

Department of Health: *Promoting professionalism, reforming regulation*

January 2018

The Medical Protection Society (MPS) response to the Department of Health's consultation on reforming healthcare professional regulation

General Comments

We are pleased to have this opportunity to respond to the Department of Health's consultation on the future of healthcare professional regulation – "*Promoting professionalism, reforming regulation.*" This is a highly anticipated consultation, on a subject of immense importance to healthcare professionals and patients, and we welcome the Government's desire to drive forward the debate on precisely what shape and structure healthcare professional regulation should take.

From the outset, we underline our long stated view that the regulation of healthcare professionals must change. In many areas, reform is long overdue.

MPS is the world's leading protection organisation for doctors, dentists and healthcare professionals. We protect and support the professional interests of more than 300,000 members in the UK and around the world. Our in-house experts assist with the wide range of legal and ethical problems that arise from professional practice. This can include clinical negligence claims, complaints, medical and dental council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal accident inquiries. Our philosophy is to support safe practice in medicine and dentistry by helping to avert problems in the first place.

In supporting our members, we have considerable experience of the regulatory functions performed by the General Medical Council (GMC) and the General Dental Council (GDC). In recent years, both have made changes to their Fitness to Practise (FtP) processes. Some of these have been positive and have yielded success; others, less so.

The common theme amongst all recent regulatory reforms at the GMC and GDC, is that both have been heavily restricted in the changes they can make under the legislative framework underpinning healthcare professional regulation.

This initial consultation allows all those involved with the regulation of doctors, dentists and other healthcare professionals to debate the purpose and practicalities of regulation in a modern healthcare economy.

In this submission we argue that the regulators should be better able to reform their processes so they are able to be more efficient and reduce the burden on healthcare professionals. However, any additional freedom given to the regulators to reform their processes must be accompanied by safeguards - which ensure they adequately consult with stakeholders first and also that their processes must remain fair, transparent and consistent. We also argue that any reforms to the governance or the number of regulators must not lead to them losing the required understanding of the professions they regulate.

This is an immensely important issue, and we stand ready to be a thoroughly involved and constructive contributor as the governments of the UK consider the future of healthcare professional regulation.

Consultation Questions

Question 1: 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?

We are content with the PSA having a role in advising the UK governments on which healthcare professional groups should fall under a regulatory regime. However, it must be emphasised that our support is confined to it having 'a' role, rather than 'the' role, as suggested in the wording of this question.

While the PSA has researched and published extensive material on alternative models of healthcare professional regulation in recent years, there are other organisations who have expertise in this area and who approach the issue from a different vantage point. Their input could provide valuable insight as the UK governments consider this issue.

For instance, the CQC is uniquely placed to comment on the merits of regulation in a myriad of healthcare delivery areas, given its extensive monitoring and inspection experience across the sector. The same is true of Healthcare Improvement Scotland, Regulation and Quality

Improvement Authority (Northern Ireland) and Health Inspectorate Wales. Organisations representing healthcare professionals, and organisations representing patients and service users, should also have a role in advising where regulation is needed.

Question 2: What are your views on the criteria suggested by the PSA to assess the appropriate level of regulatory oversight required of various professional groups?

The criteria for this important question, suggested by the PSA, appear considered and reasonable. It is inconceivable that doctors, dentists and dental therapists – and the actions they take – would not be regulated or that they would not fall under the assessment that the PSA is proposing. This cannot be said for all professions that are currently regulated however; for example, dental nurses and dental technicians.

Essentially, we are firmly of the view that doctors and dentists would – and should - pass any test as to the need for regulation. However, if the decision is taken to adopt the PSA's criteria to determine the correct level of regulatory oversight, we encourage the UK governments to apply it consistently across all individual professional groups. This is particularly in reference to the dental team and the need to not by-pass the PSA criteria, and automatically group dental nurses, technicians and so forth, with dentists on an individual regulatory footing. The roles that make up the dental team should be assessed on an individual basis.

Question 3: 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?

Yes. Ever since the GMC was established in 1858, ad hoc and inconsistent decisions have been made by various governments about which other professions should be regulated and by which regulator. The end result is that some professionals which do not handle a high degree of risk are regulated whereas new and emerging professional groups are not.

We agree that it would be appropriate to reassess all those professions that are currently subject to statutory regulation, in order to determine the most appropriate level of statutory oversight moving forward. That being the case, as outlined in response to question 2, we believe it is

inconceivable for doctors and dentists not to be regulated on a statutory basis.

Turning to the question of which groups should be reassessed as a priority – again, as outlined in response to question 2 – with the exception of dentists, the rest of the dental team should be priorities for reassessment. Our reading and interpretation of the PSA’s proposed criteria suggests, for instance, that dental nurses and dental technicians do not meet the bar for statutory regulation. These groups, and other members of the dental team, should therefore be reassessed as a priority.

Question 4: What are your views on the use of prohibition orders as an alternative to statutory regulation for some groups of professionals?

We do not support prohibition orders as an alternative to statutory regulation. A consistent approach is far more helpful for both the public and healthcare professionals; prohibition orders in some areas, and statutory regulation in others, would likely lead to additional bureaucracy. Consistency should be sought at every stage, an excessive bureaucracy equally avoided.

Question 5: Do you agree that there should be fewer regulatory bodies?

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Question 6: What do you think would be the advantages and disadvantages of having fewer professional regulators?

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Question 7: Do you have views on how the regulators could be configured if they are reduced in number?

The four UK governments are right to explore the merits of reducing the number of regulatory bodies for healthcare professionals. If the UK in 2018 were to design the regulatory system from scratch, the end result would not be nine different regulators of such vastly different sizes. There is clearly scope for a reduction in the overall number of regulators.

For instance, a strong case has already been made for the merger of the General Osteopathic Council (GOsC) and General Chiropractic Council (GCC) with the Health and Care Professionals Council (HCPC). An argument can also be envisaged for the merger of the General Pharmaceutical Council (GPhC) and the Pharmaceutical Council of Northern Ireland.

For the purposes of this initial consultation, we confine our comments specifically to the future shape and structure of the GMC and GDC.

Doctors and dentists carry out some of the most complex work in the UK healthcare community; these two professions manage varying portfolios of work that carry high degrees of risk, and they undertake considerable and ongoing specialist education and training to enable them to provide world leading healthcare to patients. It is therefore imperative that the organisations responsible for regulating doctors and dentists have the appropriate expertise and understanding of these two distinct professions.

As has already been referenced in this consultation response, and in our submissions to the PSA's recent performance reviews - both the GMC and the GDC have scope for significant improvements to their regulatory functions. The GDC in particular still has a considerable distance left to travel despite the recent good progress, following our concerns in recent years about its FtP performance – concerns widely shared in the dental community, and crucially, by the PSA as well.

While this is the case, we believe that there is a strong case to be made for the GMC to remain the dedicated regulator of the medical profession, and for the GDC to remain the dedicated regulator of dentists and dental therapists.

An amalgamation exercise which could result in the specific expertise of each profession's regulator being lost would be of deep concern to healthcare professionals. Any new regulators, replacing the existing nine, would need to be able to understand the hugely differing roles within the many professions they would oversee. The emphasis must be on delivering more efficient regulation so healthcare professionals can get on and do their jobs, and ensuring regulators follow a fair process that patients, healthcare professionals and the governments of the UK can have confidence in.

While this consultation is not the appropriate forum to explore in great detail the rationale behind why one regulator's functions would best sit with another, and why another should retain only its current registrant base – MPS does take an early view on some of the potential scenarios left open by this consultation.

For instance, we would oppose any proposal to merge the GDC and its registrants into a new regulator that encompasses opticians, pharmacists and potentially others. Dentists carry out high

risk healthcare work and interventions on a daily basis within a clinical setting, and thus require a regulatory framework that is overseen by a regulator with the requisite experience and expertise of that form of healthcare delivery. It is hard to foresee how that same type of framework could be brought to bear, were it to be jointly applied to a healthcare service that is largely provided on an 'over-the-counter' basis.

We would also caution against the creation of super regulator for all healthcare professions, or reforms of a similar magnitude. As an international organisation, we have seen regulatory reforms in other countries not yield particular success from a costs point of view. There is no evidence-base as yet that super-regulators are more efficient and generate economies of scale. For instance, recent regulatory reforms in Australia (where MPS supports more than 68,000 dental professionals) have not shown any significant cost savings for registrants. Much more detail on the financial implications of any proposed mergers of regulatory responsibilities in the UK, will of course be needed.

We look forward to reviewing more precise proposals from the Department of Health for the realignment of regulatory responsibility in the near future. This question is fundamental to the entire debate about the future shape of healthcare professional regulation, and the question of where regulatory responsibility for each profession should sit will require careful consideration and specific, widespread consultation.

Question 8: Do you agree that all regulatory bodies should be given a full range of powers for resolving fitness to practise cases?

After the question of what organisation should regulate which healthcare professional, no issue is of more fundamental importance to the reform debate than fitness to practise [FtP]. It is therefore unfortunate that this question is posed in a very general sense, and does not seek respondents' views on some specific principles of FtP reform. We urge the Government to ensure that this forms part of subsequent consultation exercises.

In our submission to this consultation question below, we answer this question directly and provide some indicative examples of FtP reform that legislation could enable at the GMC/GDC. We do not seek to use this initial consultation as a vehicle to outline every specific FtP reform that we would

seek at the GMC and GDC, but would be very happy to engage further with the Government on this issue.

Range of powers for resolving FtP cases

The legislation which underpins the work of the GMC and GDC is outdated and in some areas requires them to conduct their operations in a way that is inefficient and not in the best interest of patients or professionals. There is clearly scope to improve their legislation in a way that would benefit all concerned. This does not however mean that the logical conclusion is that the regulatory bodies should be given an undefined 'full range of powers' to resolve FtP cases, as this consultation proposes.

Regulators should be able to introduce uncontentious reforms following significant consultation with interested parties and without requiring Parliament to amend the relevant legislation. But it is equally important that they are required to retain important statutory safeguards which ensure a transparent, consistent and fair FtP processes. We would have significant concerns about proposals that would give regulators a full range of powers to reform their processes without adequate requirements for consultation and scrutiny. We would look to work closely with the Government to ensure any subsequent legislation strikes the right balance.

Reducing the burden on health professionals

It is vital that, as the future of healthcare professional regulation in the UK is reviewed, consideration is continually given to how regulators can be best equipped to manage the impact that their regulatory actions have on registrants. We believe regulators have a duty of care to the people they regulate.

We welcome that the GMC has recognised the potentially harmful consequences of an FtP investigation on the health of individual doctors, and that in recent years it has been looking at how to address this. Figures from the independent review, commissioned by the GMC in 2014, revealed that 28 doctors had died by suicide between 2005 and 2013 while undergoing a GMC investigation.¹ Since then, evidenced most notably in the Louis Appleby Review, the GMC has

¹ The General Medical Council (GMC), *Doctors who commit suicide while under GMC fitness to practise investigation. Internal review by Sarndrah Horsfall. December 2014*

recommitted itself to improving its FtP process. Nevertheless, that figure of 28, alongside the testing nature of an FtP investigation for all registrants involved, means the wellbeing of doctors (and dental professionals) must be an active consideration of the four UK governments moving forward.

We are acutely aware of the impact GMC and GDC FtP proceedings can have on doctors. Our professional advisers support doctors and dental professionals' day in day out as they go through this often long, complex and difficult process. A 2015 MPS survey of 180 medical members - who had been the subject of a recent GMC investigation - found that:

- 93% reported stress and/or anxiety
- Three in four respondents said the investigation impacted on their personal life
- Almost three quarters of respondents (72%) believed that experiencing a GMC investigation had a detrimental impact on their mental and/or physical health
- Looking at the support the GMC offers to doctors throughout the investigation process – 47% of respondents believed they had not received enough.
- 70% of respondents said that the GMC should offer more support to doctors facing an investigation.²

More broadly, the regulation and general scrutiny of the medical profession is widely held to be a key contributing factor to the scale of the pressure felt by doctors. A 2016 survey of more than 1,300 doctors by the Royal Medical Benevolent Fund (RMBF) found that 80% of respondents said that increased scrutiny is a significant issue contributing to the pressure felt by doctors.³

It is in the interests of patients and the profession, that doctors' and dental professionals are supported to fulfil their crucial role of providing care to those in need. It is of course important that doctors and dentists are regulated, but as a society we need to balance that against ensuring they do not become disillusioned and leave the profession.

Reducing the length of investigations and hearings

² MPS Casebook, May 2015 – The High Anxiety of the GMC.

³ RMBF *What's Up Doc?* Survey. January 2016. Press release: Alarming numbers of doctors experiencing mental health issues as a result of work pressures

A doctor or dental professionals' life can effectively be on hold while under investigation by the GMC/GDC, so lengthy delays must be avoided wherever possible. As part of a wide package of FtP reform, we strongly urge the governments of the UK to consider how regulators can be mandated to conduct FtP within a given time frame.

In 2015/2016 the GMC reported that the median time taken to conclude a case that is referred for a final fitness to practise hearing (from the receipt of the complaint) is 99.7 weeks.⁴

The PSA has been concerned for some time about the length of time it takes the GMC to bring investigations to a conclusion. In its 2014/2015 performance review (when the median time stood at 92.6 weeks), it noted:

'In 2014/2015 the GMC made 415 applications to the High Court to extend interim orders. This means that the GMC did not conclude these cases within the lifetime of the interim orders, which can be up to 18 months in length (we recognise that they may be imposed for shorter periods, and therefore a need to extend an interim order may arise sooner than 18 months after the original order was imposed). The High Court refused to extend four of these orders – in two of these four cases, the High Court criticised the GMC for delays.'

In respect of the GDC, in 2016/17 it reported that the median time taken to conclude a case that is referred for a final fitness to practise hearing (from the receipt of the complaint) is 90 weeks.⁵

In both cases, these median figures are concerning and much too high.

We recognise that there will always be cases that are of such complexity, that they inevitably take much longer to conclude than is the norm. Due process and fairness to all parties must be central to FtP. However, such a fact should not detract from Department of Health's focus on how a regulatory framework can be in place to ensure median times for FtP cases are brought down.

Proportionality

⁴ PSA Performance Review of the GMC 2015-16. P4 <https://www.professionalstandards.org.uk/docs/default-source/publications/performance-reviews/performance-review-2015-16-gmc.pdf?sfvrsn=8>

⁵ PSA Performance Review of the GDC 2016-17. P5 <https://www.professionalstandards.org.uk/docs/default-source/publications/performance-reviews/performance-review-2016-17-gdc.pdf?sfvrsn=6>

FtP proceedings should also be proportionate, and there are a number of legislative changes that the governments of the UK could consider to improve proportionality. The PSA defines proportionality in this context as regulators intervening only when necessary – with the remedies it applies being appropriate to the risk posed, with costs both identified and minimised.

We agree with the notion that the core purposes of the GMC and GDC is to ensure safe practise. However, doctors and dentists do expect, and should be subject to, a regulatory system that is proportionate to the risk posed, as well as consistent, fair and transparent.

The GMC recently published its State of Medical Education and Practice report which showed that the vast majority of GMC investigations are closed without action. The end result is that over a thousand doctors go through a needless, stressful and slow process each year, while many patients making a complaint also end up disappointed with the outcome.

As already indicated, some improvements have been made in this area, but any legislative reforms to healthcare professional regulation must allow regulators to improve the complaints triage process as a priority to avoid unnecessary investigations.

In the case of the GMC, the Medical Act 1983 needs amending so the GMC is given more discretion to not take forward investigations in cases where the allegations clearly do not require action. In the 35 years since the Act came into a force, the number of complaints received by the GMC has grown beyond recognition. In 1983 the number was so small the GMC could investigate every complaint it received. The GMC now receives over 8,000 complaints a year but very few of these come close to the threshold of serious concern that the GMC was set up to address.

In its work on developing proposals for regulatory reform, this is another area that the Department of Health should be considering for the GMC and GDC, and addressing why so many cases proceed to full investigation.

Presumption of erasure

There has long been discussion around the GMC's proposals that there should be a 'presumption of erasure' from the List of Registered Medical Practitioners (LRMP), when a doctor has been convicted of a serious criminal offence. We are firmly opposed to this power being granted.

It is for the Criminal Courts to determine a defendant's guilt or innocence. It is for the Criminal Courts' to determine a sentence, and to punish the convicted. It is not – nor should it be – for the GMC or MPTS to punish a doctor.

The MPTS is the body responsible for 'making independent decisions about a doctor's fitness to practise, measured against professional standards set by the General Medical Council'⁶. In coming to a decision on sanction, it is necessary for the Tribunal to make a judgement taking into account what is sufficient for the protection of the public. Panel members have training and expertise appropriate to their role. The Tribunal has the facility to consider a much broader range of evidence than the Court, and take full account of all the circumstances of a case. This includes information relevant to systems failures, patient safety and the capacity to remediate. It is therefore right that the Tribunal, and not the Court, should be the decision-maker in matters relating to impairment and fitness to practise.

A 'presumption of erasure' would undermine the role of the MPTS as an adjudicator of professional fitness to practise. This should not happen.

Anonymity for defendants

It is not uncommon for doctors and dental professionals to attract media attention when they are investigated by the GMC/GDC. This attention can have considerable reach into both their professional and personal lives. The adverse effect on both can be significant. When a member finds themselves in the media spotlight, MPS provides support - including advice, liaising directly with journalists and drafting statements. This gives us a front row view of the damaging consequences for the doctor following adverse publicity.

A registrant exonerated at a hearing, whose case has been the subject of media coverage since its inception, seldom leads to the same level of publicity that earlier negative stories attracted. We are concerned about the impact 'trial by media' can have on doctors and dental professionals, particularly when no impairment is found but where the alleged impairment was particularly damaging to their reputation.

⁶The role of the MPTS <https://www.mpts-uk.org/about/1595.asp>

As discussions in criminal law continue about whether anonymity should be granted in some instances until the closure of the trial, we would encourage governments keep this matter firmly under review in respect of professional FtP hearings as well. In New Zealand, where MPS supports over 17,000 healthcare professionals, the Medical Council as a matter of policy does not publically name a practitioner who is subject to an FtP hearing. It considers that to do so would be overstepping its statutory function: to ensure the health and safety of the public. The MPTS/GMC and GDC's statutory function should be examined closely, to ensure its policy of naming registrants as a matter of course at FtP hearings, is not overstepping its requirements.

Question 9: What are your views on the role of mediation in the fitness to practise process?

The consultation document does not define what the Department of Health means by mediation, and given how broad the concept is, we are unable to comment in any detail at this stage of the consultation process.

One observation however, would be that mediation is best used as an arm's length arrangement with separate bodies to the regulator, where proceedings are separate to FtP. It is difficult to see how it could instantly form part of the FtP process, as the concept of mediation is usually associated to complaints and claims. We are not sure whether one could, or indeed should, seek to mediate between parties when there is a question over a healthcare professional's fitness to practise.

Again, considerably more detail is required on this point.

Question 10: Do you agree that the PSA's standards should place less emphasis on fitness to practise performance and consider the wider performance of the regulators?

We strongly disagree with this proposal.

The GMC and GDC's (and other regulators') fitness to practise [FtP] procedures are central to their work. Their performance against the PSA standards in this area serves as a vital indicator of their effectiveness as regulators. If FtP procedures are handled badly by a regulator, they can have significant career and health implications for the registrant, as well as for patients and their families.

FtP performance must remain central to the PSA assessment of a regulator's overall performance.

Question 11: 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?

The GMC recently acquired the power to appeal decisions of the MPTS regarding the fitness to practise of GMC registrants. The PSA also has this power. Such a situation is highly unsatisfactory and it should be addressed.

Under the currently regulatory framework for doctors in the UK, the GMC is the investigator and the MPTS is the adjudicator on FtP matters. However the governments of the UK propose to proceed - either in terms of the number of regulators, or how FtP matters should be adjudicated upon – there should be only one body with the power of appeal. This should either be the PSA, or the regulator in question. It must not be a power that sits with both.

Question 12: 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?

Yes, we do see a role for regulators in supporting professionalism. However, this supporting role should not be confused with the regulators being seen as educators of the various healthcare professions. The extent to which regulators in the future spend resources on professional standards should also remain proportionate, and in line with what they should be expected to achieve.

Question 13: Do you agree that the regulators should work more closely together? Why?

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Question 14: 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?

There is certainly scope for healthcare regulators – irrespective of their future shape and composition – to work more closely together. As the consultation document notes at paragraph 4.7, even without a reduction in the number of regulators, there is scope for sharing functions

between them. The proposal for regulators to share back-office functions like IT and HR support, on the face of it, would make sound economic sense. We are confident that registrants would welcome any such move given its potential for cost savings and subsequent reductions in their registration fee.

On the proposal for a single set of generic standards for all healthcare professionals – providing profession specific standards remain in place, and that any duplication between the two is minimised by the relevant regulators – MPS would be supportive of the idea being explored.

The question of whether joint working could extend to a shared adjudication function, akin to that of the now former Office of the Health Professions Adjudicator (OHPA), is a much more complex, but interesting proposal.

We were broadly supportive of the creation of the OHPA. MPS maintains that, subject to the adjudicator panel in each case being composed of a member of the relevant healthcare profession (to provide specific expert knowledge and experience), in addition to a legally qualified chair and lay member, an organisation such as the OHPA could prove a viable way forward for the adjudication of FtP matters.

In short, if the four governments of the UK are minded to actively explore the creation of a single adjudicator for all FtP matters, it must ensure that profession specific expertise and knowledge is maintained.

Governments must all go further than the GMC-MPTS arrangement; whereby the former investigates, and the later adjudicates. The adjudication function must have the confidence of the profession, as well as the public. It must be independent and be seen to be so. It also must be operationally separate, and be seen to be so.

MPTS is constituted as an operationally independent entity of the GMC, yet the perception of many doctors – and indeed MPS as a medical defence organisation – can sometimes be quite different. In the past 12 months alone, we have had to raise concerns with the leadership of the MPTS that tribunal members are seen using GMC headed paper to make their case notes during hearings, and that MPTS employees are seen in the hearing rooms wearing GMC branded items. While seemingly minor in of themselves, these visual indicators alongside a shared office location with

the GMC, and the regular secondment of staff, damages the profession's confidence that the MPTS has absolute independence from the GMC.

MPS raises the MPTS as an exemplar. The current Chair of the MPTS has been very receptive to our feedback and we see that procedural improvements are made in response to suggestions. However, our view is that there will always be concerns about the independence of an adjudicator when it is constituted as part of a regulator. If the UK governments do proceed down a path of a single adjudicator for healthcare professional FtP matters, it must create an entity with undisputable separation from the regulators.

Finally, subject to examining any detailed proposals, we would be broadly supportive of a shared online register, for all healthcare professionals, as a means of streamlining the regulatory process.

Question 15: Do you agree that data sharing between healthcare regulators including systems regulators could help identify potential harm earlier?

We very much support this proposal. Regulators already operate under a variety of data sharing arrangements, and as widespread regulatory reform is considered, we would encourage all regulators to publish Memorandums of Understanding (MOUs) between them on this subject. This would enshrine processes, and also aid consistency, as well as transparency. Effective, fully agreed and fully implemented MOUs would be needed to make sure a registrant is not subjected to disproportionate and unnecessary investigations simultaneously by multiple regulators.

Question 16: Do you agree that the regulatory bodies should be given greater flexibility to set their own operating procedures?

Any greater flexibility that regulatory bodies are given over the setting of their operating procedures will have to come with increased safeguards and oversight.

We fully recognise that regulators need greater flexibility to address the ever changing healthcare landscape. Indeed, many of the reforms that MPS have long called for at the GMC and GDC – particularly on FtP matters – have not been possible because of legislative restrictions on their operating procedures.

When a preliminary decision is taken by the governments of the UK as to extent of flexibility that regulators are to be given, a much more detailed discussion will be needed on precisely what form safeguards and oversight functions could take.

There should be requirements, enshrined in legislation, for regulators to conduct meaningful consultations with stakeholders prior to making any changes to their operating procedures. Without this, we would not be able to support regulators being given greater flexibility than they have at present.

Question 17: Do you agree that the regulatory bodies should be more accountable to the Scottish Parliament, the National Assembly for Wales and the Northern Ireland Assembly, in addition to the UK Parliament?

We strongly support this proposal. It is right and proper that the Scottish Parliament, the Welsh Assembly and the Northern Ireland Assembly scrutinise those who regulate healthcare professionals working in the national healthcare services of the UK.

While we note that while the Westminster Parliament has the facility to hold regulators to account, at present it rarely uses this power. The rarity of an accountability hearing of the GMC or GDC before a committee of the House of Commons is regrettable, as it is a missed opportunity to hold these powerful bodies to account for the benefit of patients and registrants.

We recognise however that this is not a matter for Government but for the relevant health committees in the parliaments and assemblies to determine whether to take up this role. A decision by them to do so would be welcome.

It is worth noting that at present there are significant inconsistencies between the healthcare professions as to whether the responsibility for regulation is reserved or devolved. Any review as to how the parliaments and assemblies hold the regulators to account should also consider whether the current relationship between the regulators and the devolved administrations is appropriate.

Question 18: Do you agree that the councils of the regulatory bodies should be changed so that they comprise both non-executive and executive members?

We would not welcome any move to remove professional members from the GMC and GDC councils.

Furthermore, we reject the notion that having 50% of the council made up of members of the profession in some way means that these people serve as the ‘representatives’ of either doctors or dentists, or that this constitutes the ‘vestiges of the old system of self-regulation’. Instead, these people bring considerable expertise to council deliberations, and with correct governance procedures to do so in a way that is right and proper.

In the case of the GMC and GDC, very few members of their current workforce are healthcare professionals. Thus, having such professional perspectives on their councils is highly valuable.

Question 19: 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?

We disagree with this proposal. On one front, the consultation proposes removing the requirement for professionals to sit on the councils of regulatory bodies, but simultaneously, proposes introducing a requirement for an employer representative to be included.

Healthcare employers are regulated by other regulatory bodies, such as the CQC. This should remain the case. There should be a clear separation between employers and individual registrants in the regulation of healthcare professionals. Not to do so would create the potential for conflict of interest questions to arise. This would be unwelcome for all concerned.

Question 20: 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?

Regulatory bodies should not only be asked but be compelled to set out these proposals – both on an initial basis, and then at regular pre-set intervals moving forward. Ensuring that regulators are properly accountable for their work is an important issue for MPS.

For organisations like the GDC and GMC to operate effectively, the profession, the public and government must have confidence in them. Accountability and transparency are both integral to this confidence. On the question of accountability, we believe that the GDC and GMC’s

accountability to the professions they regulate, as well as the public, could be improved as the Department of Health considers the next steps for the regulatory reform proposals.

In our experience, doctors and dental professionals can be frustrated by a lack of information about the service that they should receive, and what they can expect from their regulator. The clearer this can be made, and the more steps taken to make the GMC and GDC truly accountable and transparent, the greater the benefits for all parties.

We would advocate the creation of 'a 'Regulators Charter' to outline a service level agreement, so those regulated know they can expect from their regulator.

The Charter should create a service level agreement between the regulator and the regulated. The Charter should include a specific commitment to allocate a 'named person' at the GDC and GMC to each and every case. This person would be the lead contact for the registrant, throughout the time a matter concerning their practice is before the regulator. In addition, the Charter would specify data that would be published each year, with a view to greater transparency. The data would include but not be restricted to, specific data sets for - the average length of time of an investigation; the number of investigations that last for more than 12 months; the number of cases that last beyond two years.

Within the charter, there should also be a clear commitment about timeframes for investigations and hearings. Being investigated is a difficult time for the registrant(s) involved, so a clear time frame commitment would help support their wellbeing during the process. We suggest there should be an ultimate long-stop period to ensure that no cases are allowed to drag on indefinitely, unless there is a very clear and necessary reason – such as the registrant being seriously ill. At the centre of the Charter, there needs to be a clear recognition on the part of the GDC and GMC of its responsibility to ensure investigations are undertaken in such a way as not to cause further detriment to the health of the registrant.

For this commitment to have weight, a clear and robust method of recourse will need to be available to the registrant. The Regulators' Charter should outline how a registrant can complain when the regulator's commitment to them is not met. The method of recourse envisaged is not one where a doctor or dental professional could complain about regulatory action that was taken against them, but rather the means by which it was done.

We would welcome the opportunity to explore this specific issue with the Department of Health in more detail.

Question 21: 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 believe that any financial savings generated through reforms, must be passed back to the registrant in full. The Executive Summary of the consultation document notes that the days of self-regulation in healthcare are over, yet all registrants of the GMC and the GDC still have to pay to be regulated. The governments of the UK should not lose sight of this fact, and therefore registrants should not pay a penny more than is necessary, and receive a reimbursement from any cost savings made from reform of their regulatory framework.

Question 22: How will the proposed changes affect the costs or benefits for your organisation or those you represent?

At this very early stage in the consultation process, it is not possible for MPS to comment on this question.

Question 23: How will the proposed changes contribute to improved public protection and patient safety (health benefits) and how could this be measured?

MPS has no comment to make on this question.

Question 24: 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?

MPS has no comment to make on this question.

About MPS

The Medical Protection Society Limited (“MPS”) is the world’s leading protection organisation for doctors, dentists and healthcare professionals. We protect and support the professional interests of more than 300,000 members around the world. Membership provides access to expert advice and support together with the right to request indemnity for complaints or claims arising from professional practice.

Our in-house experts assist with the wide range of legal and ethical problems that arise from professional practice. This can include clinical negligence claims, complaints, medical and dental council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal accident inquiries.

Our philosophy is to support safe practice in medicine and dentistry by helping to avert problems in the first place. We do this by promoting risk management through our workshops, E-learning, clinical risk assessments, publications, conferences, lectures and presentations.

We are not an insurance company. All the benefits of membership of are discretionary as set out in the Memorandum of Articles of Association.

CONTACT

Should you require further information about any aspects of our response to this consultation, please do not hesitate to contact me.

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