Department of Health

Promoting professionalism, reforming regulation

Questionnaire

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1. Summary of the questions

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?

Response:

While the GDC would support this proposal at the level of very broad principle, there are a number of issues and concerns that need further work to resolve. They include, for example:

- While we have a great deal of confidence in the PSA, it is difficult to see how it will have access to the necessary data and, more importantly, soft intelligence in relation to individual professional services and settings to be able to provide advice of this nature effectively without duplicating the expertise and activity that should already be resident in individual regulators. This may be particularly marked when seeking to attribute 'risk' appropriately to different registrant groups. Within dentistry, our understanding of the differing risks between dentist and dental care professional groups has only recently matured to the point where it is capable of influencing our work streams effectively. This exercise may be even more challenging for an organisation that was also seeking to understand and allocate risk arising from a much larger collection of widely differing registrant groups from other professions.

- The proposals do, of course, refer to the PSA working with relevant stakeholders, which presumably include the regulators. We think this needs to be strengthened by requiring that the PSA's advice in relation to any particular professional grouping is agreed with, and sets out clearly the views of, the relevant regulator.

- If the PSA is to take on this role, it will need to become more visible and, arguably, answerable to the healthcare professionals on whom it has an impact. In dentistry at least, there seems to be a limited understanding of the PSA's role and the influence that it has over the regulatory regimes that are in place. In making this point we infer no criticism of the PSA. We know how hard it can be to reach individual professionals who may often be working in quite isolated circumstances, and where the ability of membership organisations to act as effective communication channels is being limited by declining membership and, in some cases, political considerations.

- In a similar vein, it is not currently the PSA's main role to reach the public directly. Even if the PSA's role were to shift in the way described, it may still be at some distance from service users.

- In addition, we would encourage the consideration of mechanisms to manage the potential conflict of interest arising from the PSA adopting the advisory role described. At present, the PSA is funded in part by a levy on regulators determined largely by the size of their registers. It is important to recognise and manage perceptions around this position when deciding on which professional groupings move in and out of regulation.

- While not a matter of great substance, we would like to make the point that the suggestion at paragraph 2.2, using the example of the HCPC, that healthcare regulators might pursue expansion of regulation out of self-interest, is both flawed and unhelpful. It is flawed in the sense that, given that regulation of new groups imposes costs and complexity that it may not be possible to recover fully through fees, *avoidance* of

expansion may be as logical a behaviour as pursuit of it. It is unhelpful in that it fails to recognise how far the regulators have moved from the historic self-regulatory models. The time has come, we suggest, to recognise that the welcome reforms of the last two decades have gone a long way towards delivering, by and large, public interest regulators acting in the public interest (and not self-interest).

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?

Response:

- The PSA's view of harm and risk may vary in relevance and perspective according to the service being provided: for understandable reasons, the PSA has tended to focus on manifestations of harm and vulnerability that are directly linked to health. In some settings, including dentistry, while health-related harm and vulnerability are clearly very important, there are other forms of harm – for example financial harm – that may arise from the fact that for most people dental treatment is not free at the point of use. This transactional relationship influences behaviours and can exacerbate the effects of "information asymmetry" between the patient and the provider. Any criteria adopted will need to reflect this factor.

- On a related point, while the PSA's criteria, as set out in the consultation document, are at first analysis sensible and logical, we see two issues:

    - They may need further development and testing to ensure that they deliver results in the public interest

    - They are, for obvious reasons focused on the constraints that regulation imposes.

- In fact, one of the natural conclusions of the consultation document, and one that is of course reflected in its title "promoting professionalism" is that regulation, sensibly deployed, offers opportunities to set out and promote models of professionalism to which healthcare professionals can actively and positively aspire, and that this might deliver better public protection confidence than the existing reactive, sanction-based regime. As we argue in Shifting the Balance, regulation is a very broad concept and consists of a wide range of mechanisms intended to influence behaviour. We also argue that regulation should start with engagement designed to achieve shared outcomes. Any criteria designed to support decision making in this area will benefit, we suggest, from building in very clearly this arguably more positive, outcomes focused, approach to regulation.

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?

Response:

In theory, if new common criteria were to be adopted for the assessment of regulatory status then it is a perfectly logical conclusion that they should be applied to groups already subject to regulation. However, in practical terms, we would suggest that such an exercise can only really be meaningful in the context of realistic legislative opportunities to effect any change that might be necessary as a result.

In addition, from the point of view of the GDC, dentistry is currently undergoing a radical transformation in training alongside a discussion to determine what sort of dental workforce would be appropriate for the future. It will be important to ensure that decisions about regulated status of any particular grouping are seen in the context of workforce planning, and that they are transparent and based on evidence.

Finally, while all decisions on regulatory decision making must be made clearly in the public interest, it is important to recognise that the transfer of groups in and out of regulation is likely to have an impact on the distribution of costs and effort within the system. Care will need to be taken to explain that impact to some groups of registrants (who may, for example, find themselves paying a larger share of fixed costs) and to ensure that the capability of individual regulators to deliver their public protection responsibilities is not compromised (for example by ensuring suitable transitional arrangements).

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

Response:

In the GDC's view, there are more significant priorities to which scarce policy and legislative resources could be devoted. There are a number of reasons for taking this view:

- The prohibition order is essentially a version of the fitness-to-practise without the supporting framework of a register, and as such the public protection benefits must be questionable.

- They are essentially a reactive mechanism, likely to be imposed *after* public exposure, and potentially harm, has already taken place. The proposal is based on what is arguably a false choice between "statutory regulation" and alternative mechanisms, when, as we argue in *Shifting the Balance*, the real choice is between the reliance placed on upstream measures and downstream enforcement. Prohibition orders are for all intents and purposes a further downstream enforcement tool and investing in their development appears to run counter to the direction of travel of the broader consultation proposals

- The proposals are likely to be unworkable in practice because of the bureaucracy involved in issuing, monitoring and, where it becomes necessary, enforcing the orders. On this last point, we know from experience with, for example, the illegal practice of dentistry, that the prosecuting authorities often find it hard to prioritise action in this area above the obvious competing demands of what most people would likely classify as more significant criminal activity.

- They may well be open to legal challenge on a broader range of grounds than FTP sanctions.

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

Response:

We agree that there is a case for exploring a reduction in the number of regulatory bodies. In doing so we would make the point, however, that it is possible to become distracted by a focus on regulatory structures. As is the case in professional healthcare regulation, the assumption that it is possible to start with a blank page is a deceptively simple one to make, and usually false – and experience suggests that the opportunity cost of focusing on structures is often paid

in operational performance in the short to medium term. So there have to be very significant long-term benefits to make this sort of fundamental structural change worth the effort.

That is not an argument, however, for not considering the question seriously, and we certainly do not advocate the preservation of the GDC or any other individual body for its own sake. Indeed, there is no overwhelming case for the historical compartmentalisation of professional regulation into separate bodies to continue at all and there are perfectly rational alternative models that would combine the regulation of services, delivery organisations and healthcare professionals more holistically.

However, there are two over-arching points to make as part of any such exploration:

- It does not follow that a reduction in the number of regulatory bodies will make the system any clearer, fairer or more effective. Without fundamental reform of the regulatory system to delivery greater agility of response and support efforts to remove the existing disproportionate reliance on reactive enforcement action at the expense of promotion of professionalism in the public interest, reduction in numbers of regulatory bodies is likely to have a very limited impact in terms of effectiveness. Even a reduction to a single body would struggle to deliver meaningful benefits if it is required to operate within the constraints, flaws and anachronisms of the existing statutory framework.

- While reduction in numbers may deliver some savings (albeit likely to be more modest than the consultation paper tends to imply), the more important criteria for decision making in this area are those that relate to the interests of the public and patients.

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

Response:

It is perhaps more useful to think in terms of the strengths and weakness that a smaller number of larger bodies may possess in comparison to a larger number of smaller ones.

Larger bodies may well deliver some economies of scale, for example in terms of leadership and other staff costs and enabling systems and services like IT. However, it is important to recognise that this is likely to be accompanied by significant implementation costs (including opportunity costs in terms of e.g. senior leadership time).

Having a smaller number of larger bodies may also provide, as the consultation paper suggests, some additional clarity for the public (including patients, employers etc) in some areas of healthcare in terms of who to contact. However, it is important to recognise two key points here.

First, the professional healthcare regulator will not always be (and indeed may not often be) the body with the most effective and proportionate tools to deal with issues that might arise.

Second, the professional healthcare regulators are far from being the only bodies with whom the public might raise issues and simply reducing their number might therefore have comparatively little effect. Our research with patients has indicated that, in dentistry at least, the public tend not to be confused about whether to approach the GDC or another professional regulator: their choice is between the professional healthcare regulator, system regulator, NHS body, Ombudsman, personal injury law firm, Citizens' Advice, Healthwatch or similar body, private dental plan provider, corporate dental business, the local MP and other potential routes. While some progress has been made (in England) by the CQC (whose initiative is to be commended in this respect), GDC and NHS England to remove some of this confusion, the work is far from complete.

We would suggest that the remedy to this specific problem lies not first and foremost in reducing the number of professional regulators (although one might do that for other reasons), but in:

- making clearer their role in dealing directly with the most serious issues – the issues that tend to indicate that a professional is not safe to provide services to the public unmitigated.

- providing them with greater scope to refer less serious issues to other bodies who possess more proportionate and effective tools to deal with them (including in many circumstances, the practice itself).

On the other hand, smaller bodies with a tighter focus on particular professional groupings may offer deeper insights into the often very complex range of influences over behaviour of healthcare professionals in particular environments. If, as we argue in *Shifting the Balance*, effective regulation relies on a degree of understanding of how those influences combine and may be mitigated or indeed harnessed to work better "with the grain" of professional practise in the public interest, it seems to us essential that this capability must remain available to a larger regulator. Indeed, there is a parallel point that larger multi-profession regulators would need to develop a significant infrastructure of specialist advisory committees and staff (or similar mechanisms), to develop the detailed understanding necessary to effective regulation.

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

Response:

As we argue above, while we are neither for or against any specific future configuration, we would make the following headline points:

- there are likely to be several different plausible models, each with variants.

- none is likely to be a neat solution (and indeed the current configuration can give rise to its own idiosyncrasies).

- the primary consideration of any future configuration should be what is best for the public and patients

It is also important to recognise that there will be a wide range of views on this matter, driven by a similarly wide range of, in our view, less important considerations. For example, the perceived status that comes with being regulated alongside (or indeed apart from) particular professional groupings is likely to feature in the deliberations on this topic: in our view issues of status should be given little priority, although we appreciate this may be received as a controversial view by some.

Linked to this point is the need to address the issue from the point of view of the patient, both as a recipient of healthcare and as a *consumer* of services that are not, in some important sectors, generally free at the point of use. While again we appreciate it may be a somewhat controversial view, this feature may be as significant a factor in the patient experience as the quality of the healthcare itself. This may suggest configurations that distinguish – admittedly very broadly – the "free at the point of use" model that characterises most people's experience of healthcare in terms of the visit to the NHS GP and referral to secondary care, from the "high street" services, paid for directly, that will be instantly recognisable to the public in relation to dentistry, optics and pharmacy. This may become even more relevant in dentistry because of the relatively high proportion of elective treatment, and as the share of provision delivered through large dental "corporates" continues to increase.

There is an additional point of distinction that comes into play here. Broadly speaking, clinical governance tends to be considerably stronger in relation to the first model than it is in relation to "high street" provision, including dentistry, a point we make in *Shifting the Balance*. That means that in the first model, the regulator(s) may expect to rely on clinical governance systems to deal with a significant proportion of issues early on that might otherwise have become more serious. In turn, that might enable different approaches to regulation (and therefore mitigate in favour of grouping those services that tend to be characterised by stronger clinical governance systems into a single regulator).

On the other hand, the "high street" services, and the corresponding regulators cannot rely to the same extent on clinical governance, at least public forms of clinical governance, and may benefit from options to pursue regulatory outcomes through a greater focus on regulating the businesses that provide those services, which may suggest a sensible grouping along those lines.

We should make the point, as above, that no solution is likely to be wholly satisfactory (although nor is the current one). For example, while the "high street"/clinical governance model may well suggest solutions that map on to many people's perceptions of dentistry it is important to recognise, for example, that some dentistry is provided in a secondary care setting within stronger clinical governance frameworks, and that many people still benefit from free dental care.

Finally, we consider it of enormous benefit in dentistry to be able to focus on the professions that comprise the whole dental team. Arguably there is even more benefit to be drawn from the growing maturity and professional stature of the non-dentist professional groupings and this might have significant benefits for patient care and, importantly, access to services.

It is possible to make the argument that the team-based system deployed in dentistry, where the team learns and shares and has a common set of standards regardless of specialty or area, has advantages over the regulatory approach in, for example, medicine, particularly where patients may be under the care of multiple specialties. The advantages in regulating a team are even more obvious from the point of view of the patient, who can expect all professionals in the team delivering their care to be working from a shared value base that reflects their unique relationship. For example, a social worker interacts and thinks very differently with a patient (or client) than a dental professional. Their point of intersection is very different: setting, patient circumstances, vulnerability, risk assessment etc and that is reflected in their education, values base and standards. Seen from this 'patient pathway' perspective there are a number of regulators already taking this approach, eg the GDC, GOC and the Northern Ireland and Scotland Social Care regulators. We strongly encourage this form of team-wide regulation to be preserved and indeed extended.

The creation of a single regulator for all healthcare professions might mean that groups such as dental care professionals, numbering around 60,000 registrants might receive less attention than is currently the case or indeed is appropriate. Winding up the GDC and splitting the regulation of dentistry across two or three regulators would mean that the benefits of a single regulator responsible for the whole dental care team would be lost.

There is an argument for applying the single regulator model of dentistry to other healthcare groups and having, say, a single regulator for hospital-based groups, another for community-based groups etc.

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

Response:

We agree strongly. Much of our thinking on this point is contained in *Shifting the Balance* and that should be seen as our primary reference. However, we would simply bring out the point that risks and issues present themselves in a very wide range of manifestations that are simply not matched by the options available to the regulator, and it is no longer necessary or indeed sensible to seek to prescribe complex regulatory processes in primary legislation. In many other spheres of regulation, the primary legislation is used to set out the statutory objectives of regulation and mechanisms to ensure public accountability of the regulatory body, with considerably greater flexibility – subject to suitable transparency requirements for example statutory requirements to consult – to set its own policies in relation to compliance and enforcement. This is at the heart of most modern regulatory systems in the UK but is not the case in professional healthcare regulation.

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

Response:

Again, our view on this matter is contained in *Shifting the Balance* and reflects the points set out in answer to question 8. The delivery of healthcare is complex and gives rise to complex issues that demand a sophisticated and flexible response on the part of systems and bodies established to deal with those issues.

The current toolkit operated by professional healthcare regulators tends to be (and in the case of the GDC certainly is) too binary to offer that sophistication. The FTP system is designed to manage very serious risk and offers correspondingly serious interventions based on restricting or removing altogether the ability of professionals to interact with patients (and the consequential restriction or loss of livelihood).

While these tools are and will continue to be necessary in some cases, they are not appropriate mechanisms for dealing with many of the less serious issues that arise. In some ways, a question about the role of mediation in the *fitness to practise* process is somewhat misplaced; the system should be capable of distinguishing much more clearly between degrees of seriousness. Mediation is less likely to be appropriate in cases of serious risk and harm – the ones on which FTP investigations and prosecutions should be focused – and more appropriate in more ordinary complaint resolution. This illustrates a central issue with current arrangements: it does not distinguish well enough between complaints *prosecution* (through FTP) and *resolution*, and as a result there is a tendency to apply a single set of processes – FTP – to both, often with sub-optimal results for all concerned, including patients.

So, we think that mediation – starting with skilled complaints handling in the practice – has a huge part to play in building public confidence in healthcare professions in the context of every day complaints *resolution*. Indeed, we have adopted a version of mediated resolution, with some success, in the form of the establishment and operation of the Dental Complaints Service. However, we would argue that it has less scope for deployment in FTP investigations and prosecutions, which should be clearly reserved for those matters so serious that restriction of practise is a serious option.

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

Response:

In the GDC’s view, there are two questions to be addressed here:

- To what extent should the PSA's standards (or rather assessment of performance of standards) focus on the measurement of detailed operational processes.

- Given that the PSA's standards, and its approach to assessment of performance, has a significant impact on the behaviour of individual regulators, how might they best be deployed to deliver the desired policy and regulatory outcomes?

In relation to the first of these questions, the PSA's historical approach to assessing the performance of regulators has, for perfectly valid reasons, tended to focus on the detailed measurement of operational processes, particularly FTP processes. Given the history of regulation in this area – essentially a transition from "self-regulation" of professions by the professions themselves to "public interest regulation" by bodies operating on behalf of society – it should not be surprising that oversight mechanisms should have focused, at least at the beginning of that transition, on ensuring that the bodies concerned had the right focus at a detailed level.

In the GDC's own case, this approach has in the past highlighted some quite serious shortcomings that we have worked very hard to address (although it must be said that the operational challenges thrown up by antique legislation will continue to be a major source of concern, effort and cost).

However, we think the time has now come for public policy frameworks to recognise that the transition from self-regulation to public interest regulation has now proceeded to the extent that it is broadly secure, and indeed irreversible; and that means a shift in emphasis away from the detailed checking of the work inherent in current approaches, to one that is much more focused on helping regulators understand better the extent to which broader regulatory outcomes are being achieved. Such an approach would need to be based on a partnership between the PSA and individual regulators, one in which the PSA acted as a critical friend to the regulators, with a recognition that the goals we pursue are shared.

On the second question, a major theme of *Shifting the Balance* is that while modern regulation is a very broad concept, in professional healthcare regulation we have collectively allowed "regulation" to become synonymous with "enforcement", that is FTP investigations and prosecutions. That is at the heart of the enormous inefficiencies we face across the sphere – because we have collectively confused "regulation" with "enforcement", we expend disproportionate amounts of effort on enforcement, which is costly and counterproductive.

That is why we are arguing for a greater recognition– that regulation will be more effective if it is viewed broadly as a collection of activities designed to influence behaviour: and that it is just as important, indeed probably more important, to promote an inspiring vision of professionalism in the public interest, as it is to prosecute those who fall seriously below this vision.

The natural conclusion of this argument is that the PSA standards, and performance assessment, would be likely to serve the public better if it focused more on "upstream" regulation: the ability to influence behaviour, the quality of the model of professionalism and its promotion, the use of educational powers to the best effect and so on. This does not mean moving away from an assessment of FTP altogether – but it does mean positioning it as one tool, and one to be deployed largely when other mechanisms have failed. But we can see important and exciting opportunities for the PSA's oversight arrangements to help deliver macro regulatory outcomes, for example in asking questions about how well the public is protected by the regulatory approaches being operated, their legality, and their financial and operational sustainability.

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?

Response:

The regulators deal with large numbers of cases, and the outcomes are decided as a matter of judgment by independent panels. As with, broadly speaking, other judicial or quasi-judicial systems, while most decisions will be within a range of reasonable outcomes, from time to time there will be outliers. It is therefore clearly sensible to have mechanisms in place to identify and rectify those outliers.

However, the GDC would raise a serious question about whether the current system is the most effective way of achieving this outcome. This is largely because it is essentially adversarial *from the outset* and can result in counter-productive behaviours on both sides that may not in fact be in the best interests of patients. As the PSA have suggested, compellingly, such adversarial approaches in FTP prosecutions need to be rethought, and we see no reason why that principle should not be extended to the oversight mechanisms operated by the PSA.

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?

Response:

Shifting the Balance sets out a vision for regulation that is based on promoting a compelling model of professionalism and fostering the leadership and partnership behaviours necessary to deliver against it. Please refer to that document in relation to this response.

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

Response:

There is a need in answering this question to get beyond the somewhat superficial notion that regulators should work together for its own sake. It is important, we suggest, to try to understand why sufficient joint working may not be happening already. And in doing so it is also important to recognise the large amount of collaboration, discussion, and liaison that happens between regulators at operational level all the time).

For all their strengths and weaknesses, the professional healthcare regulators are, broadly speaking, seeking to deliver their objectives (statutory or otherwise) in the best and most rational way. As one would expect, particularly in challenging environments, the behaviours that are observed are likely to be a result of organisations operating rationally within the policy and governance frameworks they find themselves in, all else being equal. If – and it is by no means certain – that is resulting in insufficient joint working, it becomes important to understand what it is about those policy and governance frameworks that is failing to incentivise (or indeed is penalising) joint working.

In relation to professional healthcare regulation, our statutory frameworks do not facilitate joint working, largely because they are focused on the professions regulated by individual organisations. It is true of course that as a result of the changes effected by the Health and Social Care (Safety and Quality) Act 2015, the regulators now have shared objectives based around public protection and promoting public confidence. It is equally true that these objectives are very broad and leave a great deal of discretion to regulators to devise their own delivery programmes, including through joint work. However, funding mechanisms remain very focused on the individual professions and that is often likely to be part of the thinking when deciding whether to commit resource to joint working. It is difficult to see any alternative to that.

There are also some penalties to joint working. For example, the classification for tax purposes of some regulators as “membership organisations” (which of course they no longer are) means that VAT can be a barrier to the development of shared service initiatives. In short, the benefits of joint working can be eroded by the additional costs incurred and this can be very difficult for accounting officers to justify. This is particularly important given that the regulators must cover additional costs through fees – it means that some forms of joint working may involve additional abortive costs for registrants.

Finally, while there is an active exchange of information and ideas between professional healthcare regulators (and we must not lose sight of the PSA’s valuable policy development and research work as one stimulus in this respect), there is much less such exchange between healthcare regulation and other sectors, and this may be a missed opportunity.

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?

Response:

Online portal to access registration information

In relation to a single online portal to access registration information, there are two points to make. The first is that we are not encountering any significant public concern about ease of access to registration information in relation to registered dental professionals. The second and perhaps more important point is that the most significant public protection value to be derived from the register lies, we would argue, in the standards that need to be met in order to secure and maintain a place on the relevant register. The fact that in order to be registered an individual must demonstrate possession of appropriate skills, that they are of good character, that they are indemnified and that they are investing in their ongoing development, is a benefit that goes far beyond the appearance of names on a list. Given that access to the register does not appear to be an issue, in dentistry at least, the value to be added by a single online portal still has to be defined in order to make a compelling case.

Single set of generic standards

The development of a single set of generic standards, in principle at least, ought to be a relatively straightforward task. However, as we argue in *Shifting the Balance*, the approach to professional healthcare regulation, particularly in relation to standards, has relied too heavily on publishing what are in effect books of rules. We argue that this approach needs to be developed significantly to encompass the design and – critically – *promotion* of a compelling model of professionalism in the public interest. We see a key role for the regulator in brokering consensus about that model of professionalism, working with others to embed it at all stages of a professional’s career (starting with pre-qualification training). Without this shift in emphasis, any generic standards that are developed are likely to suffer from the limited traction that our existing separate standards face.

A single adjudicator

We support this proposal very strongly. It has to be in the interests of natural justice to create a degree of separation between investigation and adjudication. It seems to us to be a logical and ultimately inescapable end point of the journey from self-regulation of the profession by the profession to independent regulation in the public interest. We would make the point also, that the arguments put forward to support the creation of a single regulator, in terms of savings of cost and reductions in complexity for the public, must also apply to a single adjudicator.

A single organisation providing back office services

While we can certainly agree with the idea that generating economies of scale in "enabling services" like HR and IT, the assertion that this might best be done by investing those responsibilities in a single organisation does not appear to be supported by the analysis. We would suggest that those efficiencies should be driven by the regulators themselves as they look to secure the best possible value for fee income generated: and in this respect it is important to recognise that a considerable volume of enabling services are already provided through third parties.

There may be learning to be derived from experience in the local authority sector of pursuing similar initiatives.

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

Response:

Yes. We agree strongly with this proposal. However, it is important to recognise that the fact that this does not happen sufficiently is driven by the inadequacies of the legislative framework. Existing statute is built on a model of pursuing individual investigations and prosecutions against individual registrants for what are largely individual failings, and to do so after those failings have occurred. It provides very little scope for a risk-based, preventative approach to regulation based on a picture of a registrant in the round, and very little discretion over decisions as to when a concern, or concerns, should translate into action to restrict practice or otherwise limit risk.

These constraints on discretion may have been more appropriate under the self-regulatory arrangements of the past, when there would have been a legitimate concern about over-leniency or other conflicts of interest. However, we argue that the time has come to recognise how far along the road towards public interest regulation we have come and to ensure that is reflected in the legislative framework.

This may take the form put forward in, amongst other sources, Dr Chris Hodges' work in connection with the Government's own Regulatory Futures work, which focuses on the early identification of harm, including poor practice, quickly and pro-actively rather than waiting for others to report it. While there will clearly always be the need for processes with some elements of litigation, particularly for serious cases in which the only real remedy is significant restriction of practise, the real challenge for regulators of professions is to spot poor practice early, when it is still capable of being addressed through more supportive interventions, rather than respond reactively when the problem has become so severe that actual harm has occurred. This approach may open up questions of the role that "big data" might play. In such a future, the key for regulators and policy makers would be building different capacity and technical knowledge to use data – often data generated by others – effectively. And this will depend on multiple relationships of trust and confidence (including confidence in the regulator that it is capable of holding and deploying data competently and in the public interest).

In summary, if efforts to share data and intelligence have not made as much progress as desired, this is largely because the somewhat antiquated approach to regulation enshrined in legislation does not support a clear need, and therefore appetite, to go further. A modern and genuinely risk-based approach, on the other hand, would depend on effective intelligence and data collection and analytical capabilities: but would in turn depend on finding ways to change the statutory framework.

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

Response:

Yes. As we argue in response to question 8 above, it seems to us that professional healthcare regulation has been left far behind by modern regulatory thinking. A feature of regulation across large swathes of economic life in the UK is that the regulator has a considerably wider margin of appreciation and flexibility to set its own procedures, counterbalanced by considerably strengthened checks and balances designed to deliver public accountability (and not necessarily delivered by an oversight body, but perhaps through an architecture more akin to the framework of the statutory regulators' code, Hampton and McCrory principles, as enshrined in the Enterprise Act that has been effective in other spheres).

We think the time has come to consider seriously how to reflect that model in professional healthcare regulation.

In practical terms, this might mean restricting the use of primary legislation to establish purposes, regulatory objectives, powers and accountability mechanisms (such as statutory requirements to consult and publish). Secondary legislation would be used *minimally* to specify provisions in areas where the regulator's discretion should be limited (largely in support of national policy objectives). Much of the detail of operating principles and procedures would be expressed in tertiary legislation developed by the regulator in meaningful (and mandatory) consultation with stakeholders, in the form of statements of principles, codes of practice etc.

Such an approach is likely to improve the capability of the regulators to protect the public by taking advantage of emerging developments that improve our understanding of the most effective interventions. For example, there is a growing body of evidence, of the important of "human factors" in healthcare failures, and of the distinction between performance and competence. Under the current structures, the ability of the regulators to adapt is heavily constrained by the legislative framework and we consider this to be to the public's detriment.

As an important caveat, it is important to bear in mind that transition to this or similar models cannot be considered in isolation: it would need to be part of wholesale reform, and we of course appreciate the challenges in delivering that in the current climate. As an example, such a model becomes much more realistic if it is accompanied by the separation of adjudication into a separate body, with an effective route of appeal.

As a coda, we would like to set out our view that concepts of "autonomy" in relation to this question seem to us to miss the point. We quite agree that there should be suitable checks and balances to ensure that regulators are focused on delivering regulatory outcomes. What we are arguing for is greater responsibility for designing and operating the detail of the regulatory approach, coupled with the right checks and balances to ensure delivery of regulatory outcomes in the public interest. That is not the same, in our view, as autonomy.

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?

Response:

We support the idea that there should be mechanisms in place to provide for a relationship of informal accountability between regulatory bodies and Parliaments in the nations served. Equally important, however, is the need to develop and maintain an appropriate understanding of the conditions and concerns prevailing in the nations and regions, and their implications for regulation. And while we recognise that each nation and indeed region will have different

priorities, overall public accountability is likely to be served best by a single set of requirements against which regulators can be held accountable.

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?

Response:

No. We consider this question to be somewhat less important that some of the other issues raised by the consultation, and in some ways a distraction. Both two-tier and unitary boards are capable of operating effectively (and it should be added that they are not the only governance models in existence). What matters more is that the organisation has a clear purpose embedded throughout the organisation, and that executives and non-executives are focused on working together constructively to deliver those purposes, in line with accepted principles of modern corporate governance. Extending this argument, the time has probably come to reconsider the use of the term “Council”, which, we suggest is less relevant and appropriate now that it may have been in the self-regulatory past. At the GDC we have been adopting approaches to organisational governance that are more aligned to the concept of the modern board that would be recognisable across other parts of the public and private sector (taking care, of course, to ensure that those approaches are conducive to sustained standards of governance and accountability).

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?

Response:

We agree that it is essential that the regulatory bodies have access to all the views and information necessary to regulate effectively, including those of employers where relevant. However, we would seriously question whether the most effective way to secure that access is to appoint Council members to “represent” particular views. Even from a purely practical point of view, the healthcare landscape is so complex that this aim would be more or less impossible to achieve: and if even if one succeeded, the necessary focus on public protection and confidence is likely to be compromised significantly.

There is a very wide range of alternative mechanisms to provide access to this information with varying degrees of structure, including requirements to consult specific groups, focused survey research, planned stakeholder engagement, the establishment of interest-specific panels etc, many of which are already a feature of the landscape in this and other sectors.

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?

Response:

The proposals in the consultation document may benefit from some further development to support a full response. However, our initial view is that we agree that professional healthcare regulators play a key role in ensuring that the individual professionals that make up the healthcare workforce are appropriately trained and fit to practise. However, it is not the role of regulators to produce professionals of any sort. That is a role for society more widely, led by Government: making decisions about the broader framework of demand and supply of healthcare professionals to deliver the volume and quality of services considered necessary and/or desirable, and the system of incentives and disincentives that contribute to achieving that objective (recognising that regulation is one part of that often complex picture).

Furthermore, under current arrangements the regulators are simply not equipped to be the central decision makers in relation to workforce matters of this nature. And there is an

implication inherent in the question that role of the existing national workforce planning and delivery bodies would be replaced by multiple, narrow, sectoral functions. We would argue that this is likely to run counter to the policy objectives suggested in other parts of the consultation in relation to larger bodies being more efficient.

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?

Response:

We do not think it is helpful to pose this as a binary question, as that suggests that the two are mutually exclusive. As we argue in *Shifting the Balance*, investment in upstream measures, designed to get ahead of harm and therefore reduce reliance on often costly enforcement action, has the potential to deliver better cost-effectiveness across the system.

Alongside mandatory functions set out in their legislation, regulators will have considerable discretion in how they achieve their statutory objectives, including the implementation of "upstream" measures to promote and support professionalism. Their programmes of work must be designed to ensure that they are meeting their statutory objectives, and the income they raise from fees must therefore be sufficient to meet the cost of those programmes. They also have a duty to their registrants to minimise the burden on them and ensure value for money. This should be done by identifying and seeking efficiencies wherever possible.

Regulators also need to have the ability, within an appropriate accountability framework, to manage their finances effectively, and ensure their own sustainability. There will therefore be calls on fee income that do not relate to upstream activity that nevertheless prevent a reduction in fees for registrants.

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.

Response:

It is not possible to make a meaningful estimate at this stage. Some of the proposals, eg prohibition orders, are likely to increase costs. Some – eg greater flexibility accompanied by strengthened public accountability – may act to decrease costs.

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

Response:

Our views on this question are set out in *Shifting the Balance.* Pursuing a model of regulation that incorporates upstream measures to reduce risk and prevent harm before it happens and reduces reliance on enforcement action after harm has been done appears to offer significant benefits in terms of public protection and confidence.

Benefits mapping and measurement is likely to require some sophistication and granularity of approach, incorporating, for example, survey research, qualitative study and data analysis.

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?

Response:

Depending on how they are deployed, the proposals have the potential to support the achievement of the listed aims. For example, establishing a model of regulation much more firmly founded on promoting professionalism to build public confidence in the services being delivered might contribute to a better understanding of the impact of particular behaviours on the confidence of particular groups e.g. those sharing a relevant protected characteristic. In another example, the increased reliance on data and evidence likely to be a key part of new regulatory models may help expose issues to be addressed, as they have in relation to the GDC's own recent publication of fitness to practise data analysis.

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?

Response: