UK Healthcare Professional Regulatory Reform Team
Professional Regulation
Department of Health
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Dear colleague,

Promoting professionalism, reforming regulation

The British Medical Association (BMA) is an apolitical professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care.

We welcome the ambition to provide better and more responsive healthcare regulation. We agree that the current system can be slow, expensive, complicated and overly adversarial. This is particularly worrying when underfunding of the NHS and increasing demand on its services have created a situation in which, as the General Medical Council (GMC) acknowledges, “there are clear warning signs ... that some doctors are being pushed beyond the limit”.

Our responses to the questions in the consultation are below.

Q1: Do you agree that the PSA should take on the role of advising the UK governments on which groups of healthcare professionals should be regulated?

It is difficult for us to judge whether the Professional Standards Authority (PSA) would be more effective in advising the UK governments on which groups of healthcare professionals should be regulated than the Health and Care Professions Council is currently. We agree that the ultimate decision about whether a group of healthcare professionals should be regulated should be made by ministers rather than by the PSA but would expect any changes in which groups are regulated to require legislation. We also would not want the cost of providing the advice to be passed on to registrants.

Q2: What are your views on the criteria suggested by the PSA to assess the appropriate level of regulatory oversight required of various professional groups?

It is also difficult for us to comment on the proposed two stage assessment of whether professional groups should be regulated without knowing more about how this assessment would work. We are concerned, however, about the inclusion of “risk perception”, i.e. the effect on confidence levels for the

1 General Medical Council (2017), The state of medical education and practice in the UK, p. 4.
relevant profession, as a criterion in the second stage of the assessment. There is a risk that this criterion could introduce an unacceptable level of subjectivity into judgements about which professions should be regulated. If it is included, a clear explanation should be provided of how it will be related to the regulators’ overarching objective of protection of the public. With regard to the inclusion of “the scale of the risk” we do not accept the presupposition that smaller professions need a lower level of regulatory oversight than larger ones. With regard to the inclusion of “sector impact” we would not want impact on the cost or supply of the workforce to become an excuse for inadequate regulatory oversight.

Q3: Do you agree that the current statutorily regulated professions should be subject to a reassessment to determine the most appropriate level of statutory oversight? Which groups should be reassessed as a priority? Why?

We remain unclear why this is necessary. The consultation document does not provide any reasons why the level of statutory oversight of any of the current statutorily regulated professions might need to be reduced (or increased). However, given the impact of their decisions on patient care, we would like to see a system of regulation for non-clinical managers in the NHS and other providers.

Q4: What are your views on the use of prohibition orders as an alternative to statutory regulation for some groups of professionals?

We are not convinced that the use of prohibition orders is a satisfactory alternative to statutory regulation. A system of regulation should be flexible enough to allow the use of a range of sanctions including conditions or warnings. It should also encourage continuing professional development that enables registrants to maintain the standards required to stay fit to practise.

Q5: Do you agree that there should be fewer regulatory bodies?

Each of the groups of registrants covered by the healthcare regulators is different, particularly in terms of educational standards at entry and continuing professional practice. We believe that, given the diversity of training structures, career paths and healthcare responsibilities among the different healthcare professions, the public interest is best served by continued regulation of doctors through a separate medical regulator. We do not ourselves have a view on how many other regulators there should be but would expect any changes in the number of regulatory bodies to be considered only with the full involvement of the organisations representing the professions affected by the changes.

Q6: What do you think would be the advantages and disadvantages of having fewer professional regulators?

We recognise that, as the consultation document suggests, having fewer regulators could potentially produce more consistency of approach, cost savings and greater clarity about with whom concerns should be raised. We are unclear, however, to what extent these advantages could be realised in practice. A potential disadvantage is that professional regulators might be less attuned to the needs of the specific professions they regulate.

Q7: Do you have views on how the regulators could be configured if they are reduced in number?

We believe doctors should continue to be regulated through a separate medical regulator (see our response to question 5). We do not ourselves have a view on how the other regulators could be configured if they are reduced in number but would expect any changes in the configuration of regulatory bodies to be considered only with the full involvement of the organisations representing the professions affected by the changes.

Q8: Do you agree that all regulatory bodies should be given a full range of powers for resolving fitness to practise cases?

The consultation document notes that the GMC has the widest range of powers. (These are exercised by the Medical Practitioners Tribunal Service, which manages medical practitioners tribunal hearings and
interim orders tribunal hearings, and GMC case examiners. We do not ourselves have a view on whether other regulatory bodies should be given the same range of powers as the GMC but would expect any changes in their powers to be considered only with the full involvement of the organisations representing the professions affected by the changes.

**Q9: What are your views on the role of mediation in the fitness to practise process?**

We recognise the public interest in open resolution of cases where fitness to practise is in question. If an allegation is serious enough to meet this threshold, the outcome of the process should not be subject to negotiation. With regard to using mediation to resolve cases at an earlier stage we remain unclear how this would work, given that matters where fitness to practise is not in question can be addressed in other ways (for example through the NHS complaints procedure), and would want to make sure that participation in mediation was entirely voluntary.

**Q10: Do you agree that the PSA’s standards should place less emphasis on the fitness to practise performance?**

The PSA already has standards for guidance and professional standards, education and training and registration as well as for fitness to practise. We have a concern that a greater emphasis on issues other than fitness to practise, which is central to the role of professional regulators, could stimulate regulators to create unnecessary layers of regulation and/or to duplicate the roles of other organisations (e.g. regulators of higher education).

**Q11: Do you agree that the PSA should retain its powers to appeal regulators’ fitness to practise decisions to the relevant court, where it is considered the original decision is not adequate to protect the public?**

We believe that the PSA should not be able to appeal fitness to practise decisions where the regulator has been given the right of appeal against the decision of an independent adjudicator (which is the case with the GMC).

**Q12: Do you think the regulators have a role in supporting professionalism and if so how can regulators better support registrants to meet and retain professional standards?**

We agree that regulators have a role in supporting professionalism, especially in relation to education and in relation to revalidation and continuing professional development. We have supported events organised by the GMC in which frontline clinicians have discussed the challenges to professionalism that emerge in their daily practice. We would not, however, want professional regulators to duplicate the roles of regulators of higher education. We are also concerned that medical revalidation has become unduly burdensome on doctors and, in particular, has resulted in unjustified burdens being imposed on them at local level. We believe that regulators should recognise the impact of system pressures on education and training and on patient care and, where appropriate, encourage registrants to raise concerns about this impact.

**Q13: Do you agree that the regulators should work more closely together? Why?**

The answer to this question must depend on the kind of joint working involved. With regard to a shared online register, we have no objection to improved access to information that is already publicly available but would not want this improvement to be treated as an opportunity to include more information about registrants or to remove control of the information from the existing regulators. With regard to a new core set of professional standards for all health professionals, we have no objection to existing professional standards being made more accessible to the public but would not want the regulatory burden on registrants to be increased. Also, given the diversity of training structures, career paths and healthcare responsibilities among the different healthcare professions and the specific expertise of the MPTS, we do not support the creation of a single adjudicator for all fitness to practise decisions. If such a body were to be created, it would need to be fully independent of the regulators. With regard to a single organisation conducting back office functions, we are happy for each regulator to consider the risks and benefits of
integrating these functions but any changes which could affect the professions themselves should be considered only with the full involvement of the organisations representing the relevant professions.

Q14: Do you think the areas suggested above are the right ones to encourage joint working? How would those contribute to improve patient protection? Are there any other areas where joint working would be beneficial?

See our response to question 13.

Q15: Do you agree that data sharing between healthcare regulators including systems regulators could help identify potential harm earlier?

We recognise the possibility that data sharing could help identify potential harm earlier but believe it is essential that proper safeguards are in place with regard to the sharing of any data about individual professionals. We assume this question does not refer to the sharing of confidential medical information about patients.

Q16: Do you agree that the regulatory bodies should be given greater flexibility to set their own operating procedures?

We support sensible moves to ensure that regulators have enough flexibility to adapt their approach to the needs of the professions they regulate, provided there is appropriate parliamentary and public accountability in place. Such moves might permit the GMC to take supportive action when education providers are struggling, to agree sanctions with a registrant without a public hearing in appropriate cases and to reduce the bureaucracy facing doctors who apply for the specialist or general practitioner register through the ‘equivalence route’. However, any legislation giving the regulatory bodies greater flexibility to set their own operating procedures should ensure that changes to these procedures will be subject to meaningful consultation with relevant individuals and organisations including the organisations representing the professions affected by the changes. Legislation should still be required for significant changes in the roles of regulatory bodies.

Q17: Do you agree that the regulatory bodies should be more accountable to the Scottish Parliament, the National Assembly for Wales and the Northern Irish Assembly, in addition to the UK Parliament?

Yes. We would support implementation of the suggestion in the consultation document that the Scottish Parliament, the National Assembly for Wales and the Northern Ireland Assembly might each hold hearings or take evidence from the regulators and/or the PSA about the impact of their work in its jurisdiction. We also agree that the regulatory bodies should lay copies of annual reports before the legislatures of all the UK countries in which they operate. These annual reports should be country specific in Scotland, Wales and Northern Ireland.

Q18: Do you agree that the councils of the regulatory bodies should be changed so that they comprise of both non-executive and executive members?

No. We believe that the separation between the members of a regulatory body and its staff should be maintained in order to ensure that councils can hold the executive officers to account properly. We also believe that the majority of members of the GMC Council should be licensed medical practitioners.

Q19: Do you think that the views of employers should be better reflected on the councils of the regulatory bodies, and how might this be achieved?

No. If the concept of council members representing the professions themselves is unacceptable, the concept of council members representing employers should be unacceptable too. We cannot assume that the interests of employers are identical to those of patients.

Q20: Should each regulatory body be asked to set out proposals about how they will ensure they produce and sustain fit to practise and fit for purpose professionals?
Since the regulatory bodies should be considering these issues as a matter of course and should be taking account of the PSA’s standards, we are unclear about the purpose of this specific request.

Q21: Should potential savings generated through the reforms be passed back as fee reductions, be invested upstream to support professionalism, or both? Are there other areas where potential savings should be reinvested?

We would like to see some of any potential savings in relation to the regulation of doctors passed back as fee reductions. We also support a shift towards public funding of the GMC. We would expect any decisions about the balance between fee reductions and reinvestment to be made with the full involvement of the organisations representing the relevant professions.

Q22: How will the proposed changes affect the costs or benefits for your organisation or those you represent?

- an increase
- a decrease
- stay the same

Please explain your answer and provide an estimate of impact if possible.

It is difficult for us to comment on this issue in the absence of more specific proposals.

Q23: How will the proposed changes contribute to improved public protection and patient safety (health benefits) and how could this be measured?

A number of measures suggested could have a beneficial impact on public protection including creating a system which is more easily understood by the public and one in which risks are identified at an earlier stage. However, success would depend on other factors such as the adequate resourcing of the healthcare system as a whole.

Q24: Do you think that any of the proposals would help achieve any of the following aims:

- Eliminating discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010 and Section 75(1) and (2) of the Northern Ireland Act 1998?
- Advancing equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it?
- Fostering good relations between persons who share a relevant protected characteristic and persons who do not share it?

If yes, could the proposals be changed so that they are more effective?

If not, please explain what effect you think the proposals will have and whether you think the proposals should be changed so that they would help achieve those aims?

The consultation suggests measures to shift the focus of regulation towards supporting registrants. This may have a positive impact on groups with protected characteristics who have previously been disproportionately represented in fitness to practise processes.
Yours sincerely,

Raj Jethwa
Director of Policy