) Reword bullet 4 "a CPD portfolio comprising between 4 and 10 CPD cycles, a minimum 30 hours of CPD learning, and fully compliant with the requirements of this CPD Framework, within 2 months of the date of restoration of the pharmacist's name to the Register." (previously para. 81)	
81	Change "Independent Assessor" to "IA" (previously para. 82)	For consistency
82	Additional wording added to paragraph - "…at or shortly after application, and whose CPD portfolio meets standard at assessment, …" (previously para. 83)	

83	Additional wording added to paragraph - "… the applicant's prior agreement to comply" (previously para. 84)	
84	No changes (previously para. 85)	
85	Additional wording added to paragraph "..who has not been registered as a pharmacist, or has not worked as a pharmacist, within the last 12 months" Additional wording at the end of the paragraph. "This portfolio must be submitted within 2 months of the pharmacist joining the Register." (previously para. 86)	For clarity, do we need to add a sentence advising this does not apply to foundation trainees joining the Register for the first time.
86	Rewording "independent assessor" should read "IA" Additional wording at the end of the paragraph. "This portfolio must be submitted within 2 months of the pharmacist joining the Register." (previously para. 87)	
87	No changes (previously para. 88)	
88	Additional wording "…to make a full 30 hour portfolio…" (previously para. 89)	
89	Rewording "independent assessor" should read "IA" (previously para. 90)	
90	No changes (previously para. 91)	
91	No changes (previously para. 92)	
92	No changes (previously para. 93)	Heading - Check if correct phrasing is Data Protection or GDPR or both ie Data Protection/ GDPR
93	No changes (previously para. 94)	
94	No changes (previously para. 95)	
n/a	Transitional Arrangements – relevant?	Possibly only point A is relevant but needs reworded?
n/a	Further Arrangements – no changes	

n/a	This will need to be updated and a revision number added when wording and date agreed	

DRAFT - Good practice in rulemaking – Principles and guidance for regulators on developing, making and amending rules

January 2024

1. About the Professional Standards Authority

1.1 The Professional Standards Authority for Health and Social Care (PSA) promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and voluntary registration of people working in health and care. We are an independent body, accountable to the UK Parliament.

1.2 We oversee the work of 10 statutory bodies that regulate health professionals in the UK and social workers in England. We review the regulators' performance and audit and scrutinise their decisions about whether people on their registers are fit to practise.

1.3 We also set standards for organisations holding voluntary registers for people in unregulated health and care occupations and accredit those organisations that meet our standards. To encourage improvement we share good practice and knowledge, conduct research and introduce new ideas including our concept of right-touch regulation. We monitor policy developments in the UK and internationally and provide advice to governments and others on matters relating to people working in health and care.

1.4 Our organisational values are: integrity, transparency, respect, fairness and teamwork. We strive to ensure that our values are at the core of our work. More information about our work and the approach we take is available at www.professionalstandards.org.uk.

2. Introduction

2.1 As part of the legislative reform programme being undertaken by the Government to modernise the legislation for the healthcare professional regulators, regulators will receive new powers to make and amend their own operational rules. This will include the removal of the requirement for Privy Council approval of rules which is currently in place.

2.2 We have produced this good practice guidance to help regulators make effective use of their new rulemaking powers.

2.3 This guidance has been developed in parallel with the development of the Anaesthesia Associates and Physician Associates Order[1] and with work being undertaken by some regulators to develop their rules. We have drawn on

[1] The Anaesthesia Associates and Physician Associates Order 2024: https://www.legislation.gov.uk/ukdsi/2024/9780348255195

existing good practice, our own evidence base, information from other sectors and research, especially about regulatory consistency.

Status of guidance

2.4 This document provides good practice guidance to regulators to help them make best use of the new powers they will receive to develop, make and amend their operational rules. This guidance is advisory and intended to support and guide regulators in developing their own guidance and approach.

2.5 The PSA will not have any formal role within the rulemaking process. This guidance will therefore not have any official status or be binding on regulators. However, in the future, we may choose to look at how regulators are making use of their new rulemaking powers under our performance review and may take this guidance into account in assessing their approach. We may ask regulators to provide a rationale for the approach that they have taken and to explain how they have assured themselves that it maintains public protection.

Scope of guidance

2.6 This guidance relates to the rulemaking powers laid out in the Anaesthesia Associates and Physician Associate Order 2024 (AAPA Order)[2] which is expected to act as the template for reform across the healthcare professional regulators. It does not apply to any regulator until and unless its powers are reformed to bring them into line with those set out in the AAPA Order. It will not apply in the same way to Social Work England, which already operates a rulemaking process in line with its legislative powers, although the principles and information provided may be of relevance.

2.7 This guidance is based on the best available evidence we have at this time to support a good practice approach to rulemaking. As no regulators are yet using the rulemaking powers as laid out in the AAPA Order, the guidance is currently high level. However, it is likely that as the new approach is rolled out, further information will become available on good practice in this area. It is our intention to keep this guidance under review to reflect the roll out of these powers more widely and to incorporate further good practice as it emerges.

2.8 The focus of the guidance is primarily on the rulemaking process - the process of creating the rule framework that outlines how the regulator will operate. However, as rules themselves are usually an expression of an agreed policy approach, the principles and further information in the document are also intended to help regulators in taking account of key considerations when developing policy as well as the formal rule development process.

2.9 Whilst the main focus of the guidance is producing rules, we recognise that regulators are also likely to produce significant pieces of guidance and policy documents which are central to a particular regulatory function – for example standards of practice and associated guidance. Whilst these aren't the direct

[2] The Anaesthesia Associates and Physician Associates Order 2024: https://www.legislation.gov.uk/ukdsi/2024/9780348255195

focus of our guidance, we expect the principles and information outlined to also support regulators in these areas.

2.10 This document includes:

- Part 1
  - A summary of the legislative framework underpinning the powers that professional regulators will receive to make and amend operational rules
  - Principles to guide a good practice approach to rulemaking by regulators following the roll out of new rulemaking powers
- Part 2
  - Further information on key areas to support regulators in putting our principles into practice.

Part 1 – Legislative Framework and good practice principles

3. The legislative framework

3.1 The Anaesthesia Associates and Physician Associates Order (AAPA Order) will form the legislative template for new powers for all healthcare professional regulators.[3]

General legislative requirements

3.2 In common with current legislation, the overarching objective for regulators will remain the protection of the public.[4] This objective includes the following three sub-objectives:

- to protect, promote and maintain the health, safety and well-being of the public,
- to promote and maintain public confidence in the [named] profession, and
- to promote and maintain proper professional standards and conduct for members of that profession.[5]

3.3 This overarching objective and sub-objectives will remain the primary touchstone for regulators in carrying out their statutory responsibilities, including the development and implementation of rules.

3.4 There are a number of new wider provisions referenced in the AA PA Order which regulators will need to take into account when developing rules and processes. These include:

- The duty to discharge functions in a way which is transparent, accountable, proportionate and consistent
- The duty to co-operate [insofar as is appropriate and practicable, with persons concerned with the employment (whether or not under a contract of service), education or training of associates or the services they provide][6]

[3] The Anaesthesia Associates and Physician Associates Order 2024: https://www.legislation.gov.uk/ukdsi/2024/9780348255195

[4] This is currently the overarching objective for all regulators under the PSA's oversight with the exception of the Pharmaceutical Society of Northern Ireland whose overarching mission is the protection of the public as agreed by Council in their mission statement Page 7 'Safeguard Patients and Public through High Quality Pharmacy'. which is supported by the Pharmacy (1976 Order) (Amendment) Order (Northern Ireland) 2012.

[5] To note: as the Anaesthesia Associate Physician Associate Order will form an addition to the Medical Act 1983, the provisions within it specific to the regulation of Anaesthesia Associates and Physician Associates should be read alongside the general pre-existing legislative requirements for the General Medical Council within the Medical Act 1983 – this includes the overarching objective of public protection. When reforms are rolled out more widely for the General Medical Council to cover doctors, the Medical Act will also be replaced with updated legislation.

[6] This duty as outlined in the AAPAO is in addition to the GMC's pre-existing duties of co-operation under para 9A of Schedule 1 to the Medical Act 1983:-

- The principle that regulatory activity should be targeted.

3.5 They will also be required to comply with wider public law principles.

Rulemaking requirements

3.6 In contrast to current legislation, the Anaesthesia Associates and Physician Associates Order leaves a considerable discretion to be defined in rules how regulators will exercise their regulatory functions.

3.7 Schedule 4 of the draft Order outlines the rulemaking powers that regulators will have over different areas - this broadly includes rules relating to:

- The register and registration processes
- Procedural rules including for education and training
- Panels, including constitution and appointment process
- Non-compliance
- Fees
- Notifications (covering notifications as part of a wide range of regulatory processes)
- Fitness to practise (FtP rules will cover procedures for decision making)
- Revisions and appeals
- When Panel decisions take effect
- Evidence gathering
- General provisions allowing regulators to make rules which: 'may contain such incidental, consequential, transitional, transitory, saving or supplementary provisions as appear to the Regulator to be necessary or expedient.'

3.8 The General provisions about rules also require that the regulator, before making rules: 'must consult, to the extent it considers proportionate, representatives of any group of persons which appear to the Regulator likely to be affected by the rules, including representatives of -

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In exercising their functions, the General Council shall—
have proper regard for—
(i)the interests of persons using or needing the services of provisionally or fully registered medical practitioners in the United Kingdom, and
(ii)any differing interests of different categories of provisionally or fully registered medical practitioners;
(b)co-operate, in so far as is appropriate and reasonably practicable, with public bodies or other persons concerned with—
(i)the employment (whether or not under a contract of service) of provisionally or fully registered medical practitioners,
(ii)the education or training of medical practitioners or other health care professionals,
(iii)the regulation of, or the co-ordination of the regulation of, other health or social care professionals,
(iv)the regulation of health services, and
(v)the provision, supervision or management of health services.

- (a) associates;
- (b) employers of associates;
- (c) users of the services of associates;
- and (d) persons providing, assessing or funding education or training for associates of prospective associates.'[7]

3.9 These legislative provisions should underpin regulators' approach to rulemaking once they are rolled out more widely.

4. Principles for good rulemaking

4.1 We have outlined some principles to guide what good rules should aim to do or be, and the process. Where relevant, we have provided further information in section 2 of this document to support regulators in putting the principles into practice.

4.2 Good rules and a good rulemaking process should result in regulation which:

- Is consistent with the regulator's legislative duties and statutory remit of public protection
- Is consistent with the principles of right-touch regulation (proportionate to the risk of harm, accountable, consistent, targeted, transparent, and agile)
- Promotes equality, diversity and inclusion
- Supports consistency of regulatory practice between regulators, justifying disparity where appropriate
- Is agile, allowing regulators to swiftly respond to changes in the external environment
- Facilitates multi-disciplinary team working and innovative practice.

4.3 The process should be:

- Based on evidence of risks, benefits and impacts
- Underpinned by robust internal governance
- Built on meaningful consultation, collaboration and engagement with a wide variety of stakeholders, including patients and the public.

[7] References to 'associates' reflect the wording of the AA PA Order, but this will be amended to refer to other professions as the reforms are rolled out across regulators.

Part 2 - Further information to support a good practice approach to rulemaking

5. Right-touch regulation principles

5.1 The PSA developed its right-touch regulation principles building on the better regulation principles by adding 'agility'.[8] The aim is to make sure that the level of regulation is proportionate to the level of risk to the public.

5.2 Whilst right-touch regulation is likely to be more relevant at the policy development stage which generally sits before the development of rules, we recommend it as a useful framework for regulators and therefore have included an overview here.

5.3 The principles state that regulation should aim to be:

- Proportionate: regulators should only intervene when necessary. Remedies should be appropriate to the risk posed, and costs identified and minimised
- Consistent: rules and standards must be joined up and implemented fairly
- Targeted: regulation should be focused on the problem, and minimise adverse side effects
- Transparent: regulators should be open, and keep regulations simple and user friendly
- Accountable: regulators must be able to justify decisions, and be subject to public scrutiny
- Agile: regulation must look forward and be able to adapt to and anticipate change.

5.4 There are eight elements that underpin applying a right-touch regulation approach to a policy problem:

- Identify the problem before the solution
- Quantify and qualify the risks
- Get as close to the problem as possible
- Focus on the outcome
- Use regulation only when necessary
- Keep it simple
- Check for unintended consequences
- Review and respond to change.

[8] Professional Standards Authority 2015, *Right-touch regulation.* Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-regulation-2015.pdf?sfvrsn=eaf77f20_20

6. Consistency between regulators

6.1 The Government's policy consultation on reforming the legislation of the healthcare professional regulators outlined its intention to 'provide all UK healthcare regulators with broadly consistent powers', building on the simplification review of the Law Commissions in 2015.[9] The Government's response to the consultation published in 2023 was clear that there was an expectation of greater consistency between regulators, with appropriate variation where necessary.

6.2 The Anaesthesia Associates and Physician Associates Order, as the template for reformed legislation, includes duties for regulators to discharge functions in a way which is 'transparent, accountable, proportionate and consistent'.[10]

6.3 Multiple inquiries and reviews have highlighted the need for greater regulatory consistency, including the Williams Review into gross negligence manslaughter which identified concerns about inconsistent fitness to practice (FtP) outcomes arising from the Bawa Garba case. On the back of the Williams Review, the PSA commissioned UCL (on behalf of DHSC) to produce a structured approach to understanding the factors influencing consistency and to propose a methodology that could take this work forward. A key recommendation was to refocus research towards avoiding "unjustifiable disparity".[11]

6.4 In 2021 the Authority commissioned research into patient, carer, public and professional perspectives on the principle of consistency in health and care professional regulation.[12] The research uncovered five arguments for 'sameness', which usually mapped to four roles that regulators were perceived to play when carrying out their functions (arbiter, assurer, service provider and team enabler). The arguments for sameness included – correct, fair, adequate, simple and coherent. Five arguments for difference were also identified. These were – risk, scope, expectation, narrative and team.

6.5 A key finding from this research was that the public, patients and registrants expect regulators to work in dialogue with one another, to ensure consistency of approach and transparency about why variation exists.

6.6 We have used the findings from the research to develop a three-step process for establishing whether inter-regulatory consistency is desirable across the regulatory functions. The steps are:

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[9] *Regulating healthcare professionals, protecting the public*, 2021. Available at: https://assets.publishing.service.gov.uk/media/607daac6d3bf7f0132941916/Regulating_healthcare_professionals__protecting_the_public.pdf

[10] The Anaesthesia Associates and Physician Associates Order 2024: https://www.legislation.gov.uk/ukdsi/2024/9780348255195

[11] *Developing a methodology to assess the consistency of fitness to practise outcomes*, 2019. Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/developing-a-methodology-to-assess-the-consistency-of-fitness-to-practise-outcomes-2019.pdf?sfvrsn=97c57420_0

[12] Christmas S., et al. (2021) *Patient, carer, public and professional perspectives on the principle of consistency in health and care professional regulation*. Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/research-paper/does-consistency-between-regulators-matter.pdf?sfvrsn=fbcc4920_4

1. Establishing relevant arguments for making things the same (in relation to a specific rule change or policy development)
2. Identifying moderating factors
3. Balancing arguments for sameness against moderating factors.

6.7 These steps are outlined in full in Annex A. These are intended to help regulators consider how to avoid unjustifiable disparities and aim for appropriate consistency where possible. This is in line with ambitions for the reforms that regulators should have broadly equivalent powers to maintain a level of consistency and effective public protection.

6.8 The consistency steps outlined are intended to support discussions about where consistency across regulators is valuable and should be pursued, or conversely, where disparity is justified and why. As highlighted previously, these steps may also be relevant at an earlier stage of the process when the policy underlying rule changes is being developed. They may also be relevant when developing significant pieces of guidance or standards for professionals.

6.9 Some examples of areas where regulators may wish to weigh up the arguments for maintaining consistency or pursuing a different approach as part of their rule development process may include:

- Development of standards of practice for professionals
- Standards in relation to education and training and the approach to assessing providers
- CPD and revalidation requirements
- Publishing data about their registrants beyond the minimum required by legislation
- Registration processes, including removal and readmittance processes to the register for administrative reasons, and appeals procedures
- Information published on the register
- Deciding whether to and how best to investigate a fitness to practise concern
- The details of how the fitness to practise panel stage operates
- Processes for restoration to the register in relation to fitness to practise cases.

6.10 Inevitably, those regulators that are first to receive reformed legislation will effectively create a template for other regulators to consider as they themselves receive reformed legislation and develop rules.

6.11 However, this guidance is intended to be relevant not just during the initial rule creation stage but also during future iterations and rule amendments with the hope that, over time, regulatory approaches will achieve a greater level of coherence.

7. Consultation

7.1 Consultation is generally acknowledged as an important part of the policy making process. It allows a government, public body or organisation to seek input from its stakeholders on a particular policy proposal or range of proposals. It can be a way of strengthening policy by seeking relevant views and information from those with particular knowledge, expertise or interest.

7.2 Whilst definitions of consultation and its purpose vary, the Scottish Government, in its overview of how consultation is used in government policy making outlines that: 'A good consultation should be accessible for people. The consultation should clearly outline what it is seeking people's views on and make sure that people are able to respond.'[13]

7.3 The 2018 Cabinet Office consultation principles also provide useful guidance to all organisations in formulating and carrying out effective and meaningful consultation.[14]

7.4 In the Anaesthesia Associates and Physician Associates Order the general provisions about rules require that the regulator, before making rules: *'must consult, to the extent it considers proportionate, representatives of any group of persons which appear to the Regulator likely to be affected by the rules, including representatives of -*

- *(a) associates;*
- *(b) employers of associates;*
- *(c) users of the services of associates;*
- *and (d) persons providing, assessing or funding education or training for associates of prospective associates.'*

7.5 Consultation will be an increasingly important accountability mechanism for rulemaking with the removal of the Privy Council approval stage. Although we recognise that regulators may well have their own guidance in place on how and when they consult, we suggest that regulators will need to review this in light of the new importance it will take on following the roll out of the reforms as a means of balancing out enhanced autonomy with accountability.

7.6 As there is little detail in the AA/PA Order to guide regulators on when and how they should consult, we have outlined some considerations for regulators to consider when developing their approach.

7.7 In doing so we have drawn on good practice already in use by the regulators we oversee, good practice and requirements in place in other sectors including those in place for regulators in the legal services sector and general good practice available on consultation, including that published by the Government.

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[13] Consultations in the Scottish Government: guidance: https://www.gov.scot/publications/consultations-in-the-scottish-government-guidance/
[14] Cabinet Office 2018, *Consultation principles: guidance*: https://www.gov.uk/government/publications/consultation-principles-guidance

When to consult

7.8 Factors which regulators may want to consider when deciding whether consultation is appropriate include:

- Legal requirement/legitimate expectation of a consultation – is there a legal requirement to consult or a legitimate expectation by stakeholders that a consultation will be held?
- Nature of the rule change – are there public protection implications, does it bring about major changes to the regulatory process?
- Who is affected – is there likely to be a particular impact on patients, service users, registrants, wider stakeholders?
- Does the rule change have human rights or EDI implications or opportunities?
- Potential for regulatory duplication or conflict – is there the potential for rule changes to duplicate or conflict with activity by any other regulatory bodies, including other professional regulators?
- Scale of change/complexity of change – is the change significant or is it largely a minor or non-substantive change?

Type of consultation and wider engagement activity

7.9 If a regulator concludes that a consultation is required, they may also want to consider the nature of the consultation, including whether to carry out formal or informal consultation, who to consult with and whether to plan any additional consultation activities to ensure participation from under-represented groups.

- Formal or informal consultation – considering whether a formal public consultation or informal engagement or consultation is needed is likely to be influenced by the scale and significance of the change in question as well as the best way to get the input needed from relevant stakeholders
- Who to consult/engage with – identifying the groups that regulators wish to consult with will be an important part of deciding on the type of consultation required, alongside planning any additional engagement activity. This should take into account the challenges that some groups may face in participating in different ways
- Ensuring participation from under-represented groups – regulators may wish to consider developing tailored plans around engagement and consultation with under-represented groups likely to be impacted by any changes, including those who share protected characteristics. This may include consideration of any Welsh language requirements.

Consultation good practice and wider considerations

7.10 Regulators may wish to consider the cumulative burden on stakeholders of responding to multiple consultations at once. This is particularly relevant to stakeholders who might have an interest in providing input to rule changes by

multiple regulators, for example patient organisations, if consultations are carried out in parallel or very close together.

7.11 Although there may be limited scope for regulators to stagger consultations as there may be external or internal time pressures, it will be a relevant consideration for regulators when considering how best to engage stakeholders in consultations.

7.12 As consultation is an important element of demonstrating accountability to stakeholders, it is good practice to keep a record of decisions made on whether to consult and how consultation responses were evaluated. It is also good practice to provide a report back to those who took part in a public consultation.

8. Governance

8.1 As the Privy Council will no longer approve rules and rule changes, regulators should establish appropriate internal governance for developing, making and amending rules.

8.2 Regulators' internal governance structures will change following the roll out of the new legislation. This includes the introduction of Unitary Boards to replace the existing Councils. Regulators undertaking rulemaking in advance of these changes will need to account for the transition between current and future governance arrangements.

8.3 Areas that regulators should consider when defining the governance pathway for rule changes include:

- Scale/significance of the rule change
- The role that the Council/Unitary Board will play
- Documenting decisions made about the approach taken including the governance pathway and decisions made on whether to consult.

8.4 We have previously produced guidance on governance in the public interest. Although largely focused on Board competencies and operation, it provides useful pointers for regulators when considering how to develop an appropriate governance process for the new approach to rulemaking.

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professional standards authority

Annex A – Inter-regulator consistency tool

Step 1. Establishing relevant arguments for making things the same

- The following table sets out key arguments for sameness mapped out against particular role(s) regulators may be carrying out (reflecting the findings in Christmas et al.). A regulator might be playing more than one role when carrying out its functions and therefore numerous arguments for consistency could be relevant.

		(2) What arguments for consistency are most relevant to decision-making?				
		'Correct'	**'Fair'**	**'Adequate'**	**'Simple'**	**'Coherent'**
(1) What role are regulators playing?	**Arbiter** – Decides appropriate response to cases	Consistency is required by legal obligations, e.g., Equality duties	Consistency is required to ensure fair treatment and outcomes			
	Assurer – Ensures professionals maintain standards		Consistency is required to ensure fair treatment and outcomes	Consistency helps to ensure a minimum standard is met across professions		
	Service provider – Meets the needs of users of its services			Consistency helps to ensure a minimum standard for how the public and registrants experience engaging with regulators and the regulatory system	Consistency reduces complexity and potential for confusion for the public and registrants in their engagement with regulators and the regulatory system	
	Team enabler – Supports functioning of a team around a patient				Consistency provides clarity for professionals working at the edge of or across professional boundaries	Consistency supports a joined-up, coherent system necessary for public and professional confidence and to facilitate multi-professional working

Step 2. Identifying moderating factors

- Variation between regulators is not a bad thing, but divergence should be clearly explained to ensure trust and confidence in regulation. Moderating factors that might lead regulators to adopt different approaches include:
  - The risks associated with professional practice, including the extent of harm and benefit that can potentially be caused, and its context
  - The level of interaction and nature of the relationship between the profession and patients/ service users
  - The roles which professionals take within teams involving members of other professions
  - The speed of change in areas of professional practice and expertise (particularly with regards to fitness to practise and education and training)
- Any moderating factors should be identified and catalogued.

Step 3. Balancing arguments for sameness against moderating factors

- The final stage of the process involves weighing the arguments for sameness against the identified moderating factors and making a value judgment. This should be a transparent, discursive process.

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Annex B – Further information and references

- The Anaesthesia Associates and Physician Associates Order 2024: https://www.legislation.gov.uk/ukdsi/2024/9780348255195Christmas S., et al. (2021) *Patient, carer, public and professional perspectives on the principle of consistency in health and care professional regulation*. Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/research-paper/does-consistency-between-regulators-matter.pdf?sfvrsn=fbcc4920_4
- Professional Standards Authority 2015, *Right-touch regulation.* Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-regulation-2015.pdf?sfvrsn=eaf77f20_20
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DRAFT

DRAFT - The use of accepted outcomes in fitness to practise: Guidance for regulators

January 2024

1. About the Professional Standards Authority

1.1 The Professional Standards Authority for Health and Social Care promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and voluntary registration of people working in health and care. We are an independent body, accountable to the UK Parliament.

1.2 We oversee the work of 10 statutory bodies that regulate health professionals in the UK and social workers in England. We review the regulators' performance and audit and scrutinise their decisions about whether people on their registers are fit to practise.

1.3 We also set standards for organisations holding voluntary registers for people in unregulated health and care occupations and accredit those organisations that meet our standards. To encourage improvement, we share good practice and knowledge, conduct research and introduce new ideas including our concept of right-touch regulation. We monitor policy developments in the UK and internationally and provide advice to governments and others on matters relating to people working in health and care.

1.4 Our organisational values are: integrity, transparency, respect, fairness and teamwork. We strive to ensure that our values are at the core of our work. More information about our work and the approach we take is available at www.professionalstandards.org.uk

2. Preface

2.1 This document identifies key factors for regulators to consider when using accepted outcomes as part of their fitness to practise processes. It is drawn from our long experience of scrutinising regulators' final fitness to practise panel decisions. We intend it to help regulators to use accepted outcomes well, for the right cases, in the right way.

2.2 This document contains two parts:

- Part I: Factors to consider when using accepted outcomes: guidance for regulators
- Part II: Context, evidence and explanation of factors

2.3 Part I consists of guidance for regulators on using accepted outcomes in fitness to practise. The purpose of the guidance is to aid regulators to develop their own guidance and processes for using accepted outcomes. Part II contains the background and context to the guidance, including details of the changes to fitness to practise resulting from the Government's programme of reform to the healthcare professional regulators. It also contains a fuller explanation of the

factors for regulators to consider, along with details of the underpinning evidence.

Part I: Factors to consider when using accepted outcomes: guidance for regulators

3. Status of this guidance

3.1 The PSA has no formal role in relation to the accepted outcomes process. This guidance does not therefore have any official status, nor is it binding on regulators. However, in future we may look at how regulators are making use of accepted outcomes under our performance review process and may take this guidance into account in assessing their approach. We may ask regulators to provide a rationale for the approach they have taken and to explain how they have assured themselves that it maintains public protection.

3.2 We recognise that individual regulators will develop their own guidance and procedures in relation to accepted outcomes. Our intention is that our guidance should support and guide this process rather than replace individual regulator approaches.

4. Scope of this guidance/ How regulators should use this document

4.1 This document is intended for healthcare professional regulators to use when developing their own accepted outcomes guidance and processes. For most regulators, this will only be applicable once their legislation has been updated in line with the government's programme of regulatory reform.

4.2 This guidance applies to the accepted outcomes process set out in the Anaesthesia Associates and Physician Associate Order 2024 (AAPA Order)[1] which is expected to act as the template for reform across the healthcare professional regulators. It does not apply to any regulator until and unless its powers are reformed to bring them into line with those set out in the AAPA Order. It does not directly apply to Social Work England, which already operates an accepted disposal process in line with its legislative powers, although many of the factors identified may be of relevance.

4.3 This document identifies key factors for regulators to consider when developing their own guidance on the use of accepted outcomes. The guidance includes factors to consider when determining disposal route (i.e. whether a case is best resolved by case examiners or a fitness to practise panel) as well as factors for regulators to consider to ensure the accepted outcomes process is fair and transparent, and to promote effective decision-making.

4.4 We aim to support regulators to make best use of the reforms to fitness to practise introduced under the AAPA Order (and expected subsequent legislation), whilst continuing to effectively deliver the three limbs of public protection. We have sought to draw together the available evidence to suggest a list of factors that regulators should have regard to when developing their

[1] The Anaesthesia Associates and Physician Associates Order 2024: https://www.legislation.gov.uk/ukdsi/2024/9780348255195

accepted outcomes processes. We do not seek to be prescriptive in terms of how regulators should apply these factors to their work.

5. Principles for effective use of accepted outcomes

5.1 When using accepted outcomes, we expect regulators to be guided by the following principles:

- Decisions protect the public in accordance with the three limbs of public protection[2]
- Decisions are fair, consistent and transparent
- The decision-making process supports equality, diversity, and inclusion for patients, service users and registrants.

6. The legislative framework

6.1 The primary consideration for all regulators when determining case disposal route is compliance with their legislative framework.

6.2 The core purpose of health and care professional regulation is *'the protection of the public'*, as set out in the Health and Social Care (Safety and Quality) Act 2015.[3] This overarching duty applies to the health and care regulators we oversee[4] as well as to the PSA. Public protection is further defined by the Act as encompassing three tenets (often referred to as the 'three limbs of public protection'):

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

6.3 Sitting alongside the overarching duty to protect the public, each health and care professional regulator has its own unique legislation setting out its regulatory functions. These Acts include provisions detailing how regulators must approach fitness to practise. The Government is in the process of reforming the legislation of all healthcare professional regulators to bring their powers into line with those set out in the AAPA Order. The factors to consider outlined in this guidance have therefore been developed in accordance with both the overarching duty to protect the public and the legislative framework set out in the AAPA Order.

6.4 The reforms to fitness to practise introduced under the AAPA Order introduce two separate routes for resolving fitness to practise cases: the case examiner route (through which cases can be concluded using an accepted outcome or an

[2] The three limbs of public protection are: the protection of patients, the maintenance of public confidence in the profession, and upholding proper standards of conduct and behaviour.
[3] Health and Social Care (Safety and Quality) Act 2015: Health and Social Care (Safety and Quality) Act 2015 (legislation.gov.uk)
[4] With the exception of the Pharmaceutical Society of Northern Ireland (PSNI)

imposed measure) and the fitness to practise panel route. Case examiners are required to decide in every case whether to make a determination on impairment and seek to agree an accepted outcome with a registrant, or whether to refer a case to a panel for a hearing. Both case examiners and fitness to practise panels are able to make a decision on impairment and sanction.

6.5 A case examiner can conclude a case with the registrant's agreement (we refer to this as an 'accepted outcome')[5] where:

- the registrant has agreed to a final measure
- the registrant has accepted that their fitness to practise is impaired
- the registrant has accepted the case examiner's findings

6.6 Where a registrant does not respond to a case examiner's offer of an accepted outcome within the prescribed period, a case examiner can impose a final measure without their agreement.[6]

6.7 This guidance is intended to apply primarily to accepted outcomes, rather than to final measures that are imposed without the registrant's agreement. However, many of the factors to consider will be relevant to both circumstances.

6.8 Under the AAPA Order, case examiners have the same range of measures available to them as panels and there are no limitations on the types of cases they can resolve. This enables regulators to use case examiners to resolve fitness to practise cases that would previously have been referred to a fitness to practise panel for a hearing.

6.9 The Order does not outline a process for determining which cases should be resolved by case examiners and which should be determined by a panel, nor does it express a preference for either route. Resolution through an accepted outcome is likely to be swifter, less adversarial and more cost efficient in most cases. It is therefore likely to be beneficial to complainants, registrants and the public to resolve cases using accepted outcomes where appropriate.

6.10 However, in some cases, case examiners may be more confident that referral to a panel, rather than using an accepted outcome, would result in a final outcome that fulfils all three limbs of public protection. This may occur, for example, when the safest way to determine impairment is through testing the evidence at a hearing.

6.11 This guidance constitutes our view on the factors case examiners should consider when deciding whether a case is best disposed of using an accepted outcome or by referral to a fitness to practise panel. In our view, for a case examiner to decide to resolve a case using an accepted outcome they must be confident that such an outcome would fulfil all three limbs of public protection.

[5] Whilst the policy intent as articulated by the Department of Health and Social Care is clear that where the registrant agrees to the measure this constitutes an 'accepted outcome', it should be noted that the AAPA Order does not use this term. The Order refers only to 'Final Measures' which are 'imposed' (rather than agreed).
[6] The Anaesthesia Associates and Physician Associates Order 2024: https://www.legislation.gov.uk/ukdsi/2024/9780348255195

Where there are factors present in a case that suggest disposal by an accepted outcome may not fulfil the three limbs, consideration should be given to referring the case to a panel for a hearing.

7. Factors to consider when using accepted outcomes: guidance for regulators

7.1 This guidance contains 4 sections:

- Factors to consider when determining disposal route
- Factors to consider when determining the composition of decision-makers
- Factors to consider when publishing case examiner decisions
- Promoting a fair and effective accepted outcomes process

Factors to consider when determining disposal route

7.2 When determining whether a case is best dealt with by an accepted outcome or referral to a panel for a hearing, regulators should consider the following:

- Has the registrant failed to accept the findings and/or impairment?
- Is there a dispute of fact/conflict of evidence that can only be fairly tested at a hearing?
- Does the complexity of the case suggest that a hearing may be beneficial?
- Would it be beneficial and proportionate to test insight at a hearing?

7.3 If the answer to the above questions is no, this would suggest that a case can be fairly and safely disposed of using an accepted outcome. If the answer is yes, regulators should consider whether public protection is best served by holding a fitness to practise hearing.

7.4 These factors are considered in more detail below.

Has the registrant failed to accept the findings and/or impairment?

7.5 An accepted outcome is capable of being used where a registrant (who has responded to the associated notification) accepts the case examiner's findings and that their own fitness to practise is impaired (in addition to the proposed sanction).

7.6 We do not consider that every single allegation or finding has to be accepted. In some cases, minor discrepancies (for example as to the date on which the conduct took place) may not be material. In others, disputed facts may not add anything to the gravity of the admitted ones. However, there must be certainty about the factual basis on which a finding of impairment is reached. This is both so that on review of a sanction all parties are clear about the basis for the original sanction, and because acceptance by a registrant of the key factual aspects of the case against them is an important indicator in assessing insight. Further, it is important for transparency and public confidence that the facts of

the case have been clearly established, and that any resulting public protection measures have been recommended on the basis of those facts.

7.7 Where a registrant does not accept facts that are the basis of the regulatory concern(s), case examiners would be expected to either refer the case to a panel, or to have good reasons why they still consider that the case is best dealt with by means of an accepted outcome.

7.8 Acceptance of impairment is also a legislative requirement for disposal of a case by accepted outcome. Impairment as a concept may not be well understood by registrants and we encourage regulators to take steps to explain it. Any forms/documents for a registrant to complete to assent to an accepted outcome should make clear that in doing so they are accepting current impairment and what that means.

7.9 In determining whether impairment has been accepted, regulators may consider the totality of a registrant's conduct. However, where a regulator has no evidence that impairment has been accepted, we expect them to refer a case to a panel.

7.10 Factors to consider:

- Does the registrant dispute any material facts (such as those that form the basis of a regulatory concern)? If so, are there reasons as to why the case is still best dealt with using an accepted outcome?
- Is there certainty amongst all parties about the factual basis on which the findings have been reached?
- Does the registrant clearly accept current impairment?

Is there a dispute of fact/conflict of evidence that can only be fairly tested at a hearing?

7.11 Some cases involve a dispute of fact that can only be fairly and effectively resolved by hearing live evidence. Where such disputes exist, panels have a crucial advantage over case examiners as they can ask probing questions of registrants and witnesses and allow for thorough cross-examination. Panels are therefore able to assess information in a more dynamic way than can be achieved by a paper-based process.

7.12 Cases that are less likely to be suitable for disposal by accepted outcome are those where there are material disputes about facts or uncertainty around the background to, and seriousness of, the conduct (for example if the registrant interprets the facts in a way which contradicts the impression of other witnesses). There may also be cases where the account given in writing by one or more parties appears lacking, or where case examiners consider that the evidence of the registrant or a witness would benefit from further exploration/examination at a hearing.

7.13 Where there is competing evidence which is material to the case, and where two or more differing accounts are plausible and the dispute cannot be resolved with reference to the other evidence that is available, the substantive panel is the correct arena for testing the evidence of both the registrant and the witness. A hearing may be particularly beneficial in cases which lie on the borderline

between sanctions, where testing the evidence would have the potential to assist with assessment of seriousness.

7.14 Factors to consider:

- Are there material disputes about facts where two or more competing accounts are plausible and the dispute cannot be resolved with reference to the other evidence that is available?
- Is there uncertainty about the background to, or seriousness of, the conduct?
- Would the written accounts of the registrant or any of the witnesses benefit from further exploration/examination at a hearing?
- Does the case lie on the borderline between sanctions and if so would testing the evidence have the potential to assist with assessment of seriousness?

Does the complexity of the case suggest that a hearing may be beneficial?

7.15 Case examiners should be generally capable of dealing with complex cases without the need to refer to a panel. However, there may be cases with particular complexities where the evidence/issues under consideration would benefit from further exploration/examination at a hearing to support understanding and decision-making. This may, for example, include complex clinical cases involving a number of expert witnesses.

7.16 Factor to consider:

- Are the complexities of the case such that the evidence/issues under consideration would benefit from further exploration/examination at a hearing? Would a hearing support understanding and decision-making?

Would it be beneficial and proportionate to test insight at a hearing?

7.17 Insight is integral to fitness to practise as it is key to understanding whether the registrant continues to pose a risk and to the assessment of any attitudinal failings. A registrant who shows genuine insight and attempts to remediate is more likely to comply with any conditions placed on them, and less likely to repeat the behaviour than one who does not. Failure to demonstrate insight is likely to lead to a more restrictive sanction.

7.18 Effective assessment of insight is crucial to both the impairment and sanction stages of fitness to practise. There remain doubts over the extent to which insight can be determined on the papers alone in more difficult and complex cases and those which may indicate serious/fundamental attitudinal issues. There are also concerns that it may be difficult to reliably assess the level of insight expressed in reflective statements where registrants may have received significant support producing them or used Artificial Intelligence (AI).

7.19 In general, panels are likely to be better placed to make a robust assessment of insight than case examiners as they can ask probing questions of the registrant. However, it would not be proportionate to refer all cases where there is a question about insight to a panel. We recommend referral to a panel where the

doubts about a registrant's level of insight are significant and/or the evidence available is incomplete or lacking credibility. This may be particularly important in cases where there are deemed to be serious attitudinal issues.

7.20 Factors to consider:

- Are there significant doubts over the registrant's insight? (this may be due to the content of the registrant's reflective statement or the nature of the concern)
- Would it be both beneficial and proportionate to test insight at a hearing?
- Is this a case that involves serious attitudinal issues?

Factors to consider when determining the composition of decision-makers

7.21 This section contains consideration of:

- Lay representation in decision-making
- The use of single decision-makers

Lay representation in decision-making

7.22 Legislation determines that fitness to practise panels are comprised of at least one registrant and one lay person. However, there is no corresponding requirement in relation to the composition of case examiners when determining impairment or imposing a Final Measure

7.23 Evidence suggests that patients and the public are concerned about the risk of bias in the fitness to practise process. We are of the view that lay representation in decision-making must remain a feature of the system in order to maintain and uphold public confidence. We do not seek to determine how or when lay decision-makers should be involved, but expect regulators to be mindful of the need to incorporate lay decision-makers at some point in the process.

The use of single decision-makers

7.24 The accepted outcomes process allows for decisions on impairment and sanction to be made by a single case examiner.[7] Research into decision-making has emphasized that all decision-making processes (including all individual decision-makers) are subject to bias. Many different factors influence bias and decision-makers are likely to be affected differently by different biases. Having more than one decision-maker may help to counteract bias and lead to more balanced decisions. It may also help to counter perceptions of bias and unfairness.

[7] The AAPA Order does not specify the number of case examiners that are required for decision-making. However, the Government has made clear that they intend regulators to be able to use more than one case examiner where appropriate. This position is set out in 'Consultation response to regulating anaesthesia associates and physician associates' Dec 2023: Consultation response to regulating anaesthesia associates and physician associates - GOV.UK (www.gov.uk)

7.25 Some cases may be safely and fairly disposed of using a single decision-maker. These are likely to be ones which involve little ambiguity about the facts and current impairment, for example cases involving a conviction.

7.26 Cases that may benefit from more than one decision-maker are likely to be those which are complex or 'paper heavy', involve significant ambiguity as to what has occurred and/or as to current impairment, or where there are particular cultural considerations. There may also be merit in ensuring more than one person is involved in decision-making where a case is particularly high-profile or controversial and is likely to be subject to significant scrutiny.

7.27 In addition to the number of decision-makers assigned to a case, it is important that regulators have due regard to the training and expertise of those making decisions.

7.28 All regulators need to be mindful of their obligations to protect and promote equality, diversity and inclusion (EDI). Where a regulator is relying on a single decision-maker, they would need to ensure that the individual had relevant cultural competence.

7.29 Factors to consider:

- Is at least one case examiner a lay person? If not, is there lay involvement at some stage in the fitness to practise decision-making process?
- Does the case involve complex issues, large amounts of evidence or significant ambiguity?
- Are cultural considerations a significant factor in the case? If so, does the case examiner have relevant cultural competence?

Factors to consider when publishing case examiner decisions

7.30 This section contains consideration of:

- Promoting transparency and public confidence
- Case law

Promoting transparency and public confidence

7.31 Ensuring that decisions are transparent and accessible is a key means by which confidence in regulators, and regulatory processes, is maintained. The shift away from a panel-based hearings model to the paper-based accepted outcomes model has the potential to reduce the transparency of the decision-making process, which may in turn have adverse consequences for public confidence and the maintenance of standards.

7.32 In order to ensure that the public interest in transparent decision-making is upheld, regulators must give clear reasons for regulatory decisions, including providing sufficient detail about cases and how they are resolved. Regulators should make decisions publicly available and include enough information so that a third party with no prior knowledge of the case would be able to fully understand both the basis of the concern and the rationale for the decision. To satisfy these requirements, it is likely to be necessary to include:

- sufficient details of the regulatory concern or allegations

- the relevant facts and background of the case
- details of the admissions and submissions made by the registrant
- the regulator's decision in respect of the statutory grounds
- the regulator's assessment of impairment
- the final outcome including sanction.

[Note that there are cases where some of the information outlined above should remain confidential, for example those involving a registrant's health concerns, or where there is other sensitive or confidential evidence.]

Case law

7.33 The requirement to give clear reasons for regulatory decisions is underpinned by case law. For example, the judgement in the case of PSA and General Optical Council v Honey Rose outlines a panel's obligation to uphold public confidence by giving proper reasons for its decision. In the case of Professional Standards Authority for Health and Social Care v General Medical Council [2023] EWHC 967 (Admin) the court quashed a finding of the Medical Practitioners Tribunal Service on the basis of 'serious procedural irregularity' due to a failure by the panel to give cogent reasons for its decision. The judgement noted that a panel must *'expose the relevant analysis so the reader understands what the principal issues were, and what the Panel made of them. This is part and parcel of their function in protecting the public interest.'*

7.34 Factors to consider:

- Is the decision published in a place that is easy for the public to access?
- Is the decision sufficiently detailed that a third party with no prior knowledge of the case would be able to fully understand both the basis of the concern and the rationale for the decision?

Promoting a fair and effective accepted outcomes process

7.35 This section sets out factors regulators should consider to ensure the fairness and effectiveness of investigation and decision-making procedures.

7.36 This section contains consideration of:

- Complainant voice in accepted outcomes
- The role of case examiners in proposing fair and proportionate accepted outcomes
- Equality, diversity and inclusion

Complainant voice in accepted outcomes

7.37 Regulators should ensure patients and service users who are witnesses in proceedings are treated with dignity and respect, feel heard, and are kept informed throughout each stage of the accepted outcomes process. This should include ensuring that complainants (particularly where the complainant is a

patient or service user) are able to make representations within the accepted outcomes process before a decision is made.

The role of case examiners in proposing fair and proportionate accepted outcomes

7.38 Case examiners are generally skilled and proficient at making good decisions and proposing accepted outcomes to registrants that are fair and proportionate. However, the fact that, unlike panels, they are not independent of the regulator, may result in certain regulatory risks. In particular, it is possible that case examiners may be subject to pressure or targets that affect the objectivity of their decisions.

7.39 We expect regulators to be alive to the risk of case examiners' judgement and objectivity being impacted by internal pressures or targets and ensure that quality assurance processes are in place to mitigate such risks.

Equality, diversity and inclusion considerations

7.40 The move to a paper-based approach in fitness to practise may have differential impacts, both positive and negative, on people with shared protected characteristics. This applies to complainants (and other witnesses) and to registrants.

7.41 Some participants in the fitness to practise process may feel better able to express themselves verbally than in writing, or vice versa. This may apply particularly to people with certain disabilities, those who are neurodiverse, and those for whom English is not their first language.

7.42 There is also some evidence that different socio-economic groups may be impacted differently by the process. Registrants with access to legal advice (which may be more likely to include members of 'wealthier' professions as well as those who hold a UK qualification) may benefit from more lenient sanctions than those lacking representation. It is likely that the two groups will vary in terms of their protected characteristics. We would expect regulators to be mindful of this risk and monitor outcomes for different groups.

7.43 We expect regulators to conduct an equality impact assessment as part of the development of their accepted outcomes process and to take steps to mitigate any negative impacts identified on people with shared protected characteristics or other needs and/or vulnerabilities. This may include making reasonable adjustments to normal processes to meet the needs of individuals. It is important that no participants are disadvantaged by the accepted outcomes process due to a protected characteristic that they hold or other specific needs that are not met.

7.44 Factors to consider:

- Has due consideration been given to ensuring that complainants are treated with dignity and respect, feel heard, and are kept informed within the accepted outcomes process?

- Have steps been taken to protect the independence of decision-makers and ensure that they are able to make impartial and fair decisions, free from undue pressure to meet targets or save costs?
- Have steps been taken to identify any differential impacts of accepted outcomes on people who hold shared protected characteristics? Where the process may impact negatively on certain groups, have steps been taken to mitigate this?
- Are accepted outcomes monitored and recorded in such a way that it is possible to assess any differentials in sanction by protected characteristic?

Part II: Context, evidence and explanation of factors

8. Introduction

8.1 The Government is currently undertaking a programme of regulatory reform that will grant the healthcare professional regulators we oversee significantly more freedom to make their own rules and determine how they exercise their powers. At the same time, the reforms will transform the fitness to practise processes of the regulators, allowing many more cases to be resolved using 'accepted outcomes' without the need for a fitness to practise panel hearing.

8.2 We support these reforms, which we expect to significantly improve regulatory processes and benefit all those involved in fitness to practise cases, including complainants, the public, and registrants. We hope that they will result in a system that is more efficient, less adversarial and fairer to all concerned. However, we have also identified certain risks that may result from the use of accepted outcomes in some fitness to practise cases. These risks relate to the robustness, independence and transparency of decision making in certain contexts, as well as possible adverse impacts on public confidence and people with shared protected characteristics.

8.3 The changes to fitness to practise represent a generational shift in how the process operates, and we aim to support regulators to make the most of what the reforms can offer whilst ensuring they continue to effectively deliver the three limbs of public protection.[8] We are therefore undertaking work to help support implementation of the reforms. This document seeks to analyse the available evidence and draw out factors for regulators to consider when developing their own fitness to practise rules and procedures.

9. Background and regulatory context

The purpose of fitness to practise

9.1 The core purpose of health and care professional regulation is *'the protection of the public'*, as set out in the Health and Social Care (Safety and Quality) Act 2015.[9] This overarching duty applies to the health and care regulators we oversee[10] as well as to the PSA. Public protection is further defined by the Act as encompassing three tenets:

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

[8] The three limbs of public protection are: the protection of patients, the maintenance of public confidence in the profession, an upholding proper standards of conduct and behaviour.
[9] Health and Social Care (Safety and Quality) Act 2015: Health and Social Care (Safety and Quality) Act 2015 (legislation.gov.uk)
[10] With the exception of the Pharmaceutical Society of Northern Ireland (PSNI)

9.2 These three elements are commonly known as the 'three limbs' of public protection and underpin the work of the health and care professional regulators.

9.3 Ensuring that health and care professionals are 'fit to practise' is fundamental to regulators fulfilling their duty to protect the public. Fitness to practise can be defined as having the ability to practise safely and effectively.[11] It encompasses *'having the appropriate skills, competencies, knowledge, character and health'* to perform the role.[12]

9.4 Where a professional lacks any of these, they pose a public protection risk. It is the job of regulators to ensure that these risks are managed and that the public are protected from registrants who are not fit to practise.

The fitness to practise process

9.5 Where concerns are raised about a registrant's fitness to practise, regulators follow a formal process to determine whether a registrant is 'fit to practise' or 'impaired'. In broad terms, the fitness to practise process involves the following (as outlined in Cohen v GMC)[13]:

- Finding whether the facts are proved and if so whether they amount to misconduct, lack of competence (or other grounds of impairment)
- Considering whether the registrant's fitness to practise is currently impaired, based on the three limbs of public protection
- Deciding on what sanction is appropriate to adequately address the failings identified.

9.6 All fitness to practise cases contain the essential elements outlined above, although regulators have differing procedures for processing and disposing of cases. Each regulator's individual powers and duties are set out in their respective legislation, which is currently a mix of primary and secondary legislation.

Screening

9.7 The first stage of the fitness to practise process, often known as screening or triage, determines whether a referral amounts to an allegation that a registrant's fitness to practise might be impaired under one of the statutory grounds. These are: misconduct; lack of competence; a conviction or caution for a criminal offence; physical or mental health; not having the necessary knowledge of English; and a determination by another regulatory body.

9.8 If a referral amounts to an allegation of impaired fitness to practise the regulator must investigate it. At the end of the investigation, the regulator decides whether there is a real prospect of a hearing finding current impairment. A case

[11] General Medical Council 2023, *Fitness to practise explained*: Fitness to practise explained - GMC (gmc-uk.org)
[12] Finn, G et al, November 2022, *Experiences of GDC fitness to practise participants 2015 – 2021: A realist study:* Experiences of GDC fitness to practise participants 2015 – 2021: A realist study November 2022 (gdc-uk.org)
[13] Cohen v GMC [2008] EWCH 581: Cohen v General Medical Council | [2008] EWHC 581 (Admin) | England and Wales High Court (Administrative Court) | Judgment | Law | CaseMine

may then either be disposed of using a consensual disposal (such as undertakings or an accepted disposal) or progress to a panel hearing.

Fitness to practise panel hearings

9.9 Fitness to practise panels are normally constituted of three independent members,[14] at least one of which is a registrant and one lay person. They sit in public unless they are considering matters relating to the registrant's health or there are specific circumstances that outweigh the public interest in holding the hearing in public.

9.10 The regulator presents the case and evidence to the fitness to practise panel. The registrant may be present and represented. The panel decides whether the facts are proved, whether they amount to grounds of impairment and, if so, whether the registrant's fitness to practise is impaired either on public protection grounds (for example, because the registrant may repeat the conduct) or on public interest grounds (because a finding is necessary to uphold professional standards or maintain public confidence). If a panel decides that the registrant's fitness to practise is impaired, it then considers what sanction should be imposed. The sanctions available vary from a warning or caution, through conditions of practice, to suspension or expulsion from the register.

9.11 We can refer a decision made by a final fitness to practise panel to the High Court if we believe it to be insufficient to protect the public. This power was granted to the PSA under Section 29 ("s29") of the National Health Service Reform and Health Care Professions Act 2002,[15] and is therefore commonly referred to as our 'section 29 power'.

Consensual disposals

9.12 Whilst for most regulators, serious cases will always progress to a panel hearing, many do have the power to dispose of lower-level cases by a consensual process.[16] These take the form of 'accepted disposals' in the case of Social Work England, and 'consensual disposals' or 'undertakings' for the other regulators. Cases resolved consensually involve an agreement between the regulator and the registrant that the registrant admits to the substance of any allegations that have been investigated by the regulator and agrees to the regulator's proposed sanction. This allows a case to be concluded without the need for a formal hearing.

9.13 Undertakings are a commonly used form of consensual disposal and may comprise one or more restrictions or requirements placed on a registrant. Eight of the regulators we oversee use undertakings (or similar) but there is variation across them in terms of where they are situated in the fitness to practise process.

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[14] This is the case for all regulators except the General Optical Council which uses an independent Hearings Panel constituted of up to five panellists

[15] National Health Service Reform and Health Care Professions Act 2002: National Health Service Reform and Health Care Professions Act 2002 (legislation.gov.uk)

[16] Social Work England is currently the only health or care professional regulator able to deal with all categories of case by means of an accepted outcome.

9.14 Four regulators, GDC, GMC, NMC and PSNI, have legislation that explicitly permits them to resolve cases consensually. Three others, HCPC, GPhC, and GOsC, have a process by which a registrant can agree to undertakings once their case has been considered by a panel, but without any contestation of the facts that underpin the case. The GOC does not use undertakings but is able to agree a sanction with a registrant. The GCC is alone in having no recourse to consensual disposal contained in either its primary legislation or its rules.

The case for change

9.15 We have long called for reform to fitness to practise to make it less adversarial, swifter and more efficient for all involved. Our 2015 publication *Rethinking regulation*[17] highlighted the expense of the current fitness to practise frameworks and the increasing numbers of complaints. In our follow-up paper *Regulation rethought*[18] we called for a radical overhaul of fitness to practise, which we described as *'protracted and expensive'*. We promoted a move to a less adversarial approach with more early opportunities for remediation.

9.16 Numerous studies have outlined the negative impact on practitioner health and wellbeing of being subject to a fitness to practise investigation. A 2022 report commissioned by the GDC brought much of this evidence together and concluded that there were *'severe and far-reaching impacts on those undergoing FtP investigations. The identified impacts included those with the potential to affect the individual's personal wellbeing (e.g. feelings of vulnerability or shame, stress, loss of trust, self-doubt) and their professional wellbeing (e.g. change of career, increased surveillance and documentation, defensive practice, blame culture).'* [19]

9.17 Similarly, research by Professor Tom Bourne of Imperial College London has highlighted the emotional toll of complaints processes on doctors,[20] and GMC commissioned research has explored cases where doctors have died from suicide while undergoing a fitness to practise investigation.[21]

9.18 We have also commissioned three separate pieces of research with complainants in fitness to practise cases: *Enhancing confidence in fitness to practise adjudication*,[22] *The patient and public perspective on future fitness to*

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[17] Professional Standards Authority, 2015, *Rethinking regulation*: rethinking-regulation-2015.pdf (professionalstandards.org.uk)
[18] Professional Standards Authority, 2016, *Regulation rethought: proposals for reform:* regulation-rethoughtd6c718f761926971a151ff000072e7a6.pdf (professionalstandards.org.uk)
[19] Finn, G et al, 2022, *Experiences of GDC fitness to practise participants 2015-2021: a realist study*: Experiences of GDC fitness to practise participants 2015 – 2021: A realist study November 2022 (gdc-uk.org)
[20] Bourne, T, et al 2015, *The impact of complaints procedures on the welfare, health and clinical practice of 7926 doctors in the UK: a cross-sectional survey*. BMJ Open 2015;5:e006687. doi: 10.1136/bmjopen:http://bmjopen.bmj.com/content/5/1/e006687
[21] Sarndrah Horsfall for the GMC, 2014, *Doctors who commit suicide while under GMC fitness to practise investigation: Internal review*: Doctors who commit suicide while under GMC fitness to practise investigation (gmc-uk.org)
[22] CHRE, 2011 '*Enhancing confidence in fitness to practise adjudication: research report'*: Microsoft Word - 110525 Research Works FINAL REPORT.doc (professionalstandards.org.uk)

practise processes,[23] and *Public Response to Alternatives to Final Panel Hearings in Fitness to Practise Complaints*.[24] These found that complainants find panel hearings particularly stressful, with the latter report noting that all the complainants they interviewed *'had one shared experience – that the reality of attending the hearing was more stressful than they had ever anticipated…The hearing itself was described as an intimidating and generally unpleasant experience.'*

9.19 One factor driving the high level of stress experienced by participants in the fitness to practise process is the legalistic and adversarial nature of the proceedings. As the GDC study notes, *'the adversarial nature of the process, including legal representation and legal argumentation in many cases, firmly established the principle of 'establishing guilt or innocence' in the perceptions of those who had been through FtP. This is misaligned with the FtP process being concerned with establishing a finding of fact about a registrant's potential impairment, as set out in the legal framework governing that process.'*[25]

9.20 Not only are fitness to practise proceedings stressful for both registrants and complainants, they are also expensive and time consuming. In 2021 alone the GMC spent in excess of £46m on fitness to practise,[26] accounting for approaching 40% of total expenditure.

9.21 The time taken to resolve fitness to practise cases averages over a year for all regulators,[27] and in excess of two years for all but three (GCC, GOC, GOsC). The median time taken to conclude a case from receipt of initial complaint to final fitness to practise hearing determination varies across the regulators from 58 weeks (GOsC) to 178 weeks (SWE).[28,29] The average median time to conclude a case to final determination across all regulators is 118.6 weeks.

9.22 Whilst we do not have data on how quickly cases could be resolved under the proposed new system using an accepted outcome, data on the time from case examiner decision to completion at final hearing provides some useful insights. This shows that for the four largest regulators[30] (GMC, NMC, HCPC, GDC) the median time from case examiner decision to completion at final hearing is 27,

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[23] Community Research for the Professional Standards Authority, May 2020, *Patient and public perspective on future fitness to practise processes:* patient-and-public-perspectives-on-future-fitness-to-practise-processes.pdf (professionalstandards.org.uk)
[24] Professional Standards Authority, May 2013, *Public Response to Alternatives to Final Panel Hearings in Fitness to Practise Complaints*: https://www.professionalstandards.org.uk/docs/default-source/publications/research-paper/public-response-to-alternatives-to-final-panel-hearings-2013.pdf?sfvrsn=65c47f20_8
[25] Finn, G et al, 2022, *Experiences of GDC fitness to practise participants 2015-2021: a realist study*: Experiences of GDC fitness to practise participants 2015 – 2021: A realist study November 2022 (gdc-uk.org)
[26] GMC, 2021, *Our annual report*: annual_report_2021_full_220822.pdf (gmc-uk.org)
[27] Professional Standards Authority, 2023, *Annual report and accounts 2022/23:* E02935349_PSA ARA 22-23_COVER.indd (professionalstandards.org.uk)
[28] Note that Social Work England's data is affected by the caseload it inherited from the previous regulator of social workers (HCPC) upon its inception in 2019
[29] Professional Standards Authority, 2023, *Annual report and accounts 2022/23:* E02935349_PSA ARA 22-23_COVER.indd (professionalstandards.org.uk)
[30] By number of registrants

54, 83 and 42 weeks respectively.[31] Whilst we cannot say that all this time would be 'saved' were a case to be closed consensually at the case examiner stage, this data does give some indication of the additional time required for a case to progress from case examiner to panel hearing.

9.23 Long waits for cases to be resolved impact the wellbeing of registrants and complainants, and pose challenges for employers as registrants may be suspended or placed on restricted duties while awaiting a final outcome.

9.24 Further, long waits for cases to be resolved may undermine the effectiveness of the process itself; witnesses may be less likely to remain engaged and willing to participate where considerable time has elapsed since the incident(s) in question. Long delays also mean that the public is not protected as quickly as they could be (albeit registrants may be subject to interim measures) and are likely to undermine public confidence in the regulatory process.

9.25 We have consistently argued that some of the negative factors outlined above could be reduced by giving regulators the power to make greater use of accepted outcomes. As we argued in *Right touch reform: 'greater use of remediation and consensual disposal, for cases that are suitable, could allow regulators to fulfil [the three limbs of public protection] with less reliance on expensive and legalistic hearings.'*[32]

9.26 Consensual disposals are able to facilitate a fitness to practise process which is faster, less onerous and less stressful. Further, where a registrant does not contest the facts of the case against them, it can be a constructive means to support registrants who are willing to address identified and remediable impairment.

Regulatory reform and the impact on fitness to practise

9.27 The Government is currently engaged in a programme of reform to the health professional regulators. The first stage of these reforms is the legislation, published in December 2023 by the Department of Health and Social Care (DHSC) to bring Anaesthesia Associates (AAs) and Physician Associates (PAs) into regulation under the General Medical Council (GMC).[33] This legislation is intended to act as the 'template' for the reform of all the health professional regulators we oversee.[34]

9.28 Regulatory reform will provide the regulators with far greater freedoms to determine how they operate, including the flexibility to set and amend their own rules. The legislation will include sweeping reforms to regulators' powers and governance arrangements, and an entirely new process for handling fitness to practise.

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[31] Figures taken from the most recent set of data supplied by regulators to the PSA as part of the performance review process at the time of writing (October 2023). Unpublished.
[32] Professional Standards Authority, 2017, *Right-touch reform: a new framework for assurance of professions*: https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-reform-2017.pdf?sfvrsn=2e517320_5
[33] The Anaesthesia Associates and Physician Associates Order 2024: https://www.legislation.gov.uk/ukdsi/2024/9780348255195
[34] This does not include Social Work England which already operates a fitness to practise system which is substantially different from the other regulators and more in line with the proposed new system

9.29 The consultation issued by the Department of Health on bringing AAs and PAs into regulation,[35] and the subsequent Government response to that consultation,[36] sets out how the department envisages fitness to practise operating in future. Under the proposed new system there will be two final decision-making roles in the fitness to practise process: case examiners and fitness to practise panels.

9.30 Under this system more cases will be resolved by case examiners without the need for a panel hearing. This will be achieved by the introduction of new powers for case examiners enabling them to resolve cases using accepted outcomes. Under the accepted outcomes process, case examiners will carry out a detailed assessment of the case from the written information and evidence and '*where possible, make a decision on impairment and whether action is needed to protect the public.*'[37]

9.31 Where impairment is found, case examiners will be able to impose a sanction on the registrant and will have the power to conclude a case using an accepted outcome where the registrant accepts both the findings (including impairment) and the proposed measure. Case examiners will also be able to impose a final measure where a registrant doesn't provide a 'reasoned response' within a reasonable time.[38] Case examiners will have the same range of measures available to them as panels, and there will be no limitations on the types of cases they can resolve.

9.32 However, cases will still be considered by panels where the registrant does not accept the findings and/or the proposed measure, 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*.'[39]

9.33 The Government has stated that the proposed changes will '*deliver a fitness to practise process that is swifter, fairer and less adversarial, which will benefit all parties involved in fitness to practise proceedings and, most importantly, will ensure swift public protection where needed.*'[40] This new system for handling fitness to practise cases will in due course be rolled out across the health

[35] Department of Health and Social Care, 2023, *Regulating anaesthesia associates and physician associates:* Regulating anaesthesia associates and physician associates - GOV.UK (www.gov.uk)
[36] Department of Health and Social Care, 2023, *Consultation response to regulating anaesthesia associates and physician associates:* Consultation response to regulating anaesthesia associates and physician associates - GOV.UK (www.gov.uk)
[37] Department of Health and Social Care, February 2020, *Regulating healthcare professionals, protecting the public: consultation response analysis:* Regulating healthcare professionals, protecting the public: consultation response - analysis (publishing.service.gov.uk)
[38] The AAPA Order requires regulators to set rules specifying the timeframe for responding, which must be no less than 28 days (see: The Anaesthesia Associates and Physician Associates Order 2024: https://www.legislation.gov.uk/ukdsi/2024/9780348255195)
[39] Department of Health and Social Care, February 2020, *Regulating healthcare professionals, protecting the public: consultation response analysis:* Regulating healthcare professionals, protecting the public: consultation response - analysis (publishing.service.gov.uk)
[40] Department of Health and Social Care, February 2020, *Regulating healthcare professionals, protecting the public: consultation response analysis:* Regulating healthcare professionals, protecting the public: consultation response - analysis (publishing.service.gov.uk)

professional regulators; DHSC has set out its intention that in future *'all regulators should have broadly consistent fitness to practise arrangements'*.[41]

9.34 The new fitness to practise arrangements contained within the AAPA Order are broadly similar to those already operated by Social Work England, which has had the power to resolve cases using case examiners and accepted disposals since its inception in 2019. However, unlike the system operated by Social Work England, the provisions under the AAPA Order will enable case examiners to reach a finding on impairment.

Putting the reforms into practice: maximising benefits and mitigating risks

9.35 We support the Government's programme of regulatory reform, which heralds a new era for the regulation of health professionals. The reforms have the potential to significantly improve regulatory processes, giving regulators more freedom and flexibility to make and amend their own rules. The reforms to fitness to practise will be transformational and should allow many more cases to be resolved more quickly and easily, with benefits to all involved.

9.36 However, whilst the reforms to fitness to practise present significant opportunities for improvement, they also open up new risks which need to be considered and managed. As we noted in our *Review of Social Work England's process for accepted outcomes in fitness to practise cases*: *'while the system has substantial advantages in terms of speed and avoiding the costs and other impacts of the hearing, this should not be at the expense of public protection'*. [42]

9.37 We have always maintained that public protection must remain at the heart of the reformed fitness to practise framework. In addition, the new system should be in alignment with the principles of right touch-regulation (these principles state that regulation must be: proportionate, consistent, targeted, transparent, accountable and agile).[43]

9.38 Whilst we cannot entirely anticipate how the new system will work in practice, we have a significant evidence base built up through our oversight of Social Work England,[44] and from research findings, to suggest how the reforms may impact regulators, registrants and the public.

9.39 In broad terms, the advantages in using accepted outcomes need to be balanced against possible risks (real or perceived) to the robustness and independence of decision-making, the transparency of the process, and to public confidence.

9.40 The regulatory risks of accepted outcomes may include:

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[41] Department of Health and Social Care, February 2020, *Regulating healthcare professionals, protecting the public: consultation response analysis:* Regulating healthcare professionals, protecting the public: consultation response - analysis (publishing.service.gov.uk)
[42] Professional Standards Authority, May 2021, *Review of Social Work England's process for 'accepted outcomes' in fitness to practise cases:* Review of Social Work England's process for 'accepted outcomes' in fitness to practise cases (professionalstandards.org.uk)
[43] Professional Standards Authority, October 2015, *Right Touch Regulation:* right-touch-regulation-2015.pdf (professionalstandards.org.uk)
[44] Social Work England's accepted outcomes process is similar to that proposed for the health professional regulators

- That case examiners use accepted outcomes for the wrong cases. This might arise where the registrant has not accepted all the allegations, there are doubts over the registrant's level of insight, or the evidence would benefit from testing at a hearing
- That case examiners undercharge cases, or offer sanctions that are likely to be accepted in order to expedite case progression
- That the loss of lay and registrant input into decision-making leads to perceptions that decisions are biased or unfair to one or more interested parties
- That public confidence is undermined when high-profile, complex or serious cases are dealt with 'behind closed doors' without a public hearing. Concern may be heightened where a single case examiner makes decisions about the case
- That the accepted outcomes model reduces the voice or role of complainants in the process, and that this undermines confidence in the process or outcome
- That regulators fail to publish sufficient information about cases, meaning that the public cannot understand the circumstances of the case or the reasons for the decision. Where decisions are not sufficiently transparent, this could result in a loss of trust in the regulatory system
- That the combined effects of the above result in a system which is less effective at fulfilling the three limbs of public protection.

9.41 Not all of these risks are likely to be realised, and some may be realised but effectively mitigated. It is also likely that the benefits of using accepted outcomes will outweigh many of the disadvantages.

9.42 We want to support regulators to make the most of what the reforms can offer by maximising the benefits of the new fitness to practise framework whilst mitigating the potential risks. For the new system to be a success, it is vital that it continues to effectively deliver the three limbs of public protection.[45]

9.43 In this document we suggest a number of factors for regulators to consider in order to mitigate the risks outlined above. These include: factors for decision-makers to consider when determining whether a case can be disposed of using an accepted outcome; factors that may indicate a case would benefit from the involvement of more than one decision-maker; and factors for regulators to consider as part of promoting a fair and effective accepted outcomes process. We have also made suggestions as to what information should be published following an accepted outcome in order to maintain public confidence in the fitness to practise process and professional regulation more broadly.

[45] The three limbs of public protection are: the protection of patients, the maintenance of public confidence in the profession, an upholding proper standards of conduct and behaviour.

10. Factors to consider when determining disposal route

Has the registrant failed to accept the findings and/or impairment?

10.1 The AAPA Order stipulates that in order for a case to be disposed of using an accepted outcome, a registrant (who has responded to the associated notification) must accept the case examiner's findings and that their own fitness to practise is impaired (in addition to the proposed sanction). These requirements also form part of Social Work England's accepted disposals process.

10.2 Whilst the requirements that the registrant accepts both the findings and impairment may appear straightforward, examination of Social Work England's use of accepted disposals has found that this is not always the case.

10.3 In relation to the case examiner's findings, in some instances a registrant may accept some but not all of these, or interpret events differently to the other witnesses. We do not consider that every single allegation or finding has to be accepted. In some cases, the discrepancies may not be material (for example as to the date on which the conduct took place). In others, disputed facts may not add anything to the gravity of the admitted ones. However, where a registrant does not accept facts that are the basis of the regulatory concern(s), case examiners would be expected to either refer the case to a panel, or to have good reasons why they still consider that the case is best dealt with using an accepted outcome.

10.4 As we outlined in our 2021 review of Social Work England's accepted outcomes process, *'certainty about the factual basis on which a finding of impairment is reached is important.'*[46] This is both so that on review of a sanction all parties are clear about the basis for the original sanction, and because acceptance by a registrant of the key factual aspects of the case against them is an important indicator in assessing insight. Further, it is important for transparency and public confidence that the facts of the case have been clearly established, and that any resulting public protection measures have been recommended on the basis of those facts.

10.5 With regards to impairment, the need for a registrant to clearly accept that their fitness to practise is impaired when agreeing to an accepted disposal is an issue over which we have had ongoing discussions with Social Work England. Social Work England have told us that impairment as a concept is not always well understood by registrants and therefore it considers that its acceptance can be evidenced by the totality of the registrant's conduct. It has also taken steps to make clear to registrants that by consenting to an accepted disposal they are accepting that their fitness to practise is impaired by including this in the Accepted Disposal Response Form.

10.6 We accept that impairment is not always well understood by registrants. However, as acceptance of impairment is a legislative requirement for disposal of a case by way of an accepted outcome, we would encourage regulators to

[46] Professional Standards Authority, May 2021, *Review of Social Work England's process for 'accepted outcomes' in fitness to practise cases:* Review of Social Work England's process for 'accepted outcomes' in fitness to practise cases (professionalstandards.org.uk)

take steps to explain impairment to registrants. Any forms/documents for a registrant to complete in order to assent to an accepted outcome should make clear that in doing so they are accepting current impairment and what that means.[47]

10.7 Where a regulator has no evidence that impairment has been accepted, we would expect them to refer a case to a panel.

Summary

Factors to consider: Has the registrant failed to accept the findings and/or impairment?

- Does the registrant dispute any material facts (i.e. those that form the basis of a regulatory concern)? If so, are there reasons as to why the case is still best dealt with using an accepted outcome?
- Is there certainty amongst all parties about the factual basis on which the findings have been reached?
- Does the registrant clearly accept current impairment?

Is there a dispute of fact/conflict of evidence that can only be fairly tested at a hearing?

10.8 Whilst it is expected that a large number of cases will be capable of being disposed of using an accepted outcome, there may be cases where there is a dispute of fact that can only be fairly and effectively resolved by hearing live evidence.

10.9 Panels have the ability to ask probing questions of registrants and witnesses and allow for thorough cross-examination. They can assess information in a more dynamic way than can be achieved on paper. As we noted in our review of Social Work England's accepted outcomes process: *'case examiners lack two tools that [panels] possess: they cannot call witnesses… and they cannot see the registrant and so gain a more concrete impression'*[48] We cited case examiners' inability to interrogate the evidence directly as *'a major disadvantage'* of the accepted disposal system.

10.10 In responding to our fitness to practise disposal route questionnaire, a number of regulators highlighted the importance of hearing oral testimony and the ability to cross-examine witnesses in certain cases:

[47] Social Work England's Accepted Disposal Response Form make clear that by accepting the proposal the social worker is accepting that their fitness to practise is currently impaired and asks them to acknowledge this.

[48] Professional Standards Authority, May 2021, *Review of Social Work England's process for 'accepted outcomes' in fitness to practise cases:* Review of Social Work England's process for 'accepted outcomes' in fitness to practise cases (professionalstandards.org.uk)

- *'where there is a material dispute of fact which cannot be resolved on the papers, there is the benefit to hearing live evidence from relevant witnesses and for the witnesses to be questioned by other parties to the proceedings and the panel' [healthcare professional regulator]*
- *'A full and frank review of all the evidence takes place during a hearing and this might not be the case if it is considered on the papers. This review allows the testing and challenging of evidence to ensure that it is accurate and relevant.' [healthcare professional regulator]*

10.11 The benefit of hearing live evidence was also highlighted by fitness to practise panel members in the GDC/NMC funded report *The concept of seriousness in fitness to practise cases*.[49] Panellists suggested that being able to question registrants presented an opportunity to test written evidence:

- *"you're… thinking well how deep is that, or is it something someone helped them write a week before, so the opportunity to ask the registrant questions and to try and explore than a bit more is hugely beneficial.' (Lay panel chair and panel member)*[50]

10.12 There is no doubt that important facts often do come to light only as a result of a hearing. For example, in a recent case considered by the Medical Practitioners Tribunal Service (MPTS) the panel considered the evidence against a doctor caught using his phone to cheat in an exam.[51] The determination notes that in evidence submitted in writing the doctor had *'expressly stated that he had not planned to use his phone in advance of the Examination*.' However, *'it was only in answering the Tribunal's questions that [the Dr] admitted that he had used his phone throughout the Examination and that he had been thinking about cheating, if he could, in the week before the Examination.'* This particular case involved serious professional dishonesty and therefore the panel gave *'serious consideration'* to a sanction of erasure. In such cases which lie on the borderline between sanctions, the ability to test the evidence may take on even greater significance.

10.13 The importance of hearing live testimony was also a recurrent theme in our research with patients and the public on the future of fitness to practise.[52] Participants expressed concerns that if a case did not go to a hearing this may equate to a less thorough assessment of the evidence, and that without cross-examination regulators may fail to ascertain 'the truth':

- *'[research participants] pointed out that sometimes only the 'true' character becomes apparent during a face to face meeting and that issues or true feelings (for example, a lack of remorse on the part of the registrant) could be masked on paper.' [extracted from 'The patient and public perspective*

[49] Bryce, M et al, February 2022, *The concept of seriousness in fitness to practise cases*: The concept of seriousness in fitness to practise cases (gdc-uk.org)
[50] Bryce, M et al, February 2022, *The concept of seriousness in fitness to practise cases*: The concept of seriousness in fitness to practise cases (gdc-uk.org)
[51] Medical Practitioners Tribunal Service, April 2023, *Record of determination: Dr Chak Ip:* dr-chak-ip-6-apr-23.pdf (mpts-uk.org)
[52] Community Research for the Professional Standards Authority, May 2020, *Patient and public perspective on future fitness to practise processes:* patient-and-public-perspectives-on-future-fitness-to-practise-processes.pdf (professionalstandards.org.uk)

on future fitness to practise processes', Professional Standards Authority, May 2020]

10.14 The same study noted the existence of *'a cultural discourse that honesty (or dishonesty) or remorse can be seen on a person's face.'* This was important to the patients and members of the public who participated. [53] However, it should be acknowledged that although the public may believe that the character or honesty of a witness can be better judged in person, case law sets out that a witness's credibility should not be assessed on their demeanour, nor the confidence with which they give evidence.[54]

10.15 Some regulators outlined in their responses to our questionnaire that conflicts of evidence should be able to be resolved by case examiners, and should only be referred to a panel in exceptional circumstances:

- *'Where case examiners are faced with competing versions of events, then it is only where they consider that neither one is more probable than the other, based on their assessment of all the written evidence, that they will be justified in referring the matter to a panel' [healthcare professional regulator]*
- *'Exceptionally where decision on impairment can't be reached on the papers, a hearing provides an alternative mechanism which may allow an evidential dispute to be resolved' [healthcare professional regulator]*

10.16 In our review of Social Work England's accepted outcomes process we concluded that there were cases which were *'likely to be less suitable for summary assessments based on the papers only.'* These included cases where there were disputes about the material facts or uncertainty around the background to, and seriousness of, the conduct (for example, if the registrant interprets the facts in a way which contradicts the impression of other witnesses or where there may be concerns about the evidence of those witnesses).[55]

10.17 Social Work England's guidance on fitness to practise notes that while their case examiners cannot resolve conflicts of fact 'they can assess the weight of the evidence. In some instances where there is a factual dispute, there may be clear and cogent evidence supporting one side of the dispute. This may also be confirmed and supported by other evidence. The evidence to the contrary may also be inconsistent or wholly implausible.'[56] We agree that in many cases the weight of evidence will mean that case examiners are able to make a robust decision about competing evidence. However, as the Social Work England

[53] Community Research for the Professional Standards Authority, May 2020, Patient and public perspective on future fitness to practise processes: patient-and-public-perspectives-on-future-fitness-to-practise-processes.pdf (professionalstandards.org.uk)
[54] R (on the application of) Dutta v General Medical Council [2020] EWHC 1974 (Admin)
[55] Professional Standards Authority, May 2021, *Review of Social Work England's process for 'accepted outcomes' in fitness to practise cases:* Review of Social Work England's process for 'accepted outcomes' in fitness to practise cases (professionalstandards.org.uk)
[56] Social Work England, December 2022, *Case examiner guidance:* Case examiner guidance - Social Work England

guidance goes on to note, 'if there is a significant evidential dispute, the case may need to be referred to a hearing'.[57]

10.18 We are of the view that where there is competing evidence which is material to the case, and where two or more differing accounts are plausible and the dispute cannot be resolved with reference to the other evidence that is available, the substantive panel is the correct arena for testing the evidence of both the registrant and the witness. Further, there may be cases where the account given in writing by one or more parties appears lacking, or where case examiners consider that the evidence of the registrant or a witness would benefit from further exploration/examination.

10.19 We do not seek to spell out circumstances or types of cases where a hearing may be required to test the evidence, but would expect case examiners to be able to identify these. In our review of Social Work England's accepted outcomes process we noted that *'all the cases where we considered that the decision might be insufficient to protect the public, were ones which in our view ought to have been heard by panels. Since Case Examiners are the gate-keepers deciding whether a matter should reach a panel, it is essential that their training and guidance should stress these considerations.'*[58]

[57] Social Work England, December 2022, *Case examiner guidance:* Case examiner guidance - Social Work England

[58] Professional Standards Authority, May 2021, *Review of Social Work England's process for 'accepted outcomes' in fitness to practise cases:* Review of Social Work England's process for 'accepted outcomes' in fitness to practise cases (professionalstandards.org.uk)

Summary

Factors to consider: Is there a dispute of fact/conflict of evidence that can only be fairly tested at a hearing?

- Are there material disputes about facts where two or more competing accounts are plausible and the dispute cannot be resolved with reference to the other evidence that is available?
- Is there uncertainty about the background to, or seriousness of, the conduct?
- Would the written accounts of the registrant or any of the witnesses benefit from further exploration/examination at a hearing?
- Does the case lie on the borderline between sanctions and if so would testing the evidence have the potential to assist with assessment of seriousness?

Does the complexity of the case suggest that a hearing may be beneficial?

10.20 In responses to our fitness to practise disposal route questionnaire, two regulators suggested that a panel hearing may be beneficial where the case under consideration is particularly complex:

- *'there may be some types of cases that might be more appropriately dealt with by a panel hearing. This could include cases involving more complex or challenging clinical issues, where there is a difference of opinion that needs to be explored.' [healthcare professional regulator]*

10.21 This is supported by the report Advice on biases in fitness to practise decision-making in accepted outcome versus panel models for the Professional Standards Authority,[59] which suggests that 'paper heavy cases' (which can to some extent serve as a proxy for complexity) may be less suitable for an accepted outcome. However, the author makes this recommendation on the basis that decision-makers may be more prone to certain biases (e.g. the absent-mindedness bias) in such cases, rather than due to an explicit need to hear oral evidence.

[59] Cuthbert, L, 2021 for the Professional Standards Authority, *Advice on biases in fitness to practise decision-making in accepted outcome versus panel models for the Professional Standards Authority*: advice-on-biases-in-fitness-to-practise-decision-making.pdf (professionalstandards.org.uk)

10.22 We would expect case examiners to be generally capable of dealing with complex cases without the need to refer to a panel. However, they may wish to consider whether the complexities arising in a case are such that the evidence/issues under consideration would benefit from further exploration/examination at a hearing to support understanding and decision-making. This may be particularly relevant in complex clinical cases involving a number of expert witnesses. In such cases, pre-hearing case meetings can be useful in that they can enable experts to produce a joint report, leaving adjudicators to deal only with the outstanding disputed points. The subsequent hearing provides an opportunity for the panel to test the evidence of the expert witnesses, and others.

Summary

Factor to consider: Does the complexity of the case suggest that a hearing may be beneficial?

- Are the complexities of the case such that the evidence/issues under consideration would benefit from further exploration/examination at a hearing? Would a hearing aid understanding and decision-making?

Would it be beneficial and proportionate to test insight at a hearing?

10.23 Insight can be described as 'a registrant's genuine understanding and acceptance of the concerns which have been raised in relation to their conduct or competence.'[60] In fitness to practise proceedings, registrants can demonstrate insight in a range of ways, usually involving accepting that they should have behaved differently and expressing remorse, showing empathy and understanding, and taking steps to remediate. This is set out in case law in Kimmance v GMC, where the judgement notes that *'a doctor or other professional who has done wrong has to look at his or her conduct with a self-critical eye, acknowledge fault, say sorry and convince a panel that there is real reason to believe he or she has learned a lesson from the experience.'*[61]

10.24 Insight plays an integral role in fitness to practise as it is key to understanding the ongoing risk posed by a registrant and is relevant to an assessment of any attitudinal failings. The relevance of remediation and risk of repetition to the assessment of current impairment is underpinned by case law (for example Cohen v GMC)[62] and is detailed in the sanctions (and other) guidance published by regulators. A registrant who shows genuine insight and attempts to

[60] Health and Care Professions Council, March 2019, *Sanctions Policy*: sanctions-policy.pdf (hcpc-uk.org)
[61] Dr Kimmance v GMC [2016] EWHC 1808 (Admin): Kimmance v General Medical Council | [2016] EWHC 1808 (Admin) | England and Wales High Court (Administrative Court) | Judgment | Law | CaseMine
[62] Cohen v GMC [2008] EWCH 581: Cohen v General Medical Council | [2008] EWHC 581 (Admin) | England and Wales High Court (Administrative Court) | Judgment | Law | CaseMine

remediate is more likely to comply with any conditions placed on them, and less likely to repeat the behaviour, than one who does not. Such is the importance of insight that failure to express it is likely to lead to a more serious sanction, whereas demonstrating full insight may mitigate the need for any regulatory action at all:

- *'A key factor in determining what, if any, sanction is appropriate is likely to be the extent to which a registrant recognises their failings and is willing to address them. Where a registrant does recognise their failings and is willing to address them, the risk of repetition is reduced.' [HCPC 'Sanctions Policy']*[63]
- *'Evidence of the nurse, midwife or nursing associate's insight and any steps they have taken to strengthen their practice will usually be central to deciding whether their fitness to practise is currently impaired' [NMC 'Insight and Strengthened Practice']*[64]
- *'[risk is increased where] the doctor has demonstrated a lack of insight in relation to their dishonest behaviour. This may increase the likelihood of future repetition and the overall risk posed by the doctor.' [GMC 'Making decisions on cases at the end of the investigation stage: Guidance for the Investigation Committee and case examiners']*[65]

10.25 The central role of insight in determining appropriate regulatory action makes its assessment crucial to the impairment and sanctions stages of the fitness to practise process. When cases are disposed of using accepted outcomes, insight will have to have been demonstrated on paper, most commonly in the form of reflective statements/pieces of writing. This is often accompanied by evidence of more concrete action to remediate failings such as evidence of attendance at relevant training courses.

10.26 There remain doubts over the extent to which insight can be determined on the papers alone in more difficult and complex cases and those which may indicate serious/fundamental attitudinal issues. This was considered in the Court of Appeal judgment of The Professional Standards Authority vs. The Health and Care Professions Council and Benedict Doree,[66] where the judgement outlined that oral evidence may sometimes be the *'best'* and *'only convincing'* evidence of insight (although the Court accepted that it was possible for insight to be demonstrated on paper):

- *'Whether a registrant has shown insight into his misconduct, and how much insight he has shown, are classically matters of fact and judgment for the professional disciplinary committee in the light of the evidence before it. Some of the evidence may be matters of fact, some of it merely subjective.*

[63] Health and Care Professions Council, March 2019, *Sanctions Policy*: sanctions-policy.pdf (hcpc-uk.org)
[64] NMC, 2021, *Insight and strengthened practice:* Insight and strengthened practice - The Nursing and Midwifery Council (nmc.org.uk)
[65] GMC, 2021, *Making decisions on cases at the end of the investigation stage: Guidance for the Investigation Committee and case examiners:* Making decisions on cases at the end of the investigation stage: Guidance for the Investigation Committee and case examiners (gmc-uk.org)
[66] Professional Standards Authority and (1) The Health and Care Professions Council (2) Benedict Doree [2015] EWHC 822 (Admin): Court of Appeal Judgment Template (professionalstandards.org.uk)

In assessing a registrant's insight, a professional disciplinary committee will need to weigh all the relevant evidence, both oral and written, which provides a picture of it… Of course, there will be cases in which the registrant's own evidence, given orally and tested by cross-examination, will be the best evidence that could be given, and perhaps the only convincing evidence.'

10.27 Insight was also considered in Kimmance, where Mr Justice Kerr noted that: 'Nine times out of ten, you cannot [demonstrate insight] if you do not turn up to the hearing. The panel will want to ask questions'.[67]

10.28 The panel's role in probing insight is further explored in the report *The concept of seriousness in fitness to practise cases*[68] which notes that:

- *'Panel members explained the importance of being able to question registrants and examine their evidence in person in informing their views of that registrant's insight into their conduct, and the extent of any remorse shown or remediation activities undertaken. These factors are key to panels' decisions about whether the registrant has effectively mitigated any risk posed by their past conduct, and strongly inform decisions about impairment and sanction.'*

10.29 This view is supported by the Doctor's Defence Service, which notes that: 'MPTS panels and GMC prosecutors have a knack of asking questions that draw out the hollowness of a doctor's assurances, that they have full insight.'[69]

10.30 In responding to our questionnaire on fitness to practise disposal routes, a number of regulators expressed the view that insight is easier to assess at a hearing, and some detailed the types of cases where they believed this to be particularly relevant:

- *'A key part of the fitness to practise process is testing whether a registrant has insight into the issues under investigation. Therefore, a factor in deciding whether a case should be dealt with by accepted outcome or panel hearing is whether the registrant is able to show insight and whether the format allows for that insight to be explored or examined. For example, in cases involving dishonest behaviour, criminal activity or a poorly managed health concern, it may be best for the case to go to a panel hearing. This would more easily allow the registrant to demonstrate their insight and the panel to assess that insight, than could happen through the accepted outcome process.' [healthcare professional regulator]*

- *Cases [more appropriately dealt with by a panel are ones] where insight and remediation would be difficult for a registrant to demonstrate or a case examiner to determine…These include cases which are so egregious that*

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[67] Dr Kimmance v GMC [2016] EWHC 1808 (Admin): Kimmance v General Medical Council | [2016] EWHC 1808 (Admin) | England and Wales High Court (Administrative Court) | Judgment | Law | CaseMine

[68] Bryce, M et al, February 2022, *The concept of seriousness in fitness to practise cases*: The concept of seriousness in fitness to practise cases (gdc-uk.org)

[69] Doctors Defence Service, *Reflective Writing in GMC Cases – Showing Insight*: Reflective Writing in GMC Cases – Showing Insight | Doctors Defence Service – UK.

declarations of insight and remediation may be contested by others. Such cases may include allegations of:

- *Sexual misconduct*
- *Bullying and discrimination*
- *Dishonesty e.g. fraud*
- *Pre-meditation*
- *Allegations that fall within the 'Listed Offences' but were not charged by CPS (e.g. rape). [health/care professional regulator]*

- *'We have found that panels may be better placed to undertake an assessment of the level of insight and remediation as they are able to ask a [registrant] to address these areas in person and test them accordingly.' [healthcare professional regulator]*

10.31 However, this view was not universally shared among regulators, with some stating that case examiners are experienced at taking insight into account and capable of making a robust assessment:

- *'Case examiners are already experienced at taking insight into account when making decisions under the current legislation. In the future, as part of the reforms, we will have the power to require information from the professional at an early stage and throughout the process. This includes comprehensive written evidence of insight and strengthened practice. We expect that an earlier engagement with the professional on insight and strengthened practice will help case examiners to carry out a robust assessment of insight.' [healthcare professional regulator]*

10.32 Whilst we accept that case examiners are experienced at assessing and weighing all the evidence before them, we maintain the view that panels often have an advantage in assessing insight in terms of seeing the registrant in person, hearing oral evidence and being able to ask probing questions.

10.33 Hearing oral testimony may also help to overcome some of the other challenges of assessing insight on paper. These are primarily that:

- registrants may receive significant support in producing their reflective statements
- technology such as AI is increasingly capable of writing such statements.

10.34 Whilst some regulators told us that they would train their case examiners to identify statements that may have been produced using AI, it is not clear whether such training would be effective. Whilst some sectors use technology to identify AI generated text, there is evidence that, at present, such software is flawed. Research has indicated that in the university sector attempts to combat the use of AI are *'ineffective'* with software aimed at detecting it being found to have been *'neither accurate nor reliable.'*[70]

[70] The Times, 4 September 2023, *Students 'double cheat' to hide AI in their answers*: Students 'double cheat' to hide AI in their answers (thetimes.co.uk)

10.35 In our own reviews of the regulators' current practices we have found deficiencies in the way that case examiners assess insight on the papers on some occasions. We have also previously said that we *'question the reliability of written statements as evidence of insight'* and stated that we didn't support consensual disposals where *'insight is a major factor in determining impairment or where it may be difficult to establish whether insight is genuine'*.[71] We have also noted that *'while insight can be demonstrated on paper through reflective pieces, the clarity with which it comes across may vary… We have seen, in a number of cases from other regulators, panels finding themselves better able to get a picture of a registrant's insight by seeing the registrant in person and being satisfied that, for example, a non-restrictive sanction may be appropriate.'*[72]

10.36 Overall, we are of the view that whilst panels generally might be better placed to assess insight, it clearly would not be proportionate to refer all cases where there is a question about insight to a panel. We would therefore only expect cases to be referred on this basis where the doubts are significant and/or the evidence available is incomplete or lacking credibility. In such cases panels are better placed than case examiners to make a full and robust assessment. This may be particularly important in cases where there are deemed to be serious attitudinal issues.[73]

Summary

Factors to consider: Would it be beneficial and proportionate to test insight at a hearing?

- Are there significant doubts over the registrant's insight? (this may be due to the content of the registrant's reflective statement or the nature of the concern)?
- Would it be both beneficial and proportionate to test insight at a hearing?
- Is this a case that involves serious attitudinal issues?

[71] Professional Standards Authority, 2017, *Right-touch reform: A new framework for assurance of professions*: https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-reform-2017.pdf?sfvrsn=2e517320_7

[72] Professional Standards Authority, May 2021, *Review of Social Work England's process for 'accepted outcomes' in fitness to practise cases:* Review of Social Work England's process for 'accepted outcomes' in fitness to practise cases (professionalstandards.org.uk)

[73] Research into seriousness in fitness to practise suggests that all regulators consider sexual misconduct, dishonesty and criminal convictions to be serious. See: Bryce, M et al, February 2022, *The concept of seriousness in fitness to practise cases*: The concept of seriousness in fitness to practise cases (gdc-uk.org)

11. Factors to consider when determining the composition of decision-makers

11.1 At present, all health professional regulators that use case examiners as part of a consensual disposal process assign two case examiners per case: one registrant and one lay.[74] This is also the case for Social Work England, which has the power to dispose of all categories of case by means of case examiners offering an accepted disposal.[75] Fitness to practise panels (which are usually comprised of three people) always include a registrant and a lay person.

11.2 Using one lay and one registrant case examiner per case has two distinct advantages:

- using one registrant and one lay decision-maker is widely seen as fair to both the public and the profession subject to regulation
- the use of more than one decision-maker may result in more robust decisions and help to reduce bias.

11.3 The AAPA Order does not mandate the use of more than one case examiner, although the Government has made clear that they intend regulators to be able to use more than one where appropriate, stating that '*the regulator is best placed to assess where multiple case examiners may or may not be required.*'[76] The Order also provides discretion to regulators in terms of whether case examiners are registrants and/or lay people (although requirements for registrant and lay members will continue to apply to panels and there continues to be an expectation of lay representation at Board level). This means that in future regulators will have greater flexibility in terms of the composition and number of case examiners they use. This will likely reduce costs, especially where a regulator decides that a single case examiner is sufficient.

11.4 While there are advantages in terms of cost and efficiency in the single case examiner model, there are also potential risks to fairness (or perceptions thereof).

Lay representation in decision-making

11.5 The principle that fitness to practise decision-making should involve lay people and registrants is a long-established one. The issue was examined in detail in the Fifth Shipman Report which criticised proposals to curtail the involvement of lay people in fitness to practise decision-making and concluded that it was a *'fundamental requirement for lay involvement in all cases that might be closed without referral to a FTP panel.'*[77]The report goes on to note that *'lay*

[74] A registrant case examiner must be a practicing member of the profession. A lay case examiner is someone who is not, and never has been, a member of the profession.
[75] Rule 34 of Social Work England's Fitness to practise rules 2019 sets out the requirement for cases at the case examiner stage to be considered by at least one lay person and at least one registrant.
[76] Department of Health and Social Care, 2023, *Consultation response to regulating anaesthesia associates and physician associates:* Consultation response to regulating anaesthesia associates and physician associates - GOV.UK (www.gov.uk)
[77] The Shipman Inquiry, 2004, *Fifth report: Safeguarding Patients: Lessons from the Past - Proposals for the Future*: [ARCHIVED CONTENT] The Shipman Inquiry - Fifth Report (nationalarchives.gov.uk)

involvement in all decisions is likely to result in improved quality decision-making.'[78]

11.6 In terms of registrant representation, this is something that is widely valued by regulated professionals, as highlighted by regulators in response to our fitness to practise disposal route questionnaire:

- *'Many registrants take assurance from being judged by people who share their professional background.' [healthcare professional regulator]*
- *'Registrants may take comfort from being judged by someone who has 'walked in their shoes' and understands their profession.' [healthcare professional regulator]*

11.7 The majority of regulators that responded to our questionnaire reported that they intended to continue to use both registrant and lay case examiners in most cases in any future fitness to practise arrangements:

- *'Our view is that it is important for both lay and professional case examiners to be involved in decision-making in order to maintain the confidence of members of the public and the professionals on our register in our FtP processes.' [healthcare professional regulator]*
- *'It has been standard practice for many years within regulation for a professional to be 'judged' by a peer and a member of the public. This has seemed to work well. [healthcare professional regulator]*

11.8 In contrast, some questioned the need for such an arrangement, particularly as the registrant case examiner may not work in the same field or speciality as the person subject to fitness to practise proceedings, and the lay case examiner is not a patient representative.

11.9 In our view, registrant representation in decision-making may bring benefits in terms of maintaining the confidence of the profession and for the quality of decision making. It would be reasonable for regulators to take this into account when developing fitness to practise processes, although we acknowledge that there are a range of ways of ensuring registrant input, for example through expert reports.

11.10 We know from various research reports that we have commissioned that whilst the public largely support the use of accepted outcomes in fitness to practise, they do have concerns over the robustness and independence of decision making.[79] [80] Much of this concern is driven by a fear that regulators may be biased in favour of registrants. For example, our report *The patient and public perspective on future fitness to practise processes* highlighted that *'whilst*

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[78] The Shipman Inquiry, 2004, *Fifth report: Safeguarding Patients: Lessons from the Past - Proposals for the Future*: [ARCHIVED CONTENT] The Shipman Inquiry - Fifth Report (nationalarchives.gov.uk)

[79] Community Research for the Professional Standards Authority, May 2020, *Patient and public perspective on future fitness to practise processes:* patient-and-public-perspectives-on-future-fitness-to-practise-processes.pdf (professionalstandards.org.uk)

[80] Professional Standards Authority, May 2013, *Public Response to Alternatives to Final Panel Hearings in Fitness to Practise Complaints*: https://www.professionalstandards.org.uk/docs/default-source/publications/research-paper/public-response-to-alternatives-to-final-panel-hearings-2013.pdf?sfvrsn=65c47f20_8

participants were unsure if the individual regulators would actually favour registrants, there was certainly a fairly widespread assumption that this was a possibility.'[81]

11.11 From a public protection - and particularly public confidence – perspective, we are of the view that lay representation in decision-making must remain a feature of the fitness to practise process. We would expect regulators to be mindful of the need to incorporate lay decision-makers at some point in the process.

The use of single decision-makers

11.12 Research into decision-making has emphasized that all decision-making processes, and indeed all individual decision-makers, are affected by bias.[82] Whilst it is not possible to eliminate bias from decision-making, it is important to reduce it where possible.

11.13 Research we commissioned into biases in fitness to practise decision-making defined cognitive biases, and their impact, as follows:

- *Cognitive biases are mental shortcuts which reduce the cognitive load on an individual but bias the way attention is then allocated in processing data the individual receives. This has a number of effects including: making us be too quick to make a decision (ignoring evidence that is contrary to our opinion), being overly zealous in justifying our personal opinions, and selectively searching for evidence that supports our past judgments, rather than objectively evaluating all the information available to us.*[83]

11.14 The study notes that biases are likely to occur in fitness to practise decision-making as *'cognitive biases are particularly likely to influence reasoning when people are making decisions under uncertainty.*'[84] The research outlines a comprehensive list of biases that may affect both individual and group decision-making, including absent-mindedness bias, ambiguity bias, blind spot bias, and the backfire effect.[85] It concludes that there are different biases likely to impact case examiners and fitness to practise panels, and suggests that on the basis of these, some cases may potentially be more appropriate for disposal by one

[81] Community Research for the Professional Standards Authority, May 2020, *Patient and public perspective on future fitness to practise processes:* patient-and-public-perspectives-on-future-fitness-to-practise-processes.pdf (professionalstandards.org.uk)
[81] Community Research for the Professional Standards Authority, May 2020, *Patient and public perspective on future fitness to practise processes:* patient-and-public-perspectives-on-future-fitness-to-practise-processes.pdf (professionalstandards.org.uk)
[82] Cuthbert, L, 2021 for the Professional Standards Authority, *Advice on biases in fitness to practise decision-making in accepted outcome versus panel models for the Professional Standards Authority*: advice-on-biases-in-fitness-to-practise-decision-making.pdf (professionalstandards.org.uk)
[83] Cuthbert, L, 2021 for the Professional Standards Authority, *Advice on biases in fitness to practise decision-making in accepted outcome versus panel models for the Professional Standards Authority*: advice-on-biases-in-fitness-to-practise-decision-making.pdf (professionalstandards.org.uk)
[84] Cuthbert, L, 2021 for the Professional Standards Authority, *Advice on biases in fitness to practise decision-making in accepted outcome versus panel models for the Professional Standards Authority*: advice-on-biases-in-fitness-to-practise-decision-making.pdf (professionalstandards.org.uk)
[85] See pages 10-17 of the following for a description of these, and other, biases that may impact decision making: Cuthbert, L, 2021 for the Professional Standards Authority, *Advice on biases in fitness to practise decision-making in accepted outcome versus panel models for the Professional Standards Authority*: advice-on-biases-in-fitness-to-practise-decision-making.pdf (professionalstandards.org.uk)

route over the other. The author suggests that cases more suited to an accepted outcome include those with *'very little missing information and very little ambiguity'* whereas those which may be more appropriate for a panel are:

- *'Paper-heavy cases as there would be less likelihood of a number of the biases which would impact on an individual decision maker considering matters on the papers having a significant effect e.g. the absent-mindedness bias.*
- *Cases which may involve different cultural considerations (providing the panel itself is diverse) as individual decision makers may be more prone to blind spot bias and to stereotyping, whether intentionally or not.*
- *Cases with significant 'gaps' in the information and/or with substantial ambiguity as to what occurred.'*[86]

11.15 The above recommendations notwithstanding, we do not think the evidence is sufficiently robust to recommend cases progress to a panel hearing purely on the basis of mitigating risk of bias. As we noted in our review of Social Work England's accepted outcome process, *'there appears to be nothing inherent in the role of Case Examiners which makes their decisions of higher or lower quality than those of panels. The good decisions that we saw were reasoned to a similar level to good panel decisions and the poor ones we saw were not markedly worse than poor panel decisions.'*[87]

11.16 However, we do see merit in regulators considering which cases may benefit from the involvement of more than one decision-maker. As the research into biases notes, whilst all individuals are susceptible to bias, it is likely that *'each decision maker would be affected differently by different biases, especially if the backgrounds of the Case Examiners were diverse.'*[88] It is therefore likely that two decision-makers may counteract each other's biases to some extent.

11.17 This is supported by the interviews with decision-makers conducted as part of the research into seriousness in fitness to practise:

- *'Other forms of informal calibration during decision-making came from the process of discussion between decision-makers. At both Case Examiner and FtP panel stages, interview participants described how working with colleagues to make decisions served to moderate those decisions. The composition of panels changes with each case, and participants described that working with different people brought different perspectives and experiences to the decision-making process'.*[89]

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[86] Cuthbert, L, 2021 for the Professional Standards Authority, *Advice on biases in fitness to practise decision-making in accepted outcome versus panel models for the Professional Standards Authority*: advice-on-biases-in-fitness-to-practise-decision-making.pdf (professionalstandards.org.uk)
[87] Professional Standards Authority, May 2021, *Review of Social Work England's process for 'accepted outcomes' in fitness to practise cases:* Review of Social Work England's process for 'accepted outcomes' in fitness to practise cases (professionalstandards.org.uk)
[88] Cuthbert, L, 2021 for the Professional Standards Authority, *Advice on biases in fitness to practise decision-making in accepted outcome versus panel models for the Professional Standards Authority*: advice-on-biases-in-fitness-to-practise-decision-making.pdf (professionalstandards.org.uk)
[89] Bryce, M et al, February 2022, *The concept of seriousness in fitness to practise cases*: The concept of seriousness in fitness to practise cases (gdc-uk.org)

11.18 The importance of decision-makers working together is also emphasised in job specifications for the case examiner role, with the NMC's job description noting that: *'you will reach consensus on the most appropriate outcome for a case…You may initially have divergent views, but will negotiate to reach agreement.'*[90]

11.19 Not only does using a single decision-maker potentially increase the risk of bias, there is also increased risk in terms of perceptions of bias and unfairness. Our research with patients and the public noted that *'particular concerns were expressed about a small number of people (sitting on Investigating Committees or as Case Examiners) making decisions on cases in private with no further oversight.'*[91] This was also discussed in the report of the Fifth Shipman Inquiry, which noted that *'concern was also expressed by some individuals and organisations that the proposed model would place too much responsibility in the hands of one individual.'*[92] This point was further echoed in responses to the Government consultation on regulating healthcare professionals, with the consultation analysis quoting one respondent as follows: *'there is a risk of lack of impartiality and unconscious bias when decisions are made by one person'*.[93]

11.20 In responding to our fitness to practise disposal route questionnaire, some regulators suggested that the number of decision makers required could vary depending on the case:

- *'The level of input needed may vary depending on the characteristics of a case and a case dealing with a conviction for child abuse might not require the same input as a case dealing with a complex clinical issue' [healthcare professional regulator]*

11.21 Although the evidence on bias in decision-making is not conclusive, there are legitimate concerns that the use of a single decision-maker may increase the risk and/or perception of bias. Conversely, there is evidence that decision-makers working together may bring a wider perspective which can help to counteract bias and may lead to more balanced decisions.

11.22 We agree with the view expressed by some regulators that some cases could be safely and fairly disposed of using a single decision-maker. These are likely to include cases where there is little ambiguity about the facts and current impairment, such as those involving a conviction.

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[90] NMC, 2019, *Job description:* case examiner – lay: google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwiGjvTXtM2BAxUyQkEAHY_pBJcQFnoECDkQAQ&url=https%3A%2F%2Fwebmicrosites.hays.co.uk%2Fdocuments%2F6167491%2F0%2FCase%2BExaminer%2B%2B-%2BLay%2BRole%2BProfile.doc%2F6d249b9f-e1d5-7598-1c04-ad7b8c1d7fd5%3Ft%3D1594114538454&usg=AOvVaw0Z9F_Eskn9Jz1OJpNJ7r3O&opi=89978449

[91] Community Research for the Professional Standards Authority, May 2020, *Patient and public perspective on future fitness to practise processes:* patient-and-public-perspectives-on-future-fitness-to-practise-processes.pdf (professionalstandards.org.uk)

[92] [92] The Shipman Inquiry, 2004, *Fifth report: Safeguarding Patients: Lessons from the Past - Proposals for the Future*: [ARCHIVED CONTENT] The Shipman Inquiry - Fifth Report (nationalarchives.gov.uk)

[93] Department of Health and Social Care, February 2020, *Regulating healthcare professionals, protecting the public: consultation response analysis:* Regulating healthcare professionals, protecting the public: consultation response - analysis (publishing.service.gov.uk)

11.23 Cases that may benefit from more than one decision-maker are likely to be those which are complex or 'paper heavy', involve significant ambiguity as to what has occurred and/or as to current impairment, or where there are particular cultural considerations. There may also be merit in ensuring more than one person is involved in decision-making where a case is particularly high-profile or controversial and is likely to be subject to significant scrutiny.[94]

11.24 In addition to the number of decision-makers assigned to a case, it is important that regulators have due regard to the training and expertise of those making decisions. As we outlined in our advice to the Secretary of State on how public confidence is maintained in fitness to practise:

- *'the views of Panellists and the Courts are inevitably shaped by their background and experience. Although Panel members have assured us that they exercise the utmost professionalism in carrying out their role and seek to avoid channelling their own views directly, regulators must play a role by ensuring that Panels have access to a wide range of public views to broaden their thinking and by seeking to ensure that Panels are drawn from a sufficiently diverse pool.'*[95]

11.25 Whilst the above is focused on fitness to practise panellists, it applies equally to case examiners. From an equality, diversity and inclusion (EDI) perspective, where a regulator is relying on a single decision-maker, they would need to ensure that the individual had relevant cultural competence. This aligns with Standard 3 of our Standards of Good Regulation, which includes the requirement for regulators to '*ensure that its processes do not impose inappropriate barriers or otherwise disadvantage people with protected characteristics*.[96] Our guidance document on the standard further outlines that

[94] The Scottish Social Services Council advised us that they would expect to refer all high-profile or controversial cases to a hearing
[95] Professional Standards Authority, 2019, *How is public confidence maintained when fitness to practise decisions are made? Advice to the Secretary of State*: https://www.professionalstandards.org.uk/docs/default-source/publications/how-is-public-confidence-maintained-when-fitness-to-practise-decisions-are-made.pdf?sfvrsn=c8c47420_0
[96] Professional Standards Authority. *The Standards of Good regulation*: standards-of-good-regulation145e23f761926971a151ff000072e7a6.pdf (professionalstandards.org.uk)

regulators should *'provide appropriate training on EDI issues to help staff, panellists and others to make fair and unbiased decisions.'*[97]

Summary

Factors to consider: the composition of decision-makers

- Is at least one case examiner a lay person? If not, is there lay involvement at some stage in the fitness to practise decision-making process?
- Does the case involve complex issues, large amounts of evidence or significant ambiguity?
- Are cultural considerations a significant factor in the case? If so, does the case examiner have relevant cultural competence?

12. Factors to consider when publishing case examiner decisions

12.1 The shift away from a panel-based hearings model to the paper-based accepted outcomes model has the potential to reduce the transparency of the decision-making process, which may in turn have adverse consequences for public confidence and the maintenance of standards. Whilst panel hearings are by and large conducted in public, accepted outcomes will be considered and agreed in private. This has led to concern from some stakeholders about decisions being made 'behind closed doors', and corresponding concerns that this may affect the quality and robustness of decision-making.

Promoting transparency and public confidence

12.2 As we have previously explored, 'public confidence' and the 'public interest' (terms which are closely related) are somewhat nebulous concepts.[98] However, there is an understanding common to regulators and the public that there is a 'public interest' in decisions being made in an open and transparent way. This corresponds with Article 6 of the European Convention on Human Rights which enshrines the right to a fair and public hearing.[99]

12.3 Whilst the legislation underpinning Social Work England determines that a case must be referred to a panel if it is in the public interest to do so, no such provision is contained within the AAPA Order.

[97] Professional Standards Authority, 2023, *Guidance for regulators: assessing performance against Standard 3:* Assessing performance against Standard 3 - guidance for regulators (professionalstandards.org.uk)
[98] Professional Standards Authority, 2019, *How is public confidence maintained when fitness to practise decisions are made? Advice to the Secretary of State*: https://www.professionalstandards.org.uk/docs/default-source/publications/how-is-public-confidence-maintained-when-fitness-to-practise-decisions-are-made.pdf?sfvrsn=c8c47420_0
[99] Equality & Human Rights Commission, *The Human Rights Act – Article 6: Right to a fair trial*: Article 6: Right to a fair trial | Equality and Human Rights Commission (equalityhumanrights.com)

12.4 Two separate pieces of research we commissioned have identified that decisions being made in private is an area of concern. Research with patients and the public found that participants '*were concerned about decisions being made 'behind closed doors' and felt that, in the emerging fitness to practise model, action needs to be taken to ensure that information is accessible.'*[100]A further study with members of the public found *'an assumption that because the visible, public face of the process would be removed that the whole FtP complaints process would become more closed, and that complaints would be more easily 'brushed under the carpet' than they are at the moment.'*[101]

12.5 A similar point was raised in the Shipman Inquiry, which cautioned against the introduction of processes that may result in a loss of transparency.[102] AvMA (Action Against Medical Accidents) have also warned that *'there are already significant concerns around the transparency of decision making with existing procedures operated by some regulators.'*[103]

12.6 Ensuring that decisions are transparent and accessible is a key means by which confidence in regulators, and regulatory processes, is maintained. Although we have previously stated that we *'are not aware of evidence that public hearings are the most effective means of maintaining public confidence'*, we have also noted that the accepted outcomes model *'places a great deal of trust in the regulatory bodies, by removing potentially large numbers of decisions from the public forum that is a hearing. This would need to be counter-balanced with improved accountability and transparency of decision-making'*.[104]

12.7 In responding to our questionnaire on fitness to practise disposal routes, most regulators were of the view that public confidence in decision making could be maintained by publishing fitness to practise decisions, be that in respect of a panel hearing or an accepted outcome:

- *'Public confidence in the Accepted Outcome process is achieved through good quality decisions and transparency about those decisions. We propose that full decision-reasoning for action taken in the Accepted Outcome process will be published in the same way as for tribunal decisions.' [healthcare professional regulator]*
- *'Transparency and openness are essential when handling cases disposed of using an accepted outcome. We believe that it is essential to publish the*

[100] Community Research for the Professional Standards Authority, May 2020, *Patient and public perspective on future fitness to practise processes:* patient-and-public-perspectives-on-future-fitness-to-practise-processes.pdf (professionalstandards.org.uk)
[101] Professional Standards Authority, May 2013, *Public Response to Alternatives to Final Panel Hearings in Fitness to Practise Complaints*: https://www.professionalstandards.org.uk/docs/default-source/publications/research-paper/public-response-to-alternatives-to-final-panel-hearings-2013.pdf?sfvrsn=65c47f20_8
[102] The Shipman Inquiry, 2004, *Fifth report: Safeguarding Patients: Lessons from the Past - Proposals for the Future*: [ARCHIVED CONTENT] The Shipman Inquiry - Fifth Report (nationalarchives.gov.uk)
[103] Action against Medical Accidents, 2021, *AvMA response to Regulating Healthcare Professionals, Protecting the Public*: AvMA-Response-to-Regulating-Healthcare-Professionals-June-2021.pdf
[104]Professional Standards Authority, 2017, *Right-touch reform: a new framework for assurance of professions*: https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-reform-2017.pdf?sfvrsn=2e517320_5

allegations, the acceptance of those allegations by the registrant and the outcome from the panel. This marks the seriousness of the concern and allows the public to understand how the regulator has dealt with the concern.' [healthcare professional regulator]

12.8 However, some felt simply publishing the outcome of a paper-based process would not always be enough, and that there would still be cases where a hearing was required to satisfy the public interest:

- *'We believe that cases involving the public interest are precisely the sorts of cases that may benefit more from a panel hearing, to support open justice' [healthcare professional regulator]*

12.9 We acknowledge that there are differing views on how public confidence in decisions, and decision-making, can be achieved, particularly in cases that are likely to be of greater interest to the public. We are not persuaded that there are categories of cases that should be referred to a panel purely on public interest grounds, particularly as this is not provided for in the AAPA Order. However, this is an area we may review over time. This does not apply to Social Work England, for whom it is a legislative requirement to consider whether cases should be referred to a hearing in the public interest.

12.10 In our view, the public interest in transparent decision-making determines that the decision itself, the information underpinning it, and the way it is communicated are capable of maintaining public confidence and declaring and upholding professional standards. The public must be able to have confidence in both the process and the outcome. Key to achieving this is ensuring that sufficient detail about cases and how they are resolved is published.

12.11 In order for a decision to maintain public confidence and uphold professional standards it must be publicly available and include enough detail so that a third party with no prior knowledge of the case would be able to fully understand both the basis of the concern and the rationale for the decision. To satisfy these requirements, it is likely to be necessary to include:

- sufficient details of the regulatory concern or allegations
- the relevant facts and background of the case
- details of the admissions and submissions made by the registrant
- the regulator's decision in respect of the statutory grounds
- the regulator's assessment of impairment
- the final outcome including sanction.

12.12 We acknowledge, however, that there are cases where some of the information outlined above should remain confidential, for example those involving a registrant's health concerns, or where there is other sensitive or confidential evidence.

Case law

12.13 The requirement to give clear reasons for regulatory decisions is also underpinned by case law. For example, in the case of PSA and General Optical Council v Honey Rose, Justice Collins Rice outlines a panel's obligation to uphold public confidence by giving proper reasons for its decision:

- *"… the duties that expert tribunals have to the public – to ensure that the public can understand why certain decisions have been reached in its name; can be reassured that healthcare professionals on whom they must depend are well and fairly regulated; and can know that the overarching obligation professionals have to deserve the trust the public places in them, and to discharge their professional duties with the interests and safety of patients uppermost, has a secure foundation."*[105]

12.14 Similarly, in the case of Professional Standards Authority for Health and Social Care v General Medical Council [2023] EWHC 967 (Admin) the court quashed a finding of the Medical Practitioners Tribunal Service on the basis of 'serious procedural irregularity' due to a failure by the panel to give cogent reasons for its decision. The judgement noted that a panel must *'expose the relevant analysis so the reader understands what the principal issues were, and what the Panel made of them. This is part and parcel of their function in protecting the public interest.'*[106]

12.15 We consider that the level of detail included by Social Work England in its published case examiner decisions[107] serves as a good template for other regulators to follow. In providing full details of regulatory concerns, grounds for actions, the reasoning behind any decision-making, and the final sanction, regulators can ensure that their duties to uphold public confidence and maintain standards are discharged in relation to the publication of fitness to practise decisions that are resolved by way of an accepted outcome.

Summary

Factors to consider: publishing case examiner decisions

- Is the decision published in a place that is easy for the public to access?
- Is the decision sufficiently detailed that a third party with no prior knowledge of the case would be able to fully understand both the basis of the concern and the rationale for the decision?

[105] PSA and General Optical Council v Honey Rose [2021] EWHC 2888 (Admin) at [82]: https://www.professionalstandards.org.uk/docs/default-source/section-29/court-judgments/goc/high-court-judgment---authority-v-goc-and-rose---1-november-2021.pdf?sfvrsn=c0f34820_4

[106] *Professional Standards Authority for Health and Social Care v General Medical Council [2023] EWHC 967 (Admin)*: https://www.judiciary.uk/wp-content/uploads/2023/04/PSA-v-GMC-judgment-270423.pdf

[107] Social Work England, *Case examiner decisions*: https://www.socialworkengland.org.uk/concerns/hearings-and-decisions/case-examiner-decisions/

13. Promoting a fair and effective accepted outcomes process

13.1 In addition to ensuring that cases are determined by way of the most appropriate route, involve the right composition of decision-makers, and that published determinations are sufficiently detailed, we will expect regulators to have robust processes in place to ensure the fairness and effectiveness of investigation and decision-making procedures. Regulators should have particular regard to:

- ensuring that complainants (particularly where the complainant is a patient or service user) are able to make representations within the accepted outcomes process before a decision is made
- ensuring that case examiners' use of accepted outcomes is fair and proportionate, and that case examiners do not face pressure to offer sanctions that are insufficient to protect the public on the basis that they are more likely to be accepted
- ensuring that equality, diversity and inclusion is fully considered within the accepted outcomes process, and to minimise risks that the process results in adverse outcomes for complainants or registrants with certain protected characteristics compared with those who do not share those characteristics.

13.2 Regulators should also consider how they communicate with patients, the public and registrants, and seek to ensure that all communications are compassionate.

Complainant voice in accepted outcomes

13.3 Fitness to practise proceedings are concerned with whether the registrant in question has the skills, abilities, competence and character to practise safely. Action taken against a registrant is focused on the need to protect the public (in the widest sense), not to deliver 'justice' to those who may have been harmed by a registrant's actions, nor to punish the registrant for wrongdoing. The role of complainants is therefore to provide evidence relevant to the regulatory concern.

13.4 It is imperative that complainants (particularly where they are patients or service users) feel that their concerns have been heard within the fitness to practise process, that they are treated with respect, and that they are kept informed about the progress of the case. This is not just because doing so is right and fair, but because the fitness to practise process itself is reliant on the goodwill and co-operation of witnesses and those who report wrongdoing in order to function. Regulators would be incapable of discharging their duty to protect the public without the support and confidence of complainants.

13.5 Through our commissioned research and our engagement with patient groups we have heard concerns that the accepted outcomes process may marginalise complainants. Our research with patients and the public on the future of fitness to practise found that participants' *'immediate question'* was whether *'patients or service users will still have a voice in the process.'*[108] The research concludes

[108] Community Research for the Professional Standards Authority, May 2020, *Patient and public perspective on future fitness to practise processes:* patient-and-public-perspectives-on-future-fitness-to-practise-processes.pdf (professionalstandards.org.uk)

that while on the whole accepted outcomes are supported, the requirement for patients to have a voice was felt to be *'essential.'*

13.6 Similarly, AvMA has welcomed the ability for cases to be dealt with more swiftly through the accepted outcomes process but cautioned that *'this should not be at the expense of excluding patients and families from the process.'*[109] AvMA has raised a particular concern about whether patients will have the right and opportunity to respond to evidence, particularly where the evidence of the registrant counteracts the evidence of the patient.

13.7 We believe that ensuring patients and service users who are witnesses in proceedings are treated with dignity and respect, feel heard, and are kept informed, is vital to ensuring confidence in the regulatory process. We expect regulators to have regard to these objectives throughout each stage of the accepted outcomes process.

The role of case examiners in proposing fair and proportionate accepted outcomes

13.8 The change in the status of decision-makers from independent members (panels) to employees (case examiners) is one of the most significant differences between the two models of disposal.

13.9 Our oversight of Social Work England has shown us that case examiners are generally skilled and proficient at making good decisions and proposing accepted outcomes to registrants that are fair and proportionate.

13.10 However, the fact that case examiners are not independent of the regulator does create the risk that they may be subject to pressure or targets that affect the objectivity of their decisions. This risk may be heightened in a context in which regulators are experiencing major backlogs in fitness to practise cases.

13.11 Concern about the (lack of) independence of case examiners has been extensively highlighted by consumer research, patient groups and other stakeholders. Two pieces of research we have commissioned have found concerns amongst the public that regulators may offer lighter sanctions to registrants who are willing to forego a hearing.[110,111] In one of these, the public explicitly raised the possibility that regulators' decision-making would be influenced by the imperative to save costs: *'some [participants] wondered if regulators would be tempted to be more lenient with registrants in order to*

[109] Action against Medical Accidents, 2021, *AvMA response to Regulating Healthcare Professionals, Protecting the Public*: AvMA-Response-to-Regulating-Healthcare-Professionals-June-2021.pdf
[110] Professional Standards Authority, May 2013, *Public Response to Alternatives to Final Panel Hearings in Fitness to Practise Complaints*: https://www.professionalstandards.org.uk/docs/default-source/publications/research-paper/public-response-to-alternatives-to-final-panel-hearings-2013.pdf?sfvrsn=65c47f20_8
[111] Community Research for the Professional Standards Authority, May 2020, *Patient and public perspective on future fitness to practise processes:* patient-and-public-perspectives-on-future-fitness-to-practise-processes.pdf (professionalstandards.org.uk)

ensure that more cases are agreed and, therefore, avoid an expensive and lengthy hearing.'[112]

13.12 This view is supported by some with extensive knowledge of the fitness to practise process, including Dame Janet Smith, Chair of the Shipman Inquiry who has expressed concerns that caseworkers may be subject to targets, and by AvMA:

- *'There have been continued assurances that 'plea bargaining' will not take place but in reality, there will be pressures on case examiners to identify outcomes that are more likely to be accepted and which will bring a case to a conclusion, creating in effect an 'internalised' form of plea bargaining' [AvMA]*[113]

13.13 From our oversight of Social Work England's accepted outcomes process we have seen no evidence that case examiners are routinely offering inappropriately lenient sanctions. There is in fact some evidence to suggest that at times registrants may benefit from their case proceeding to a panel.[114]

13.14 However, we do expect regulators to be alive to the risk of case examiners' judgement and objectivity being impacted by internal pressures or targets. Regulators should ensure that quality assurance processes are in place to mitigate such risks.

Equality, diversity and inclusion considerations

13.15 The move to a paper-based approach in fitness to practise may have differential impacts, both positive and negative, on people with shared protected characteristics. This applies to complainants (and other witnesses) and to registrants.

13.16 Some participants in the fitness to practise process may feel better able to express themselves verbally than in writing, or vice versa. This may apply particularly to people with certain disabilities, those who are neurodiverse, and those for whom English is not their first language.[115]

13.17 We expect regulators to conduct an equality impact assessment as part of the development of their accepted outcomes process and to take steps to mitigate any negative impacts identified on people with shared protected characteristics or other needs and/or vulnerabilities. This may include making reasonable adjustments to normal processes to meet the needs of individuals. It is important that no participants are disadvantaged by the accepted outcomes

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[112] Community Research for the Professional Standards Authority, May 2020, *Patient and public perspective on future fitness to practise processes:* patient-and-public-perspectives-on-future-fitness-to-practise-processes.pdf (professionalstandards.org.uk)
[113] Action against Medical Accidents, 2021, *AvMA response to Regulating Healthcare Professionals, Protecting the Public*: AvMA-Response-to-Regulating-Healthcare-Professionals-June-2021.pdf
[113] Professional Standards Authority, May 2013, *Public Response to Alternatives to Final Panel*
[114]Finn, G et al, November 2022, *Experiences of GDC fitness to practise participants 2015 – 2021: A realist study:* Experiences of GDC fitness to practise participants 2015 – 2021: A realist study November 2022 (gdc-uk.org)
[115] These factors were identified by regulators in response to our fitness to practise disposal route questionnaire

process due to a protected characteristic that they hold or other specific needs that are not met.

13.18 We are also aware of some evidence that accepted outcomes are offered to registrants who may not be found to be impaired were the case to progress to a hearing, and that this may affect fairness.[116,117] Registrants may accept the sanction offered in order to avoid the stress of a hearing and see the case concluded more quickly. This risk was highlighted both in our review of Social Work England's accepted disposal process, and by participants in the GDC's report on experiences of fitness to practise: *'A contentious point is that it is often 'better' for registrants to go to a full panel "to have their voice heard and be deemed innocent", rather than accept undertakings. Registrants need to balance the wait, the hearing, and stress against getting an earlier, but perhaps less fair decision.'*[118]

13.19 The decision whether to agree to an accepted outcome or progress to a panel hearing may be impacted by the registrant's access to legal advice. This in turn is likely to be affected by a number of factors including the profession of the registrant and their place of qualification. For example, the GDC and NMC report on seriousness in fitness to practise identified that legal representation *'was reported by interviewees to vary between professional groups, with doctors, dentists and pharmacists typically said to have legal representation while nurses, dental care professionals and pharmacy technicians were reported as having higher levels of self-representation.'*[119]

13.20 There are also distinct variations within the same profession, with, for example, a higher percentage of GPs with overseas qualifications lacking legal representation when compared with those who qualified in the UK.[120] The differential rate of legal representation matters because research demonstrates that legal representation is positively correlated with more lenient sanctions in fitness to practise. [121]

13.21 We therefore believe that the accepted outcomes process has the potential to impact differently on different groups. Those with legal representation (which may be more likely to include members of 'wealthier' professions as well as those who hold a UK qualification) may end up, when averaged across the

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[116] Professional Standards Authority, May 2021, *Review of Social Work England's process for 'accepted outcomes' in fitness to practise cases:* Review of Social Work England's process for 'accepted outcomes' in fitness to practise cases (professionalstandards.org.uk)
[117] Finn, G et al, November 2022, *Experiences of GDC fitness to practise participants 2015 – 2021: A realist study:* Experiences of GDC fitness to practise participants 2015 – 2021: A realist study November 2022 (gdc-uk.org)
[118] Finn, G et al, November 2022, *Experiences of GDC fitness to practise participants 2015 – 2021: A realist study:* Experiences of GDC fitness to practise participants 2015 – 2021: A realist study November 2022 (gdc-uk.org)
[119] Bryce, M et al, February 2022, *The concept of seriousness in fitness to practise cases*: The concept of seriousness in fitness to practise cases (gdc-uk.org)
[120] Pulse, 16 May 2022, *Overseas GPs lack representation at fitness-to-practise hearings and face 'harsher sanctions':* Overseas GPs lack representation at fitness-to-practise hearings and face 'harsher sanctions' - Pulse Today
[121] Pulse, 16 May 2022, *Overseas GPs lack representation at fitness-to-practise hearings and face 'harsher sanctions':* Overseas GPs lack representation at fitness-to-practise hearings and face 'harsher sanctions' - Pulse Today

group, with more lenient sanctions than those lacking representation. It is likely that the two groups will vary in terms of their protected characteristics. We would expect regulators to be mindful of this risk and monitor outcomes for different groups.

Summary

Factors to consider: Promoting a fair and effective accepted outcomes process

- Has due consideration been given to ensuring that complainants are treated with dignity and respect, feel heard, and are kept informed within the accepted outcomes process?
- Have steps been taken to protect the independence of decision-makers and ensure that they are able to make impartial and fair decisions, free from undue pressure to meet targets or save costs?
- Have steps been taken to identify any differential impacts of accepted outcomes on people who hold shared protected characteristics? Where the process may impact negatively on certain groups, have steps been taken to mitigate this?
- Are accepted outcomes monitored and recorded in such a way that it is possible to assess any differentials in sanction by protected characteristic?

Annex A – Method

13.22 Our evidence has primarily been drawn from desk research, questionnaire responses from the health and care professional regulators we oversee, and meetings with stakeholders.

13.23 We have reviewed:

- consultations and policy papers issued by Government with respect to regulatory reform, including the Physician Associates and Anaesthesia Associates Order
- guidance produced by the regulators for decision-makers including for case examiners and fitness to practise panels
- relevant research and policy papers. This has included research we have commissioned into public and patient perspectives on fitness to practise and biases in decision-making. We have also reviewed papers published by regulators and others including on experiences of fitness to practise
- relevant public inquiry reports
- reviews we have conducted into the accepted outcomes and undertakings procedures operated by the regulators we oversee
- responses to the questionnaire we issued to regulators on fitness to practise disposal routes (available at Annex B)
- a selection of published case examiner decisions and fitness to practise tribunal determinations
- relevant case law

13.24 We have also met with patient groups, employer representative bodies, a selection of the regulators that we oversee, regulators from sectors outside of health and social care, and a regulator from within health and social care that does not fall under our remit.

13.25 In producing this document we have sought to assimilate all relevant evidence and draw out key points for consideration.

Annex B – survey questions

13.26 The questions below were included in a questionnaire sent to all regulators we oversee seeking their views on fitness to practise disposal routes post regulatory reform. The questionnaire was sent on 26 July 2023.

1. Under the reformed FtP system, do you envisage there being cases that would be more appropriately dealt with by a panel hearing rather than an accepted outcome, irrespective of whether the registrant accepts/may accept the findings and any proposed measure? If yes, please give details.
2. What factors (if any), might mean that a case would be more appropriately dealt with by means of a panel hearing than an accepted outcome?
3. Under the reformed FtP system, it is not expected that cases will be referred for a panel hearing on public interest grounds. Do you have any observations or concerns about the ability of the accepted outcomes model to maintain public confidence in terms of the process by which cases are dealt with? If so, how could such concerns be mitigated?
4. What are the benefits of the accepted outcomes model, and what can the model deliver that a panel hearing cannot?
5. What benefits does a hearing have over a decision made on the papers?
6. Under the new system, what do you envisage a panel being able to do that case examiners cannot?
7. How can regulators ensure a robust assessment of insight as part of an accepted disposal? What steps can be taken to ensure that registrants are not relying on AI to help produce reflective statements?
8. How important do you think it is, if at all, for decision-making to include input from both a registrant and a lay person? Might this vary in importance depending on the characteristics of the case?
9. What information do you think it is necessary to publish about cases disposed of using an accepted outcome in order to maintain public confidence?
10. Are you aware of any particular impacts the new powers to use accepted outcomes will have on people with protected characteristics (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation)?
11. Are you aware of any research, guidance or data that might be relevant to determining how FtP cases should be disposed of?
12. How can consistency of approach to fitness to practice between regulators be promoted post regulatory reform?
13. Do you have any other comments or observations you would like to make?